CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 93 **Date: November 29, 2013**

SUBJECT: State Operations Manual (SOM) Chapter 1 revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

I. SUMMARY OF CHANGES: Revisions have been made throughout Chapter 1 to reflect the federally mandated ICF/IID nomenclature (the nomenclature is no longer ICF/MR).

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 29, 2013
IMPLEMENTATION DATE: November 29, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/1000/1000B-Medicaid Provisions
R	1/1008/1008D-Waivers of Standards
R	1/1008/1008E-Look-Behind Authority
R	1/1012/1012A-Meaning of Certification

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

1000B - Medicaid Provisions

(Rev.93, Issued: 11-29-13, Effective: 11-29-13, Implementation: 11-29-13)

Medicaid is a State program that provides medical services to clients of the State public assistance program and, at the State's option, other needy individuals, as well as augments hospital and nursing facility (NF) services that are mandated under Medicaid. States may decide on the amount, duration, and scope of additional services, except that care in institutions primarily for the care and treatment of mental disease may not be included for persons over age 21 and under age 65. When services are furnished through institutions that must be certified for Medicare, the institutional standards must be met for Medicaid as well. In general, the only types of institutions participating solely in Medicaid are NFs, Psychiatric Residential Treatment Facilities (PRTF), and Intermediate Care Facilities for *Individuals with Intellectual Disabilities* (*ICFs/IID*). Medicaid requires NFs to meet virtually the same requirements that SNFs participating in Medicare must meet. *ICFs/IID* must comply with special Medicaid standards. Section 1902 (a)(23) of the Act provides Medicaid recipients a free choice of providers if the provider undertakes to provide the recipients with medical services. However, such freedom may be restricted under §1932(a) of the Act if the State determines that an individual must receive his or her medical assistance from a managed care organization.

1008D - Waivers of Standards

(Rev.93, Issued: 11-29-13, Effective: 11-29-13, Implementation: 11-29-13)

For a few of the standards, the statute or regulations allow for waivers in the presence of verified temporary shortages of health personnel or in the presence of equivalent alternative patient safeguards. Medicare waiver authority is re-delegated to the ROs. Waivers for NFs to provide licensed personnel on a 24-hour basis repose with the States. Life safety code waivers for NFs and *ICFs/IID* are the responsibility of the States [See 42 CFR 483.470(j)(2)(A)].

1008E - Look-Behind Authority

(Rev.93, Issued: 11-29-13, Effective: 11-29-13, Implementation: 11-29-13)

The Secretary has authority under §§1902(a)(33), 1919(g)(3), and 1910(b)(1) of the Act to cancel approval of all Medicaid facilities, including NFs and *ICFs/IID*, that do not meet Federal health or safety requirements. Such a determination is in lieu of, or overrides, a determination by the State and is binding on the SMA. Section 1902(a)(33) gives CMS the authority to question State determinations regarding Medicaid facilities' compliance with Federal requirements and authorizes CMS to make independent and binding determinations concerning the extent to which individual institutions and agencies meet requirements for participation.

Section 1919(g)(3)(A) states that if the State determines that an individual NF meets Federal requirements, but CMS determines that the facility does not meet such

requirements, CMS' determination as to the facility's noncompliance is binding and supersedes that of the State.
Section 1910(b)(1), the look-behind authority, gives CMS similar authority to terminate the Medicaid approval of *ICFs/IID*. The CMS' decision to cancel the approval or terminate an *ICFs/IID* can be made as the result of complaint or Federal validation surveys or CMS' review of SA survey findings.

CMS also may, under 42 CFR Part 442.30, invalidate a Medicaid provider agreement after determining that the agreement does not constitute valid evidence of the provider's compliance with the Federal regulatory requirements. In the latter situation, the effect is to deny and recoup all Federal matching funds in the Medicaid payments to the facility that were made under the improper agreement. The authority to investigate and either cancel approval or invalidate improper agreements, called "old" look-behind authority, is re-delegated to an office in each CMS RO.

1012A - Meaning of Certification

(Rev.93, Issued: 11-29-13, Effective: 11-29-13, Implementation: 11-29-13)

Certification is when the SA officially recommends its findings regarding whether health care entities meet the Act's provider or supplier definitions, and whether the entities comply with standards required by Federal regulations. State agencies do not have Medicare determination-making functions or authorities; those authorities are delegated to CMS' RO. State agency certifications are the crucial evidence relied upon by the ROs in approving health care entities to participate in Medicare and CLIA. Recertifications are performed periodically by the SAs.

Regardless of whether the finding is for Medicare, Medicaid, or CLIA purposes, the SA surveys an institution in exactly the same way to ascertain whether it meets the Federal health and safety requirements for participation. Except for nursing homes that participate in both Medicare and Medicaid, CMS' determination is binding for both programs. For dually participating nursing homes, regardless of whose decision prevails (CMS' or the State's), that decision is adopted by CMS and applied to the entire facility.

Surveys are necessary for the SA to be able to certify. The law provides Federal funding for these surveys. SAs survey many institutions simultaneously for Medicare, Medicaid, and State licensure, and sometimes for other inspection programs, so the costs are equitably allocated between the sharing programs.

Part of a survey may concern a provider's efforts to prevent environmental hazards due to contagion, fire, contamination, or structural design and maintenance problems. However, a survey is neither a mere building inspection nor a "white glove inspection" which, on no more than an annual basis, would be pointless. Its more realistic focus is ascertaining that the responsible provider officials and key personnel are effectively doing all **they** must do to protect health and safety.

Many aspects of the survey are accomplished by scrutinizing the provider's records to show that professional staff members have been properly noting and evaluating the

progress of patients' care or managing provider operations with continuing vigilance. Surveys of SNFs, NFs, HHAs, and *ICFs/IID* are conducted in accordance with outcome-oriented survey protocols, which were designed to concentrate on patient/resident/client outcomes of care in determining the provider's compliance with the Federal requirements rather than focusing on "process-oriented" requirements. A provider's certification is not questioned merely on grounds that the institution has moved a short distance or slightly modified the scope of its services. See 42 CFR 488.26 and 488.330.