Ref: S&C-02-40

DATE: **July 2, 2002**

FROM: Director
            Survey and Certification Group, CMSO

SUBJECT: Fiscal Year (FY) 2003 State Survey and Certification Budget Call Letter—
            ACTION

TO: State Agency Directors

The purpose of this memorandum is to provide state agencies (SAs) with the program requirements and budget guidelines to be used for the FY 2003 survey and certification budget process.

Overview of the FY 2003 President's Budget

The President's FY 2003 Medicare state survey and certification budget request would make available $202,400,000 to the states for Medicare total direct survey expenditures and an additional $25,040,000 for Nursing Home Oversight Improvement Program (NHOIP) activities. The budget also requests $8,218,000 for support contracts. At this time, the Congress is currently considering the FY 2003 President's budget. **Final funding levels for FY 2003 will be based upon the final appropriation**, however, states should immediately begin their FY 2003 planning and submit their FY 2003 budget requests based upon the FY 2003 President's budget. Consistent with the FY 2002 budget process, the Centers for Medicare and Medicaid Services (CMS) remains committed to providing FY 2003 Medicare survey and certification budget allocations to SAs as early in the fiscal year as possible.

The level of Federal matching payments for Medicaid survey activity has been targeted at $228,600,000. SAs should ensure that they have made adequate provisions for obtaining the necessary Medicaid state share of survey and certification activities.

Overview of the FY 2003 Budget Process

For FY 2003, SAs will prepare budget requests based on FY 2003 workload priorities. To assist SAs in this effort, we have we have outlined the FY 2003 President's budget in Tab A of this memorandum and included in Tab A, the FY 2003 priority ranking of state workload. This year,

we have prioritized the Survey and Certification workload into four Tiers. The four Tiers reflect statutory mandates and program emphases. Tier I includes legislatively mandated workload and as such, is considered top priority. States must assure that Tier I will be completed before Tier II work is begun. Similarly, states must assure that Tier II work will be completed before Tier III work is begun. The same policy applies for Tiers III and IV. States are instructed to prioritize workloads within each Tier.

SAs should use the priority ranking of state workload to begin planning for FY 2003 survey and certification activities and use current FY 2002 funding levels as a basis for projecting FY 2003 funding requirements as SAs develop FY 2003 budget requests. SAs should submit budget requests to Central Office and Regional offices **by August 2, 2002**.

SAs should identify in their FY 2003 budget requests, if they currently maintain a toll-free line for nursing homes to receive complaints and/or answer questions regarding nursing home certification requirements. If a SA does maintain a toll-free line for nursing homes, please indicate the approximate cost associated with its operation in your budget request package.

This year, in order to ensure the essential participation of states in meetings, such as the October 2002 ESRD conference, we will be retaining a pool of funds to provide assistance with state travel costs, to those states with documented needs.

Regional offices will analyze SA budget requests and discuss workload projections, related budget requirements, and expenditure computations so that a mutually understood funding level may be worked out that addresses all the workload requirements. Regional offices should also review state budget requests in light of historical workload and expenditure information.

The Regional Offices will provide a recommendation memorandum to Central Office on your state budget request that details the Region's proposed action on that budget request. Once Central Office has received and reviewed all state requests and Regional Office budget recommendations and has received the final FY 2003 appropriation amounts, Central Office will provide final budget approvals for each state.

As in prior years, SAs should submit all budget request documents and supporting narratives and schedules to Regions and Central Office via **e-mail** in order to facilitate the transmission and review of those documents. Given the amount of information being exchanged and the time frames detailed below, we request that you not forward information in hardcopy or via fax. Budget request packages e-mailed to Central Office should be addressed to smaccarroll@cms.hhs.gov, jhackenberg@cms.hhs.gov or ncastro2@cms.hhs.gov.

Regarding the automated Survey and Certification reporting system, states will be required to complete the required budget documentation in the automated reporting system <u>following receipt of the final FY 2003 budget approval amounts from central office</u>. SAs should not submit budget request documents in response to this memorandum via the automated reporting system.

Key Dates For FY 2003 Budget Submission
The process that will be used for FY 2002 follows:

(1)   No later than **July 5** Central Office issues FY 2003 budget call letter to Regions and SAs.

(2)   No later than **August 2** states submit FY 2003 budget request to Regions and simultaneously e-mail a copy of the FY 2003 budget request to one of the following central office staff: Sean MacCarroll (smaccarroll@cms.hhs.gov), Jim Hackenberg (jhackenberg@cms.hhs.gov) or Nora Castro (ncastro2@cms.hhs.gov).

(3)   Regions submit FY 2003 Regional Office budget decision recommendations to Central Office.

(4)   No later than **September 30**, or upon enactment of the FY 2003 appropriation, which ever is later, Central Office approves final budget levels for states. In the event that an appropriation is not passed at the beginning of the fiscal year, states will be funded in accordance with the terms of the continuing resolution(s) that the Congress usually enacts until such time as the full appropriation is enacted.

Attached to this memorandum are the following documents:

Tab A -- FY 2003 Program Requirements and Budget Guidelines
Tab B -- FY 2003 Proposed Schedule of Training Courses
Tab C -- FY 2003 General Budget Formulation Guidelines
          Attachment 1 -- Form CMS-434, Excel File
          Attachment 2 -- Form CMS-435, Excel File
          Attachment 3 -- Nursing Home Oversight Improvement Program (NHOIP) Request
                     Form, Excel File

Thank you in advance for your assistance. If you have any questions please call Todd Lawson on 410-786-5366 or have your staff contact Sean MacCarroll on 410-786-6660 or Jim Hackenberg on 410-786-9325 or Nora Castro on 410-786-3498.

/s/

Steven A. Pelovitz

Attachments

cc: Associate Regional Administrator, DMSO
        CMS Regional Budget Contacts

Ref: S&C-02-40

DATE: **July 2, 2002**

FROM: Director
          Survey and Certification Group, CMSO

SUBJECT: Fiscal Year (FY) 2003 State Survey and Certification Budget Call Letter—
          ACTION

TO: Regional Administrators

The purpose of this memorandum is to provide regions with the program requirements and budget guidelines to be used for the FY 2003 survey and certification budget process.

Overview of the FY 2003 President's Budget
The President's FY 2003 Medicare state survey and certification budget request would make available $202,400,000 to the states for Medicare total direct survey expenditures and an additional $25,040,000 for Nursing Home Oversight Improvement Program (NHOIP) activities. The budget also requests $8,218,000 for support contracts. At this time, the Congress is currently considering the FY 2003 President's budget. **Final funding levels for FY 2003 will be based upon the final appropriation**, however, states should immediately begin their FY 2003 planning and submit their FY 2003 budget requests based upon the FY 2003 President's budget. Consistent with the FY 2002 budget process, the Centers for Medicare and Medicaid Services (CMS) remains committed to providing FY 2003 Medicare survey and certification budget allocations to state agencies as early in the fiscal year as possible.

The level of Federal matching payments for Medicaid survey activity has been targeted at $228,600,000. States should ensure that they have made adequate provisions for obtaining the necessary Medicaid State share of survey and certification activities.

Overview of the FY 2003 Budget Process
During the FY 2002 budget process, Regions were requested to analyze state budget requests and work with states in order to prepare budget recommendations based on workload priorities and funding levels requested in the FY 2002 President's budget. For FY 2003, we are again requesting that Regions analyze state budget requests and work with states as Regions prepare and submit budget recommendations (to Central Office) based on FY 2003 workload priorities.

To assist Regions and states in this effort, we have outlined the FY 2003 President's budget in Tab A of this memorandum and included in Tab A, the FY 2003 priority ranking of state workload. This year, we have prioritized the Survey and Certification workload into four Tiers. The four Tiers reflect statutory mandates and program emphases. Tier I includes legislatively mandated workload and as such, is considered top priority. States must assure that Tier I work will be completed before Tier II work is begun. Similarly, states must assure that Tier II work will be completed before Tier III work is begun. The same policy applies for Tiers III and IV. States are instructed to prioritize workloads within each Tier.

Please instruct states to use the priority ranking of state workload as they begin planning for FY 2003 survey and certification activities, and advise states to use FY 2002 funding levels as a basis for projecting FY 2003 funding requirements in developing FY 2003 budget requests. State budget requests should be submitted to Central Office and the Regional offices **by August 2, 2002**.

Also, please ask your states to identify in their FY 2003 budget requests, if they currently maintain a toll-free line for nursing homes to receive complaints and/or answer questions regarding nursing home certification requirements. If a state does maintain a toll-free line for nursing homes, please ask the state to indicate the approximate cost associated with its operation in its budget request package.

This year, in order to ensure the essential participation of states in meetings, such as the October 2002 ESRD conference, we will be retaining a pool of funds to provide assistance with state travel costs to those states with documented needs.

Similar to the FY 2002 budget process, Regions should analyze state budget requests and discuss with states applicable state workload projections, related budget requirements, and expenditure computations so that a mutually understood funding level may be worked out that addresses all the workload requirements. Regions should also review state budget requests in light of historical workload and expenditure information.

In FY 2003, we again ask that Regions provide a recommendation memorandum to Central Office on the state budget request that details the Region's proposed action on that budget request, and fully explains the Region's basis for that decision. We ask that you provide Central Office with your Regional Office decision recommendations (Form CMS-434, Form CMS-435, the annual activity plan) via **e-mail** to smaccarroll@cms.hhs.gov, jhackenberg@cms.hhs.gov or ncastro2@cms.hhs.gov **by August 30, 2002**. We ask that you request your states to submit all budget request documents and supporting narratives and schedules to Regions via **e-mail** as well, in order to facilitate the transmission and review of those documents. Given the amount of information being exchanged and the time frames detailed below, we request that information not be mailed in hardcopy or sent via fax.

Regarding the automated Survey and Certification reporting system, states will be required to complete the required budget documentation in the automated reporting system <u>following receipt of the final FY 2003 budget approval amounts from central office</u>. Regions should instruct states not to submit budget request documents in response to this memorandum via the automated reporting system.

Finally, we ask that Regions not issue final budget approval notices to the states until the final approvals are received from Central Office. Following receipt of the final FY 2003 appropriation amounts and a national review of all state estimates and Regional Office budget recommendations, Central Office will release final budget approvals for each state.

Key Dates For FY 2003 Budget Submission
The process that will be used for FY 2002 follows:

(1)   No later than **July 5** Central Office issues FY 2003 budget call letter to Regions and SAs.

(2)   No later than **August 2** states submit FY 2003 budget requests to Regions and simultaneously e-mail a copy of the FY 2003 budget request to one of the following central office staff: Sean MacCarroll (smaccarroll@cms.hhs.gov), Jim Hackenberg (jhackenberg@cms.hhs.gov) or Nora Castro (ncastro2@cms.hhs.gov).

(3)   No later than **August 30** Regions submit FY 2003 Regional Office budget decision recommendations to Central Office.

(4)   No later than **September 30**, or upon enactment of the FY 2003 appropriation, which ever is later, Central Office approves final budget levels for states. In the event that an appropriation is not passed at the beginning of the fiscal year, states will be funded in accordance with the terms of the continuing resolution(s) that the Congress usually enacts until such time as the full appropriation is enacted.

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/s/

Steven A. Pelovitz

Attachments
cc: Associate Regional Administrator, DMSO
        CMS Regional Budget Contacts

FY 2003 State Survey and Certification Budget Call
Program Requirements and Budget Guidelines

Survey activities for FY 2003 should be scheduled and conducted in accordance with national priorities. The Survey and Certification priority ranking of state workload is provided below. This year, we have prioritized the Survey and Certification workload into four Tiers. The four Tiers reflect statutory mandates and program emphases. Tier I includes legislatively mandated workload and as such, is considered top priority. States must assure that Tier I work will be completed before Tier II work is begun. Similarly, states must assure that Tier II work will be completed before Tier III work is begun. The same policy follows for Tiers III and IV. States are instructed to prioritize workloads within each Tier.

CMS anticipates that the President's FY 2003 Medicare State Certification budget request would provide sufficient funds to accomplish all of the proposed FY 2003 priority workload requirements. The FY 2003 prioritized workload is listed below.

TIER I   LEGISLATIVELY MANDATED SURVEYS

Medicare
- Recertifications of nursing homes (SNFs and SNF/NFs) every year
- Recertifications of home health agencies (HHAs) within 3 years commensurate with the need to assure quality. The flexible survey cycle will continue in FY 2003.
- Validation surveys of accredited hospitals. CMS policy is 1%.

Medicaid
- Recertifications of nursing homes (NFs and SNF/NFs) every year
- Recertifications of ICFs/MR every year

Also Includes:
- Timely OSCAR data entry of Tier I survey workload
- Attendance at mandatory federal surveyor training

TIER II

- Nursing Home Oversight and Improvement Program (NHOIP)
- Collaborate with the Quality Improvement Organizations (QIO's) on the CMS Quality Initiative(s)
- Complaint Investigations
  Includes:
    - Complaints that allege immediate jeopardy within 2 days
    - Complaints that allege patient dumping-EMTALA violations—within 5 days
    - Complaints that allege actual harm in nursing homes within 10 days
    - All other complaints
    - Data entry into the ASPEN Complaint/Incident Tracking System (ACTS) for SNFs, NFs, home health agencies, end stage renal disease facilities and hospitals.

- Timely OSCAR data entry of Tier II survey workload

TIER III
- Surveys of Non-accredited hospitals
  Includes:
    - At least 33% recertification coverage level of the facilities in your state (including critical access hospitals)
    - All new rehabilitation hospitals or units and all new psychiatric units for exclusion from PPS (onsite verifications are to be completed no later than 90 days prior to the beginning of the hospital's cost reporting period).
    - At least 5% (but no less than 2 per state) of previously PPS-excluded rehabilitation hospitals, rehabilitation units and psychiatric units that have attested to continued compliance with the PPS exclusion requirements. (Onsite verifications are to be completed no later than 90 days prior to the hospitals cost reporting period).
- Recertifications of ESRD facilities every 3 years
- MDS, OASIS, and QIES systems activities
- Maintenance of the nurse aide registry and assessments of nurse aide training and competency evaluation programs
- Maintenance of a home health hotline
- Other types of facilities
  Includes:
  Recertifications every 6 years for Hospices, Outpatient Physical Therapy providers, Comprehensive Outpatient Rehabilitation facilities, Portable X-ray suppliers, Rural Health Clinics, Ambulatory Surgery Centers, 5% validation surveys of deemed HHAs, Hospice, Ambulatory Surgery Centers, and Psychiatric Residential Treatment Facilities
- Initial certifications
- Timely OSCAR data entry of Tier III survey workload

TIER IV
- Performance Measurement Activities
- Chapter 11 Monitoring
- Other Tier IV workload

TIER 1 WORKLOAD
The following state workload activities represent statutorily mandated workloads. States are reminded that CMS will not approve any FY 2003 state budget request that fails to meet these requirements.

Long-Term Care Facilities
All skilled nursing facilities (SNFs) and nursing facilities (NFs) are subject to a standard survey not later than 15 months after the previous standard survey, with a statewide average interval between standard surveys of 12 months. The President's budget requests $137.1 million for the Medicare portion of state long-term care survey and certification activities.

The President's budget requests $186.8 million for the Medicaid portion of long-term care survey and certification activities, including recertification surveys and associated revisits of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) once per year. States are

reminded to secure the necessary Medicaid state share for funding those long-term care survey and certification activities attributable to Medicaid facilities and dually certified facilities.

<u>LTC Survey Process</u>
With respect to long-term care enforcement, states are reminded that CMS supports state surveyors in citing instances of non-compliance with program standards. CMS enforcement policy does not support a quota program under which states are encouraged to cite more deficiencies than necessary.

<u>Home Health Agencies</u>
Under section 1891(b) of the Act, the Secretary is responsible for assuring that CoPs, and their enforcement, are adequate to protect the health and safety of individuals under the care of a home health agency (HHA) and to promote the effective and efficient use of Medicare funds. In accordance with Sections 1864 and 1891(c) of the Act, state agencies generally conduct surveys of HHAs to determine whether they are complying with the CoPs.

HHAs are subject to a standard survey not later than a minimum of 36 months after the previous standard survey. CMS has established a frequency within this 36-month interval commensurate with the need to assure the delivery of quality home health services. In FY 2002, we adopted a comprehensive state performance standard for compliance with the 36-month statutory requirement. The President's budget requests $25.5 million for states to conduct recertification surveys of home health agencies within this 36-month interval. The flexible survey cycle for HHAs will continue in FY 2003.

A survey frequency code was added to the OSCAR system to enable SAs, ROs, and CMS Central Office (CO) to track and monitor the survey cycles of HHAs. This survey frequency code is required when entering HHA surveys into the system. In response to a pending final Government Accounting Office (GAO) 2002 report regarding Federal and state oversight of HHAs, CMS intends to develop processes to hold states accountable for performing HHA surveys based on our variable 4-36 month survey schedule. We will develop protocols for revealing and analyzing survey cycle data to identify survey frequency noncompliance.

In addition, we anticipate that we will have survey protocols developed that will allow states to better identify those HHAs whose outcome reports may indicate quality of care problems. These new protocols are expected to be released in early FY 2003.

We also expect to begin implementing survey protocols that would put more emphasis on quality of care being delivered by HHA branches. During FY 2003, states will identify and enumerate according to CMS protocol, all branches associated with parent and subunit HHAs.

States will begin the process of assigning a unique identification number to every branch of a parent or subunit HHA during the third quarter of FY 2002. Each branch will be numbered with the same Federally assigned provider number as the parent or subunit with two modifications. There will be a "Q" between the state code and four-digit provider designation plus three more digits for a 10-character branch identifier. The last three digits will allow us to assign up to 999 branches to one parent or subunit HHA.

During FY 2003, we expect states to begin entering these identification numbers into a branch identification field in the Automated Survey Processing Environment (ASPEN), which is expected to be available during the first quarter. States will maintain an accurate database of

branch identification numbers from this point on.

In addition, states will continue to be responsible for conducting complaint surveys and validation surveys of 5 percent (sample will be selected by CMS based on the accreditation survey schedule) of HHAs that are deemed to meet the Medicare conditions of participation by virtue of their accreditation, and notifying accreditation organizations of the outcomes. CMS will be revising the validation procedures to bring them into alignment with the new hospital validation protocols.

Implementation of New Conditions Of Participation (CoP) for HHAs
The CoP for HHAs are scheduled to be published in FY 2003 and implemented 90 days after final publication. CMS will develop a revised survey process, which is expected to increase the time required to complete an HHA survey. It is expected that as much as 1.5 days may potentially be added to the existing HHA survey.

Accredited Hospitals - Validation Surveys
CMS has a statutory responsibility to monitor accredited hospitals with deemed status nationwide. CMS policy has been revised to instruct States to conduct validation surveys on one percent of accredited hospitals. The President's budget requests $5.5 million for States to conduct these validation surveys comprising both random sample validation and complaint investigations. As part of the Hospital Initiative, CMS continues to explore and evaluate alternative approaches to the evaluation of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals deemed to participate in Medicare through accreditation by these organizations.

States should plan for accredited hospital surveys in accordance with the following sample selection criteria:

Number of Accredited Hospitals in State:	Number of Validation Surveys:
Less than 100	1
101 – 200	2
201 – 300	3
301 – 400	4
More than 400	5

Please note that these are random sample validation surveys. Complaint investigations of accredited hospitals will be prioritized with all other complaints (Tier 2). The one percent sample described above should be used for budget planning purposes. Within that budgeted amount, CMS may instruct a state to perform a greater number of focused validation surveys in lieu of a smaller number of full validation surveys within the budget parameters.

OSCAR Data Entry of Tier I Survey Workload (Completion and Use of the CMS-670)
States should continue to ensure accurate and timely completion of the CMS-670 and evaluate their own surveyor times. States should continuously reference the CMS-670 National Guidance Package in order to ensure consistent national reporting practices.

TIER II WORKLOAD

Nursing Home Oversight and Improvement Program

The President's budget requests an additional $25 million in direct survey costs for states to continue implementation of the Administration's Nursing Home Oversight and Improvement Program (NHOIP) in FY 2003. With this additional funding, states will be expected to: intensify their review of nursing homes' abilities to prevent bed sores, dehydration and malnutrition as part of the annual survey process; fund the additional costs associated with imposing immediate sanctions on nursing homes found guilty of a second offense for violations harming residents; fund the additional costs associated with conducting surveys on repeat offenders with serious violations; and fund the costs associated with staggering a set amount of nursing home inspections, to be started mornings, evenings and/or weekends.

The level of Federal matching payments for Medicaid NHOIP survey activity has been targeted at $19.9 million. States are reminded to secure the necessary Medicaid state share for funding those NHOIP activities attributable to Medicaid facilities or dually certified facilities.

CMS Quality Initiative

In early FY 2003, CMS expects to implement a national quality initiative. This includes public reporting of nursing home quality measures and a nationwide quality improvement effort in nursing homes by quality improvement organizations (QIOs). This initiative will require the involvement of state survey agencies for coordinating improvement activities with QIOs, for training and technical assistance, and for addressing other issues that arise through this initiative. It is expected that there will also be a home health quality initiative in FY 2003.

Complaint Investigations

We anticipate continued emphasis on complaint investigations. This is due to a number of factors including implementation of the ASPEN Complaint/Incident Tracking System (ACTS), and the CMS Quality Initiative.

Effective October 1, 2002, ACTS will be implemented for the following provider types: skilled nursing facilities, nursing facilities, home health agencies, end-stage renal disease facilities and hospitals. ACTS will track complaints and self reported incidents from intake through close out. We expect complaints including self-reported incidents to be input since this system will permit tracking of any problem associated with noncompliance with Federal requirements. In addition, ACTS will include more refined instructions on the management of complaints for all providers.

Scope of ACTS and Complaint/Incident Processing requirements:
   a. State survey agencies (SAs) and Regional Offices (ROs) are required to enter into ACTS all allegations that relate to the violation of Federal conditions of participation, conditions for coverage or long-term care requirements whether or not the allegations would result in an on-site complaint survey;
   b. ACTS includes allegations received by the SA, a separate complaint unit within the state government (we are referring to those states that have investigation of compliance with Federal certification requirements assigned to a unit or agency separate from the SA), or the Federal RO;
   c. If the allegation requires an on-site survey and the allegation involves both Federal requirements and State licensure requirements, a Federal on-site complaint investigation is completed and entered into ACTS, at a minimum.
   d. The use of ACTS is optional if the allegation involves only State licensure requirements and not Federal requirements.

The budget contains funds for conducting complaint investigations consistent with Federal expectations contained in regulation and the State Operations Manual (SOM). In addition to general expectations for all provider complaints contained in regulation and the SOM, the investigation of complaints in nursing homes encompasses adherence to the operational guidance issued October 13, 1999 titled "Guiding Principles For Complaint Investigations".

CMS policy requires that dumping complaints--EMTALA violations--be investigated within 5 days of receipt. This timeframe is essential for all states. States are required to report to CMS, on a monthly basis, the status of complaints and their investigations.

The Patient Rights CoP that was published in July 1999 requires investigation and reporting of deaths that may be related to use of restraints or seclusion. These investigations are to occur within 5 days of receipt of the complaint.

CMS policy further requires that an immediate on-site visit be conducted for complaints alleging an immediate and serious threat to patient mental or physical health or safety. Furthermore, CMS expects states to respond to immediate jeopardy complaints within 2 days.

All other Medicare and Medicaid complaint investigations should be conducted promptly, according to guidance in the State Operations Manual (SOM). When conducting a complaint investigation for non-long term care provider types, if one or more condition level deficiencies are recognized, then a full survey should be performed.

The level of Federal matching payments for Medicaid complaint survey activity has been targeted at $21.8 million. States should secure the necessary Medicaid State share for funding those complaint investigation activities attributable to Medicaid facilities and/or dually certified facilities.

TIER III WORKLOAD

Non-Accredited Hospitals
The President's budget targets a national recertification coverage level of 33 percent for non-accredited hospitals. States will be responsible for conducting recertification surveys, associated revisits of 33 percent of non-accredited hospitals, and initial surveys.

States will also be responsible for conducting an on-site re-verification of PPS exclusion criteria for at least 5 percent of previously PPS-excluded rehabilitation hospitals, rehabilitation hospital units and psychiatric units. These surveys must be scheduled at least 90 days prior to beginning of the hospital cost reporting period.

In addition, states will continue to be required to conduct first-time on-site verification surveys of all new rehabilitation hospitals or units and all new psychiatric units for exclusion from PPS. These first-time verifications must be scheduled at least 90 days prior to beginning of the hospital cost reporting period.

Accredited PPS-excluded rehabilitation hospitals should be validated for compliance with exclusion criteria at least once every six years. These surveys must be scheduled at least 90 days prior to the end of the hospital cost reporting period.

NOTE: PPS-exclusion verifications or re-verifications may always be conducted concurrently with a

regular hospital survey, as long as the cost-reporting period timeframes are observed.

Critical Access Hospitals (CAHs)
An initial survey is required for each new CAH. A one-year follow-up resurvey will occur to ensure continued compliance. After this follow-up, the CAH will be on the same survey cycle as non-accredited hospitals.

In addition, state agencies will perform validation surveys on 5 percent (sample will be selected by CMS based on the accreditation survey schedule) of accredited/deemed CAHs.

End Stage Renal Disease (ESRD) Facilities
The President's budget targets a national recertification coverage level of 33 percent for ESRD facilities. In FY 2003, states will be responsible for conducting recertification surveys, associated revisits of ESRD dialysis facilities (whether freestanding or hospital-based) and renal transplant facilities, and initial surveys. Following these surveys, states will continue to be responsible for sending CMS-2567 forms to the appropriate ESRD Network.

ESRD surveys are conducted to protect the health and safety of ESRD beneficiaries because of the extraordinary health and safety risks associated with dialysis treatments. Many of the potentially life-threatening procedures associated with dialysis treatments have resulted in patient deaths. States must survey ESRD facilities for such potentially life-threatening areas as water treatment safety, dialyzer reuse safety, infection control and prevention precautions, equipment operation and maintenance, and staffing qualifications and abilities.

CMS has implemented a system of providing facility-specific data reports for use by states as a guide for ESRD surveys. During FY 2003, each state will be expected to use these data reports to better understand and monitor the performance of renal facilities. States will be expected to implement and evaluate the use of the data profiles to (1) select facilities for survey; and (2) as part of the pre-survey activity for individual surveys. Survey agencies will be expected coordinate activities with ESRD networks and provide results of surveys to the appropriate network.

Minimum Data Set (MDS)
The President's budget requests $4 million to fund MDS activities during FY 2003. These activities include: adequate core staff for administrative and technical support to efficiently maintain the system; the expansion of the system to includes swing bed hospitals; and the collection and housing of data in order that states can develop and test a wide range of program improvement initiatives.

States should note that MDS expenditures are reflected as long-term care costs on the CMS form 435. For more reporting instructions, please refer to TAB C.

CMS contracted with a Data Assessment and Verification (DAVE) Contractor to perform MDS data accuracy verification protocols. As part of this effort the DAVE is expected to establish a process to communicate to the state agency (SA) MDS accuracy results as well as coordinate other MDS accuracy related activities that will support the nursing home survey process. One critical activity will be training/technical assistance support provided by the SA related to a revised MDS user's manual and "feedback reports" generated by the DAVE activity. We anticipate increased SA involvement and general assistance to providers coordinating activities with DAVE staff and taking enforcement actions as required.

All certified nursing homes and swing bed hospitals are required to encode and transmit MDS records to a repository maintained by the state in accordance with CMS established record specifications and time frames.

During FY 2003, states will continue to fund the positions of a Resident Assessment Instrument (RAI) Coordinator and an MDS Automation Project Coordinator.

The RAI State Coordinator will have the responsibility for the following tasks:

- Providing training and technical support to SNF and swing bed hospital providers;
- Attending training sessions; and
- Coordinating with CMS, FIs, and Associations

The MDS Automation project coordinator will assist in promoting national consistency and will be responsible for MDS system operations and troubleshooting.

HHA/Outcome and Assessment Information Set (OASIS)
The President's budget requests $3 million to fund OASIS activities during FY 2003. States will be required to operate the state OASIS data system and report OASIS data to the central CMS repository during FY 2003. States should note that OASIS expenditures are reflected as non-long-term care costs on the CMS form 435.

All certified home health agencies are required to encode and transmit OASIS records to a repository maintained by states in accordance with CMS established record specifications and time frames. During FY 2003, states will continue to play an active role in providing HHAs with outcome-based quality improvement (OBQI) reports, using CMS-developed software as well as consultation on interpreting and using the report. In addition, the outcome-based quality monitoring reports (i.e., case mix and adverse event reports) will continue to be available to HHAs. HHAs will use these reports to target care practices for improvement by learning how to correctly read the reports, identifying potential areas for improvement, developing and using audit tools to evaluate current care practices, and developing plans to improve care practices in areas that have been targeted for improvement. During FY 2003, pending publication of a Federal Register Notice, states will be receiving OASIS data from non-Medicare/non-Medicaid patients receiving skilled services when masking of identifiable patient information is effective. CMS expects the states to continue to play a key role in providing the educational and technical resources to the home health agencies in each state.

States will continue to fund the positions of the OASIS Educational Coordinator and the OASIS Automation Coordinator and will continue with the responsibilities outlined in prior year guidance.

States will provide OASIS education in these areas:

- New HHA providers;
- SOM Revisions, Interpretive Guidelines;
- Ongoing training of existing and new providers;
- Clarification of OASIS/PPS activities;
- Reports from the data system and OASIS outcome reports;

- The masking and encryption process;
- The OASIS survey and enforcement process; including any changes based on the recommendations of the Secretary's Regulatory Reform Committee
- Replicating computer-based training (CDs) and videos as available from CMS or CMS contractors as part of training activities for new and existing HHAs;
- Participating in CMS-sponsored workgroups and training upon request.
- Completing a semi-annual OASIS training worksheet and transmitting to the RO by April 15th and September 15th.

CMS has contracted a Data Assessment and Verification (DAVE) Contractor to perform both on-site and off-site OASIS data accuracy verification protocols. As part of this effort the DAVE has established a process to coordinate the activities of the DAVE contract with the state agencies as well as communicate any OASIS accuracy results that will support the home health survey process.

In addition, as a result of activities undertaken by the Secretary's Regulatory Reform Committee, there may be a series of modifications to the OASIS data collection requirements. CMS will actively communicate any impending changes to the states. In addition, once the proposed modifications are made final, we will work with the OASIS coordinators to notify and educate the provider community.

MDS and OASIS Automation and Related Activities
Overall responsibility for fulfilling requirements to operate the state MDS and OASIS data systems rest with the survey agency. However, the survey agency may enter into an agreement with the state Medicaid agency, another component or a private contractor to perform day-to-day operations of the system. Prior to entering into an agreement with subcontractors, SAs must receive RO approval if the state MDS or OASIS system is operated by an entity other than the survey agency. The state must ensure that the survey agency is provided real-time access to this system to fully support all MDS and OASIS-driven functions which will be required of the survey agency (e.g., quality indicator reporting, survey targeting, etc.). Off-site operation of the MDS and OASIS systems will require high capacity, fault-tolerant network connections to ensure reliable support for the state survey agency's daily operations, which will be affected by this system. The state is also responsible for reporting MDS and OASIS data to a CMS central repository.

During FY 2003, CMS will continue to add software applications to states' standardized hardware environments to support evolving needs for MDS, OASIS, and related survey and certification functions in the states under the QIES initiative discussed below.

During FY 2003, CMS will continue to conduct training of state personnel responsible for administrative and technical aspects of the MDS, Swing Bed (SB) MDS, and OASIS system operation. States should reference the training schedule (TAB B) for a listing of proposed MDS, SB-MDS and OASIS conferences and training courses. During FY 2003, states should budget for travel of as many as two data processing personnel to attend a four-day MDS/SB-MDS/OASIS Coordinators Conference. OASIS/MDS Automation Coordinators will also attend this conference. In order to assess how information about OASIS, MDS and SB-MDS is disseminated across the nation, CMS will request from the states on a semi-annual (twice a year) basis information about training and technical assistance. The CMS regional office will contact the state to determine information on what type of training and technical assistance the state has provided in the past six months, classification of the participants, how many participants were

trained, and identification of key issues.

With CMS technical support and guidance, states will be expected to continue to work closely with the provider community and their MDS, SB-MDS and OASIS software vendors to provide information on specific requirements related to the submission of MDS, SB-MDS and OASIS assessments to the appropriate state or CMS repository. CMS expects that a facility's private sector software vendor will provide primary support to the facility in terms of MDS, SB-MDS and OASIS encoding and transmission to the state. State personnel, however, will be required to work with facilities and software vendors to educate them about this process. States no longer need to fund the monthly line charges associated with installation, maintenance, and transmission of the MDS and OASIS data from the facilities to the state. CMS has converted SNF and HHA providers to a virtual private network (AT&T Global Network Services) to meet confidentiality and security requirements. However, each state must have one line accessible by CMS's systems maintainers to ensure their system can be updated. CMS has also established a separate CMS repository for SB-MDS data. CMS will make this data available to each state system upon request.

State personnel will continue to work with facilities and their software vendors in troubleshooting any difficulties facilities experience as they transmit records.

Each state should review its FY 2002 staffing requirements experience for support of state automation functions and recommend changes as needed. Staffing recommendations for systems support are listed in the "MDS/SB-MDS/OASIS/QIES System Support" section on pg. 12 of this call letter.

Each state should also review its state MDS and OASIS Automation Project Plans submitted with their FY 2002 budget requests and provide any updates detailing continuing activities such as facility training, vendor and provider education, and technical assistance to providers.

Reimbursement for MDS and OASIS Costs
Provider costs for MDS, SB-MDS and OASIS will be compensated through the Medicare and Medicaid programs according to the rules for such reimbursement effective for Medicare and Medicaid in each state.

CMS will continue to fund any needed upgrades to the state MDS and OASIS systems and related software, as well as, the cost of upgrading client computers needed to access the MDS and OASIS servers (discussed under Information Systems Hardware). CMS will also continue to fund the cost of transmitting MDS and OASIS data from the state to the CMS central repository. Provider costs for hardware and software to maintain and transmit MDS, SB-MDS and OASIS data from their facility to the states will continue to be the provider's responsibility. However, states are, again, expected to incur some costs associated with operating the MDS, SB-MDS and OASIS systems, specifically for staff time, training, and supplies to support the automated MDS and OASIS systems.

When states use MDS data in administering the Medicaid program, Federal costs associated with automating MDS, and the operating data system should be apportioned by the states between two funding sources: the Medicare and Medicaid Survey and Certification program and the Medicaid program (under administrative costs). States should apportion MDS costs to these programs based on the states' determination of each program's utilization of the MDS system. Costs charged to the Medicare and Medicaid Survey and Certification Program will be prorated

in terms of the portion of SNFs and NFs in the states that participate in the Medicare and Medicaid program. Similarly, costs associated with downloading and transferring SB-MDS data to the Medicaid program should be apportioned by the state between these two funding sources. The Federal match for the Medicaid Survey and Certification Program will be 75 percent. Budget estimates should be prepared and submitted as part of each state's FY 2003 Survey and Certification budget request.

Costs related to the publication, dissemination, and validation of software vendors' ability to comply with state specifications for any added MDS, SB-MDS or OASIS sections or data (i.e., that portion of the MDS or OASIS that may be added to the state's RAI or HHA instrument at the state's discretion) will not be funded through the Survey and Certification budget. To the extent that a state develops customized applications for information maintained in the MDS or OASIS 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.

We do not anticipate that any state will allocate more than a minimal amount of its MDS and OASIS costs to the Medicaid Program as administrative costs. The Federal match for costs apportioned as Medicaid administrative costs will be 50 percent and should be reported by the state on line 14 (Other Financial Participation) of the quarterly Form CMS-64. Also, where state licensure programs benefit from the automation of the MDS and OASIS, the state itself should also share in the MDS and OASIS automation costs.

The Quality Improvement and Evaluation System (QIES)
CMS's goals for the standardized MDS/OASIS system go well beyond providing states with the ability to collect assessment data from providers and transmit that data to a central repository for analysis and support of prospective payment systems. CMS has always intended that the MDS/OASIS data management system would support a suite of applications/tools designed to provide states and CMS with the ability to use performance information to enhance on-site inspection activities, monitor quality in an ongoing manner, and facilitate providers' efforts related to continuous quality improvement. This overall initiative, known as the Quality Improvement and Evaluation System (QIES), also includes:

- extension of the MDS/OASIS systems to include new provider types in future years

- continued development of Windows-based ASPEN integrated with state standard systems;

- implementation of the classroom learning system that supports most day-to-day operations of the survey and certification training program, and

- integration of these functions and systems into a comprehensive information system, subsuming the functions of the current OSCAR system and integrating a distributed state system with a central repository of assessment and Survey and Certification data linked to other vital CMS systems such as the National Provider System, the Provider Enrollment and Chain Ownership System, and others.

During FY 2003, CMS will continue major aspects of the OSCAR redesign phase of QIES with

integration of enforcement data, X-ray, CORF, OPT and other providers, and expanded reporting capabilities. Other significant phases will begin to further integrate the MDS/OASIS QIES server into day-to-day state agency operations.

During FY 2003, states should budget for two staff members to attend up to four, two-day train the trainer sessions for QIES systems releases and ASPEN. Once trained, these trainers will be expected to perform comparable, hands-on training for agency staff in each of these areas.

CMS also plans to conduct four, 3-4 day requirements, prototyping testing and training workgroup sessions in Baltimore, including up to 5 state agency representatives each (selectees will be announced.)

QIES/SB-MDS/MDS/OASIS State Systems Support
During FY 2003, each state must continue to provide adequate staff for technical systems support based on the staffing recommendations provided below.

Rank	Number of HHAs, Nursing Homes and Swing Bed hospitals/state	FTE
1	≤230	4.0
2	231- 606	5.0
3	>606	6.5

These FTEs should be allocated approximately as follows:
- MDS/SB-MDS/OASIS Automation Coordinator - 1 FTE
- Systems Administrator - .5 to 1 FTE
- Technical operations/system management support - .5 FTEs
- Technical support/training for providers, vendors, and SA staff - 1-3 FTEs
- ASPEN/OSCAR Coordinator - 1 FTE

These estimates reiterate CMS's staffing recommendations from prior budget call letter guidance. They do not represent new staffing requirements.

Information Systems Hardware
The standard MDS/OASIS system and components that will be integrated with it, such as ASPEN/QIES, are comprised of technologies that have been selected to deliver the most powerful access to a broad range of information related to facility quality monitoring and to support state agency survey operations within a user-friendly interface. While the core components of the MDS/OASIS/QIES system (i.e., hardware and software) have been or will be provided and installed by CMS within each state, additional computers for state agency end-users will be required to access this core system. These end-user systems are referred to as clients' and include computers for users that work on-site within the state agency office as well as off-site users including facility survey staff. As the state MDS/OASIS/QIES server assumes a larger role in day-to-day state operations, states should ensure that it is integrated into their existing systems infrastructure such as state LANs.

State agencies currently vary in the number of laptop/notebook systems they have available for field surveyors' use in accessing ASPEN. Internally, most agencies provide network-based computing support for in-house staff managers. Furthermore, over the past few fiscal years, many states have included extensive system upgrades as part of their budget requests. CMS expects that states will use their existing systems to the fullest extent possible to provide client

access to the standard system components. To provide users with access to the standard system, states should follow one, or a combination of, the following approaches:

1) Existing state machines that meet the minimum requirements, as described below, are used to provide user access to the standard system. This includes desktop systems connected to an internal network, as well as laptop/notebook systems used mainly for operation of the forthcoming Windows-based ASPEN system.

2) To the extent that existing state systems do not meet the minimum requirements (e.g., insufficient RAM memory), the state submits a plan and budget request to support upgrading of these systems to the recommended performance levels, which includes the type of equipment to be purchased and associated costs.

   Upgrading an existing computer can include adding more RAM and disk capacity, replacing monochrome monitors with color displays, and even purchasing processor upgrades. States should also include in the budget those costs associated with upgrading current computer operating systems to Windows 32 bit operating system. The costs associated with upgrading equipment should not exceed the cost for actual replacement. Finally, it is also appropriate for states to include a budget for additional staff/contractor costs incurred to manage the computer and operating system upgrade process.

3) To the extent that a state does not possess sufficient systems that are currently capable or able to be upgraded to the minimum standard, the state should submit a plan and budget request to support the acquisition of the number of new systems that are necessary to provide appropriate access. The budget request shall include the number of each type of machine to be purchased and associated costs.

Guidelines for the recommended system configuration and state-size-based estimates for the number of systems required are found below. Please note that the standard system components are based on 32-bit Windows operating systems, which is the primary factor driving the minimum requirements for system hardware. For FY 2003 planning purposes, it is expected that at least 10 client systems will be required for in-office access to the standard system and related components, for each tertile of state size (i.e., small, average, large) as used in the FY 2002 Budget Call Memorandum. In other words, a large state should have 30 client systems that meet the minimum standards for agency staff. For field systems, states should seek to maintain a ratio of at least one laptop/notebook system per two surveyors.

Minimum Standard System Client Requirement		
Component	**Desktop**	**Laptop**
Processor	Pentium Class @ 266mHz	Pentium Class @ 266mHz
Memory (RAM)	64 MB	64 MB
Disk Capacity (Free space)	200 MB	100 MB
Monitor	15" Color VGA	Monochrome/VGA
Operating System	32 bit Windows Operating System	32 bit Windows Operating System
Floppy Disk Drive	3.5" HD	3.5" HD
Pointing Device	Mouse	Mouse or equivalent (e.g., trackball)
Network Interface Card	Yes	Optional
Modem	Not Required	Recommended (28.8)
CD/ROM	Recommended	Recommended

Minimum Client Requirement: New Purchases		
Component	**Desktop**	**Laptop**
Processor	Pentium Class @ 266mHz	Pentium Class @ 266mHz
Memory (RAM)	64 MB	64 MB
Disk Capacity Total/Free	2GB/200 MB	1 GB/100 MB
Monitor	15" Color VGA	Color VGA
Operating System	32 bit Windows Operating System	32 bit Windows Operating System
Floppy Disk Drive	3.5" HD	3.5" HD
Pointing Device	Mouse	Mouse or equivalent (e.g., trackball)
Network Interface Card	Yes	Recommended
CD-ROM	Yes	Yes
Modem	Not Required	Recommended (28.8)
Expected Cost	***<$2,000***	***$2,000***

Nurse Aide Registry (NAR)/Nurse Aide Training and Competency Evaluation Program (NATCEP)

States are required to maintain a registry of all individuals who have completed a nurse aide training course and have passed a competency evaluation test. States must also investigate allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide or other individuals.

The allowable costs that can be charged to the Medicare State Certification program are outlined in sections 1819(e)(1) and (2) of the Social Security Act. These costs relate to the state requirements to specify and review nurse aide training and competency evaluation testing programs together with the establishment and maintenance of the nurse aide registry. States are required to conduct these activities as part of the 1864 Agreement as authorized by section 1864(d) of the Social Security Act. The actual training and competency evaluation testing of nurse aides is not payable as part of this Agreement.

See TAB C of this call letter for instructions on the reporting of NAR/NATCEP expenses and associated full-time equivalent amounts.

A notice of proposed rulemaking (NPRM) has been issued that would create a category of nursing home employee called feeding assistant. We anticipate there will be changes to the current regulation and the SA may be involved if the state decides to allow the use of feeding assistants. There may be state costs associated with implementation of this regulation.

Home Health Toll-Free Hotline and Investigative Unit - OBRA 87

States must maintain a toll-free hotline to receive complaints and to answer questions about HHAs. States must also maintain a unit to investigate complaints. CMS pays for the maintenance of the hotline and complaint unit and also for necessary survey or survey-related activity to follow-up on complaints regarding Federal home health agency requirements only.

With the national implementation of ACTS in FY 2003, states will be expected to devise a means to ensure complaints from the HHA hotline are effectively captured in the ACTS system.

Recertification Surveys of Other Types of Facilities

Consistent with the FY 2003 President's budget request, CMS is targeting a national annual recertification coverage level of 17 percent, or once every 6 years, for the other non long-term care (NLTC) providers, including:

- ambulatory surgical centers;
- comprehensive outpatient rehabilitation facilities;
- hospices;
- outpatient physical therapy providers;
- portable x-ray suppliers;
- psychiatric hospitals; and
- rural health clinics.

CMS does not require that each provider/supplier type be resurveyed at these coverage levels. States must resurvey some of each provider type, but they may, according to priorities and needs as approved by the CMS regional office, resurvey certain provider types more or less than the 17 percent overall state/national average coverage level.

Ambulatory Surgical Centers (ASCs)

Recent concerns over the quality of care in ASCs and rapid industry growth necessitate close attention to surveys of these facilities. State agencies will perform validation surveys on 5 percent (sample will be selected by CMS based on the accreditation survey schedule) of accredited/deemed ASCs.

Hospices

All hospice surveys are being conducted according to the outcome oriented survey process contained in the SOM. Surveyors are instructed to include the different types of settings in which a hospice provides routine home care (i.e., nursing facilities) in their random sample for home visits. State agencies will perform validation surveys on 5 percent (sample will be selected by CMS based on the accreditation survey schedule) of accredited/deemed hospices.

Nursing home surveyors are expected to initiate enforcement action against the hospice when they identify compliance issues associated with care to residents who have elected the hospice benefit.

Rural Health Clinics (RHCs)

States should use their individual history of growth, in addition to any state and local events/initiatives, as a guide to project FY 2003 workloads. Due to changes required by the Balanced Budget Act of 1997, some onsite investigations may be needed for implementation.

Psychiatric Residential Treatment Facilities

The CoP on the use of restraint or seclusion in Psychiatric Residential Treatment Facilities was published in final rule in May 2001. The rule requires the use of restraint or seclusion only under emergency situations and requires each facility that provides this service to individuals under 21 who are under a state plan to attest, in writing, that the facility is in compliance with the standards set forth in this rule. We require the facility to provide the State Medicaid Agency with its attestation of compliance. The rule further requires the state to survey 5 percent of the PRTFs annually to validate the accuracy of the attestations. CMS will work with the states to develop a process for sampling psychiatric residential treatment facilities to validate the facilities' attestations of compliance with this standard.

We expect to issue a standardized survey protocol for validation surveys in 2003 and conduct a training class to review the protocol.

Swing-Beds

Swing-beds will continue to be surveyed as part of a scheduled hospital survey, but need not be targeted for an exclusive survey, unless a hospital is applying for a swing-bed agreement. States should include swing beds during hospital and critical access hospital recertification surveys. CMS promulgated the application of the SNF PPS to swing beds in July 2001. Swing bed hospitals will transition to the SNF PPS starting on the first day of the hospital's first cost reporting period on or after July 1, 2002. States must provide technical assistance and training to providers on both clinical and systems aspects of swing bed assessment submissions.

Surveys of Psychiatric Hospitals

CMS's contract to supply consultant surveyors to conduct surveys of psychiatric hospitals will continue in FY 2003. CMS's contract surveyors should be used for surveys of problematic public psychiatric hospitals (with a history of non-compliance), problematic private hospitals,

including chain corporations, and complaint investigations. States are expected to conduct initial and recertification surveys for the two special conditions of participation (staffing and medical records) for 17 percent of all privately owned psychiatric hospitals, as well as conduct complaint investigations.

If states are unable to conduct the required surveys due to staffing constraints, states should alert their Regional Office to communicate this information to Central Office.

Initial Surveys
States will conduct initial certification of facilities requesting participation in the Medicare and or Medicaid programs in accordance with national priorities. On August 15, 2001, CMS issued Survey and Certification 01-21 which outlined new procedures for issuance of the CMS-855A and B. Under these procedures, Fiscal Intermediaries or Carriers are responsible for issuing CMS-855s. These procedures were designed to streamline the provider enrollment process and minimize significant time lapses between application and certification. However, many providers continue to experience delays in scheduling of initial surveys, including those in medically underserved areas experiencing access to care problems. It is for this reason that, beginning FY 2003, our expectation is that states should attempt to survey new providers within 90 days of receipt of completed applications.

TIER IV WORKLOAD

Performance Measurement Activities
State budget submissions should include thorough and well-structured action plans for effecting Survey and Certification program goals and objectives. The plans should outline effective strategies for achieving performance targets and conforming to CMS's stated performance standards and priorities. States should also identify how national goals and standards are being translated into individual performance objectives.

Chapter 11 Monitoring
States are required to have plans and processes in place to protect the health and safety of patients/residents in financially distressed nursing homes and are to continue Chapter 11 Monitoring activities during FY 2003. States are to track related expenditures on the NHOIP Expenditure Report.

OTHER TIER IV WORKLOAD
INCLUDING:

Informal Dispute Resolution (IDR) Pilot Project
CMS has proceeded with efforts toward conducting a pilot study in two states to evaluate an IDR process by an independent entity. The pilot is envisioned to run until the Spring 2003. Each pilot state has transferred its IDR process from the survey agency to an independent review entity. Funding will be available through the survey and certification budget to assist the SA in contracting with an independent review entity and providing oversight to the process.

Inpatient Rehabilitation Facilities Prospective Payment System (IRFPPS)
CMS has developed a patient-centered assessment instrument (IRF-PAI) to assess short stay patients for inpatient rehabilitation facilities to support the Prospective Payment System for reimbursement. IRF-PAI data will be collected on all Medicare patients who receive inpatient services from an inpatient rehabilitation facility (free standing rehabilitation hospital or

rehabilitation unit in an acute care hospital) certified for Medicare payments. State agencies will have access to this information through the CMS system for monitoring quality of care issues. The system is web-based and there will be a plug-in that must be downloaded to the workstation. The states will not be responsible for training or technical assistance to providers.

Organ Procurement Organizations (OPOs)
OPOs are organizations that perform or coordinate the performance of retrieving, preserving and transporting organs and maintain a system of locating prospective recipients for available organs. The existing OPO provider agreements have been extended until December 2005. ROs will be responsible for any OPO activities, including routine certification and complaint surveys, during FY 2003. States will not be required to perform these surveys.

Community Mental Health Centers (CMHCs)
If a complaint is received regarding a CMHC, states should refer the complaint to the Regional Office. CMS convened a partial hospitalization workgroup to address the potential for abuse in CMHCs providing partial hospitalization services. CMS regional offices will make on-site visits to CMHCs and states will continue to play a role to assure that licensure requirements are met and applications are processed.

FY 2003 Survey and Certification Training Program

CMS will continue to provide a program of instruction to surveyors, supervisors, and other SA staff members. In addition to traditional classroom training, CO will provide satellite broadcasts, computer and web-based training applications, videotapes, train-the-trainer modules, audio conferencing, and other instructional techniques, which will expand the opportunities for training to occur and be replicated at the local levels. These efforts will increase the reach of training in terms of numbers and types of participants and the consistency of training across the survey and certification population.

State Responsibilities for Training and the Role of the State Training Coordinator
States are responsible for assuring that their survey and certification staff members are trained in all regulatory and program requirements and that surveyors have the necessary skills to perform surveys. In addition, each state is responsible for identifying training needs and providing continuing education to its staff. Each state must identify a state training coordinator who will be the overall lead for survey and certification training. The state training coordinator is responsible for:

- Needs assessment, including collaborating with internal and external partners to determine training needs for individuals, groups, program areas, or across the SA;

- Training, including developing and/or revising training programs to meet SA needs identified through assessments; providing program information; validating and implementing training using formal training packages issued by CMS or other materials developed locally; assuring quality of instructional delivery; recommending policies and procedures for inclusion in standardized curricula; ensuring provision and implementation of orientation programs; and serving as a resource for educational materials;

- Quality assurance and quality improvement, including assessing, evaluating and reporting on the effectiveness of the state's training at both the level of the individual staff member and on an aggregate basis; and

- Facilitation, including serving as liaison with regional and central office training contacts; providing logistical support for traditional training methods (e.g., classroom instruction, videotapes, etc.) plus distance learning and other technology-based training forums; and participating in training budget development and allocation of training resources.

- In addition to these traditional duties, during FY 2003, the state training coordinator will have an ongoing role in the operation of the classroom learning system, as outlined below.

Each state Training Coordinator should have a designated backup who can fill in during any absences, etc.

Each state should ensure that its state training coordinator has CD-ROM/DVD, Internet and E-mail capability at his or her desktop in order that he/she might access the most current training programs, information and schedules.

States should plan to send their state training coordinators to regional, consortium level and national meetings and conferences convened to resolve coordination issues and learn about their roles and responsibilities in the national training program. Such meetings will also serve as a forum for sharing training packages and initiatives developed at the local level.

Classroom Learning System
In FY 2002, CO implemented a nationwide, university-style training administration data management system designed to capture and manage student and course information from the survey and certification training program in a uniform, automated manner. CMS provided the necessary training management software to the states. States must provide the following **minimum** hardware and software systems capabilities to support the classroom learning system (CLS), including any necessary hardware maintenance:

➢ Pentium processor, 550 MHz;
➢ Windows 98, NT 4.0, or Windows 2000;
➢ 128 MB RAM;
➢ 200 MB of additional hard disk space;
➢ SVGA (800 x 600) monitor;
➢ DVD CD-ROM drive (for installation);
➢ Microsoft Word 7.0 (or later) for creating and printing letters;
➢ MAPI compliant E-mail system to send correspondence by E-mail (e.g., MS Exchange, MS
➢ Mail, cc:Mail, Lotus Notes, etc.); Oracle Client 8.1.7.4;
➢ Oracle Universal Installer Software (license); and
➢ Printer.

The workstation and printer must be connected to the QIES system. This equipment should be assigned or readily available to the state training coordinator. It will require periodic accessing and data entry by the state training coordinator, but it does not constitute an entirely new workload or labor intensive maintenance requirements for SA staff. CLS took the place of some manual data collection and reporting processes.

The state training coordinator will be responsible for operating the CLS at the SA in support of the national survey and certification training program. Fundamentals classes lasting 3-1/2 days will be offered in FY 2003. State training coordinators and back-ups hired after 7/31/02 must attend a Fundamentals class prior to using CLS.

Training for New Surveyors:
All new surveyors must successfully complete the Orientation Program for Newly Employed Health Facility Surveyor as outlined in Exhibit 42 of the <u>State Operations Manual</u>. The

Orientation Program is a prerequisite for attendance at a Basic Course. States should also use the lesson plans included in the Preceptor Manual to prepare their new surveyors, particularly new LTC surveyors. All new surveyors must attend a Basic Course within their first year of employment.

With the FY 2003 call letter, CMS is clarifying the intent of Section 4009C of the SOM. Specifically, 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 attended the relevant provider-specific Basic course.

CMS CO is in the process of revising and updating the curricula for its Basic courses. The revision process employs instructional design concepts and standardizes course content and format. At this time, Basic Hospital, Basic LSC, and Basic LTC are being revised. Other Basic courses will be targeted for similar revision in upcoming years.

Beginning in FY 2003, the Basic Hospital Surveyor training course will consist of three separate training pieces called Basic Hospital Surveyor Module 1, Module 2 and Module 3. Modules 1 & 2 will be in the form of self-paced workbooks to be taken via Distance Learning. The student will register for the training in the usual manner (refer to information about the CLS registration procedures) and must complete the first two modules, in sequence, before registering for Module 3. This will be tracked by use of the CLS. Module 3 will be a new classroom course that will allow students who have met the prerequisites to attend and demonstrate their ability to apply the knowledge they have gained in Modules 1 & 2. They will also be given a review test of all modules. Students taking the prerequisite Modules should be allowed duty time to work on the distance learning training, since they would normally be using duty time to take a classroom course. A method for attesting to their satisfactorily completing the Modules will be forthcoming.

For Basic LSC, the revision process will carry over into FY 2003 and will provide for two pilot sessions of the new course. It is hoped that these pilots will be run at the FEMA/National Fire Academy in Emmitsburg, Maryland. This facility includes a fire protection lab, with working automatic sprinkler and alarm systems. The revised course will emphasize job skills via a sampling of challenging, realistic scenarios. The revised Basic LTC is scheduled for pilot testing in FY 2003. After the course is validated, video clips will be incrementally integrated into the course content to further enhance the training.

Any state with unusual or extraordinary needs for Basic training course slots for its staff due to increased hiring authority, changes in organizational structure within the state agency, etc. should alert its ROs to the need as soon as it is identified. The RO will, in turn, work with CO to accommodate the need.

When a Basic course is not scheduled and a state needs immediate relief to carry out its program responsibilities, a state may provide a modified Basic Course for surveyors at the discretion of the Regional Office. The modified Basic course is available for all courses, except Basic LTC, using training materials and other implementing guidance provided by CO. However, any new surveyor trained in this manner must also attend a CO sanctioned Basic course when one is

available.

Surveyors who have successfully completed the Orientation Program and the Basic course must also attend other specified training, as necessary or as required by CMS.

Training for Experienced Surveyors, Supervisors and Certification Staff

During FY 2003, CMS will provide training programs directed at experienced surveyors, supervisors and certification and support staff. As each program is announced, the target audience will be identified and participation/completion requirements will be stated. Most programs will be available locally via satellite broadcast, computer or web-based training or videotape, but some may require classroom or face-to-face training. For training programs with mandatory completion requirements, states will be expected to maintain records identifying each person successfully trained, including the date training was completed for each person. This information will be captured in the CLS.

Multimedia Training and Requirements--General

In FY 2003, CMS will continue to use the various multimedia vehicles to disseminate training, including satellite broadcasts, CD-ROM, DVD training packages and Internet/web-based courses. These technologies provide expedient communication and real-time training to state survey agency staff.

Satellite Broadcasts/Webcasts

State survey agencies that have neither a CMS downlink nor access to and control of their own satellite systems should continue to make arrangements to send staff to universities, community colleges and other nearby downlink sites to receive CMS satellite broadcasts. Although CMS will continue to record and send out videotape copies of its satellite broadcasts after each broadcast, states should plan to participate in the live satellite broadcasts whenever possible so that their staff members can participate in the interactive portions of the programs. CMS will produce and broadcast 4-6 satellite programs in FY 2003.

CMS will continue to seek partnerships with other telecommunication and training entities in order to combine resources and expand opportunities for survey and certification staff to participate in a broad spectrum of training activities. As other training opportunities from non-CMS sources are identified, information will be shared. It is expected that most of these opportunities will be provided via satellite at minimal or no cost to participants at the local level.

In the past, satellite training programs were offered to state and RO staffs on an optional viewing basis. For FY 2003 satellite broadcasts, viewing will be **mandatory** for the stated target audience, and the training must be completed within stated timeframes. The target audience will be specified in the advance announcement. All CMS satellite broadcasts will be offered live via satellite and on the web via live or archived webcast. This means that viewers will be able to watch the program live via downlink or on the web on the date of the broadcast, or they can watch an archived version of the live broadcast on the web after the date it was aired. The programs will be available for accessing via the web 24 hours a day, 7 days a week, and they can be viewed on any computer equipped with the following **minimum** system requirements:

- Pentium II (or equivalent) processor;
- 17" SVGA monitor;
- Video card capable of 800 x 600 resolution and 16-bit color;
- Sound card;
- Windows Media Player;
- Windows 98 or higher;
- Internet Explorer 4.0 (www.browser);
- Internet connectivity;
- 1 MB of space on the "C" drive (for tracking information);
- CD-ROM;
- 56K bps modem; and
- Headphone set.

States must provide their staffs with access to equipment that meets or exceeds these requirements. In addition, states must ensure that their computer systems do not have firewalls that would prevent staff from viewing these programs.

Web Based Training (WBT)
In FY 2003, CMS will implement standalone web-based training modules to support Basic Health Facility Surveyor training (i.e., Principles of Documentation, How to be an Effective Witness, Legal Aspects of Surveying, etc.) and other program initiatives. These training programs will not be tied to satellite broadcasts. For programs that support Basic training, each new surveyor will be required to complete the training modules prior to attending a Basic training course. In order to access WBT, the states must provide staff with access to computers that meet the same minimum system requirements as those outlined above for webcasts.

Training Equipment and Technology
States should continue to purchase, update and maintain equipment as needed for their training/learning centers and processes. The extent and nature of purchasing should be based on a review of past equipment purchases funded by the survey and certification program, an assessment of current use and estimates of future use.

Survey and Certification Policy Letters
In addition to formal training programs, states are expected to share program guidance, instructions and updates with every staff member with a need for the information. This includes distribution of or access to Survey and Certification Policy Letters issued by CMS CO to state survey agency directors. Each Policy Letter contains a section on **Training,** which identifies the audience for the information, as well as the **Effective Date**. States should carefully review the information included in these sections of the Policy Letters and take appropriate action to ensure distribution and implementation of the information. State training coordinators should always receive copies of Policy Letters for use in developing in-service training programs and revising existing training. The Policy Letters are numbered and posted on CMS's website as they are issued. They may be accessed at **http://www.hcfa.gov/medicaid/ltcsp/ltcmemos.htm**.

Coordination of Training Efforts
For FY 2003, states may be asked to fund travel and per diem for instructors and state training

coordinators who will be involved in teaching CMS sponsored courses, planning or revising training, or participating in other activities for the national survey training program. States should set aside a small amount from their funding allocation, approximately $10,600, for this purpose. CMS CO will make the request for state assistance and use of this funding through the RO.

FY 2003 - Tentative Survey and Certification Training Schedule
The proposed schedule of training courses to be offered in FY 2003 is provided separately in this document. States should use this proposed schedule when formulating the budget requests.

FY 2003- TENTATIVE SURVEY & CERTIFICATION TRAINING SCHEDULE

- 19 - BASIC HEALTH FACILITY COURSES (4-5 DAYS)
  - 8-LONG TERM CARE
  - 1-ESRD
  - 2-BASIC LIFE SAFETY CODE
  - 2-HOSPITAL
  - 1-CRITICAL ACCESS HOSPITALS
  - 2-ICF/MR
  - 1-HOME HEALTH
  - 1-RURAL HEALTH CLINICS
  - 1-PSYCHIATRIC HOSPITAL

- 1 - ICF/MR ANNUAL FOCUSED TRAINING (3-DAYS)

- 1 - ICF/MR ANNUAL FOCUSED TRAINING FOR DD SPECIALISTS (RO only) (2 DAYS)

- 3 - ICF/MR SATELLITE BROADCASTS – (2 MINI REFRESHER COURSES, 1 KEY COMPONENTS ABUSE AND NEGLECT TRAINING)

- 1 - SOM REVISIONS: CHEMICAL RESTRAINTS AND UNNECESSARY DRUGS UPDATE AND APPLICATION (4 DAYS)

- 1 - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES PSYCH UNDER 21 (2-3 DAYS)

- 1 - ADVANCED PSYCHIATRIC HOSPITAL SURVEYOR TRAINING

- 1 - END STAGE RENAL DISEASE (ESRD) ANNUAL UPDATE (4 DAYS)

- 1 - STATE TRAINING COORDINATORS' CONFERENCE (4 DAYS)

- 1 - STATE MDS/SB-MDS/OASIS AUTOMATION COORDINATOR'S CONFERENCE (4 DAYS)

- 5 - LSC UPDATE – 2000 EDITION

- 1 - FSES/HC (3 DAYS)

- 1 - FSES/BC (3 DAYS)

- 1 - ESRD TECHNICAL TRAINING FOR EXPERIENCED SURVEYORS (4 DAYS)

- 2 - NEW HHA CONDITIONS OF PARTICIPATION (CoPs) TRAINING (1 SATELLITE, 1 PICTEL)

- 1 - HHA/OASIS TRAINING (4 DAYS)

- 1- OASIS TRAINING (SATELLITE)

- 1 – MDS/SB-MDS TRAINING (5 DAYS)

- 1 - MDS DATA ACCURACY AND REPORTS (3 DAYS)

- 1 - HOSPITAL VALIDATION TRAINING: IMPLEMENTATION OF CONCURRENT / OBSERVATIONAL AND FOCUSED HOSPITAL VALIDATION SURVEYS (3 DAYS)

- 4 - TRAINING MANAGEMENT SYSTEM (3-1/2 DAYS)

- 1 - CRYSTAL REPORTS (2 DAYS) CO ONLY

- 1 - CRYSTAL REPORTS (2 DAYS) RO ONLY

- 6 – CLS REPORT WRITER (2 DAYS) STATE AGENCY ONLY

- 2 - SPECIAL SURVEY ISSUES FOR LTC (4 DAYS)

- 4 - COMPLAINT MANAGEMENT/INVESTIGATIVE PROTOCOLS (4 DAYS)

- 4 - SCOPE AND SEVERITY TRAINING (4 DAYS)

- 1 - STATE SURVEY AGENCY DIRECTORS CONFERENCE

- 1 - QIES TRAINER TRAINING – ENFORCEMENT (2 DAYS)

- 1 - QIES TRAINER TRAINING – SCHEDULING AND TRACKING (2 DAYS)

- 1 - QIES TRAINER TRAINING – ESRD, CORF, RHC, OPT, XRAY, (2 DAYS)

- 1 - ASPEN TECHNICAL TRAINING – (2 DAYS)

* ***ALL COURSES ARE SUBJECT TO CHANGE AND WILL BE OFFERED BASED ON DEMAND***

➢ <u>**BASIC HEALTH FACILITY**</u>
(19 Offerings) (Baltimore)

Number of Participants: 110 for ICF/MR; 100 for HHA; 80 per course for LTC; 80 per course for other providers; 30 per course for LSC; 100 per course for psychiatric hospitals.

Program Focus: The Basic Health Facility Surveyor Training Course is a 5-day didactic and interactive training experience designed to teach new state and federal surveyors how to correctly apply and interpret federal regulations in a consistent and time efficient manner. This course is designed, with selected modules, to meet the needs of surveyors who survey nursing facilities, ICF/MRs, ESRD, HHAs, hospitals, etc.

Target Audience: All newly employed health facility surveyors who have completed the State Orientation Program for Newly Employed Surveyors and whose primary job responsibility is to survey health care facilities.

➢ <u>**ICF/MR ANNUAL FOCUSED TRAINING**</u> (3 DAYS)
(1 Offering) (Chicago)
Number of Participants: 110

Program Focus: The ICF/MR Annual Focused Training is designed for three full days as a didactic and interactive course for use with ICF/MR federal regional office surveyors, regional office DD specialists (or, in their absence, their alternates). Specific topics are selected based on needs assessment or findings from the federal comparative surveys that indicate inconsistent interpretation and implementation of the regulations. Training is geared to enhancing the surveyors' skills in remaining current with the field of developmental disabilities and consistently implementing the regulations and revised survey protocol.

Target Audience: Participants will be weighted based on the number of ICFs/MR per state; participants should not have attended an Annual Focused Training (formerly Advanced Training) in the past three years (with the exception of RO DD Specialists and contract surveyors). The majority of the participants are state surveyors who have current direct ICF/MR survey responsibilities; a minority of the participants may be supervisors of state ICF/MR surveyors. Identified federal contract surveyors are also part of the targeted audience. Designated providers are also invited to attend. Additional participants: All RO DD specialists should attend. In the event no DD Specialist or alternate is able to attend, a member of the Regional Office Designee (RODs) group assigned to the ICF/MR program from each region may be substituted.

➢ <u>**ICF/MR ANNUAL FOCUSED TRAINING FOR DD SPECIALISTS (2 DAYS)**</u>
(1 Offering) (Chicago) (RO only)

Number of Participants: 20 Regional Office DD Specialists/identified alternates and approximately 20 federal contract surveyors (at no cost to CMS except for materials), CO staff, ICF/MR consultant.

Program Focus: This program is geared to assisting Regional Office DD Specialists and federal contract surveyors to interpret and implement the regulations in a consistent manner. Training is also geared to an analysis of current issues in the field that may be impacting on the delivery of services to individuals living in ICFs/MR. This training session will be held for two full days immediately following the Annual Focused Training for surveyors.

Target Audience: Since this is the only CMS training that RO DD Specialists receive annually, it is imperative that each designated DD Specialist or their alternate from the Regions attend. Federal contract surveyors will also attend.

➢ **ICF/MR SATELLITE BROADCAST TRAINING – 2 MINI-REFRESHER COURSES, 1 KEY COMPONENTS ABUSE AND NEGLECT TRAINING**
(3 Offerings) (Satellite)

Number of Participants: Satellite

Program Focus: 2 mini-refresher courses will be aimed at clarifying regulatory interpretation as identified by data collected from the comparative survey results or from feedback from state and federal surveyors. Topics may include such issues as informed consent, supporting individual rights, implementing restrictive interventions, etc. The Key Components Abuse and Neglect training will be aimed at sharing CMS's approach to abuse and neglect prevention and detection.

Target audience: State surveyors that have completed the Basic ICF/MR course, have surveyed in ICFs/MR for at least one year past the Basic course and have current, direct ICF/MR survey responsibilities; supervisors for state surveyors; Regional Office federal surveyors; federal contract surveyors and ICF/MR providers.

➢ **SOM REVISIONS: CHEMICAL RESTRAINTS AND UNNECESSARY DRUGS UPDATE AND APPLICATION** (4 DAYS)
(1 Offering) (Baltimore)

Number of Participants: 100

Program Focus: The purpose of this course is to increase the awareness and application of the medication related changes to the SOM for unnecessary drugs and chemical restraints. This course will also increase the skills of state and Regional Office surveyors in conducting a comprehensive review of residents.

Target Audience: Selected SA and RO surveyors including pharmacists and nurses.

➢ **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES**
   PSYCH UNDER 21 (2-3 DAYS)
   (1 Offering) (Baltimore)

   Number of Participants: 40-50

   Program Focus: The purpose of this training will be to: familiarize surveyors with the history of and need for this CoP; define the focus of the survey for compliance with the CoP; define the survey process; teach interpretative guidelines for evaluating compliance with this CoP; teach survey probes that will establish presence or absence of facility compliance with this CoP; teach methods to review facility systems and the use of record review to evaluate compliance with this CoP; teach methods of interview and the use of interview to evaluate compliance with this CoP; teach methods of observation and the use of observation to evaluate compliance with this CoP; train in documentation techniques and report writing requirements; define follow-up activities and enforcement actions. Training will be accomplished by a combination of lecture, video presentation, reading, discussion, and an opportunity to complete hands-on practice in survey activities.

   Target Audience: State Agency and Regional Office surveyors.

➢ **ADVANCED PSYCHIATRIC HOSPITAL SURVEYOR TRAINING** (4 DAYS)
   (1 Offering) (Atlanta)

   Number of Participants: 110

   Program Focus: The Advanced Psychiatric Hospital Surveyor Training is designed as a 3-day didactic and interactive course for the federal contract psychiatric consultant panel surveyors. Specific topic areas to be covered will be principals of documentation, ASPEN training, psychotropic medication update, and survey training for psychiatric units in general hospitals.

   Target audience: Panel contract surveyors and RO designees who work with the Psychiatric Hospital Program.

➢ **END STAGE RENAL DISEASE (ESRD) ANNUAL UPDATE** (4 DAYS)
   (1 Offering) (Dallas)

   Number of Participants: 180

   Program Focus: This program is intended for all ESRD surveyors. It is a meeting that should be attended annually in order for surveyors to be able to update themselves on new technologies. This conference will share new practice guidelines in dialysis and other new technologies and advancements with surveyors. The training session includes hands on training with new equipment and technologies at a major Exhibit Hall associated with a National organizational meeting. In 2003 this meeting will be held in conjunction with the National Kidney Foundation.

   Target Audience: State agency and regional office ESRD surveyors.

> ### STATE TRAINING COORDINATORS CONFERENCE (4 DAYS)
> (1 Offering) (Site to be Announced)

    Number of Participants: 90

    Program Focus: This conference will provide State and Regional Training Coordinators with information needed to successfully manage a training program of Medicare/Medicaid surveyors and to augment the training efforts of CO.

    Target Audience: This training is mandatory for state agency and regional office training coordinators.

> ### STATE MDS, SB-MDS & OASIS AUTOMATION COORDINATORS' CONFERENCE (4 DAYS)
> (1 Offering) (Baltimore)

    Number of Participants: 200

    Program Focus: This meeting will provide information on the operating and maintenance of the MDS, SB-MDS and OASIS software, technical issues related to hardware and software requirements for nursing homes and HHAs, how to encode and transmit the data set, communication software issues, and system operation support for the agency report processing and data management. This discussion will include information on CMS's expectation for nursing homes, swing bed hospitals and HHAs and state responsibilities. This meeting will be used as a forum to solicit ideas for system improvements and expanded functionality.

    Target Audience: CMS has asked each state to designate one individual as the OASIS Automation Project Coordinator and one individual as the MDS/SB-MDS Automation Project Coordinator. These individuals are responsible for coordinating and managing all aspects of MDS and/or OASIS automation. CMS intends to convene an annual meeting of these individuals, who will be CMS's primary contacts on state automation issues. Responsibilities of the coordinator/conference attendee should include liaison with the provider community on automation/data transmission issues, oversight/management of the MDS and/or OASIS automation systems, and liaison/consultation within the state on MDS, SB-MDS and/or OASIS data uses and applications. Note that state survey agencies may delegate responsibility for these functions to another component within the state, or an independent contractor. Those individuals that actually perform the above functions should attend the conference. If appropriate, one Coordinator from both the survey agency and the agency actually performing the above functions may attend. Each CMS regional office is also asked to designate one individual to serve as a liaison to respective states on OASIS and one on MDS/SB-MDS automation/system issues. These individuals are also invited to attend. This course will provide educational components for the MDS and OASIS systems, and as such will encompass 4 days of training.

- **LIFE SAFETY CODE UPDATE** – 2000 edition
  (5 Offerings) (Baltimore, Atlanta, Dallas, Kansas City, San Francisco) (1-1/2 DAYS)

  Number of Participants: Approximately 150 per class

  Program Focus: To update all Life Safety Code surveyors on the newly adopted 2000 edition of the Life Safety Code. This course will introduce the new survey form and associated policies for use and compare the earlier editions of the LSC and forms with the newly adopted code and forms. Application of waivers, and the FSES to existing facilities will be reviewed.

  Target Audience: All State agency and Regional Office Life Safety Code surveyors and supervisors.

- **FIRE SAFETY EVALUATION SYSTEM\HEALTH CARE (FSES\HC)** (3 DAYS)
  (1 Offering) (Baltimore)

  Number of Participants: 85 per course

  Program Focus: The FSES\HC course is designed to instruct participants on how to effectively use the appropriate survey instrument to evaluate the level of safety from fire in new and existing health care facilities.

  Target Audience: Surveyors who have completed the Basic Life Safety Code Training (LSC) and have responsibilities in connection with determining a facility's compliance with LSC requirements.

- **FIRE SAFETY EVALUATION SYSTEM\BOARD AND CARE (FSES\BC)** (3 DAYS)
  (1 Offering) (Baltimore)

  Number of Participants: 85

  Program Focus: The FSES\BC training course is designed to train surveyors how to rate residents in small ICFs/MR and the buildings used as residences for mentally and physically disabled individuals.

  Target Audience: Surveyors who have previously completed the Basic LSC and FSES/HC training courses and have responsibility for surveying small ICFs/MR in connection with LSC requirements.

- **ESRD TECHNICAL TRAINING FOR EXPERIENCED SURVEYORS** (4 DAYS)
  (1 Offering) (Denver)

  Number of Participants: 100

  Program Focus: This training will allow for hands-on instruction with a variety of water treatment equipment and systems; reuse treatment and systems; and dialysis machinery.

  Target Audience: Experienced state agency and regional office ESRD surveyors.

➢ **NEW HHA CONDITIONS OF PARTICIPATION (CoPs) TRAINING**
(2 Offerings) (1 PicTel, 1 Satellite)

Number of Participants: All RO/SA representatives if possible.

Program Focus: This course is designed to provide surveyors with skills required in surveying the compliance of Home Health Agencies with current Conditions of Participation. The course will offer an overview of statute, regulations, interpretive guidelines, survey and enforcement activities, including future directions.

Target Audience: SA and RO surveyors who have been designated to survey HHAs.

➢ **HHA/OASIS TRAINING** (4 DAYS)
(1 Offering) (Baltimore)

Number of Participants: 180

Program Focus: Update for OASIS Educational Coordinators and Automation Coordinators on program issues, a review of how to sample and interpret OBQI reports, and an update of any modifications to OASIS data collection as a result of recommendation from the Secretary's Regulatory Reform Committee.

Target Audience: SA/RO OECs

➢ **OASIS TRAINING**
(1 Offering) (Satellite)

Number of Participants: Satellite

Program Focus: To provide training to HHAs and SAs on recent changes in OASIS data collection as a result of recommendations from the Secretary's Regulatory Reform Committee.

Target Audience: HHAs, SAs, ROs, and HHA professional organizations.

➢ **MDS/SB-MDS TRAINING** (5 DAYS)
(1 Offering) (Baltimore)

Number of Participants: 180

Program Focus: Update for MDS/SB-MDS Educational Coordinators on program issues, and provide them with skills on how to sample and interpret OI reports.

Target Audience: SA/RO MDS Educational Coordinators

➢ **MDS DATA ACCURACY AND REPORTS** (3 DAYS)
(2 Offerings) (Baltimore / Denver)

Number of Participants: 250

Program Focus: To provide training on use of information resulting from the Data Assessment Verification Evaluation (DAVE) contract.

Target Audience: SA surveyors and mid-level managers responsible for oversight of the MDS system.

➢ **HOSPITAL VALIDATION TRAINING: IMPLEMENTATION OF CONCURRENT / OBSERVATIONAL AND FOCUSED HOSPITAL VALIDATION SURVEYS** (3 DAYS)
(1 Offering) (Baltimore)

Number of Participants: 120

Program Focus: This course will provide Federal and state surveyors training and instructional materials on the procedures for conducting the Focused and the Concurrent/Observational Hospital Validation Surveys. Information will be provided on the pilots of these surveys in FY 2001 and CMS's use of these surveys in FY 2002 to enhance CMS's oversight of hospital accreditation organizations and accredited hospitals. Emphasis will center on use of these surveys to focus on areas with a high rate of deficiencies to identify the need for quality improvement practices to increase patient safety.

➢ **CLASSROOM LEARNING SYSTEM (CLS)** (3-1/2 DAYS)
(4 Offerings) (Owings Mills, MD)

Number of Participants: 12 per course

Program Focus: This course provides instruction on use of the CLS, which is required to register for CMS training classes effective 7/1/02.

Target Audience: State and Regional training coordinators who have not previously attended this training.

➢ **CRYSTAL REPORTS (2 DAYS)**
(2 Offerings) (Owings Mills, MD)

Number of Participants: 12

Program Focus: Use of Crystal Reports software with the CLS.

Target audience: DQIT and RTA Coordinators ONLY

- ## **CLS REPORT WRITER (2 DAYS)**
  (6 Offerings) (Owings Mills, MD)

  Number of Participants: 12

  Program Focus: How to use report writing software with the CLS.

  Target audience: State Training Coordinators

- ## **SPECIAL SURVEY ISSUES FOR LTC** (4 DAYS)
  (2 Offerings) (Baltimore)

  Number of Participants: 120

  Program Focus: To provide updates to the state surveyors on clinical issues related to the efficient operation of the survey system. Topics to be discussed include: surveying for rehabilitation potential, nutrition/hydration, weight loss, pressure ulcers, incontinence, hospice issues, and MDS determination of clinical decline.

  Target Audience: Experienced SA and RO surveyors.

- ## **COMPLAINT MANAGEMENT/INVESTIGATIVE PROTOCOLS** (4 DAYS)
  (4 Offerings) (Baltimore)

  Number of Participants: 150

  Program Focus: This course will address complaint management and use of investigative protocols.

  Target Audience: Experienced SA and RO surveyors.

- ## **SCOPE AND SEVERITY TRAINING** (4 DAYS)
  (4 Offerings) (Baltimore-2) (Kansas City) (San Diego)

  Number of Participants: 150

  Program Focus: The course will provide information regarding SOM revisions and procedures associated with the new guidance on Scope and Severity.

  Target Audience: SA and RO staff

- ## **STATE SURVEY AGENCY DIRECTORS CONFERENCE** (4 DAYS)
  (1 Offering) (Baltimore)

  Number of Participants: 130

  Program Focus: The conference will provide information on current initiatives/issues associated with the certification program.
  Target audience: State Survey Agency Director and one key subordinate, Regional Office

Staff (ARA and one key subordinate)

➢ **QIES TRAINER TRAINING** - ENFORCEMENT
(1 Offering) (Baltimore)

Number of Participants: 120 total

Program Focus: To provide training on QIES enforcement data

Target Audience: RO and SA staff who have been designated to train other systems users upon completion of training.

➢ **QIES TRAINER TRAINING** – SCHEDULING AND TRACKING
(1 Offering) (Baltimore)

Number of Participants: 120 total

Program Focus: To provide training on QIES scheduling and tracking capabilities and systems.

Target Audience: RO and SA staff who have been designated to train other state users upon completion of training.

➢ **QIES TRAINER TRAINING** – ESRD, CORF, RHC, OPT and X-RAY
(1 Offering) (Baltimore)

Number of Participants: 120 total

Program Focus: To provide training on QIES capabilities and systems releases for ESRD, CORF, RHC, OPT, and X-RAY.

Target Audience: RO and SA staff who have been designated to train other state users upon completion of training.

➢ **ASPEN TECHNICAL TRAINING** – Technical Training on Managing and Using ASPEN ACO, ASE, and ARO
(1 Offering) (Baltimore)

Number of Participants: 120 total

Program Focus: To provide training to state staff responsible for administering the ASPEN products.

Target Audience: RO and SA technical staff responsible for administering the ASPEN products.

* ***ALL COURSES ARE SUBJECT TO CHANGE AND WILL BE OFFERED BASED ON DEMAND***

TAB C

GENERAL BUDGET FORMULATION GUIDELINES

States are to prepare budget requests in accordance with the instructions in Chapter IV of the State Operations Manual - Program Administration and Fiscal Management. States should review the Budgetary Process covered in sections 4600 through 4642, in particular, before preparing their budget requests.

Budget and Expenditure Reporting Requirements
States are to continue requesting and reporting all NAR/NATCEP costs and FTEs on the Miscellaneous line 14A of the CMS 435. These expenses are <u>not</u> to be included in salaries/fringe benefits. States' budget requests should be tied to the number of nurse aides and/or training programs. CMS will not approve any FY 2003 budgets that fail to include NAR/NATCEP associated FTEs and expenses under line 14A (Miscellaneous) on the CMS-435 (columns C and D, respectively).

Nurse Aide Registry expenses and nurse aide training and competency evaluation costs incurred for Title XIX-only facilities are considered administrative costs and are to be reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64). There are no provisions for covering these expenses in the Medicaid Survey and Certification budgets.

Costs incurred in joint Titles XVIII/XIX facilities for NAR/NATCEP will be charged and reimbursed 50 percent by Medicare and 50 percent by Medicaid (50%-50% split). Expenses incurred for Title XVIII should be reported on the CMS-435; expenses for Title XIX on the CMS-64.

Again in FY 2003, each state is required to prepare a CMS 435 that captures all projected expenditures (including MDS, OASIS and NHOIP) spread across appropriate lines. In addition, a "mini-budget" CMS 435 must be separately prepared for MDS and for OASIS, indicating FTEs and proposed costs in the appropriate line items.

Again in FY 2003, the budget request for NHOIP is to be prepared on the NHOIP budget request form (Excel template file Attachment 3). Please note that the NHOIP budget request form is only for the purpose of the state's request for Medicare NHOIP funding, and therefore does **not** replace the quarterly NHOIP expenditure report. Following enactment of the state budgets, states are to continue tracking all NHOIP expenditures on the NHOIP Expenditure Report during FY 2003 (please refer to NHI Expenditure Report Instructions from Central Office dated December 30, 1999, as needed). As you are aware, states are to submit four quarterly reports, and one cumulative NHOIP Expenditure Report, at the same time as the quarterly and cumulative CMS-435 expenditure reports are submitted.

In summary, the budget package should include one CMS-435 that captures all projected FY 2003 expenditures (including MDS, OASIS, and the NHOIP) spread across the appropriate lines of the CMS-435. In addition, the budget request packages should include 2 mini-CMS 435s for MDS and OASIS, and one completed NHIOP budget request form (Attachment 3).

States are also reminded that, under no circumstance, should the costs reported in the training

line on the CMS-435 be zero. As discussed in the State Operations Manual, this line item includes **any** non-salary costs associated with training.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATE SURVEY AGENCY
BUDGET/EXPENDITURE REPORT

Public reporting burden for this collection of information is estimated to average xx minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-xxxx), Washington, D.C. 20503.

REGION/STATE CODE:

| X | (1) PLANNED WORKLOAD |

BUDGET PERIOD:

| | (2) ACCOMPLISHED WORKLOAD |

FY QUARTER ENDING:

TYPE OF PROVIDER	Facility Counts (a)	INITIAL VISITS (b)	RESURVEY VISITS (c)		FOLLOW-UP VISITS (d)	COMPLAINT VISITS (e)	TOTAL VISITS (f)
INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED							0
NURSING FACILITY XIX							0
SKILLED NURSING FACILITY-XVIII							0
SKILLED NURSING FACILITY-XVIII/XIX							0
ACCREDITED HOSPITAL VALIDATION							0
NON-ACCREDITED HOSPITAL							0
PSYCH HOSPITAL - ACCREDITED							0
PSYCH HOSPITAL - NON-ACCREDITED							0
CRITICAL ACCESS HOSPITAL							0
SWING BEDS							0
PPS EXEMPT UNITS							0
HOME HEALTH AGENCY - ACCREDITED							0
HOME HEALTH AGENCY - NON-ACCREDITED							0
HOSPICE							0
OUTPATIENT PHYSICAL THERAPY/OUTPATIENT SPEECH PATHOLOGY							0
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY							0
PORTABLE X-RAY							0
RURAL HEALTH CLINICS							0
AMBULATORY SURGICAL CENTER							0
ORGAN PROCUREMENT ORGANIZATION							0
COMMUNITY MENTAL HEALTH CENTERS (CMHC)							0
FEDERAL QUALIFIED HEALTH CENTERS							0
END STAGE RENAL DISEASE							0
OTHER -							0
OTHER -							0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**

SIGNATURE: _____ TITLE: _____ DATE: _____

FORM HCFA-434 (XX-93)

Attachment 2

STATE SURVEY AGENCY
BUDGET/EXPENDITURE REPORT

AGENCY:	REGION/STATE CODE:	BUDGET PERIOD: From: To:	FY QUARTER ENDING:

(1) _____ TITLE XVIII STATE BUDGET REQUEST	(6) _____ TITLE XIX STATE FFP ESTIMATED BUDGET	
(2) _____ TITLE XVIII RO BUDGET APPROVAL	(7) _____ TITLE XIX RO APPROVED FFP ESTIMATED BUDGET	
(3) _____ TITLE XVIII STATE QUARTERLY EXPENDITURES	(8) _____ TITLE XIX STATE QUARTERLY EXPENDITURES	
(4) _____ TITLE XVIII RO APPROVED QUARTERLY EXPENDITURES	(9) _____ TITLE XIX RO APPROVED QUARTERLY EXPEND.	
(5) _____ TITLE XVIII CUMULATIVE EXPENDITURES	(10) _____ SUPPLEMENTAL (CHECK APPROPRIATE BLOCK(S))	
	(11) _____ OTHER (EXPLAIN)	

COST CENTERS	TITLE XVIII N/LTC S-Y (A)	N/LTC (B)	LTC S-Y (C)	LTC (D)		TITLE XIX LTC S-Y (E)	FFP (F)	STATE (G)		TOTAL LTC COL. D, F, & G (H)
SALARIES										
1a. Surveyor										$0
1b. Non-Surv. Prof.										$0
2. Clerical										$0
3. Total Salaries	0.00	$0	0.00	$0		0.00	$0	$0		$0
OTHER DIRECT COSTS										
4. Rate %										
5. Ret/Fringe Benefits										$0
6. Travel										$0
7. Communications										$0
8. Supplies										$0
9. Office Space										$0
10. Equipment Purchases										$0
11. Training										$0
12. Consultants										$0
13. Subcontracts										$0
14. Miscellaneous										$0
A. Nar/Natcep										$0
B.										$0
C.										$0
D.										$0
E.										$0
F.										$0
G.										$0
15. Total Other Direct Costs		$0		$0			$0	$0		$0
16. **TOTAL DIRECT COSTS**		$0		$0			$0	$0		$0
17. **INDIRECT COSTS**										$0
18. Rate %										
19. **TOTAL COSTS**		$0		$0			$0	$0		$0
20. **UNLIQUIDATED OBLIG.**										$0

SIGNATURE: _____   TITLE: _____   DATE: _____

FORM HCFA-435 (XX-93)

Nursing Home Oversight and Improvement Program Budget Request

State: _____   **Period Covered:** 10/1/02 to 9/30/03

Staggered Recertification Survey Starting Times

Facility	Projected Number of Staggered Start Recertification Surveys		Projected Incremental Medicare Expenditures
SNF			
SNF/NF			

Special Focus Facility Visits

Facility	Projected Number of Special Focus Facility Surveys and Visits		Projected Incremental Medicare Expenditures
SNF			
SNF/NF			

Surveys Using Revised Survey Protocol

Facility	Projected Number of Revised Protocol Surveys During FY 2003		Projected Incremental Medicare Expenditures
SNF			
SNF/NF			

Additional IDRs: New Poor Performer Criteria

Facility	Projected Additional IDRs in FY 2003		Projected Incremental Medicare Expenditures
SNF			
SNF/NF			

Ten Working Day Complaint Response Policy

Facility	Projected Additional Complaint Visits in FY 2003		Projected Incremental Medicare Expenditures
SNF			
SNF/NF			

Training and Other Costs

			Projected Incremental Medicare Expenditures
Training			
Other			
Total State Title 18 NHI Budget Request			

Nursing Home Chain Monitoring Visits

Facility	Projected Number of Nursing Home Chain Monitoring Visits		Projected Incremental Medicare Expenditures
SNF			

SNF/NF