

Maryland Long Term Care Survey

Frequently Asked Questions about the Long Term Care Survey:

- **How do I access the survey?**

To access the survey go to the Commission's website at <http://mhcc.maryland.gov>

Under Health Care Community, click on **Surveys**,

click on **Annual Long Term Care Survey**,

click on **20YY Long Term Care Survey**.

(YY represents the last 2 digits of the current survey year)

- **How do I print the survey?**

To Print the Survey, Look for the Print Symbol on the survey menu page,

(1) click on **PRINT SURVEY REPORT** or

(2) click on Submit Long Term Care Survey, and then click on **PRINT YOUR SURVEY FOR YOUR RECORDS**.

- **Why can't I print the survey?**

The survey can be printed from any location where a printer is connected to the computer. You may not be able to print the survey if there is not a printer connection to your computer. Please check with your IT person in your facility.

Use the Print Survey button to print a copy of your survey before you begin the survey to know the questions you are required to complete and to print a copy after you have completed your survey to keep for your records.

Use the Print Survey Submittal Receipt button to print your confirmation that the survey has been submitted or to print the current status of your survey if it has been *Rejected* or *Accepted*.

This web site uses popup windows for many of the features including Help screens. If you are running "Popup Blocker" software on your browser, your browser may not allow the window to open automatically. If you try to *print* the survey and it did not open, Go to "Tools", Pop-up Blocker and click on Turn on Pop-up blocker, then click on "Retry".

Both prior to and after transmitting your survey to MHCC, you will have the option to *print* a copy of the survey (**Print Your Survey for Your Records (click)**) for your records. After transmitting your survey you will have the option to print a copy of the survey submittal receipt (**Printer-Friendly Receipt of Submittal**).

- **What is the survey due date?**

The survey due date is the day the Commission assigned as the end date of the survey collection period. The Survey collection periods runs for 60 days (30 days for the Comprehensive Care which are required to complete the Assessment Survey). All surveys must be submitted and accepted by the Commission on or before the due date. The \$100 (\$1000 for Comprehensive Care) per day penalty for **non-approved surveys** begins to accrue the next day.

Extensions:

Under COMAR 10.24.03; a provider may request an extension of its submission date by letter to the Executive Director:

- Only if the request is received no later than 15 days before the submission is due;
- Explains in detail the reason for the extension request; and
- Provides a reasonable requested due date.

Reasons for extensions must be compelling and documented. Extensions cannot be granted for self-created failure to meet the deadline (e.g. vacations). Not all requests for extensions are granted.

- **How do I submit my survey?**

To **submit** your survey: Make sure that you have completed all six sections (8 Sections for Comprehensive Care) of your survey (check box filled with a green check). At the bottom of the page, click on the button **SUBMIT LONG TERM CARE SURVEY**, on the Certify Screen, check the certify box, and write the full name (First and Last Name) of the person responsible for answering questions about the survey responses, then click on the button **CERTIFY AND SUBMIT SURVEY**. We advise you to use the link **PRINT YOUR SURVEY FOR YOUR RECORDS (click)**, to print a copy of the survey prior to submitting your survey.

- **How do I resubmit my survey after receipt of a Rejection Notice?**

To resubmit your survey, sign in as you did to submit your survey. You will receive the following message: **“Your survey has been rejected. Click on the button below to proceed to the Survey Menu. Go to the Message Center where your errors will be described in an email. Proceed to the Sections that need to be corrected.” Click on the CORRECT SURVEY button.** Make the necessary corrections and follow the **Submit Survey** instructions (see *How do I submit my survey?*).

NOTE: You are strongly encouraged to use the link [PRINT YOUR SURVEY FOR YOUR RECORDS](#) to print a copy of the survey prior to submission.

- **Who is responsible for completing the survey?**

The Commission is required to submit all notices and other correspondence about the Long Term Care Survey to the Administrator/Director of the facility. Whether the survey is completed by the Administrator/Director, by their staff or individuals at the corporate office, the Administrator/Director **remains responsible for timely and accurate submission of the survey.**

If a facility changes ownership during a survey year, the current owner is responsible for obtaining any data required from the previous owner. It is **not** the responsibility of the Commission to request data from the previous owner.

- **What is the difference between Survey Submission and Survey Acceptance?**

Once you have completed all sections of your survey and click “submit survey”, your survey is transmitted to the Commission. The status is then changed from “in progress” to “completed.” After submission, the survey is reviewed for accuracy by the Survey Administrator. The survey may be rejected if there are errors that need correction. Only when the survey is completed and there are no errors and no questions that require follow-up, will you receive a message that it has been “accepted.”

- **How will I know that my survey was rejected?**

When a survey is rejected, the Survey Administrator sends a Rejection Notice email to the official email address listed in the survey. We advise that you open this email upon receipt. You may also open the Message Center to obtain any message from the Survey Administrator.

- **Why was my survey rejected?**

Your survey may be rejected **if** your responses to question(s) were incorrect and it was not picked up by the edit check feature within the survey application. Rejected responses may include, overstatement or understatement of values such as, total available patient days, total routine days and total routine revenue, revenue by payer sources, total participant days, total operating expenses, Medicaid waiver days, and toilets (toilets are crossed checked against the number of licensed beds by bed type in question 15 for Comprehensive Care facilities only).

A survey may be rejected more than once if the changes requested in the first rejection were not corrected. A rejected survey status means that the survey was not complete and has NOT been accepted by the Commission. Therefore, if you do not submit your corrected response on or before the survey due date, your survey will be considered late. Fines may be assessed on any late survey.

- **Why was my survey rejected when I received a message stating that my survey was submitted successfully?**

When you click on the submit survey to MHCC, your survey is transmitted/sent to the Commission. That is, the status of the survey has automatically been changed from “In Progress” to “Completed” and waiting to be reviewed by the Survey Administrator. You are provided with an automatically system generated message, a received receipt stating that you have successfully submitted your survey. However, when the Administrator reviews your survey it may be rejected for errors that require correction.

Your survey may be rejected if your responses to question(s) were incorrect and it was not picked up by the edit check feature within the survey application (**see Why was my survey rejected?**)

- **My facility completed the survey. When will I know if it was accepted?**

When you complete and submit your survey to the Commission you receive a message stating that your survey was submitted successfully, and that you should check within 2 to 3 business days to see if your survey was accepted or rejected. Surveys sent in within a week or two of the start date of the survey are processed within two business days as there are no backlogs.

When your survey is accepted an email message is sent to the Official Email Address reported in the survey. If you sign on to your survey and received an acceptance message but did not get an email, please logon to your survey to verify the email address you reported in the survey. If the email address is accurate, check with your IT staff at your office to see if any mail from the Commission had been blocked or that it was rerouted to your JUNK folder. If you have checked all of these go to the Message Center and notify the Survey Administrator.

- **My facility was sold during the survey year. Do I still need to complete the survey?**

In accordance with Code of Maryland Regulations, COMAR 10.24.03, which governs the Long Term Care survey, any facility that was licensed and operating during the survey year is required to complete the survey for the Commission. If a facility changes ownership during a survey year, the current owner is responsible for obtaining any data required from the previous owner. It is not the responsibility of the Commission to request data from the previous owner.

- **My facility changed ownership during the survey year. Do I still need to complete the survey?**

The current owner is responsible for the survey and should make all arrangements with the previous owner to ensure that they obtain all data required to complete the survey for the entire survey year.

- **My facility was open during the survey year but did not have any residents. Do I still need to complete the survey?**

If a facility was open during a survey year, but did not admit any residents, the Administrator of the facility must seek an exemption from the Executive Director of the Commission in writing prior to the start of the survey. The letter must provide a detailed explanation as to why the facility did not admit residents. Any supporting documentation should accompany the letter. The Executive Director will determine whether or not to exempt the facility for the survey year only. The facility will be expected to complete future surveys if they serve residents.

- **My facility is a Comprehensive Care Facility (Nursing Home / SNF) that changed ownership during the survey year. How do I answer question 45AB on the survey?**

If a facility changed ownership during the survey year, when completing Section 6 of the survey, the response to Question 45AB should be NO (for the purpose of the survey) even if both owners submitted a Medicaid Cost Report to the State. The current owner must manually enter the data for the entire Fiscal Year, in Question 48 of the survey.

Note: *It is the responsibility of the current owner to ensure that the Commission receives 12 months of data for the fiscal period that we are surveying.*

Note: *If your facility is a hospital-based facility or a Continuing Care Retirement Community and you submitted a MEDICAID Cost Report for your entire facility, for the purpose of the survey, the response to question 45AB should be NO, and then proceed to complete questions 48.*

- **My facility is a Comprehensive Care Facility (Nursing Home / SNF) that changed ownership during the survey year and we submitted a Medicaid Cost Report to Medicaid. Do I still need to complete question 48?**

If a facility changed ownership during the survey year, and submitted a single completed MEDICAID cost report for the entire year, i.e. 12 months, which included data for the period that the old owner operated the facility, then the facility response to Question 45AB should be YES. When q45AB is Yes, Question 48a will no longer be accessible to that facility.

- **My facility is a Comprehensive Care Facility (Nursing Home / SNF) that does not participate in Medicaid. Do I still need to complete question 48?**

All comprehensive care facilities that participate in the Long Term Care survey must provide us with financial information whether or not that facility participates in Medicaid. If the facility did not participate in Medicaid, the response to question 45AB should be NO, and then proceed to complete the entire question 48.

- **My facility is an Adult Day Care Center and one participant has two different payer sources. How do I reflect that revenue and in which payer source do I reflect the participant days?**

All participant days must be paid for by a payer source. If one participant had days of care covered by two sources under routine services, the days must be allocated based on the revenue received.

For example, a participant stayed 100 days at a center and the center received \$500 dollars from VA contract and the participant paid out of pocket \$200 dollars. The days should be broken down by cost per day for each service. If VA contract paid \$10 per day, then only 50 days was covered by VA contract. The other days, 50, should be placed under private pay with \$200 in the corresponding revenue column.

- **For DDA/ Child and Adult Food Program Only**

If a participant stayed 365 days and the participant days were covered by two payer sources, i.e. Developmental Disabilities Administration Funding (DDA) and Child and Adult Care Food Program, if the facility is not able to allocate the number of days assigned to each payer source, but is able to allocate the revenue by payer source, *for the purpose of the survey only*, the facility should include all the days for that participant under DDA with the revenue from that payer source in the corresponding revenue

column and under Child and Adult Food program report zero under participant days and the revenue from that payer source in the corresponding revenue column.

- **How do I calculate total patient days?**

To calculate total patient days, you take the cumulative number of days each resident occupied a bed at your facility during the survey year including days that a bed was held for any resident temporarily away from the facility (i.e. bed hold of 14 days or less). If a resident had more than one admission to the facility during the survey year, the number of days the resident stayed on both occasions must be included when calculating total patient days. If a resident was discharged during the survey year, only include the days prior to the discharged date. If a licensed bed is occupied for the entire year, then 365 days (366 if it a leap year) should be used in the calculation for that licensed bed.

Total patient days is not the number of beds multiplied by the number of days in the year (365). 365 days is not the total available patient days. Surveys will be rejected if any of these are reported in question 25 of the survey.

- **My facility is an Assisted Living facility, and one of our residents was under the Medicaid Waiver program; however, not all of the 365 days of the resident's stay was covered by the waiver. Should I report the waiver days in question 50 and do I report the entire amount of the waiver for the resident?**

For the purpose of the survey, Medicaid waiver days are reported based on the facility's Fiscal Year reporting period. If during the Fiscal Year the facility received a waiver for a resident, the facility should respond YES to question 50c and in question 50_4a, the facility must report only the number of days within that period that was covered by that waiver. If the number of days that the resident stayed exceeded the days allowed by the waiver and another payer source covered those remaining days, then remaining the days should be allocated to the other payer source.

For example, A resident stayed 365 days at a facility, but only 300 days was covered by the Medicaid Waiver and the resident paid the 65 days out of pocket. The facility should respond "Yes" to question 50c. In Question 50_4a, 300 days should be reported under Medicaid Waiver and the revenue for Medicaid Waiver should be reported in the corresponding revenue column for that payer source. In question 50_1a Private Pay, the days reported should be 65 and the revenue for those days should be allocated in the corresponding revenue column.

- **The number of days reported for Medicaid waivers days in question 50 was too high based on question 50c. How do I calculate the correct number of days to report?**

Report the number of Medicaid waiver days utilized during the survey period not to exceed 365 days or 366 days in a leap year.

Example of an Error that will result in an automatic Error Message from the system: In q50_4a: the days reported does not correspond to the number of waiver days received in q50. $1825/4 = 456.25$ days per waiver participant. There were 365 days in 20YY. Please verify the answer to this question.

Unless you correct the above message you will not be able to complete section 6. Always verify the number of waiver days received for the fiscal year and enter the number of days that were covered by that waiver in question 50.

- **My facility only provides monthly rates but the survey is asking for daily rates. How do I calculate daily rate?**

If your facility only bills rates by the month, to obtain daily rates, for the purpose of the survey, divide the rate charged per month by 30 to obtain the daily rate.

When entering rates in the survey, always round up to the nearest whole number and do not enter cents, commas or periods.

For example: A facility charges \$2000 dollars per month for a resident private pay stay. The daily rate would be \$2000 divided by 30 which is 66.66. For the purpose of the survey the daily rate to report would be \$67. Enter the rate as 67, no cents, no commas and no periods.

- **The number of residents at the beginning of the year in question 20 is incorrect. How can it be changed?**

For the purpose of the Maryland Long Term Care Survey, we consider the number of residents on January 1 of the survey year to be the same number of residents at the facility at midnight on December 31 of the previous year.

If your facility participated in last year's Long Term Care Survey, the number of Residents at the end of last year has been entered (pre populated) for you into this question. If the number reported is found to be inaccurate please contact the Survey Administrator and provide written documentation to support your claim. Upon receipt of your supporting documents, the Survey Administrator will review the documents and

make a decision to unlock the survey to allow you to make the change. If the documentation is insufficient the Survey Administrator will notify you. Documentation may be sent by email (catherine.victorine@maryland.gov)/ or fax (410 358 -1236).

- **What is Total Operating Expenses, and does it include salaries?**

The total operating expenses includes all money spent by the facility to operate the facility during the fiscal year including: staff salaries, overhead costs such as rent and utilities, third party services, etc. This is not total revenue.

Only report the expenses for the facility type you are completing. If the facility has two (2) separate licenses, one to provide Comprehensive Care and one to provide Assisted Living, the facility will complete two separate surveys. Allocate shared expenses proportionately for the two areas shared. Only the expenses for the appropriate bed license type should be reported in each survey.