

This Worksheet is intended for use by CMS DCLIQ for its review. However, the SAs are welcome to use the template if it will help them track their compliance with the CLIA requirements.

Calendar Year 2026 SAPR

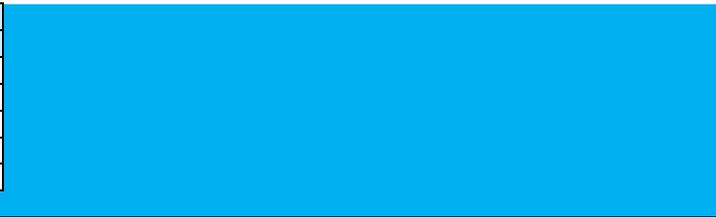
State Agency:

SAPR CY26 Criterion #1: Personnel Qualifications Training and Competency

Overall Goal:	The SA has: <ul style="list-style-type: none"> • An effective system in place to ensure that all CLIA surveys are conducted by qualified and competent individuals • An ongoing training program to improve survey skills • An ongoing program to ensure that SA CLIA clerical staff and surveyors are properly trained in a timely manner • An ongoing mechanism to maintain and improve SA CLIA staff competency 		
Performance Threshold	100%	DCLIQ Reviewer	
State		Review Date	
Quantified Performance	FALSE		
Requires a written corrective action?	A written Corrective Action Plan(CAP) is required if the Quantified Performance Result is less than Performance Threshold above		
NEW For CY 2026	The monthly CLIA All-State Call is considered mandatory online training. See PI 6. eligible SA Surveyors must successfully complete QSEP SSR & FR training within the calendar year. See PI 7.		All

Performance Indicator	Requirements	SA Response, if applicable	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch	Comments
PI 1	The staff positions—professional and clerical listed on CMS-1465A are occupied as reported. All staff changes are reported to CMS within 30 days of the end of each quarter via email to the DCLIQ State Oversight Branch.				Oversight	The SA will provide the list of their current CLIA staff and their designation—Surveyor versus Administrative roles. Provide the list of their current CLIA staff utilizing the State-specific personnel audit spreadsheet.
PI 2	Each Surveyor meets the Health Professional and clerical qualifications according to the SOM @ 4009b.				Oversight	The SA will provide documentation if applicable.
PI 3	New surveyors complete the CMS-developed Basic Surveyor Training Course within the first three (3) months of employment (SOM 4009-C) AND the individual has completed sufficient orientation for DCLIQ to evaluate their survey skills (Federal Monitoring Survey Assessment) within one year. NOTE for PI #3: If a newly hired surveyor (less than 3 months) has not completed the training, please enter a "NA". NOTE for PI #2 and PI #3: If no new surveyors have been hired in the FY under review, then PIs #2 and #3 are considered met. Please use the table below to list the new surveyors and evaluation of PI 1 and 2.				Oversight	The SA will provide documentation to support that the new staff completed the Basic training within the first 3 months of employment.
PI 4	For all surveyors, the SA's ongoing training and annual competency program utilizes feedback or information from and focuses on: a. SA orientation, any FMS performed, DCLIQ review of any CMS-2567s and PoC/AoCs to improve surveyor skills; b. Consistency in the interpretation of the regulations; and c. Ensuring surveyor adherence to the SOM; d. Improving individual surveyor skills, as needed.				Oversight	The SA will provide documentation if applicable.
PI 5	All SA surveyors attend CMS-funded mandatory training, including those budgeted for in the annual SA budget apportionment (e.g., National Training). NOTE: In some instances, a SA surveyor is unable to attend mandatory training for a variety of reasons (e.g., personal commitment or medical issue); however, the intent is that if CMS funds mandatory training, all SA surveyors must attend unless a staff member is given an approved exception. Denial by the SA to approve CMS-funded training is not an acceptable exception.				Oversight	The SA will provide documentation.
PI 6	Participate in mandatory online training, as applicable. NOTE: The monthly CLIA All-State Call is considered mandatory online training. In some instances, a SA surveyor or administrative staff member is unable to attend mandatory training for a variety of reasons (e.g., personal commitment or medical issue); however, the intent is that all surveyors and administrative staff attend. If staff are not able to attend, the SA is responsible for disseminating all information from the call.				Oversight	The SA will provide training documentation for all staff who were not present at the Monthly All-State Calls.
PI 7	All SA surveyors who are eligible must successfully complete the CLIA Surveyor Skills Review Assessment and the CLIA Foundational Refresher Training located on QSEP, within the calendar year. The SA must review their SA surveyor staff QSEP training record and ensure that the training has been completed for all "Mandatory" requirements.				Oversight	The SA will provide completion certificates for all eligible surveyors.

Worksheet for New Surveyor			
Date of Hire	Surveyor Name and Surveyor ID	PI 2	PI 3



SAPR CY26 Criterion #2: Data Management

Overall Goal:	The SA has implemented a mechanism to ensure that data entry is done both accurately and within the appropriate timeframe and that all personnel responsible for data management have been trained.		
Performance Threshold	85%	DCLIQ Reviewer	
State		Review Date	
Quantified Performance	FALSE		
Written Corrective Action Required?	A Written Corrective Action Plan is required if the Quantified Performance Result is less than Performance Threshold above		
NEW For CY 2026	All Form CMS-116 and any supporting documentation, including test lists and laboratory director credentials, must be uploaded in the CMS 116 data system, within 30 days of data entry. See PI 9.		

Performance Indicator	Requirements	SA Response	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch	Comments
PI 1	The SA has a mechanism to track receipt and entry of initial applications (Form CMS-116a), certificate type changes, and demographic updates.				Oversight	The SA will provide CMS with information on how this is done, including the supporting evidence.
PI 2	The SA has entered all reviewed initial applications (Form CMS-116) information accurately into the CLIA 116 Database. NOTE for PI #2: When evaluating PI #2, the DCLIQ reviewer should compare the initial Form CMS-116 to the information entered into the CLIA 116 Database. If the SA has requested additional information (e.g., laboratory director qualifications) prior to the 30 days, this PI is considered met as it is beyond the SA's control if a laboratory does not provide the requested information in a timely manner. The name of the laboratory currently only allows for 50 characters to be entered, so the SA may use abbreviations to meet this requirement. The abbreviations must be reflective of information on the Form CMS-116. The SA can miss 1 of the 20 total 116 entries on the "Criterion #2 Review Tool" for accuracy and timeliness and still meet PI #2 and PI #3 or miss a total of 2 fields for PIs #2, 3, 4, 5, 6, and 7 entries and still meet the requirements. The SA can miss an overall of 3 fields and still meet the requirements for the Criterion. 2 additional reviews have been added for Initial CLIA Applications (Form CMS-116), PI #2 and PI #3 on the "Criterion #2 Review Tool". The following six selected fields will be reviewed for this criterion: Facility Name, Email Addresses, Federal Tax Identification (TIN), Facility Address, Name of Director, telephone number. No other Form CMS-116 fields are required to be reviewed unless CMS DCLIQ determines an expanded review is warranted. All information for PI #2- PI #7 should be collected from the Criterion #2 Review Tool.		NA		Oversight	The SA is required to enter all Form CMS-116 information accurately as received. Where the SA encountered data system limitation, the SA must indicate what was done on the submitted form, which must be uploaded to the system. CMS may review the Form CMS-116 information for all the facilities listed on DM – A or review a sample thereof for the accuracy of the highlighted fields. Note, CMS may request that the SA correct any other errors found during the review.
PI 3	The SA has entered all complete initial applications (Form CMS-116) information into the CLIA 116 Database within 30 calendar days of receipt by the SA. Note for PI #3: This performance indicator is met if the SA has requested from the laboratory any additional information which is needed to approve the initial Form CMS-116 within 30 days of receipt by the SA.		NA		Oversight	The SA is required to enter initial applications into ASPEN web no more than 30 days after the application is received.
PI 4	The SA has entered all complete certificate changes accurately into the CLIA 116 Database. Note for PI #4: If, when reviewing certificate changes, it is noted that the demographic information does not match, further investigation should be done to ensure that the demographic information is correct, e.g., check for later CMS-116 submissions with demographic changes. See the review tool.		NA		Oversight	Sample of facilities listed on DM – B SAS Visa Report may be used to complete this review and additional source of changes may include the CASPER D140.
PI 5	The SA has entered all complete certificate changes into the CLIA 116 Database within 45 calendar days of receipt by the SA.		NA		Oversight	The SA adheres to entry of certificate changes into the ASPEN Web-116 no more than 45 days after the application is received.
PI 6	The SA has entered all complete demographic updates into the CLIA 116 Database accurately.		NA		Oversight	CMS may review the Form CMS-116 information for all the facilities listed on DM – B or review a sample thereof to review the accuracy of the information in the database. Note, CMS may request that the SA correct any other errors found during the review.
PI 7	The SA has entered all complete demographic updates into the CLIA 116 Database within 45 calendar days of receipt by the SA.		NA		Oversight	CMS reviews the timeliness of the data entry of demographic changes into the ASPEN Web-116.
PI 8	All personnel responsible for data entry have been trained to enter the information into the CMS 116 Database in accordance with their responsibilities.				Oversight	The SA must provide training documentation, if applicable, especially for new staff members.
PI 9	The SA has uploaded all Form CMS-116 and any supporting documentation, including test lists and laboratory director credentials, in the CLIA 116 Database, within 30 days of data entry.				Oversight	For all Form CMS-116s that CMS reviews for Criteria 2, CMS will verify form and supporting documentation upload
Number of No		0				
Number of Yes						
Number of Yes and No		0				

Data Reports (used to complete DCLIQ review)

Report Name	Description	Comments
DM-A: 116 Entry	A detail report, sorted by application type, identifies the laboratories that applied and entered in the CLIA program in the Calendar Year (CY) under review. Used by CMS to complete Criteria 2.	PI 2 - When evaluating PI #2, the DCLIQ reviewer compares the initial Form CMS-116 to the information entered in the CLIA CMS-116 database. PI 3 - The State Agency (SA) has entered all complete initial applications (Form CMS-116) information into the CMS-116 database within 30 calendar days of receipt by the SA. CMS may sample or use all the data for the State Agency Performance Review (SAPR) for the CY. Additional information may be requested from the SA if needed. The SA may use this report for internal auditing, to ensure the accuracy of their entries. This report is generated by CMS and used for review.
DM-B: Cert Changes	A detail report listing all Certificate changes made during the CY under review with a run-time parameter for Geography. Used by CMS to complete Criteria 2.	PI 4 - The SA has entered all complete certificate changes accurately into the CMS-116 database. PI 5 - The SA has entered all complete certificate changes into the CMS-116 database within 45 calendar days of receipt by the SA. DM - B report only captures certificate changes (for example, CDC to PPM etc.) with the certificate effective date within the CY. It does not capture certificate changes when the certificate effective date is outside the FY. It is used in conjunction with CASPER D104D to evaluate SAs performance for Criterion 2. This report is generated by CMS and used for review.
CASPER 0104D CLIA 116 Activity	A DETAIL report identifying the names of laboratories that had specific demographic fields updated during the FY under review. The report also displays the date the change was made, the user ID of the person who made the change, and the fields changed. Used by CMS to complete Criteria 2	PI 6&7 - The SA has entered all complete demographic updates into the CMS-116 database accurately and within 45 days. This report is generated by CMS and used for review.

SAPR CY26 Criterion #3: Proficiency Testing Desk Review

Overall Goal	The SA conducts PT Desk Review timely and initiates appropriate action in regard to unsuccessful participation.		
Performance Threshold	85%	DCLIQ Reviewer	
State		Review Date	
Quantified Performance	FALSE		
Written Corrective Action Required	A Written Corrective Action Plan is required if the Quantified Performance Result is less than Performance Threshold above		

Note There can be a maximum of eight (8) (15%) disparities (No) in the reviewed fields for a SA to get an overall response of "Yes."

New for CY 2026 The SA must submit evidence of all Mandatory Reports that includes annotation of actions taken by the SA, as applicable.

Performance Indicator	Requirements	SA Response, if applicable	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch	Comments
PI 1	The SA has implemented a mechanism to track PT scores every 30 - 45 days, using CASPER 0153 and 0155 reports. Review the SA's PT tracking process to determine whether Performance Indicator #1 is met.			Complete the table below	Enforcement	The SA provides information on the mechanism implemented by the SA to track PT score.
PI 2	Using the table below, CMS will select 10 laboratories (or the SA total if less than 10) and include a cross-section of initial and non-initial (subsequent) unsuccessful events. <ul style="list-style-type: none"> Indicate whether unsuccessful PT is either the initial unsuccessful or the non-initial unsuccessful. If no non-initial unsuccessful events occurred during the FY under review, select 10 initial unsuccessful events or all, whichever is fewer. See the worksheet below. 		NA	Complete the table below	Enforcement	The SA submits information on all the PT scores reviewed, to include all CASPER 153D and CASPER 155D reports generated in the quarter. The PT-A Desk Review SAS Viya report captures only the reviews that resulted in a survey. CMS may select any of the surveys for the review of the SOD.

Instructions for table below PI 1 - The SA has implemented a mechanism to track PT scores every 30 - 45 days. Review the SA's PT tracking process to determine whether Performance Indicator #1 is met. PI 2 - Select 10 laboratories (or the SA total if less than 10) and include a cross-section of initial and non-initial (subsequent) unsuccessful events. Indicate whether unsuccessful PT is either the initial unsuccessful or the non-initial unsuccessful. If no non-initial unsuccessful events occurred during the FY under review, select 10 initial unsuccessful events or all, whichever is fewer.

CLIA Number	*Unsuccessful PT Type Classification <i>*This field and row must be completed for the calculations to work correctly.</i>	PI 1: The SA has implemented a mechanism to track PT scores every 30 - 45 days.	Unsuccessful Participation: Verifies the scores using information from the PT provider and/or the laboratory prior to recommending an action, and takes any necessary follow-up actions based on collaboration with DCLIQ.	Prepares CMS-2567, including appropriate D-Tags.	Notifies the laboratory to seek training/technical assistance for initial unsuccessful participation, as appropriate.	Notifies DCLIQ for all non-initial unsuccessful participation.	Tracks each case to completion/resolution (SA can verify corrective actions and effectiveness evaluated).
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

PI2 'NA'

	PI 2 'NO'	
	PI 2 'Yes'	
	PI 1 No	
	PI1 'Yes'	
	Total PI 2 Yes & NA	
	Adjusted Yes & NA value	
	Total PI 2 fields completed	
	Overall Yes	
	Adjusted Overall No	
	Total	
	Number of Labs	

Mandatory Data Reports		
Report Name	Description	Comments
CASPER Report 0153D	Unsuccessful (2 of 3) PT Report provides current Proficiency Testing (PT) failed and Unsuccessful PT results.	0153 report provides a listing of each state's laboratories with PT failed and unsuccessful PT testing results. This report must be generated by the SA and acted upon.
CASPER Report 0155D	Individual Laboratory Profile PT Report provides current PT failed and Unsuccessful PT results.	0155D report provides an individual Laboratory's last four years PT Results to identify non-initial PT unsuccessful results. This report must be generated by the SA and acted upon.
PT-A: PT Desk RVW	A detail report listing all surveys resulting from Proficiency Testing Desk Reviews (PTDR) performed during the CY under review with a run-time parameter for Geography	PT – A report that pulls from the CMS Group's survey common table in CASPER. It includes ONLY surveys that are indicated as special surveys for PT DR. Other PTDR activities with no surveys will not show on this report. DCLIQ reviews only ten or all the Surveys on this report (if less than 10) to ensure that: <ul style="list-style-type: none"> • The SA takes appropriate actions in collaboration with DCLIQ. • The SA has notified DCLIQ of all non-initial unsuccessful participation. • The SA preparation of Form CMS-2567 includes appropriate D-tags. Generated quarterly by CMS and uploaded into BOX. This report must be acted upon by the SA.
Optional Data Reports		
CASPER 157D: PT Excused Nonparticipation	This detail report identifies the laboratories that have been given a pass for failure to participate in proficiency testing for one or more analytes/events.	
CASPER 0164S – PT Missing Enrolment	This DETAIL report lists CLIA laboratories that were enrolled in PT for the last testing event in the previous year but have failed to re-enroll for the first event of the following year for the same analyte or analytes.	

SAPR CY26 Criterion #4: Principles of Documentation (PoD) and Plan of Correction (PoC)/Allegation of Compliance (AoC)

Overall Goal	<p>The SA has a review system/process to ensure that all CLIA surveyors:</p> <ul style="list-style-type: none"> • Write clear, concise, and legally defensible Statements of Deficiencies (CMS-2567) that are consistent with the Principles of Documentation (POD). • Accept only POC/AOCs that meet the criteria for acceptability. 					
Performance Threshold	100%	DCLIQ Reviewer				
State		Review Date				
Quantified Performance	FALSE					
Written Corrective Action Required	A Written Corrective Action Plan is required if the Quantified Performance Result is less than 100 percent or Performance Indicator 1 is not met.					
Note	<ul style="list-style-type: none"> • Performance Indicators #3 and 4 may not be applicable to an individual who was hired shortly before the time of review. In SAs with few surveyors, particularly those with fewer than 2 FTEs, DCLIQ staff may need to be more directly involved in the review activities and should apply the performance indicators in a manner that is reasonable. • Performance Indicator # 8 does NOT refer to the % outcome of the SA's internal review specified in PI 8. - The SA surveyor POD review result does not have to be 100%. • The SA must submit evidence of all Mandatory Reports that includes annotation of actions taken by the SA, as applicable. 					
NEW FOR CY 2026	<p>The surveyor who performed the survey must be included in the AOC/POC review process for their survey. See PI 3. The SA must submit evidence of all Mandatory Reports that includes annotation of actions taken by the SA, as applicable.</p>					
Performance Indicator	Requirements	State Response, if applicable	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch(es)	Comments
PI 1	The SA utilizes and understands mandatory citations.				Oversight lead with input from Survey & Enforcement	The SA will review a 2567 where any of the mandatory Dtags were used to ensure its appropriate use. If no Dtags are cited, the SA can make a note of it and ensure they were not cited where they were supposed to be cited. CMS may review any of the 2567 where mandatory citations were used.
PI 2	The SA reviews CMS-2567s for clarity, conciseness and consistency with the POD on an ongoing basis. The SA reviews at least 10 of each surveyor's CMS-2567s prepared during the FY25 and CY25 under review for POD. See the table below for an example.				Oversight	The SA will provide the process for the review and the relevant documentation. The PI review above can be one of the SOD reviews.
PI 3	The SA reviews the POC/AOCs for consistency with SOM 6130. The SA reviews at least 10 of each surveyor's POC/AOCs that were accepted by the surveyor during the CY26 for acceptability of POC/AOCs. Unless there are extenuating circumstances (illness, unexpected absence), the surveyor who performed the survey must be included in the POC/AOC review process for their surveys.				Oversight	The SA will elaborate on how they perform this review and include the surveyor(s).
PI 4	CMS DCLIQ will review at least one Form CMS-2567 for each surveyor for adherence to POD. Did CMS' review of Form CMS-2567s (Review Tool Crit 4, POD Pr 3) meet POD?	NA - No response is required from the SA	NA		Survey & Enforcement	An example of a table that can be used for each of the SA's surveyor(s) is at the end of this table.
PI 5	The SA review process includes participation by all surveyors as an opportunity for skill improvement.				Oversight	This is applicable to a SA with multiple surveyors
PI 6	The SA review process must include at least quarterly review and must track the progress of surveyor improvement or document sustained proficiency.				Oversight	The SA review of CMS 2567's should be spread out to meet the quarterly review requirement
PI 7	Specific area(s) of improvement identified in DCLIQ feedback (FMS Assessment, DCLIQ, POD reviews, and any other DCLIQ reviews), if any, are incorporated by the SA into their review process. The SA will provide documentation showing how they have incorporated DCLIQ feedback into their process.				Survey & Enforcement	The Survey Branch will provide available information on any SA FMS, as applicable.

SOD-A Mandatory Citation List	A detail report listing surveys in which mandatory citations were cited during the fiscal year under review with a run-time parameter for Geography.	The SOD - A report pulls all the surveys where any of the mandatory Dtags (D2000, D2016, D5980D, D5990, D6000, D6033, D6056, D6063, D6076, D6108, D6134, D6141, D6153, D6162, D6168) were used. Samples can be made from the list to ensure appropriate use of the Dtags or for other reviews such as the SA reviews of the POC/AOCs for consistency with SOM 6130, etc. NOTE: This report does not include PT Desk Review. Generated quarterly by CMS and uploaded into BOX.
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SAPR CY26 Criterion 4 - POD - REVIEW TOOL

CLIA Number		State				
Lab Name		Surveyor ID				
Surveyor Name		DCLIQ Reviewer				
Total Number of D-Tags on CMS-2567		Review Date				
NEW for 2026	Complete one review tool for each surveyor on the survey team.					
Principle Requirement	Overall Review	All D-Tags That Meet POD	Specify D-tag Not meeting POD (1)	Specify D-tag Not meeting POD (2)	Specify D-tag Not meeting POD (3)	Reasons for those not meeting the D-tags
The specific violation of regulations stated clearly, e.g., specific action(s), error(s), lack of The DPS does not simply restate regulation.						
Extent						
Extent of deficient practice is stated in DPS						
Extent is expressed in a numerical value						
Sources of Evidence						
DPS contains the source(s) of evidence						
At least 2 sources, if possible						
Identifiers						
Identifiers are included. Personally Identifiable Information including patient names/sex/age/DOB is referred to by a coding system so they remain confidential. Individual's names/titles are referred to by a coding system so they remain confidential.						
Findings/Facts						
Findings support the DPS						
Findings/facts are organized in a concise, chronological and logical order						
The questions who, what, when, where, and how are answered						
Sources of Evidence						
All sources of evidence in the DPS are also reflected in the findings						
Observations: date, time, location						
Interviews: date, time, identifier						
Record/Document review: record name/type						
General						
The D-Tag is applicable to the requirement cited						
The deficiency citation is free of extraneous remarks and advice						

SAPR CY26 Criterion #5: Survey Workload and Outcome-Oriented Survey Process (OOSP)

Overall Goal	The SA has a system to ensure that all surveyors conduct surveys using the outcome-oriented survey process and that the SA has implemented a tracking system and meets survey time frames.		
Performance Threshold	85%	DCLIQ Reviewer	
State Agency		Review Date	
Quantified Performance	FALSE		
Written Corrective Action Required	A Written Corrective Action Plan is required if the Quantified Performance Result is less than Performance Threshold above		

Note

The SA must submit evidence of all Mandatory Reports that includes annotation of actions taken by the SA, as applicable.

To calculate the SAs percent backlog, compare the SA Survey Status report with QCOR Compliance laboratory totals. Example:
 there are 2080 compliance labs. Divide by two for biannual recertification survey to get your annual survey count - Remove: unpaid labs, current surveys uploaded, any AO and App change certificates. $1040 / (53+531-6-3-101)=474$ backlog). The formula is: Backlog divided by annual survey count equal percent backlog. $474/1040=0.456$ (45.6%) backlogged surveys

Example from the Survey Status Report:

App Change	842
Backlog AO	1
Backlog Initial Survey	2
Backlog- Recert Survey Paid	53
Backlog Recert Survey Performed	531
Initial Survey Uploaded	144
Recert Survey NOT paid	4
Recert Survey Uploaded	6
(blank)	97
	4

Performance Indicator	Requirements	SA Response	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch	Comments
PI 1	The SA completes all initial surveys within 3-12 months. (Quarterly SVY A report) Additionally, all SAs who have a backlog of overdue surveys must submit, quarterly, their plan to complete all overdue surveys. NOTE for PI #1: If the SA can demonstrate that all expired Certificates of Registration (CoR) listed on this report were due to circumstances beyond the SA's control, do not hold the SA accountable. Enter "Yes". Document the exceptions in the Comments section of this worksheet.				Oversight	<i>Refer to Attachment 2. Submit all SVY A reports with commentary to DCLIQ.</i>
PI 2	The SA completes all recertification surveys timely so that no Certificates of Compliance expire. (Quarterly SVY B report). Additionally, all SAs who have a backlog of overdue surveys must submit, quarterly, their plan to complete all overdue surveys. Backlog is defined as >10% overdue COC laboratory surveys. NOTE for PI #2: If all expired Certificates of Compliance (CoC) listed on this report were due to circumstances beyond the CLIA SA's control, do not hold the SA accountable. Enter a "Yes". Document the exceptions in the Comments section of this worksheet.				Oversight	<i>Submit all SVY B reports with commentary to DCLIQ.</i>
PI 3	The SA completes budgeted validation surveys within 90 days of the AO survey date. (Quarterly SVY C report) NOTE for PI #3: If zero or one of the time intervals between AO and CLIA surveys exceed 90 days, enter "Yes." If two or more of the time intervals exceed 90 days enter "No". EXCEPTION: If the SA can demonstrate that all the intervals which exceed 90 days were due to survey scheduling changes by the accreditation organization/laboratory, do not hold the SA accountable. Enter "Yes". Document the exception(s) in the Comments section of this worksheet. Postponing a validation survey more than once, at the request of the laboratory, is contrary to SOM instructions, and is not considered an exception for SAPR purposes.				Oversight	<i>Submit all SVY C reports with commentary to DCLIQ.</i>
PI 4	The SA must demonstrate that they have generated, evaluated, and acted on the CASPER 0080D reports every 30-45 days. The SA must submit evidence of review and all follow-up actions taken and the 0080D report generated in the quarter, within 30 days of the completion of the quarter.				Oversight	<i>Submit all CASPER 0080D reports with commentary to DCLIQ.</i>

PI 5	The SA has generated and utilized the CASPER 0850D quarterly reports to address expired certificates (CoR and CoC). The SA must submit evidence of review and all follow-up actions taken and the 0850D report generated in the quarter, within 30 days of the completion of the quarter.				Oversight	Submit all CASPER 0850D reports with commentary to DCLIQ. If the SA has no expired certificates on the CASPER 0850D report, enter "Yes". If there are mitigating circumstances beyond the SA's control as to why certificates expired, enter a "Yes". The SA should be able to show that they have generated the CASPER 0850D report each quarter even if the reports show that the SA has no expired certificates. If the SA has no expired certificates and has NOT generated the CASPER 0850D report, enter a "No".
PI 6	<p>All surveys are uploaded in a timely manner (within 45 days). (Quarterly SVY - D report). <i>The SA must submit evidence of review and all follow-up actions taken, recorded on the Quarterly SVY - D report generated in the quarter, within 30 days of the completion of the quarter.</i></p> <p>EXCEPTION: If the SA can demonstrate that survey kit uploads were due to circumstances beyond the SA's control (e.g., laboratory did not respond to a request for an AoC/PoC), do not hold the SA accountable. Enter a "Yes". Document the exception(s) in the Comments section of this worksheet.</p> <p>Please note: If the laboratory does not provide an acceptable POC/credible AOC within 45 days, the SA will not be able to upload the kit within 45 days. If the SA has documentation to show this is the case (i.e., extenuating circumstances), the SA will not be held to the 45-day upload timeframe. SA can upload Condition-level noncompliant survey kits and the system will register the upload by the SA even though L32 and L33 error messages are received.</p> <p>Outcome-Oriented Survey Process:</p> <ul style="list-style-type: none"> Any CMS-2567s reviewed throughout the review period by the CMS DCLIQ (e.g., for the purpose of FMS Assessments, Condition-level non-compliance) can be incorporated into the CMS DCLIQ review to meet this criterion. For example, a sample of FMS Assessment surveys may be reviewed to ensure follow-up actions and monitoring were completed as required. Interview the surveyor and/or supervisor to ascertain how the SA utilizes FMS feedback in the FMS Cover Letter and Summary Report, if any, for improving surveyor proficiency in OOSP. Review the SA's mechanism for communicating SOM directives and changes to surveyors. Select a couple of major program directives or SOM issuances on the OOSP and interview surveyors to determine whether they are familiar with them. <p>If, during the period under review, no new directives or changes were issued, interview surveyors, including newly hired, to ascertain their familiarity with SOM directives in the OOSP.</p>				Oversight will review the ASPEN Tracking Report for Failed and Overdue Certification Kit Uploads. Enforcement will provide information regarding PT DR kits.	Submit all SVY-D reports with commentary to DCLIQ. Note, in addition to reviewing the SA SAS Viya report, the SA must generate and act on the ASPEN Tracking Report for Failed and Overdue Certification Kit Uploads at least quarterly.

Number of No	0
Number of Yes	0
Number of Yes and No	0

Mandatory Data Reports

Report Name	Description	Comments
SVY-A: Initial Surveys - MANDATORY	A detail report identifying the laboratories that had early/late initial surveys in the fiscal year under review.	SVY-A report provides the data on initial surveys for the FY and the number of days between the certificate effective date and the survey date. Initial surveys are expected to be completed between 3 to 12 months. SAs are to provide the reasons for the delay in performing each of those surveys that were completed later than expected, i.e., >365 days. Any lab on the Survey Backlog report (see BOX) is pending survey and upload. They will not show on these reports— SVY A and SVY - B. because to allow the laboratories to continue to function, their expiration dates were artificially extended to allow States to catch up. The CASPER report may also look good, but those labs are overdue for survey. Hence, the SA should use the Survey Backlog report to capture those labs. Generated quarterly by CMS and uploaded into BOX. This report must be acted upon by the SA.
SVY-B: Expired CoC - MANDATORY	A detail report identifying the laboratories that had recertification surveys after the certificate expired.	SAs are to provide reasons for the delay in performing each of those surveys that were completed later than expected. Generated quarterly by CMS and uploaded into BOX. This report must be acted upon by the SA.
SVY-C: Validation - MANDATORY	A detail report identifying the accredited labs (application type 3) that had Validation surveys during the fiscal year under review and showing the number of days between the AO survey date and the Validation date. Note: The report displays the laboratories by AO, so a laboratory accredited by both ASHI and AABB would display (and be counted) on 2 lines.	The SVY-C report will only capture the validation survey started and completed within the FY under evaluation – "completed" means uploaded. If a CoA lab is downgraded to a CoW lab, the lab may not show on this report or drop off. DCLIQ will accept the SA documentation for validation surveys. The number of budgeted surveys can be found in the FY budget call letter.
SVY-D: Survey Upload	A DETAIL report showing laboratories surveyed during the FY under review and first uploaded into the ACO system more than 45 days after the survey date. Note: "Survey Transaction Date" is a date generated at the time the SA first attempts to upload a certification kit in ACO.	Generated quarterly by CMS and uploaded into BOX. This report must be acted upon by the SA.

CASPER 0850D	Monitor expired/expiring certificates	This report must be generated and acted upon by the SA. States use this report to plan out their survey year. The report does not provide an accurate list of labs because DCLIQ is artificially extending lab expiration dates. You need to generate separate CoRs and CoCs reports.
CASPER 0080D	Monitor laboratories for paid compliance fees - used for survey scheduling.	This report must be generated and acted upon by the SA. Use this report to identify which laboratories have paid their compliance fees. The state can only schedule a lab for a survey when their outstanding bill has been paid.
Survey Backlog Report	Monitor SA survey backlog	Generated quarterly by CMS and uploaded into BOX. This report must be acted upon by the SA.
CASPER 0074D	CLIA Labs with AO Remarks	This report must be generated and acted upon by the SA. A report that shows all laboratories that have withdrawn from an AO. Also shows the Y match.
CASPER 1400D	Recertification Kits Not Uploaded	This report must be generated and acted upon by the SA. Review for recent CY exceptions and if the SA is addressing the failed/overdue upload status.
ASPEN Tracking Report for Failed and Overdue CoC Kit Uploads	Monitor CoC ASPEN uploads and survey workload	This report must be generated and acted upon by the SA. Review for recent CY exceptions and if the SA is addressing the failed/overdue upload status.
ASPEN Tracking Report for Failed and Overdue Special Surveys Kit Uploads	Monitor Special Survey ASPEN uploads and survey workload	This report must be generated and acted upon by the SA. Review for recent CY exceptions and if the SA is addressing the failed/overdue upload status.
Optional Data Reports		
Report Name	Description	Comments
CASPER 0075D: Accredited Lab Accreditation Organization Verification	This detail report identifies the CLIA Accredited laboratories that are operating with Certificate of Registration (CoR) that have not been confirmed (Y-matched).	

SAPR CY26 Criterion #7: Quality Assessment

Overall Goal	The SA has developed Standard Operating Procedures (SOPs) related to SAPR requirements, based on written guidance from CMS, to include the applicable portions of the State Operations Manual (SOM) and all CMS memos (QSO & AdminInfo). The SA has an ongoing mechanism to monitor, assess, and when indicated, correct problems identified in their survey and certification activity (i.e., quality assessment).					
Performance Threshold	100%	DCLIQ Reviewer				
State Agency		Review Date				
Quantified Performance	FALSE					
Written Corrective Action Required		A Written Corrective Action Plan is required if the Quantified Performance Result is less than Performance Threshold above				
NEW For CY 2026	The SA must submit all required SAPR documents to CMS within 30 days of the end of the CY quarter. See PI 6.					
Performance Indicator	Requirements	SA Response	Required data submitted? (Yes, No, NA)	Requirements Met (Yes or No)	Responsible Branch	Comments, if applicable
PI 1	The SA has documented evidence of the implementation of CAP (Corrective Action Plan) and/or QIP (Quality Improvement Process).				Oversight	
PI 2	<p>The SA must establish and follow a written standard operating procedure (SOP) for:</p> <ul style="list-style-type: none"> • Surveyor and clerical orientation, training, and annual competency; • Entry of initial application, certificate changes, and demographic information updates; • Performing PT Desk Review every 30-45 days; • Handling and triaging all complaints; • Quality Assessment, including quality indicators; and • Budget <p>These procedures must follow all written guidance from CMS, to include the applicable portions of the State Operations Manual (SOM) and CMS memos (QSO & AdminInfo). NOTE: The SA is required to submit SOPs once yearly, unless the SA makes a change to the SOP.</p>				Oversight, Enforcement, Logistics, & Survey	

PI 3	<p>The SA QA Program must include an on-going mechanism to monitor, assess, and when indicated, correct problems identified in their survey and certification activity, and must include:</p> <ul style="list-style-type: none"> • Identification of areas needing improvement for surveyors; • Utilization of FMS Assessments and other DCLIQ feedback when identifying areas for surveyor improvement; • Measuring progress in improving surveyor skills when needed (data from SoD review, PoC/AOC review or other SA internal measurement); • Tracking errors in data management • Interval between running CASPER 0153D and CASPER 0155D and review of information for PT desk review; • Timeliness of sending letters and CMS 2567s for unsuccessful participation in PT; • Identification of issues in the overall process; • All activities related to QA must be documented <p>NOTE for PI #3: If any one above is not met, indicate which was not met in the "Comment" column.</p>				Oversight, Enforcement, & Survey	
PI 4	<p>The SA runs quarterly monitoring reports (See AdminInfo Memo Attachment #2: Data Reports) and when indicated, corrects problems identified in the reports. The quarterly reports include the ASPEN Tracking Report for Failed and Overdue Certification Kit Uploads, CASPER 0074D, and CASPER 1400D.</p>				Oversight	
PI 5	<p>The SA must address, and when indicated, correct problems identified in the quarterly reports provided by CMS. Quarterly reports include all Mandatory Quarterly SAPR Reports and Survey Backlog Report.</p>				Oversight	
PI 6	<p>The SA must submit all required SAPR documents (see each Criteria for the required documents) to CMS within 30 days of the end of the CY quarter.</p>	Q 1 - Q 2 - Q 3 - Q 4 -			Oversight	
Number of No		0				
Number of Yes		0				
Number of Yes and No		0				

SAPR CY26 Criterion #8: Budget

Overall Goal	The SA submits all required budget and expenditure documents within the specified time limits.		
Performance Threshold	80%	DCLIQ Reviewer	
State Agency		Review Date	
Quantified Performance	FALSE		
Written Corrective Action Required:	A Written Corrective Action Plan is required if the Quantified Performance Result is less than Performance Threshold above		
New for 2026	PI 1 and PI 2 have been combined. PI 4: Submission of CMS Form 105, and PI 5: Submission of Workload reports have been removed.		

Performance Indicator	Requirements	Required data submitted? (Yes, No)	Requirements Met (Yes or No)	Responsible Branch	Comments
PI 1	The SA submits and certifies the required annual budget forms (CMS-102, CMS-1465A, and CMS-1466) in SC/CLIA and sends the Annual Activity Plan to the Logistics Branch by the due date noted in the annual CLIA Budget Call Letter		Use the Quarterly Worksheet below	Logistics	
PI 2	The SA submits and certifies the CMS-102 (CLIA Budget/Expenditure Report) in SC/CLIA no later than 45 days after the end of each quarter. Evaluate for the four quarters - see Quarterly Worksheet below.		Use the Quarterly Worksheet below	Logistics	

Number of No	
Number of Yes	
Number of Yes and No	

Quarterly worksheet					
Performance Indicator	Requirement	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PI 1	The SA submits and certifies the required annual budget forms (CMS-102, CMS-1465A, and CMS-1466) in SC/CLIA and sends the Annual Activity Plan to the Logistics Branch by the due date noted in the annual CLIA Budget Call Letter				
PI 2	The SA submits and certifies the CMS-102 (CLIA Budget/Expenditure Report) in SC/CLIA no later than 45 days after the end of each quarter.				

Criterion	References
1. Personnel Qualifications, Training & Competency	SOM §§4003.2, 4009A-E, 4018. 6234.2, 6410, 6434 <u>Budget Call Letter</u> <u>1864 Agreement – Article IV-A, B; Article V-C</u>
2. Data Management	<u>SOM §6137</u> <u>Budget Call Letter</u> <u>1864 Agreement – Article V-C</u>
3. Proficiency Testing Desk Review	SOM §§6042-6063 Budget Call Letter 1864 Agreement – Article II-E
4. POD/POC, AOC	Appendix C Laboratory Principles of Documentation 1864 Agreement – Article II-A, E; Article V-C
5. Survey Process & Workload	SOM §§6100 – 6140 1864 Agreement, Article II-A-C, E; Article V-C Validation Survey Protocol Appendix C, I.-A.
6. Complaints	SOM: Chapter 5, sections for CLIA; ACTS Procedure Guide 1864 Agreement, Article II-E; Article V-C
7. Quality Assessment	1864 Agreement – Article II-A, E, I-J; Article IV-A, B; Article
8. Budget	1864 Agreement, Article V.C.9., Article IX.M. SOM §§6400 – 6486