CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 92 **Date: November 20, 2013**

SUBJECT: State Operations Manual (SOM) Chapter 3 Policy and Nomenclature revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

I. SUMMARY OF CHANGES: Revisions have been made to Chapter 3, Sections 3000, 3005, 3006, 3008, 3010, 3024, 3040, 3058, and 3060 to reflect current Survey and Certification policy memos regarding ICF/IID. A revision to Section 3010B-Processing of Immediate Jeopardy Terminations deletes the following sentences since ICF/IIDs are no longer under time-limited agreements (TLAs). "Do not use this procedure if there is an ICF/IID time-limited provider agreement that is subject to cancellation or nonrenewal within 23 calendar days after the survey. In such a case, process the cancellation or nonrenewal. (See §3007.)". In addition, other revisions have been made in these sections to reflect the federally mandated ICF/IID nomenclature (the nomenclature is no longer ICF/MR). Sections 3006E and 3007 have been deleted because ICF/IIDs are no longer under TLAs or automatic cancellation clauses.

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 22, 2013
IMPLEMENTATION DATE: November 22, 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	3/Table of Contents
R	3/3000/3000C/CMS Authority to Terminate Medicare and Medicaid Participation
R	3/3005/3005C/Decision to Terminate or Deny Payment for Medicaid Facilities
R	3/3005/3005E/Termination of Title XIX-Only NFs and ICFs/IID
R	3/3005/3005G/3005G1/"Look-Behind" Termination or Cancellation of ICF/IID Agreement by the Secretary
R	3/3005/3005G/3005G2/Old "Look-Behind" Termination of a NF or ICF/IID by the Secretary
R	3/3006/Denial of Payments in Lieu of Termination of ICFs/IID
R	3/3006/3006A/Authority to Deny Payment for Any New Admissions for

	ICFs/IID
R	3/3006/3006C/Agency Procedures
D	3/3006/3006E/Status of Time Limited Agreement During Denials of Payments
R	3/3006/3006F/Duration of Denial of Payment and Subsequent Termination of an ICF/IID
R	3/3006/3006.1/Sanctions for ICFs/IID – or Nonimmediate Jeopardy
R	3/3006/3006.1/3006.1A/General
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R	3/3006/3006.1/3006.2/3006.2A/Purpose
R	3/3006/3006.1/3006.3/3006.3A/Purpose
R	3/3006/3006.1/3006.3/3006.3B/Appropriate Resources for Directed In-Service Training Programs
D	3/3007/Nonrenewal or Automatic Cancellation of Time Limited Agreements (TLAs) for ICF/IID Facilities
D	3/3007/3007A/General
D	3/3007/3007B/Nonrenewal of TLAs
D	3/3007/3007C/Automatic Cancellation Clause for ICFs/IID
R	3/3008/3008.2/Services for Which Federal Financial Participation (FFP) May Be Continued After Termination of a Medicaid Provider Agreement or Nonrenewal or Cancellation of an ICF/IID Provider Agreement
R	3/3008/3008.3/3008.3A/General
R	3/3010/3010B/Processing of Immediate Jeopardy Terminations
R	3/3024/RO Termination Processing Sequence- Noncompliance With CoPs or Conditions for Coverage (Excluding SNFs)
R	3/3040/Terminating Medicaid ICF/IID Eligibility Based on “Look-Behind” Determination
R	3/3040/3040A2/No Immediate Threat to Patients’ Health and Safety
R	3/3058/Hearing on 1910(b) Cancellation of Medicaid Eligibility
R	3/3060/ Appeals of Adverse Actions for Medicaid Non-State Operated NFs (Non-State Operated) and ICFs/IID (Not Applicable to Federal Terminations of Medicaid Facilities)
R	3/3060/3060C/Informal Reconsideration (Applies to ICFs/IID for Denial of Payment for New Admissions Only)

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.**

State Operations Manual

Chapter 3 - Additional Program Activities

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

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3000C - CMS Authority to Terminate Medicare and Medicaid Participation

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

1. Noncompliance with Conditions of Participation (CoPs), Conditions for Coverage, or Requirements for SNFs - The RO is delegated authority to terminate Medicare participation of all providers and suppliers because of noncompliance with the applicable regulatory requirements, or Conditions of Participation (CoPs) or Conditions for Coverage (CfCs).

2. Violations of Provider Agreements, Quality Improvement Organization (QIO) Sanctions, or Program Abuse - The Secretary's authority to terminate provider agreements is delegated to the Associate Regional Administrator and may be redelegated to the Branch Chief, but other components may also be authorized to find that termination is in order. Accordingly, the RO handles terminations on grounds other than noncompliance with the CoPs in accordance with §3032.

3. "Look Behind" Cancellation of Medicaid Intermediate Care *Facilities for Individuals with Intellectual Disabilities* (ICF/*IID*) Agreements - The ROs are authorized to cancel the approval of an ICF/*IID* to participate in the Medicaid program when the ICF/*IID* fails to comply substantially with regulatory CoPs. (See §1910(b) of the Act.)

4. Termination of Nursing Facility (NF) Medicaid Agreements - The ROs are, under certain circumstances, authorized to terminate a NF's participation in the Medicaid program. (See §1919(h) of the Act and Chapter 7 of the SOM.)

3005C - Decision to Terminate or Deny Payment for Medicaid Facilities

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

1 - Medicaid ICFs/IID

If deficiencies do not present an immediate jeopardy to residents' health and safety, the SMA has the option to deny payments for new admissions under §1902(i) of the Act or invoke termination. The SMA is not required to accept the SA recommendation as to whether to terminate or deny payments for new admissions.

2 - Medicare-Medicaid SNFs/NFs

For dually participating SNFs/NFs, the decision to deny payments for new admissions is made in accordance with §§1819(h) and 1919(h) of the Act. (See §§7506 and 7807.)

3 - Other Providers

The SMA must terminate the Medicaid agreement when the SA determines that a provider (there are no suppliers in Medicaid) other than a long-term care facility does not

meet applicable program requirements. Where partial terminations are made, such as for specific CLIA laboratory tests, the Medicaid determination must follow suit.

3005E - Termination of Title XIX-Only NFs and ICFs/*IID*

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Medicaid regulations provide for terminations, and for ICFs/*IID* nonrenewals, and cancellations, but do not describe the implementing procedures. Each SMA has procedures for terminating agreements with NFs and ICFs/*IID* when they are not in substantial compliance with program requirements. In any Medicaid-only noncompliance situation, the SA initiates the action, prepares the necessary documents, and forwards them to the SMA, which has responsibility for the termination, nonrenewal, or cancellation of the agreement (see §7300 for the exception regarding State operated NFs). In this case, the SMA notifies CMS and the public of its action and affords the facility notice and opportunity for a hearing before an ALJ prior to termination.

Under 42 CFR 431.54(f), the SMA may "lock out" a Medicaid provider for a reasonable period if it has abused the Medicaid program. This may occur even though the SA has approved the facility. There are no certification instructions directing the SA to participate in "lock out" procedures.

3005G1 - "Look-Behind" Termination or Cancellation of ICF/*IID* Agreement by the Secretary

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

The CMS has authority under §1910(b) of the Act to terminate approval of an ICF/*IID* to participate in the Medicaid program when it determines that the facility fails to comply substantially with the CoPs, 42 CFR Part 483, Subpart I, or to submit an acceptable PoC.

The cancellation is prospective, usually after the provider has had the opportunity for a formal hearing before an ALJ.

If there is no immediate jeopardy to resident health and safety and CMS elects to terminate, the ICF/*IID* is afforded an opportunity for a pre-termination hearing before an ALJ. If the effective date of termination is held in abeyance pending an ALJ's ruling and the ICF/*IID* makes a credible allegation of compliance while the hearing is pending, it is up to the RO to determine whether it is in the recipients' and the government's interest to resurvey the facility and dispose of the case based on the findings. If a revisit is made and the ICF/*IID* failed to achieve compliance, adverse action continues based on the findings of the first Federal survey and the revisit. If the ALJ affirms the CMS decision, the effective date of termination is set by the ALJ.

If there is an immediate jeopardy to resident health and safety, CMS terminates or cancels approval of the ICF/*IID* and affords it the opportunity for a post-termination ALJ hearing.

Following termination, ICFs/*IID* wanting readmission must request a survey from the RO. The RO directs the SA to do a survey unless it feels that a Federal survey is necessary. The CMS must be satisfied that the reasonable assurance provision is met before the State executes a Medicaid agreement with the ICF/*IID*.

3005G2 - Old "Look-Behind" Termination of a NF or ICF/*IID* by the Secretary

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Under 42 CFR 442.30, a provider agreement of a SNF, NF, or ICF/*IID* is considered invalid for purposes of providing FFP to the State unless the State has followed proper survey and certification procedures. For example, the SMA may have issued the provider agreement even though it had not certified the facility as being in compliance. Other examples of procedural error include, but are not limited to:

- The SA documents noncompliance yet certifies compliance;
- The SA certifies compliance, but all cited deficiencies are not covered by an acceptable PoC;
- The SA fails to survey against all applicable requirements; or
- The SA fails to use federally approved survey and certification documents.

When procedures are not followed by either the SA or SMA, CMS considers the provider agreement void from its inception, and the State is disallowed FFP for bills related to the facility for the period covered by that Medicaid agreement. This type of adverse action, referred to as "Old Look Behind," is covered in more detail in §3042.

3006 - Denial of Payments in Lieu of Termination of ICFs/*IID*

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

3006A - Authority to Deny Payment for Any New Admissions for ICFs/*IID*

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Section 1902(i) of the Act and 42 CFR 442.118 provide the SMA with an alternative to terminating ICFs/*IID* that fail to meet program requirements. This sanction is the one-time denial of payment for new admissions for a period of up to 11 months after the month it was imposed, if the facility's deficiencies do not present an immediate jeopardy to residents' health and safety. A decision is made at the end of 11 months whether to continue participation. However, the 11-month period can be shortened if circumstances change and there is immediate jeopardy to health and safety before 11 months have passed. Alternatively, the State might rescind the denial of payments in fewer than 11

months if full compliance is achieved or if the ICF/*IID* has made significant, good-faith efforts and progress in achieving compliance.

3006C - Agency Procedures

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Before denying payment for new admissions, the SMA must comply with the following requirements:

- Provide the ICF/*IID* up to 60 calendar days to correct the cited deficiencies and comply with the CoP.

- If at the end of the specified period the ICF/*IID* has not achieved compliance, give the facility notice of intent to deny admissions and the opportunity for an informal hearing.

- If the ICF/*IID* requests a hearing and the decision of the hearing is to deny payment, the SMA must provide the facility and the public, at least 15 calendar days before the effective date of the sanction, a notice that includes the effective date of the sanction and the reasons for the denial of payment.

3006F - Duration of Denial of Payment and Subsequent Termination of an ICF/*IID*

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

The denial of payment for new admissions will continue for eleven months unless, before the end of that period, the SMA finds that the ICF/*IID* has corrected the deficiencies or is making a good faith effort to achieve compliance with the CoPs or the deficiencies are such that it is necessary to terminate the facility.

The SMA must terminate the facility's provider agreement:

- Upon finding that the ICF/*IID* has been unable to achieve compliance with the CoPs during the 11-month period that payments were denied for new admissions; and

- Termination is effective the day following the last day of the denial of payment period.

3006.1 - Sanctions for ICFs-*IID* - or Nonimmediate Jeopardy

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

3006.1A - General

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

The Balanced Budget Act (BBA) of 1997 provided the statutory authority for States to establish and impose sanctions that are additional to the already existing alternative

sanction of denial of payment for new admissions, and which are alternative to termination in cases where the ICF/*IID*'s deficiencies are not determined to pose immediate jeopardy to client health and safety. This strategy recognizes that deficiencies take on greater or lesser significance depending on the specific circumstances and client outcomes in each facility, and that additional enforcement options should be available so that the enforcement consequence to the facility is effective, proportionate, and appropriate to the specifics of the noncompliance.

3006.1B - Introduction

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Section 1902(i)(1)(B) of the Act, as revised by the BBA of 1997, provides that the State may establish alternative sanctions to use as enforcement remedies for deficiencies that do not constitute immediate jeopardy to client health and safety if the State can demonstrate to CMS' satisfaction that its alternative sanctions are effective in deterring noncompliance and correcting deficiencies (see §3006.6). One or more alternative sanctions may be imposed against private or State operated ICFs/*IID* instead of provider agreement termination, and may also be imposed instead of or in addition to the existing alternative sanction of denial of payment for new admissions. Examples of sanctions that may be appropriate as alternative sanctions are listed in subsection C.

3006.1C - Examples of Alternative Sanctions

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

States should consider establishing the following alternative sanctions in their State plan for noncompliant ICFs/*IID* having nonimmediate jeopardy deficiencies:

- Directed plan of correction;
- Directed in-service training; and
- State monitoring.

States are not limited to establishing and using these alternative sanctions and may submit others for CMS' approval. When the State wants to use alternative sanctions, it must be authorized to do so under its State plan by CMS (see §3006.6). In order to be approved, the State must provide specified information to indicate that the alternative sanction and its application is not inconsistent with applicable statutory and regulatory requirements, as well as demonstrate to CMS' satisfaction that the alternative sanction is effective in deterring noncompliance and correcting deficiencies. Many States already have experience in imposing the three intermediate sanctions specified above against nursing homes (SNF/NFs) that fail to meet participation requirements. States also have experience in imposing remedies under their State licensure authority and may also wish to submit any of those to CMS for approval as alternative remedies for ICF/*IID*. While we want States to have the three specified intermediate sanctions listed above available

for ICF/*IID* enforcement purposes, States are free to submit others for CMS approval as well.

3006.2A - Purpose

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

A DPoC is a plan that the State develops to require an ICF/*IID* to take action within specified time frames. The purpose of the DPoC is to achieve correction and continued compliance with the CoPs.

A DPoC differs from a traditional PoC in that the State, not the facility, develops the PoC. Achieving compliance is the provider's responsibility, whether or not a DPoC was followed. If the facility fails to achieve substantial compliance after complying with the DPoC, the State may impose another alternative sanction (or sanctions) until the facility achieves substantial compliance or it is terminated from the Medicaid program.

3006.3A - Purpose

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Directed in-service training is a sanction that may be used when the SA concludes that education is likely to correct the deficiencies. This remedy requires the staff of the ICF/*IID* to attend in-service training program(s). The purpose of the directed in-service training is to provide knowledge required to achieve compliance and remain in compliance with the CoPs.

3006.3B - Appropriate Resources for Directed In-Service Training Programs

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Facilities should use programs developed by well-established organizations of *intellectual disabilities*, developmental disabilities, mental health or health services education, such as special education departments in colleges or universities or schools of medicine, State departments/bureaus of mental health/ *intellectual disabilities* or developmental disabilities; Developmental Disabilities Councils; Federally funded State protection and advocacy agencies serving people with developmental disabilities; professional organizations with expertise in developmental disabilities, and a State may provide special consultative services for obtaining this type of training. The SA may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may request to use training resources internal to the organization, if the trainer was not directly involved with the area sanctioned. Examples of directed in-service training topics include, but are not limited to, client rights issues, behavior intervention, active treatment, health and safety, and outcome measures.

3008.2 - Services for Which Federal Financial Participation (FFP) May Be Continued After Termination of a Medicaid Provider Agreement or Nonrenewal or Cancellation of an ICF/*IID* Provider Agreement

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Federal Financial Participation (FFP) may continue for up to 30 calendar days after the effective date of termination (or expiration or cancellation of a provider agreement of an ICF/*IID*) if the Medicaid beneficiaries were admitted to the entity before the effective date of termination or expiration and the State is making reasonable effort to transfer those beneficiaries to other facilities or to alternate care. (See 42 CFR 441.11.) Services for which FFP may be continues:

- Inpatient hospital services;
- Inpatient hospital services for individuals age 65 or older in institutions for mental disease (IMD);
- NF services;
- NF services for individuals age 65 or older in IMD;
- Inpatient psychiatric services for individuals under age 21; and
- ICF/*IID* services.

3008.3A - General

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

There are instances when patients in Medicare and Medicaid long-term care facilities need to be transferred to other facilities. Specific actions, decisions, and events that require the relocation of patients include:

- Voluntary or involuntary termination of provider agreement;
- Expiration or renewal of an ICF/*IID* provider agreement ;
- The provider's inability to provide care and related services because of fire, natural disaster, loss of staff, or another reason beyond its control;
- The provider's voluntary termination of participation in Medicaid and/or Medicare; and
- Closure of a facility.

3010B - Processing of Immediate Jeopardy Terminations

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

When an immediate jeopardy to patient health or safety is documented, the SA and RO complete termination procedures within 23 calendar days. Processing times given here are the maximum allowed. Do not postpone or stop the procedure unless compliance is achieved and documented through onsite verification. If there is a credible allegation that the threat or deficiency has been corrected, the SA conducts a revisit prior to termination if possible.

Special Procedures for IJ in Psychiatric Hospitals

It is the RO that makes the determination of non-compliance when an immediate jeopardy to patient health or safety exists, not the CMS' contract surveyors. The CMS' contract surveyors will notify the RO when onsite during survey an immediate jeopardy to patient health or safety exists, the RO completes the termination procedures within 23 calendar days. On the last day of the survey, CMS' contract surveyors telephone Central Office (CO) to certify noncompliance and that an immediate jeopardy exists. CO immediately notifies the RO of the surveyors' findings. The CMS contract surveyors discuss their findings with the provider and tell the providers that they are mailing the RO by overnight express mail completed Forms CMS-1537A and CMS-2567. A copy is also mailed to CO for review. The RO reviews the survey package (Forms CMS-1537A and CMS-2567), and if it determines noncompliance, it mails Form CMS-2567 to the provider. After doing so, the RO follows the 23 calendar day termination procedure as outlined below beginning with the fifth working day.

23-Day Termination Procedures

1. **Date of Survey -** The date of the survey is the date on which the entire survey is completed, regardless of when the exit conference is held.

2. **Second Working Day -** No later than 2 working days following the survey date. The SA:

    - Telephones the RO that it is certifying noncompliance and that an immediate jeopardy exists; and

    - Notifies the provider/supplier (by telegram or overnight express mail or FAX) of its deficiencies and inform the provider/supplier that it is recommending termination to the RO, which will issue a formal notice. The notice advises the provider/supplier of its right to due process, the expected schedule for termination action, and that the deficiency must be corrected and verified by the SA to halt the termination. If the provider also participates in Medicaid, the SA notifies the SMA of its certification of noncompliance.

3. **Third Working Day -** The SA forwards all supporting documentation to the RO (e.g., statement of deficiencies, correspondence, contact reports, Form CMS-1539). The SA forwards the information by overnight mail to assure that the RO receives it in time to meet the 5-working-day deadline. Upon receipt of the SA information, the RO reviews the documents and makes its determination of noncompliance.

4. **Fifth Working Day** - The provider/supplier and the public are then notified by the RO of the proposed termination action by the most expeditious means available. A press release to the radio and television stations serving the area in which the provider/supplier or institution is located is acceptable if a newspaper notice cannot be arranged in the time allotted. Notice must be made at least 2 calendar days prior to the effective date of termination. (See 42 CFR 488.456(c).)

5. **Tenth Working Day -** If the SA only sent notification of the IJ deficiencies on the second working day to the provider/supplier and RO, and there are other, non-IJ deficiencies, (non-IJ condition and standard level), then the SA must write up another 2567 with the non-IJ deficiencies and forward copies to the provider/supplier, the RO and SMA within ten working days. The SA retains a copy for its records.

6. **Twenty-Third Calendar Day** - The termination takes effect unless compliance is achieved or threat is removed. If the threat has been removed, but deficiencies still exist at the Condition level, the SA gives the provider/supplier up to 67 more calendar days, or 90 calendar days total (23 plus 67). These dates are maximum times, and participation may be terminated earlier if processing allows. However, the RO must adhere to both the provider/supplier and public notice timeframes.

If the RO disagrees based upon its review of the documentation, the RO discusses the results of the review with the SA and solicits further evidence to support the SA's recommendation. The RO confers with the SA as to the appropriate action to be taken. Should the RO and the SA fail to agree that an immediate jeopardy exists, a revisit will be conducted by the RO and the SA together to ascertain whether or not immediate jeopardy to the patient's health and safety exists or has been removed. If the RO and SA agree that an immediate jeopardy exists, no revisit is necessary by the RO. Under no circumstances should the RO reverse a SA recommendation that an immediate jeopardy has been removed or not removed unless the determination is made on the basis of an onsite determination by Federal surveyors.

Medicaid agreements with facilities that concurrently participate in Medicare should be terminated on the same date the Medicare agreement is terminated. Where State law permits, Medicaid-only facilities should be terminated by the State within the above time limits. For NFs that also participate as SNFs, the State's timing of termination shall control. (See 42 CFR 488.452.)

3024 - RO Termination Processing Sequence - Noncompliance With CoPs or Conditions for Coverage (Excluding SNFs)

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Upon receipt of the SA's unfavorable certification, the RO:

A. Establishes controls for processing the termination;

B. Performs an initial documentary review to make certain that copies of all pertinent surveys, statements of deficiencies, plans of correction (if submitted by the provider), and other necessary documents are included and that all relevant issues are resolved. When unable to determine the relationship of cited deficiencies to the quality of services or the health and safety of patients, the RO requests further SA development. If necessary, the RO retains the file and phones the SA for the additional documentation needed;

C. Does a substantive review, resolves all substantive discrepancies and disputes, assesses the severity of the provider's/supplier's noncompliance, and makes its determination. The RO consults with LSC specialists in the RO, if necessary. See discussion in §3026 concerning how to treat key documents in making your determination;

D. Prepares the Termination Notice (Exhibits 181 and 182) and Newspaper Notice (Exhibit 183) and any supplemental press releases, if planned. The RO forwards a copy of its notice to the SMA, if appropriate; and

E. Inserts the effective date of termination in the notice and makes the necessary arrangements for public notice. To give both the provider and the public sufficient advance notice of termination of a provider's agreement (at least 2 calendar days if there is immediate jeopardy or at least 15 calendar days if there is no immediate jeopardy), the RO determines the effective date of termination as follows:

- Allows sufficient time for delivery of the notice to the provider, depending on the provider's location and the method of notification, i.e., letter, overnight mail, or electronic means.
- Determines the time needed for actual public notice by contacting the local newspaper or radio and television stations to determine their deadlines. (See §3034);

- Allows for receipt of the notice by the provider prior to publication of the public notice and assures that the public receives at least 2 calendar days if immediate jeopardy exists, otherwise 15 calendar days notice prior to the date of termination;

- Mails the termination notice to the provider (return receipt requested); and

- Notifies the SMA of action taken against Medicaid ICFs/*IID* and the effective dates if termination action is taken pursuant to §3000.C.3. When the termination action is taken, the RO mails the informational copies to the following offices:

    - Division of Medicare;
    - Division of Medicaid;
    - CO;
    - Intermediary;
    - SA;
    - SMA;
    - Regional Director, Department of Health and Human Services (DHHS); and
    - State Ombudsman.

3040 - Terminating Medicaid ICF/*IID* Eligibility Based on "Look Behind" Determination

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Section 1910(b)(1) of the Act authorizes CMS to terminate approval of a Medicaid ICF/*IID*'s eligibility to participate in the Medicaid program when CMS determines that the provider does not substantially meet the CoPs for ICFs/*IID* (42 CFR Part 483). The Act uses the terms "cancel" and "terminate" interchangeably. The adjudicative procedures are similar to those followed for terminating a §1866 provider agreement under §§3010 and 3012. Except in the case of immediate jeopardy situations, termination usually becomes effective after the provider has had an evidentiary hearing before an Administrative Law Judge (ALJ) and the ALJ has upheld the termination.

3040A2 - No Immediate Threat to Patients' Health and Safety

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

If the ICF/*IID* is not in compliance with one or more of the CoPs, the RO completes the actions within the time limits prescribed.

a. **Tenth Working Day -** The RO notifies the provider in writing of its deficiencies and that termination action is being initiated. Included in the notices is the provider's right to appeal this action, along with the effective date of termination. If the provider makes a credible allegation of compliance prior to the effective date of termination, the RO conducts a revisit. (See §3038.B.)

b. **Seventieth Calendar Day -** The RO completes all related documentation and notifies the facility, the SMA, and the SA.

c. **Ninetieth Calendar Day -** If compliance has not been achieved, the RO terminates participation.

If an appeal is filed by the facility, termination must be delayed pending the hearing and decision by the ALJ (see 42 CFR 498.5(j). The provider agreement remains in effect and FFP continues pending the appeal decision. If the facility makes a credible allegation of compliance during the appeal period, it is the RO's decision whether or not it is in the recipients' and the Federal Government's best interests to conduct a revisit and dispose of the case based on the findings. If a revisit is made and the facility failed to achieve compliance, adverse action continues based on the findings of the first Federal survey and the findings of the revisit. If at the time of the revisit the provider is in compliance with the requirements forming the basis for the original termination, but has new deficiencies that are also grounds for termination, the RO initiates a new termination process commencing with the revisit.

If the ALJ sustains the termination action, the effective date of termination and cessation of FFP is set by the ALJ. Further appeal by the facility to the DAB does not cause the provider agreement to be extended, i.e., payment does not continue pending a decision by the DAB.

Whenever possible, the RO conducts the termination notification and decision-making process in the 90-day timeframe used for Medicare terminations. However, there are circumstances that require that the RO give a facility extra time. For example, with State-owned facilities, it sometimes takes longer to get a PoC because of the need for action by other parts of State government, thus requiring additional processing time. Keep these situations to an absolute minimum. In addition, an ALJ hearing may not be scheduled within the usual 90-day termination timeframe.

The reasonable assurance provisions apply to ICFs/*IID* terminated by CMS.

3058 - Hearing on §1910(b) Cancellation of Medicaid Eligibility

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

If a hearing is requested on a termination of an ICF/*IID*'s Medicaid participation by CMS, send the provider's request for a hearing to the DAB.

3060 - Appeals of Adverse Actions for Medicaid Non-State Operated NFs (Non-State Operated) and ICFs/*IID* (Not Applicable to Federal Terminations of Medicaid Facilities)

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

Denials, terminations, cancellations, and denials of payment for new admissions and other adverse actions to facilities participating in Medicaid-only are State administrative actions and decisions.

State appeal procedures must be made available to facilities in cases of nonrenewal, denial, cancellation, or termination of the provider agreement. It is up to the State to designate the office or official having authority to hear and decide Medicaid appeals. Although the State retains considerable flexibility in developing its own appeal procedures, the procedures for an ICF/*IID* must at a minimum provide for an evidentiary hearing either before or within 120 calendar days **after** the effective date of the adverse action. The State must also provide an informal reconsideration prior to taking adverse action if it elects to provide a full evidentiary hearing **after** the effective date of the adverse action for an ICF/*IID* (42 CFR 431.150 through 431.154).

If a NF requests a hearing on a denial or termination of its provider agreement, the request does not delay the adverse action and the hearing need not be completed before the effective date of the action. However, a NF is entitled to a hearing before a CMP is collected (see §7526).

NOTE - In the procedures for denial of payment for new admissions for ICFs/*IID* (see §3060.C), a post-termination hearing is **not** a permitted option. The State must provide an informal hearing **before** the effective date of the denial of payments for new admissions. Consequently, reconsideration is not appropriate for these appeals.

3060C - Informal Reconsideration (Applies to ICFs/*IID* for Denial of Payment for New Admissions Only)

(Rev.92, Issued, 11-22-13, Effective: 11-22-13, Implementation: 11-22-13)

The informal hearing process must include:

- Timely notice of the reason for the action;
- A reasonable opportunity for the provider/supplier to present in writing or in person reasons for its disagreement;
- An opportunity for the provider/supplier or its representatives to be heard in person and to present documentation; and
- A written decision by an impartial decision maker, prior to the effective date of the denial of payment, setting forth the reasons for the determination. An evidentiary hearing does not follow the informal hearing.