CMS
CENTERS for MEDICARE & MEDICAID SERVICES

REGION IV
ATLANTA

State Request for Approval of Use of

Civil Money Penalty Funds

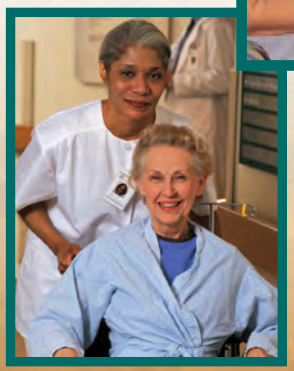
for Certified Nursing Homes

- Alabama
- Florida
- Georgia
- Kentucky
- Mississippi
- North Carolina
- South Carolina
- Tennessee

INTRODUCTION

In accordance with Survey & Certification transmittal 12-13-NH dated December 16, 2011, States must obtain approval from the Centers for Medicare & Medicaid Services (CMS) for the use of federally imposed civil money penalty (CMP) funds. A copy of this transmittal is available on the CMS website at www.cms.hhs.gov. Effective January 1, 2012, CMS has established a process for reviewing applications that seek funding to improve resident outcomes in certified nursing homes. Only CMP fund applications that meet the statutory intent of the regulations, Federal law and policy will be considered.

Special thanks to the Region IV– CMP Coalition for their assistance in developing this CMP Grant request form to promote consistency, transparency and best practices.
Region IV states include: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Requests to use CMP funds may be made by various organizations and entities. Applications may be submitted by certified nursing homes, academic or research institutions, state, local or tribal governments, profit or not-for-profit, or other types of organizations.



INSTRUCTIONS

Application Process

- Entities from which CMP requests originate shall submit the request to the applicable State Agency (SA) for an initial review and recommendation.
- All CMP requests shall be submitted electronically and sent to the applicable State Agency (SA) utilizing the Region IV: CMP Grant Request form.
- Requests will not be accepted via facsimile.
- Requests shall include a cover letter addressed to the State Agency (SA) Director.
- CMP request forms may be accepted from dually certified providers (SNF/NF) and nursing facilities (NF) and other organizations.
- The font for all CMP requests is Times New Roman, twelve (12) point, and shall include the entity name and page numbers on all documents.
- Requests should be limited to no more than twenty (20) pages, including appendices and the actual CMP request form.
- All sections of the request form shall be completed or the CMP request may be denied.
- When CMP funds are requested for educational purposes, the organization involved must also include the following: anticipated number of attendees; target audience; accrediting authorities; timeline for implementation and plan for sustainability; and letters of support. Representatives from any group requesting funding, or representatives who are in situations where a conflict of interest exists, must disqualify themselves from making recommendations.
- State Agency reviewers shall first assess the merit of each project and the ability of the project to improve resident outcomes and advance the care and services provided in certified long term care facilities.
- Applicants may contact the applicable state survey agency with questions regarding their CMP request.

Following State Agency review, the CMP request form shall be forwarded to the CMS electronic mail box for a decision.

- The mail box address is **ATLCMPGRANTAPPLICATIONPROPOSALS@cms.hhs.gov**. Only CMP request forms reviewed by the SA should be forwarded to this mailbox.

- Upon receipt by CMS, CMP request forms shall be assigned a tracking number. The tracking number consists of the year, CMS regional code, state prefix, date code, application number and entity name. For example: 2012-04-AL-12-19-01-John Doe Nursing Center. Tracking codes shall be utilized in the annual transparency report beginning in 2013.
- CMP requests are reviewed by CMS in the order of receipt.
- CMS may approve the CMP request, deny the CMP request or request additional information.
- CMP request forms that are denied are not subject to an appeal.
- Feedback to the State Agency on the status of the CMP request form submitted to CMS shall be provided within 45 calendar days of receipt.
- If the State Agency has not received a response from CMS within 45 calendar days of receipt of a completed request, the State Agency may send a request for priority processing to Stephanie.Davis@cms.hhs.gov and QualityAssurance@cms.hhs.gov.
- CMS' regional office has final authority to approve requests. If a request is approved, the organization or entity from which the request originated shall be required to submit a quarterly report on the status of the project to the CMS regional office and the State Agency.
- A follow-up report at the conclusion of the project/proposal shall be submitted within five (5) calendar days to CMS and to the State Agency. A second report monitoring the success of the project is to be submitted to CMS and to the State Agency within six months of the project conclusion. CMS Reports may be sent to:

  Stephanie M. Davis, M.S., R.D.
  Long Term Care Certification & Enforcement Branch
  Centers for Medicare & Medicaid Services
  Sam Nunn Atlanta Federal Center
  61 Forsyth Street, S.W., Suite 4T20
  Atlanta, Georgia 30303

Please be mindful that CMS is not able to approve projects in certain circumstances, such as:

Prohibited Uses

- Conflict of Interest—CMS will not approve projects for which a conflict of interest exists or the appearance of a conflict of interest.
- States may not use CMP funds to pay entities to perform functions for which they are already paid by State or Federal sources.

- CMP funds may not be used to pay for capital improvements to a nursing home, or to build a nursing home.
- CMP funds may not be used to pay for nursing home services or supplies that are already the responsibility of the nursing home, such as laundry, linen, food, heat, staffing costs, etc.
- CMP funds may not be used to pay the salaries of temporary managers who are actively managing a nursing home.
- CMP funds may not be used to recruit or provide Long Term Care Ombudsman certification training for staff or volunteers, or investigate and work to resolve complaints.

Tips for Preparing the CMP Form

- All nursing homes dually certified to participate in the Medicare program or nursing homes certified to participate in the Medicaid program shall include the CMS Certification Number (CCN) in the request.
- All organizations or entities shall include the Tax Identification Number (TIN).
- Be brief, concise and clear. Provide accurate information, including candid accounts of problems and realistic plans to address them. If any required information is omitted, explain why. Make sure the information provided in any table, chart, attachment, etc. is consistent with the proposed narrative and information in other tables.
- Be organized and logical. Reviewers should be able to readily follow the coherent and logical thought process of the applicant.
- Carefully proofread the request. Misspellings and grammatical errors will impede reviewers' ability to understand the CMP request. Be sure pages are numbered (including appendices) and that page limits are followed. Limit the use of abbreviations and acronyms, and define each one at its first use and periodically throughout request.
- Assemble and paginate the request as one pdf document, and use approved Times New Roman, 12 point font, for any appendices.
- Complete all sections of the request as instructed. Incomplete applications will be denied.
- Plan ahead and allow sufficient time for State Agency and CMS review and approval of the request.

NOTE: If the use of CMP funds is approved, the organization or entity receiving funds may still be required to complete a state contract before the funds are released.

REQUEST

Date of Application: ____ /____ /_____
MM DD YYYY

PART I: Background Information

Name of the Organization: _____

Address Line 1: _____

Address Line 2: _____

City, County, State, Zip Code: _____

Tax Identification Number: _____

CMS Certification Number, if applicable: ☐☐ – ☐☐☐☐

Medicaid Provider Number, if applicable: ☐☐ – ☐☐☐☐

Name of the Project Leader: _____

Address: _____

City, County, State, Zip Code: _____

Internet E-mail Address: _____

Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Mobile Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Have other funding sources been applied for and/or granted for this proposal? ☐ Yes ☐ No

If yes, please explain/identify sources and amount.

_____

_____

PART II: Applicable to Certified Nursing Home Applicants

Name of the Facility: _____

Address Line 1: _____

Address Line 2: _____

City, County, State, Zip Code: _____

Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

CMS Certification Number: ☐☐ – ☐☐☐☐

Medicaid Provider Number: ☐☐ – ☐☐☐☐

Date of Last Recertification Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Date of Last Complaint Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Currently Enrolled in the Special Focus Facility (SFF) Initiative? ☐ Yes ☐ No

Previously Designated as a Special Focus Facility? ☐ Yes ☐ No

Participating in a Systems Improvement Agreement? ☐ Yes ☐ No

Administrator's Name: _____

Owner of the Nursing Home: _____

CEO Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

CEO Email Address: _____

Name of the Management Company: _____

Chain Affiliation (please specify) Name and Address of Parent Organization: _____

_____

Outstanding Civil Money Penalty? ☐ Yes ☐ No

Nursing Home Compare Star Rating: _____ (can be 1, 2, 3, 4 or 5 stars)

Date of Nursing Home Compare Rating: ____ /____ /_____
MM DD YYYY

Is the Nursing Home in Bankruptcy or Receivership? ☐ Yes ☐ No

If an organization is represented by various partners and stakeholders, please attach a list of the stakeholders in the appendix.

NOTE: The entity or nursing home which requests CMP funding is accountable and responsible for all CMP funds entrusted to it. If a change in ownership occurs after CMP funds are granted or during the course of the project completion, the project leader shall notify CMS and the State Agency within five calendar days. The new ownership shall be disclosed as well as information regarding how the project shall be completed. A written letter regarding the change in ownership and its impact on the CMP Grant application award shall be sent to CMS and the State Agency.

Part III: Project Category

Please place an "X" by the project category for which you are seeking CMP funding.

☐ Direct Improvement to Quality of Care

☐ Resident or Family Councils

☐ Culture Change/Quality of Life

☐ Consumer Information

☐ Transition Preparation

☐ Training

☐ Resident Transition due to Facility Closure or Downsizing

☐ Other: Please specify _____

_____

Part IV: Funding Category

Please specify the amount and place an "X" by the funding category.

Amount Requested: $_____

☐ $2,500 or less

☐ $2,501 – $5,000

☐ $5,001 – $10,000

☐ $10,001 – $25,000

☐ $25,001 – $50,000

☐ Over $50,000

Part V: Proposed Period of Support

From: ____ /____ /_____ (e.g. 06/01/2010) **To:** ____ /____ /_____ (e.g. 12/01/2010)
MM DD YYYY MM DD YYYY

Part VI: Purpose and Summary

PROJECT TITLE

Include a cover letter to the State Agency Director with the application. The cover letter should introduce your organization, explain the purpose of the project and contain a summary of your proposal. The letter should include the amount of funding that you are requesting, the population it will serve, and the need it will help solve. Make a concerted effort to bring your project to life in the cover letter and actively engage the reader.

Part VII: Expected Outcomes

PROJECT ABSTRACT

Provide an abstract summary of the project that is no longer than one page. Include the requester's background and qualifications, the need for the project, a brief description of the project and its goals and objectives. Of the utmost importance is information regarding how the project will be evaluated to measure the success of the programs. Specify the person(s) who will be accountable for the project evaluation.

STATEMENT OF NEED

The statement of need should describe the problem that the project will attempt to address. Also describe any problems that may be encountered in the implementation of this project. Articulate the contingency plan to address these issues.

PROGRAM DESCRIPTION

Describe the project or program and provide information on how it will be implemented. Include information on what will be accomplished and the desired outcomes. A timeline shall accompany all proposals which outline benchmarks, deliverables and dates. Attach supplemental materials such as brochures, efficacy studies and peer reviewed literature.

Part VIII: Results Measurement

Include a description of the methods by which the results of the project will be assessed (including specific measures). Multi-year projects shall provide a provision for submission of interim progress reports and updates from the project leader to CMS. Staff attending training shall articulate how knowledge learned will be shared among other long term care employees and ultimately how the information will improve resident outcomes. Quarterly reports regarding the progress of the project shall be submitted to CMS and the State Agency.

Part IX: Benefits to Nursing Home (NH) Residents

A detailed description of the manner in which the project will directly benefit and enhance the well-being of nursing home residents.

Part X: Consumer/Stakeholder Involvement

Include a brief description of how the nursing home community (including resident and/or family councils and direct care staff) will be involved in the development and implementation of the project. Describe how the governing body of the nursing home or organization shall lend support to the project.

Part XI: Funding

Include an Excel spreadsheet with the budget expenses for the project, along with a narrative explanation of the costs. Mention any co-funding that you are planning to use from other sources. The narrative shall include the specific amount of CMP funds to be used for the project, the time period for such use, and an estimate of any non-CMP funds that the State or other entity expects to be contributed to the project.

Part XII: Involved Organizations

List a contact name, address, Internet e-mail address and telephone number of all organizations that will receive funds through this project. List any sub-contractors and organizations that are expected to carry out and be responsible for components of the project. Copies of contracts and subcontracts shall be available upon request to CMS and the State.

CONFLICT OF INTEREST PROHIBITION STATEMENT

CMS will not approve projects for which a conflict of interest exists or the appearance of a conflict of interest. Similarly, we will generally not approve uses that commit CMS funding to very long term projects (greater than three years). By obliging the State to fund a long and large multi-year expense, we consider such projects to raise the appearance of a conflict of interest where the levy of future CMPs could be construed to be done for the purpose of raising revenue rather than for the statutory purpose of deterring or sanctioning poor quality. We will, however, consider each project in light of the specifics of each individual case.

ATTESTATION STATEMENT

CMP funds have been provided for the express purpose of enhancing quality of care and quality of life in nursing homes certified to participate in Title 18 and Title 19 of Social Security Act. Failure to use civil money penalty funds solely for certified nursing homes and for the intended purpose of the grant proposal is prohibited by Federal law. Failure to use the CMP funds as specified will result in denial of future grant applications and referral to the appropriate entity for Medicare/ Medicaid fraud and Program Integrity. The applicant shall disclose any conflicts of interest, including family relationships.

QUESTIONS TO ANSWER BEFORE SUBMISSION OF THIS REQUEST:

NOTE: Candidates should be able to confidently answer "yes" to each question below.

Yes	No	
☐	☐	Does my project have a central focus and coherent direction, with good synergy and integration among components?
☐	☐	Does my project clearly state the benefits to residents?
☐	☐	Do I have sufficient preliminary data to support my project?
☐	☐	Is my project plan well developed?
☐	☐	Does the project have sufficient details, and focused approaches?
☐	☐	Did I address problems that may be encountered, propose alternative approaches, and describe contingency plans?
☐	☐	Did the project planning committee consider the potential difficulties and limitations of the proposed approaches?
☐	☐	Have I explained the significance of the overall program goals?
☐	☐	Have I listed all of the sites where my work will take place and listed which facilities are completing which parts of the project? Have I fully coordinated among them?
☐	☐	Have I made provisions for data management and coordination?
☐	☐	Have I labeled all materials clearly so reviewers can easily find information?
☐	☐	Did I put all items in the correct section?
☐	☐	Do I have biosketches for all personnel in the application?
☐	☐	Does each biosketch include all required sections such as positions and honors, selected peer reviewed publications or manuscripts in press, and research support?
☐	☐	Have I explained how my corporation can give me the support that I need to do the project?
☐	☐	Is there sufficient expertise for the work proposed?
☐	☐	Are benchmarks and deliverables clearly stated?

REVIEW

LEVEL 1—INTERNAL REVIEW PROCESS.
NOTE: This section of the application is completed by the State Survey Agency

THE CONTENT OF THIS REQUEST HAS BEEN REVIEWED BY:

Date Request Received: ____ /____ /_____
MM DD YYYY

Date State Agency Reviewed: ____ /____ /_____
MM DD YYYY

Date Request Forwarded to the CMS Mail Box: ____ /____ /_____
MM DD YYYY

State Agency Reviewer #1: _____

State Agency Reviewer #1 E-mail address: _____

State Agency Reviewer #1 Telephone Number: ☐☐☐–☐☐☐–☐☐☐☐

State Agency Reviewer #2: _____

State Agency Reviewer #2 E-mail address: _____

State Agency Reviewer #2 Telephone Number: ☐☐☐–☐☐☐–☐☐☐☐

NOTE: The State Agency will be responsible for providing timely notification to the applicant that the request has been received, and acted upon.

As the first line reviewer, the State Survey Agency recommends:

☐ Meets criteria ☐ Does not meet criteria

Comments: Include the rationale for your recommendation.

_____

_____

_____

_____

Signature: _____ Date: ____ /____ /_____
MM DD YYYY

NOTE: Electronic signatures are acceptable. A hard copy of the application with original signatures should be maintained and provided to CMS upon request.

LEVEL II—EXTERNAL REVIEW & RECOMMENDATION PROCESS

NOTE: This section of the application is completed by the CMS–Atlanta Regional Office

THE CONTENT OF THIS REQUEST HAS BEEN REVIEWED BY:

CMS Regional Office Reviewer #1_____

CMS Regional Office Reviewer #2 _____

CMP Tracking Number: ☐☐☐☐ – 04 – ☐☐ – ☐☐☐☐
Y Y Y Y state M M D D

CMS recommends:

☐ Approval

☐ Denial

☐ Request for more information; see comments below

Date of E-mail to State Agency and Applicant : ____ /____ /_____
MM DD YYYY

Application Comments: _____

_____

_____

_____

_____

_____

_____

_____

Signature(s):

Date: ____ /____ /_____
MM DD YYYY

FINAL DISPOSITION

Review by the LTC Certification & Enforcement Branch Manager:

_____

Date: ____ /____ /_____
MM DD YYYY

☐ Approval

☐ Denial

☐ More information, see comments below

Comments: _____

_____

_____

Signature: _____

Review by the ARA:

Date: ____ /____ /_____
MM DD YYYY

☐ Approval

☐ Denial

☐ More information, see comments below

Comments: _____

_____

Signature: _____