DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-03

DATE: **October 14, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: FY 2005 State Performance Review Protocol Guidance

Letter Summary

- Transmits the FY 2005 State Performance Review Protocol Guidance.
- FY 2005 edition is identical to the last year's edition with more clarifying language related to Life Safety Code (LSC) and new standard titles.

The purpose of this memorandum is to transmit the Centers for Medicare & Medicaid Services' (CMS) FY 2005 State Performance Review standards and the survey protocols.

Attached are the FY 2005 survey protocols. Regional offices will receive scoring forms, worksheets and other detailed instructions under a separate cover from the central office. A summary of pertinent changes is as follows:

Standard 1 – Revised standard title and provided clarifying language in Emphases A and B to include LSC.

Standard 2 – Revised standard title and provided clarifying language for more consistent interpretation of results.

Standard 3 – Revised standard title and provided clarifying language for more consistent interpretation of results.

Emphasis C: Revised Emphasis to include **Threshold 2 Criterion**: "At least 80% of overall onsite finding were correctly identified and cited by SA and found by RO." This clarifies the separate criterion for Reports 4A and 4B.

Standard 4 – Revised standard title and included clarifying language for LSC.

Standard 5 – Revised standard title.

Standard 6 – Revised standard title and provided clarifying language for more consistent interpretation of results.

Standard 7 – Revised standard title and included clarifying language for LSC.

We would like to thank the representatives from the State/CMS workgroups for their dedication and contributions towards the development of the FY 2005 State Performance Standards. For questions concerning the FY 2005 Performance Standards, please contact Kirsten Jensen at (410) 786-1095 or via email at KJensen@cms.hhs.gov.

Effective Date: Immediately.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers and the state/RO training coordinator.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment: FY 2005 State Performance Review Protocol Guidance

FY 2005 State Performance Review Protocol Guidance

Centers for Medicare & Medicaid Services
State Performance Measures

Table of Contents

Purpose

This guidance is being issued to set out the performance standards, review protocols and a reporting mechanism for State Performance Standards.

Background

FY2001 represented the first year of implementation of the new standards. In each of the last three years, the standards have been revised and clarified to enhance the process.

Representatives from both CMS and the Association of Health Facility Survey Agencies (AHFSA) developed the review protocols contained in this guide.

The 1864 Agreement, Article II (J) and the State Operations Manual (SOM) contain the regulatory authority for these review protocols. Specific references to regulations and sections in the SOM are included in the review protocols.

The review forms and worksheets are included.

Scoring should be conducted according to the methodology and calculation sections that are listed within each standard. Scoring sheets for the specific standards are included in the Appendices. CMS Regional Offices submit a completed State Performance Standard Review Summary packet (which includes all seven standards) for each State in the region.

NOTE: To promote consistency in terminology, Long Term Care (LTC) refers to nursing homes and Non Long Term Care (NLTC) refers to all other provider types, i.e., Intermediate Care Facilities for persons with Mental Retardation, (ICFs/MR), Home Health Agencies (HHAs), accredited and nonaccredited hospitals, End-Stage Renal Disease (ESRD) facilities, Hospice, Outpatient Rehabilitation, Emergency Medical Treatment and Labor Act (EMTALA) etc., excluding laboratories.

2005 STANDARDS FOR ADEQUATE STATE SURVEY AGENCY PERFORMANCE

Timeliness of survey: (Standard 1)

Off hour surveys (Emphasis A): The State Agency (SA) begins no less than ten percent (10%) of its standard surveys of nursing homes during weekends, holidays, or "off hours."

- Threshold Criterion: In no less than ten percent (10%) of the standard surveys a SA conducts during a twelve (12) month period, the time of day that surveyors begin should extend beyond the business hours of 8:00 am to 6:00 pm and should either incorporate evening hours after 7:00 pm or morning hours before 7:00 am, unless they are started during weekend days i.e., Saturdays, Sundays, and holidays. To count towards the ten percent (10%), once begun, a survey must be conducted on consecutive calendar days, even if those days encompass Sundays and holidays. Life Safety Code (LSC) surveys are exempt (i.e., LSC surveys are not required to be conducted during off hours).

- Data Source: User-defined OSCAR reports and SA survey schedules.

- Statutory/Regulatory Citations: 42 CFR 488.307 and Section 7207 B. 2 of the SOM, and S&C-04-33.

Frequency of nursing home surveys (Emphasis B): The SA complies with requirements for conducting standard surveys of nursing homes within prescribed time limits.

- Threshold Criterion: No less than one hundred percent (100%) of the consecutive standard surveys of nursing homes conducted by the SA are conducted within fifteen (15) months between surveys. The average statewide interval between consecutive standard surveys is no greater than twelve (12) months. LSC Surveys are to be conducted no later than within sixty (60) days from the end of the health survey.

- Data Source: User-defined OSCAR reports, OSCAR Report #27 for LTC survey intervals, and SA schedules.

- Statutory/Regulatory Citations: Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Social Security Act (SSA) and 42 CFR 488.308.

Frequency of non-LTC surveys (Emphasis C): The SA conducts all legislatively mandated surveys within the timeframes established by law.

- Threshold Criteria: No less than one hundred percent (100%) of HHAs, ICF/MRs, and accredited Hospitals are surveyed within the specified time frames.

- All HHAs are recertified every thirty-six months.
- All ICFs/MR are recertified before the expiration date of the existing time-limited agreement. If a survey is conducted after the original expiration date, the SA must have given the State Medicaid Agency written notice that it should extend the agreement and the recertification survey must have occurred before the expiration date of the extension.
- Validation surveys are conducted on hospitals selected as part of the one percent (1%) sample.

- Data Source: User defined OSCAR reports, SA survey schedules and other records.

- Statutory/Regulatory Citations:
  HHAs – 1891(c)(2)(A)
  ICFs/MR – 42 CFR 442.109, 442.10 and 442.16
  Validation Surveys – Sections 1864c and 1865 of the SSA and 42 CFR 488.7.

Documentation of survey results: (Standard 2)

Documentation of deficiencies: The SA documents all deficiencies on the Form CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation.

- Threshold Criterion: No less than eighty-five percent (85%) of the criteria are met.

- Data Source & Method of Evaluation: Review at least ten percent (10%), a minimum of five (5) or a maximum of forty (40) Form CMS-2567s from a random sample of recertification surveys and complaint surveys from the following provider types: LTC, hospitals, ICFs/MR, ESRDs, HHAs, and Psychiatric Hospitals.

- Statutory/Regulatory Citations: 42 CFR 488.318 and the Principles of Documentation of the SOM.

Quality of State Agency investigations & decision-making: (Standard 3)

Survey in accordance with Federal standards (Emphasis A): The SA survey teams conduct LTC surveys in accordance with CMS instructions.

- Threshold Criterion: One hundred percent (100%) of nursing home surveys are satisfactorily conducted by effectively achieving the desired outcomes of the survey using Federal standards, protocols and procedures, policies and systems specified in CMS instructions, (i.e., achieving a rating of 3.0 or greater for each of the six (6) measures).

- Data Source: Federal Monitoring Survey (FMS) results Federal Oversight And Support Surveys (FOSS) and Comparative Surveys for LTC Facilities.

- Statutory/Regulatory Citations: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the SSA.

Documentation of non-compliance (Emphasis B): The SA documents all findings of non-compliance found onsite during surveys of nursing homes at the appropriate severity level.

- Threshold Criterion: In eighty percent (80%) or more of the deficiencies on CMS-2567s issued to facilities, there is no variation in the determination of non-compliance.

- Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

- Statutory/Regulatory Citations: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the SSA.

Accuracy of documentation (Emphasis C): The SA accurately identifies and documents onsite findings of non-compliance.

- Threshold 1 Criterion : One hundred percent (100%) of "significant" onsite findings are correctly identified & cited by the SA and found by the RO. (Significant is defined as deficiencies at or above the level "F" on the scope and severity grid.)

- Threshold 2 Criterion : At least eighty percent (80%) of overall onsite findings were correctly identified and cited by the SA and found by the RO.

- Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

- Statutory/Regulatory Citations: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the SSA.

Accuracy of Immediate Jeopardy cases (Emphasis D): The SA accurately identifies and documents onsite findings of non-compliance.

- Threshold Criterion : One hundred percent (100%) of the immediate jeopardy found onsite is accurately identified and cited on surveys conducted by the SA.

- Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

- Statutory/Regulatory Citations: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the SSA.

Timeliness of adverse action procedures (Includes nursing home enforcement and excludes CLIA): (Standard 4)

Timeliness of Immediate Jeopardy cases (Emphasis A): "Immediate Jeopardy" cases involving LTC, LSC and NLTC providers and suppliers are processed timely. (Excludes CLIA and EMTALA cases.)

- Threshold Criterion: In ninety-five percent (95%) of the SA's determinations that there is Immediate Jeopardy to resident and patient health and safety in a provider or supplier that was not abated (removed) onsite (prior to the end of the survey), the SA adheres to the 23-day termination process as outlined in 42 CFR 488.410 and 42 CFR 489.53.

- Data Source: SA Provider certification files and OSCAR reports.

- Statutory/Regulatory Citations:
  Sections 1819(h)(2)(A)(1), 1919(h)(1)(A), 1919(h)(3)(B)(1), 1866(b) of the SSA; and 42 CFR 488.410 and 42 CFR 489.53.

Timeliness of DPNA (Emphasis B): Denial of Payments for New Admissions (DPNA) must be imposed by the third month when a LTC provider/supplier is not in substantial compliance for three (3) months after the date of the original survey. The SA adheres to the enforcement processing timeframes.

- Threshold Criterion: In eighty percent (80%) of the cases, the enforcement packet is sent to CMS or the SA sends notice to the provider by the seventieth (70^{th}) day.

- Data Source: Enforcement tracking system reports and SA provider certification files.

- Statutory/Regulatory Citations: Section 1819(h)(2)(D) & (E) and 1919(h)(2)(C) & (D) of the SSA; and 42 CFR 488.417(b).

Adherence to conditions of participation (Emphasis C): Noncompliance with one or more Conditions of Participation or Conditions of Coverage and cited deficiencies limit capacity of the provider/supplier to furnish adequate level or quality of care. (NLTC providers only, excluding CLIA.)

- Threshold Criterion: In eighty percent (80%) of the cases which cite condition-level noncompliance on the part of a provider or supplier the SA adheres to the ninety (90) day termination process described in Section 3012 of the SOM.

- Data Source: CMS and SA provider survey and certification files and CMS tracking systems.

- Statutory/Regulatory Citations: Section 1866 (b) of the SSA and 42 CFR 489.53.

Budget analysis: (Standard 5)

Acceptable budget utilization process: (Emphasis A): The SA employs an acceptable process for charging the Federal programs.

- Threshold Criterion: The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its Title XVIII and XIX expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.

- Data Source: The CMS Budget Call Letter, the form CMS-435 State Survey Agency Budget/Expenditure Report and the form CMS-434 State Survey Agency Workload Report.

- Statutory/Regulatory Citations: Sections 1864 and 1902 of the Act provide the basis for agreements and plans with states under which CMS pays states for costs incurred in performing survey and certification functions.

Acceptable method for monitoring expenditures (Emphasis B): The SA has an acceptable method for monitoring its current rate of expenditures and planned workload.

- Threshold Criterion: The SA monitors and analyzes both its spending and workload progress throughout the fiscal year to ensure that the program priorities are accomplished within its approved budget.

- Data Source: The OSCAR 10, 15, and 25 Reports, the form CMS-435 State Survey Agency Budget/Expenditure Report and the form CMS-434 State Survey Agency Workload Report.

- Statutory/Regulatory Citations: Sections 1864 and 1902 of the Act provide the basis for agreements and plans with States under which CMS pays States for costs incurred in performing survey and certification functions.

Timeliness & quality of complaint investigations: (Standard 6)

Prioritizing complaints and incidents (Emphasis A): The SA maintains and follows guidelines for the prioritization of complaints and incidents (that require a Federal onsite visit) for Medicare/Medicaid certified facilities in LTC, Non-accredited Hospitals, HHAs, and ESRD facilities.

- Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints in Medicare/Medicaid certified facilities.

- Data Source: OSCAR/ASPEN Central Office, and/or ACTS.

- Statutory/Regulatory Citations: Section 1819(g)(4) and Section 1919(g)(4) of the Act, 42 CFR 488.332, and SOM 7700.

Frequency of complaint and incident investigations (Emphasis B): The SA investigates all complaints it receives for Medicare/Medicaid certified facilities within the prescribed time limits for LTC, ESRDs, HHAs, non-accredited hospitals and deemed hospitals.

- Threshold 1 Criterion: The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities where it determines there is a present or ongoing immediate jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA. (LTC, ESRDs, HHAs, non-accredited hospitals, deemed hospitals)

- Threshold 2 Criterion: The SA investigates all complaints in LTC Medicare and Medicaid certified facilities it receives alleging or involving actual harm to individuals within an average of ten (10) working days with all complaints completed by twenty (20) working days. (LTC only.)

- Threshold 3 Criterion: The SA investigates all certified deemed hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within an average of forty-five (45) calendar days with all complaints completed by sixty (60) calendar days. (deemed hospitals.)

- Data Source: ACTS timeliness reports.

- Statutory/Regulatory Citations:
  Section 1819(g)(4) and Section 1919(g)(4) of the Act; 42 CFR 488.332; Sections 7700(G)(1), 3262, and 3281 of the SOM.

Frequency of EMTALA investigations (Emphasis C): The SA investigates EMTALA complaints referred by CMS in accordance with CMS policy.

- Threshold Criterion: No less than eighty percent (80%) of approved EMTALA complaints are investigated according to CMS policy.

- Data Source: CMS EMTALA logs and completed survey packets sent to CMS.

- Statutory/Regulatory Citations: Section 1819(g)(4) and Section 1919(g)(4) of the Act; Section 3406(B) of the SOM; and Article II (A)(2) of the 1864 Agreement.

Quality of Investigation (Emphasis D): The SA investigates complaints for Medicare/Medicaid certified LTC Facilities according to CMS general instructions for complaint handling.

- Threshold Criterion: No less than eighty percent (80%) of LTC complaints are investigated according to CMS policy.

- Data Source: OSCAR/ASPEN Central Office, and/or ACTS.

- Statutory/Regulatory Citations: SOM 3260; SOM 3262; and SOM 3280.

Timeliness & accuracy of data entry (LTC and Non-accredited hospitals only) (Excludes CLIA): (Standard 7)

Frequency of data entry (Emphasis (A): Certification kits for recertified non-accredited hospitals, nursing homes, and LSC are entered into the OSCAR/ODIE/ASPEN Central Office system on a timely basis.

- Threshold Criterion: The mean number of days from the latest date of the SA survey completion date (L34) to the date of data entry into OSCAR/ODIE/ASPEN Central Office does not exceed seventy (70) calendar days. (Use that which has the latest date: Health or LSC.)

- Data Source: Providing Data Quickly (PDQ) and OSCAR Reports.

- Statutory/Regulatory Citations: Article II (J) of the 1864 Agreement.

Accuracy of data entry (Emphasis (B): The SA enters data accurately into OSCAR\ASPEN Central Office for recertified non-accredited hospitals and nursing homes.

- Threshold Criterion: No less than eighty-five percent (85%) of cases reviewed demonstrate that data is entered into OSCAR\ASPEN Central Office accurately.

- Data Source: OSCAR\ASPEN Central Office reports and OMRs.

- Statutory/Regulatory Citations: Article II (J) of the 1864 Agreement.

Timeliness of survey (Standard 1)

Off hour surveys (Emphasis A): The SA begins no less than ten percent (10%) of its standard surveys of nursing homes during weekends or "off hours."

- Threshold Criterion: In no less than ten percent (10%) of the standard surveys a SA conducts during a twelve (12) month period, the time of day that surveyors begin should extend beyond the business hours of 8:00 a.m. to 6:00 p.m. and should either incorporate evening hours after 7:00 p.m. or morning hours before 7:00 a.m., unless they are started during weekend days i.e., Saturdays and Sundays. To count towards the ten percent (10%), once begun, a survey must be conducted on consecutive calendar days, even if those days encompass Sundays and holidays. Life Safety Code (LSC) surveys are exempt (i.e., LSC surveys are not required to be conducted during off hours).

    a) Data Source: User-defined OSCAR reports and SA survey schedules.

    b) Method of Evaluation: Report the percentage of staggered surveys conducted from the OSCAR report provided. If the percentage of nursing home surveys conducted during the off-hour timeframes is equal to or greater than ten percent (10%), this Emphasis is scored as "Met."

    c) Statutory/Regulatory Citations: 42 CFR 488.307 and Section 7207 B. 2 of the SOM, and S&C-04-33.

Frequency of nursing home surveys (Emphasis B): The SA complies with requirements for conducting standard surveys of nursing homes within prescribed time limits.

a) Threshold Criterion: No less than one hundred percent (100%) of the consecutive standard surveys of nursing homes conducted by the SA are conducted within fifteen (15) months between surveys. The average statewide interval between consecutive standard surveys is no greater than twelve (12) months. LSC Surveys are to be conducted no later that within sixty (60) days from the end of the health survey.

b) Data Source: User-defined OSCAR reports and SA survey schedules.

c) Method of Evaluation: Report at least two (2) numbers here from the OSCAR reports provided: (1) The average statewide interval between consecutive surveys and (2) The maximum number of months between standard surveys. For surveys that are conducted beyond the maximum fifteen (15) months, also report the number of surveys exceeding the fifteen (15) months interval. The average statewide interval and the

maximum number of months between surveys must both be met for this Emphasis to be scored as "Met."

Frequency of non-LTC surveys (Emphasis C): The SA conducts all legislatively mandated surveys within the timeframes established by law.

- Threshold Criterion: No less than one hundred percent (100%) of HHAs, ICF/MRs, and accredited Hospitals are surveyed within the specified time frames.

    - All HHAs are recertified every thirty-six (36) months.
    - All ICFs/MR are recertified before the expiration date of the existing twelve (12) month time-limited agreement. If a survey is conducted after the original expiration date, the SA must have given the State Medicaid Agency written notice that it should extend the agreement and the recertification survey must have occurred before the expiration date of the extension.
    - Validation surveys are conducted on hospitals selected as part of the one percent (1%) sample.

b) Data Source: User-defined OSCAR reports and SA survey schedules and other records.

c) Method of Evaluation: Report three (3) numbers here from the OSCAR reports:
(1) Percent of HHAs recertified every thirty-six (36) months;
(2) Percent of ICFs/MR recertified before the expiration date of the existing time-limited agreement; and
(3) Percent of validation surveys conducted on hospitals selected as part of the one percent (1%) sample.

NOTE: If all ICFs/MR have not been recertified, provide a narrative describing whether or not the State Medicaid Agency received written notice for an extension of the agreement and that a survey was subsequently conducted before the end of the extension.

HHAs, ICFs/MR and hospitals must all meet the threshold for this Emphasis to be scored as "Met."

Documentation of survey results: (Standard 2)

Documentation of deficiencies: The SA documents all deficiencies on the Form CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation.

Threshold Criterion: No less than eighty-five percent (85%) of the criterion is met.

Data Source & Method of Evaluation:

1. Review at least ten percent (10%), a minimum of (five) 5 or a maximum of forty (40) Form CMS-2567s from a random sample of recertification surveys and complaint surveys conducted at LTC facilities during the fiscal year. The sample should contain seventy-five percent (75%) recertification surveys and twenty-five percent (25%) complaint surveys.

2. Review at least ten percent (10%), a minimum of five (5) or a maximum of forty (40) Form CMS-2567s from a random sample of recertification surveys and complaint surveys conducted at NLTC facilities (HHAs, ESRDs, EMTALAs, ICFs/MR and hospitals) during the fiscal year. The sample should contain seventy-five percent (75%) recertification surveys and twenty-five percent (25%) complaint surveys.

Note: For those states that conducted less than fifty surveys in either provider pool (LTC or NLTC), the ten percent (10%) guidance would not allow for adequate review. Therefore, a minimum of five (5) Form CMS-2567s would be reviewed from that provider pool in these States during the fiscal year.

LSC citations should be reviewed for both LTC and NLTC facilities.

Sample Selection:

1. Copy and save into your OSCAR/CASPER Report Library, the User Defined Extract OSCAR/CASPER reports from GG50:

- PERF STAND 2 LTC,
- PERF STAND 2 LTCCMPL,
- PERF STAND 2 NLTC, and
- PERF STAND 2NLTCCMPL. (Note the absence of a space after the 2)
- Select a report and modify it for your Region/States. Download the report saving it as a text file.

These reports contain: Provider Number, Provider/Supplier Name, current survey date, all deficiencies cited for the specified time period (all or part of the fiscal year under review), and, if applicable, the scope/severity for each deficiency.

Note: In those states where OSCAR/CASPER data is inadequate for sample selection, the Regional Office may use other methods to determine which recertification surveys, and complaint surveys have been completed by the state. The sample should be randomly selected.

2. Import the data from the OSCAR/CASPER report into EXCEL spreadsheet columns A through G and then follow the instructions below to select your random sample:

- The data file downloaded from OSCAR/CASPER into EXCEL contains the following data columns.
  - Column A – Provider Number
  - Column B – Provider/Supplier Name
  - Column C – City
  - Column D – State
  - Column E – TAG
  - Column F – Scope & Severity rating, when applicable.
  - Column G – Date (PERF STAND 2 LTCCMPL/NLTCCMPL)
  - Column H – Empty. To be used in the process to identify duplicates.
  - Column I – Empty. To be used in the process for random number generation.

- Select all of the data and sort by State (Column D) then by Provider Number (Column A)

- Identify duplicate facilities by placing the following formula into the first open column of the first line of data.

  =IF (A3=A2, “Duplicate,” “Original”)

***Note that the provider number included on line two is being compared to the provider number on line 1. If they are equal, the word “Duplicate” will be placed in column H2. If they are not equal, the word “Original” will be placed in H2. This formula should be copied into each cell in column H resulting in the words “Duplicate” or “Original” placed in each cell.**

- Copy Column H and “Paste Special” as values. This removes the formula and allows for sorting. Sort all of the data by Column H descending, then by Column D ascending. The original facilities are now sorted by state at the top of the spreadsheet. The duplicates are now at the bottom of the spreadsheet. Identify where the duplicates begin and place new (empty) rows between the original and duplicative data. The duplicate facilities will not be included in the rest of the process.

- Insert the following formula into the first open cell in Column I.

  =RAND ()

Copy the formula into each cell in Column I. Once the formula is in each cell in Column I, copy the entire column and "Paste Special" as values. The result will be a randomly generated number in each cell.

- Sort by Column D (State) ascending then by Column I (random number) ascending. The spreadsheet now has a randomly ordered list of facilities for each state.

3. Determine the sample size needed for each State**.** See Data Source & Method of Evaluation above. An additional ten percent (10%) over sample should be selected to use for substitution if needed.

4. Begin with the first provider/supplier on the randomly ordered list of surveys. Select one to four tags per Form CMS-2567 for review. When possible select tags that identify harm, immediate jeopardy or significant potential for harm.

Conducting the Review

- One person may conduct the review with at least one additional person reviewing all criterions rated a "No."
- All "No" ratings must have a specific objective explanation in the comment section.
- The reviewer should base their rating on the written documentation on the Form CMS-2567 without assuming additional information. The citation should answer the questions of who, what, when, where and how.
- The review is recommended semi-annually.
- Include use of the following references:
  -The Principles of Documentation
  -The State Operations Manual
  -Applicable Survey and Certification Letters or Guidance

Data Sheet/Scoring

A data sheet is provided for collection of data and automatic scoring. For each tag, review the criterion and mark a "Y" for each "yes" answer and an "N" for each "no" answer. The EXCEL database will provide an overall score for the Emphasis.

Yes = 1 point. Documentation meets the scoring guidance in each criterion.
No = 0 point.
NA = Not applicable. NA may be used for criterion 4, 8, 9 and/or 10. NA will not affect the score.

Regions may use the data sheet provided for automatic scoring or:

- To manually obtain an **overall score** for the review, add the "yes" responses (for both the LTC and NLTC providers) and divide by the total

number of “yes” and “no” responses for each Form CMS-2567 times 100.

Scoring for the Standard

Met = The Emphasis is “Met” if the overall score is eight-five percent (85%) or more.

Not Met = The Emphasis is “Not met” if the overall score is less than eight-five percent (85%).

Review Criterion

	Criteria	Guidance and References
1	The citation has the full regulatory reference.	Score 1 when the regulatory reference is composed of: 1) a survey data tag number, 2) the CFR or LSC reference number, 3) the language from the regulatory reference, and 4) an explicit statement that the requirement was "NOT MET." [LSC is adopted by regulation. LSC (K-tags) & National Fire Protection Association (NFPA) numbers are NOT regulatory. LSC must cite the regulation (e.g., 483.70(a) for nursing homes) in introductory comments.] **NOTE:** The regulatory reference in ASPEN may not be correct. ASPEN may not be updated before new regulations go into effect. Regulatory reference is not automatic in all cases; e.g. F698 and LSC. Not all regulations have data tags, e.g. 483.20, 483.70(a), 482.41(b).
2	Evidence supports determination of noncompliance at the cited regulation.	Read the entire citation to score this criterion. Score 1 when the citation contains deficient practice(s) and findings that support a deficiency at the cited regulation. **Note:** In some cases the cited regulation may not always be the “best” tag, however, the evidence must have relevance to the cited regulation. For EMTALA and nursing home surveys, the citation may demonstrate current or past failure to meet the cited regulation. SOM 7510B, p. 7-64. ***REMINDER: Evidence is <u>both</u> a deficient practice AND its findings***. 1. First, read the entire deficiency citation, the regulatory reference, and all the evidence. 2. <u>Compare the survey date to the evidence dates</u>.

		Deficient practices, which occurred before the survey, must have evidence that the noncompliance is still present during the survey. If the noncompliance occurred in the past and does not exist on the current survey, the entity is currently in compliance. Example, a survey 06/01/05, with evidence 03/21-29/05 that has been corrected, does not show current noncompliance and Fails Criterion #2. 3. Carefully relate the evidence to the **exact words and intent of** the regulation. 4. Criterion #2 passes if there is at least one deficient practice and one finding showing the deficient practice that relates to the regulation. The deficient practice may be inferred from the finding and need not be a "lead-in" to pass criterion 2. However, a simple list of outcome findings such as descriptions of pressure sores, or a list of falls fails Criterion #2. 5. **Do not** evaluate nursing home severity or Condition-Standard-Element level in Criterion #2. These are in Criterion #5. 6. **Do not** evaluate the quality of deficient practices (Criterion #3) or findings (Criterion #7). 7. **Do not** fail Criterion 2 for Criterion 11 plain language, including extraneous information. Example of failure: a stasis ulcer or surgical wound cited at pressure sores (F314).
3	Each Deficient Practice Statement clearly summarizes the provider/supplier failure(s) and quantifies a relevant extent.	This criterion applies to the Deficient Practice Statement only. If the answers to the following questions are "yes," then score "1." • Does the deficient practice statement(s) summarize what the provider/supplier has failed to do to be in compliance with this regulation? • Does the Deficient Practice Statement(s) describe the resulting outcome or potential outcome for individuals, when relevant? • Does the Deficient Practice Statement(s) numerically identify the prevalence or frequency of the deficient practice? To pass Criterion #3, the deficient practice must: a. accurately and specifically summarize the findings, b. provides the reason basis or rationale for the findings of noncompliance AND,

		c. quantifies a relevant extent. Extent quantifies how many beneficiaries were affected and may be affected by the deficient practice. In non-nursing homes, a Condition is cited when, "...the deficiencies are of such a character as to limit the provider's or supplier's capacity to furnish adequate care..." 488.24(b) and 488.26(b). The extent must show a "limited capacity to furnish adequate care" if that is the basis for noncompliance. Example: Fifty of fifty psychiatric patients' care plans failed to demonstrate how staff is to evaluate the efficacy and side-effects of antipsychotic drug therapy. The deficient practice <u>should</u> explain the outcome and meaning of findings, but Criterion #3 does not automatically fail if outcome/potential outcome are not shown. Example: F314: "The facility failed to prevent pressure sores in 2 of 5 residents with high risk of pressure sores." Specific deficient practices, which should prevent pressure sores, are failure to turn and reposition, failure to provide nutritional assessment, failure to provide pressure relieving devices, etc. This example fails "a" and passes "b," but fails Criterion #3. It must not be stated that actual or potential outcomes are caused by unobservable events. Example: "Staff **did not recognize** symptoms of low potassium. The patient died because his potassium was 1.9 mEQ/l." " The facility **failed to prevent** pressure sores." Such statements may be derogatory or inflammatory and usually cannot be proven. Such a statement does not fail Criterion #3 (extraneous remarks).
4	(For nursing homes) The scope accurately reflects the evidence and the residents who are, or may be, affected by the deficient practice.	*For nursing homes,* Score 1, when the facts in the citation support the assigned scope rating (isolated, pattern or widespread). Refer to the SOM, Appendix P, revision 10, page P-72. The assigned scope must accurately reflect the evidence. Examples: ▪ Fails: The State assigns isolated scope. The reviewer shows a pattern of failure. ▪ Fails: The State assigns widespread. Findings do

		not show that all (or most of the) residents are potentially or actually affected. ▪ Pass: The State assigns G for one resident actually harmed or F-Substandard Quality of Care when the findings are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. (Appendix page P-72).
5	The severity rating in nursing homes or the Condition, Standard, Element level cited reflects the evidence and the actual and/or potential outcome to beneficiaries*.	*For nursing homes, s*core 1 when the facts in the citation support the assigned severity rating (severity is the level of outcome or potential/actual harm to residents). Refer to the SOM, Appendix P, revision 10, page P-71. *For non-nursing homes*, score 1, when the Condition, Standard or Element identifies noncompliance at the level cited. **Beneficiaries is used to mean clients, residents, and all persons receiving care.* 1. **Actual and/or potential beneficiary outcomes determine severity** in all provider types. 2. Criterion #5 evaluates whether severity shows compliance or noncompliance in all provider and supplier types. 3. **Nursing homes and LSC:** consider only the severity level. Do not consider Scope. Do not consider Extent. 4. **Non-nursing home** providers and suppliers: ▪ A Condition is cited when, "...the deficiencies ... adversely affect the health and safety of patients." 488.24(b) and 488.26(b). Thus, a Condition is cited for immediate and serious threat (I&ST) to health and/or safety or immediate jeopardy (IJ). ▪ Apply Appendix Q for I&ST and IJ. ▪ <u>Standards and elements:</u> If your review shows a Standard contains Condition-level noncompliance, the reviewer will verify that the Condition was also correctly cited to pass Criterion #5.
6	Each person referred to in the citation is uniquely identified.	Score 1 when all persons (staff and others) in the citation are identified with a unique identifier that preserves their confidentiality. It is acceptable to refer to a confidential interviewee without providing an identifier. 1. Requires one hundred percent (100%) compliance to

		pass. 2. Confidential identifiers must be unique. 3. For example, “certified nursing assistant (CNA)”, “staff”, “licensed nurse”, or “administrative staff” should be rated “NO” because they can refer to more than one person in the facility.

7	The observations, interviews and record reviews support the deficient practice statement and illustrate the entity's noncompliance.	Score 1 when:
		• the findings describe and support the deficient practice(s);
		• the findings describe the who, what, where, when and how, when possible, of the deficient practice;
		• <u>what</u> entity practice was noncompliant;
		  • <u>who</u> were the residents affected or staff involved;
		  • <u>where</u> the deficient practice occurred, e.g., specific locations in the entity or documents;
		  • <u>when</u> (e.g., for how long) the problem occurred; and
		  • <u>how</u> the deficiency was determined;
		  • the findings are organized in a logical order, generally chronological, with the most serious findings first.
		
		1. To pass Criterion #7, the findings must **answer all** relevant what, who, where, when, and how questions. Criterion #7 passes if findings about a stasis ulcer or surgical wound cited at F314 answer all what, who, where, when, and how questions even though F314 is only for pressures sores (incorrect regulation is scored at Criterion #2).
		2. To pass Criterion #7, the findings also must be logically **organized**. If used, chronological order refers to the <u>order of beneficiary events</u>. An interview during the survey is chronological when placed on the date of the events, not the date of the interview. Example: The incident report dated 10/12/05 states that Resident #1 was found on the floor on 10/10/05 at 11:30 pm. On 02/03/05, licensed Staff #1 and DON stated this was Resident #1’s first fall.
		
		Do Not evaluate whether sources in deficient practices match findings and vice versa.

8	Descriptions of observation of provider/supplier practice include date, time, duration, (when appropriate), and location.	Score 1 when the observation of provider/supplier practice describes the specific date and time of the observation(s) and, when appropriate, the frequency, location and duration. In deciding to pass or fail this criterion, consider the importance of a missing date, time or duration in showing noncompliance.
9	Descriptions of interviews include dates and times and who was interviewed.	Score 1 when the interview describes who was interviewed and the dates and times of interviews. In deciding to pass or fail this criterion, consider the importance of the missing date or time in showing noncompliance.
10	Record review includes date of entry, exact title of record, and verifies lack of additional records with a knowledgeable person.	Score 1 when the record review citation includes date and type/title of referenced records used in the identification of the deficient practices. 1. In deciding to pass or fail this criterion, consider the importance of the missing date or time in showing noncompliance. Criterion #10 does not require the date a record was reviewed. 2. The citation identifies what parts of "the record" were reviewed and which were deficient. Pass: "nurses notes," "progress notes," "MAR," etc. Fail: "clinical record," "medical record," "resident record." There must be a validating staff interview to pass Criterion #10. In deciding to pass or fail this criterion, consider the importance of the lack of validation in showing noncompliance.
11	Evidence is written in plain language that is clear, concise and easily understood.	Score 1 when the citation has: • An explanation of abbreviations and acronyms when first used in each deficiency citation; common abbreviations may be placed in introductory comments. • Short, concise sentences. • Explanation of medical terminology. • An absence of critical spelling errors. • Active voice (subject—verb—object).

		• An absence of extraneous information, defined as findings that are not relevant to demonstrating noncompliance. • An absence of vague terminology (such as, seems, appears, did not always, only, just, unsatisfactory, unnecessary, or inadequate). • An absence of unsupported conclusions. Pass: The majority of the citation is in plain language, is mostly understandable, and the chronology of beneficiary decline and facility failure are clear. If compliant findings clarify a beneficiary's decline, they are relevant. This example passes plain language: On 01/01/05, a DNR order was requested of the resident's physician. The advanced directive information and forms were given to resident #1's guardian. On 01/25/05 at 10:30 am, the resident suffered a cardiac arrest. CPR was withheld. At that time, the advance directive was not formulated and there was no DNR order.

Quality of State Agency investigations & decision-making: (Standard 3)

Survey accordance with Federal standards (Emphasis A): The SA survey teams conduct LTC surveys in accordance with CMS instructions.

a) Threshold Criterion: One hundred percent (100%) of nursing home surveys are satisfactorily conducted, by effectively achieving the desired outcomes of the survey, using Federal standards, protocols and procedures, policies and systems specified in CMS instructions (i.e., achieving a rating of 3.0 or greater for each of the six (6) measures).

b) Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

c) Method of Evaluation: The following reports will be generated from the FMS (FOSS/Comparative) Access database.

Report #1 – Rating Per Measure: This report is a listing for each measure, which shows the average rating per measure. This report would furnish the RO and the SA with an overview of the State's strengths and weaknesses for outcome achievement within the survey process. Summary analysis of narrative comments is available for low scored measures and should furnish examples of State teams' weaknesses relative to the behavioral descriptions of performance.

This emphasis examines how well the SA effectively achieves the desired outcomes, as captured by the FOSS. To meet this Emphasis, a SA must have a score of 3.0 ("satisfactory") or greater for each of the six (6) measures. The score for each measure is calculated by adding the ratings for that measure across surveys divided by the total number of surveys with ratings for that measure. This calculation achieves a separate average score for each of the individual six measures.

If EACH measure achieves a score of 3.0 or above (an average score of 3.0 or above for that measure) that measure is determined to be "satisfactory". To be considered MET for Emphasis A, each measure (ALL SIX (6) measures individually) must achieve a score of 3.0 or above.

Documentation of non-compliance (Emphasis B): The SA documents all findings of non-compliance found onsite during surveys of nursing homes at the appropriate severity level.

a) Threshold Criterion: In eight percent (80%) or more of the deficiencies on CMS-2567s issued to facilities, there is no variation in the determination of

non-compliance.

b) Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

c) Method of Evaluation: The following reports will be generated from the FMS (FOSS/Comparative) Access database.

Report #2 – Deficiencies for which there was a disagreement between the SA and the Regional Office on the CMS-2567: This report would list the deficiencies on the CMS-2567 for which there were variations in the determination of non-compliance made by the SA. Satisfactory performance is defined as a discrepancy** rate of 20% or less for the aggregate of *deficiencies cited* in a fiscal year. Refer to the individual FOSS report for the narrative comments for each tag.

Calculation: Total number of deficiencies on the CMS-2567 where the RO did not agree with the decreased severity level change and where the SA did not cite deficiencies that should have been cited/ total # of deficiencies cited on CMS-2567 x 100 = %.

****Discrepancy is defined as variations between the citing and not citing of deficiencies and/or severity level differences for which there was not Regional Office agreement**. *Examples include: deficiencies that the RO thought should have been on the 2567 but were not (although onsite information supported the deficiencies being cited and for which no post survey information changing the decision was submitted to the SA) and for which findings were not put in another citation that was appropriate; deficiencies where the RO disagrees with the SA lowering of a scope/severity level.* **When there is a variation between the RO and the SA regarding the Statement of Deficiencies, the SA may be requested to provide a written response/explanation. Individual FOSS reports supply narrative comments for each tag/deficiency in which a variation was noted.**

Accuracy of documentation (Emphasis C): The SA accurately identifies and documents onsite findings of non-compliance.

a) Threshold 1 Criterion : One hundred percent (100%) of "significant" onsite findings are correctly identified & cited by the SA and found by the RO. (Significant is defined as deficiencies at or above the level "F" on the scope and severity grid.)

b) Threshold 2 Criterion : At least eighty percent (80%) of overall onsite findings were correctly identified and cited by the SA and found by RO.

c) Data Source: FMS results FOSS and Comparative Surveys for LTC

Facilities.

d) Method of Evaluation: The following reports will be generated from the FMS (FOSS/Comparative) Access database.

To be considered MET for Emphasis B, BOTH reports must meet their individual satisfactory performance levels (100% and 80% respectively).

Report #4 – Outcomes of Comparative Surveys – This report would list the deficiencies found by the RO during the Comparative Survey that should have also been cited by the SA at the same or greater severity level (this includes citations not cited by the SA that should have been). In order to meet satisfactory performance for this Emphasis, both Report 4A and 4B must be achieved at the satisfactory level.

Report 4A: This report would list the deficiencies found by the RO during the Comparative Survey that were significant* and should have also been cited by the SA at the same or greater severity level.

* Significant is defined as deficiencies at or above the level "F" on the scope and severity grid.

Calculation 4A: # of deficiencies cited at "F" and "I" on the scope and severity grid by the RO that were not cited by the SA at the same or greater severity level for the fiscal year. In order to meet this report's satisfactory level, no citations can be missed.

Report 4B: This report would list all the deficiencies that were cited by the RO that should have been found by the SA and measures the percent agreement between the SA and RO. In order to meet this report's satisfactory level, agreement must be greater than or equal to 80 percent (80%) for the fiscal year.

Calculation 4B: Total number of deficiencies uniquely cited by the RO minus the number of deficiencies that the SA should have found/Total number of deficiencies uniquely cited by the RO.

Example:

- The RO cited nine deficiencies that were not cited by the SA.
- The RO believed that the SA should have cited four of them.
- Calculation: the numerator would be five (5), the denominator would be nine (9), and the percent agreement would be 5/9 = 55.6%. The calculation would be done for each comparative survey and the percent agreement would be averaged over all the surveys for a State in a fiscal year.

Accuracy of Immediate Jeopardy cases (Emphasis D): The SA accurately identifies Immediate Jeopardy when present onsite.

a) Threshold Criterion: One hundred percent (100%) of the immediate jeopardy found onsite is accurately identified and cited on surveys conducted by the SA.

b) Data Source: FMS results FOSS and Comparative Surveys for LTC Facilities.

c) Method of Evaluation: The following reports will be generated from the FMS (FOSS/Comparative) Access database.

Report 4C: This report would list the number of occurrences for which immediate jeopardy was not identified and cited by the SA when the RO can support that it should have been found. In order to meet Emphasis D, there cannot be any missed identifications of IJ for the fiscal year.

Calculation 4C: Number of Comparative Surveys conducted for which IJ was present during the SA survey and not identified by the SA team.

Report #5 – Areas of "Needed Improvement" identified by the Federal Surveyors. This report would list the FOSS indicators, and percentage of surveys that indicators were identified for performance improvement. The indicators are separated into specific measure sections; however, there is some overlap. Specifics about the indicators can be found in the individual FOSS reports-narrative section. While this report will not be used to determine satisfactory versus unsatisfactory performance it is intended for the regional office to monitor trends and patterns of training that may need to be provided.

Scoring:

Each report is scored as "Met" or "Not Met." Use the following chart to determine the overall score for the standard:

# Of Emphases MET	Standard Score
4 of 4	Met
3 of 4	Partially Met
2 of 4	Partially Met
1 of 4	Not Met
0 of 4	Not Met

Timeliness of adverse action procedures (includes nursing home enforcement and excludes CLIA): (Standard 4)

Timeliness of Immediate Jeopardy cases (Emphasis A): "Immediate Jeopardy" cases involving LTC, LSC and NLTC providers and suppliers are processed timely. (Excludes CLIA and EMTALA cases.)

a) Threshold Criterion: In ninety-five percent (95%) of the SA's determinations that there is an Immediate Jeopardy to resident and/or patient health and safety in a provider or supplier that was not abated (removed) onsite (prior to the end of the survey), the SA adheres to the twenty-three (23) day termination process as outlined in 42 CFR 488.410 and 42 CFR 489.53.

b) Data Source: OSCAR reports and SA provider certification files. Although CMS may utilize information from the LTC Enforcement Tracking system as an internal reference for Immediate Jeopardy cases in nursing homes, CMS will measure overall timeliness rather than individual steps in the twenty-three (23) day termination process.

c) Method of Evaluation: This emphasis evaluates the SA's performance for **all** Immediate Jeopardy cases not abated (removed) for both LTC and NLTC surveys. We are determining the timeliness of notifications by the SA to CMS and the timeliness of provider revisits prior to the twenty-three (23) day termination date. The overall evaluation will include:

   1) assessment of whether CMS received prompt notification of the visit date when Immediate Jeopardy was discovered to be able to notify the provider of a twenty-three (23) day termination action;

   2) timely revisit by the SA upon receipt of a credible allegation of IJ abatement (removal); and

   3) notification to CMS of whether or not Immediate Jeopardy has been abated (removed).

d) Timeframes: For LTC, the notification of Immediate Jeopardy removal must be no less than three (3) working days prior to the termination date. CMS needs to provide the required public notice at least two (2) days prior to the effective date of termination in all cases in which Immediate Jeopardy has not been abated (removed).

   For NLTC, the SA follows SOM timeframes and CMS guidance for notification of Immediate Jeopardy and termination processes.

Methodology:

OSCAR data and the Long Term Enforcement Tracking System can be used to identify **all** LTC Immediate Jeopardy cases in the twenty-three (23) day IJ time line to be evaluated by CMS. Initially, OSCAR report 17 and OSCAR report 43 data can be used for identification of all noncompliance cases in NLTC Providers and Suppliers. CMS has discretion to review this information quarterly or biannually. However, CMS must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining the ninety-five percent (95%) or above adherence rate.

Failure to meet any of the above timeframes in each specific case will result in the SA failing to meet this emphasis in the case under review.

Calculation:

(1) Using the identified data sources (OSCAR data, information in the enforcement database, and/or provider certification files), identify all IJ cases that were not abated (removed) onsite.

(2) Determine in how many of these cases the State notified CMS of the IJ in a timely manner, conducted a timely revisit upon receipt of a credible allegation of compliance, and notified CMS whether or not the IJ was abated (removed) within prescribed timeframes.

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than 95%, Emphasis A is scored as "Met."

Timeliness of DPNA (Emphasis B): Denial of Payments for New Admissions (DPNA)* must be imposed by the third (3rd) month when a LTC provider/supplier is not in substantial compliance for three (3) months after the date of the original survey. SA adheres to the enforcement processing timeframes.

* DPNA is a denial of payment for new admissions, which is imposed when CMS finds that a facility is not in substantial compliance with requirements of participation.

a) Threshold Criterion: In eighty percent (80%) of the cases the enforcement packet is sent to CMS or notice is sent by the State to the provider by the seventieth (70^{th}) day.

b) Data Source: LTC Enforcement Tracking System Reports and SA provider certification files.

c) Method of Evaluation: This emphasis evaluates a SA's performance for sending notice to CMS or provider for timely imposition of statutory DPNA. The overall evaluation will include: the SA sends the enforcement packet for all cases (including immediate jeopardy that was not abated on the twenty-three (23) day termination process) to CMS or the SA sends the notice to the provider by the seventieth (70^{th}) day. SA notice to CMS can occur via whatever means the SA and CMS agrees (telephone, e-mail, in writing, etc.).

Methodology:

1. The specific custom report capturing the critical dates from the LTC Enforcement Tracking System (or manual retrieval of these critical dates) will provide the detail for each case in this evaluation process.

2. CMS will evaluate the following key dates:

    a. CMS receives notification from the SA of continuing non-compliance no later than seventy (70) days after the initial survey that determines substantial non-compliance; or

    b. if applicable, the SA sends notification to the provider no later than 70 days after the initial survey that determined substantial non-compliance.

3. CMS has discretion to review this information quarterly or biannually. However, the RO must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining, the eighty (80%) adherence rate.

Failure to meet any of the above timeframes in a case will result in the SA failing to meet the emphasis in the case under review.

Calculation:

(1) Using the identified data sources (information in the enforcement data base, and/or provider certification files), identify all LTC facilities that would have faced a mandatory DPNA if they did not come into

substantial compliance within 90 days of the date of the original survey. This is the Emphasis B universe.

(2) Determine in how many of these cases the State carried out timely actions (i.e., sent enforcement packets to CMS or sent notices directly to the provider within the timeframes specified).

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than 80%, Emphasis B is scored as "Met."

Adherence to conditions of participation (Emphasis C): Noncompliance with one or more Conditions of Participation or Conditions of Coverage and cited deficiencies limit capacity of the provider/supplier to furnish adequate level or quality of care. (NLTC providers, excluding CLIA)

d) Threshold Criterion: In eighty percent (80%) of the cases, which cite Condition-level noncompliance on the part of a provider or supplier, the SA adheres to the ninety (90) day termination process described in Section 3012 of the SOM.

e) Data Source: CMS and SA provider survey and certification files, and CMS tracking systems.

f) Method of Evaluation: This emphasis evaluates the SA's performance for the following parameters: The SA sends notice to CMS, the provider, and the SMA for providers participating in Medicaid by the fifty-fifth (55^{th}) day for all NLTC cases for which termination is recommended.

Note: The ninety (90) day termination process, with the exception of EMTALA cases, begins the date the entire survey is completed onsite regardless of when the exit conference is held. In the case of EMTALA violations, the ninety (90) day termination process begins on the date CMS makes the determination of noncompliance with 42 CFR 489.24 and/or the related requirements of 42 CFR 489.20 and the violation is not considered an immediate and serious threat to patient health and safety.

If Condition-level compliance is not determined at the revisit, the SA sends the ninety (90) day termination packet to CMS by the fifty-fifth (55^{th}) day from the last day of the survey that found condition-level noncompliance. At the same time, the SA notifies the provider that termination is recommended.

CMS and SA provider survey and certification files and CMS tracking systems can be used to identify all ninety (90) day NLTC cases. CMS has discretion to review this information quarterly or biannually, but must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining the eighty percent (80%) or above adherence rate.

Calculation:

(1) Using the identified data sources (provider files or other CMS tracking systems), identify the total universe of NLTC cases in which a provider/supplier had Condition-level deficiencies cited placing the provider/supplier on a ninety (90) day termination track during the fiscal year under review.

(2) Determine in how many of these cases the State carried out timely actions (i.e., sent CMS a ninety (90) day termination packet within the specified time frame).

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than eighty percent (80%), Emphasis C is scored as “Met”.

Budget analysis: (Standard 5)

Acceptable budget utilization process: (Emphasis A): The SA employs an acceptable process for charging the Federal programs.

a) Threshold Criteria: The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its Title XVIII and XIX expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.

b) Data Source: The CMS Budget Call Letter, the CMS-435 State Survey Agency Budget/Expenditure Report and the CMS-434 State Survey Agency Workload Report.

c) Method of Evaluation: The SA is evaluated on the twelve (12) items listed below:

- The SA meets CMS assigned due dates for its budget request and proposed work plan.
- The SA meets CMS assigned due dates for budget-related data requests.
- The SA submits all the attachments and documents required by applicable program instructions to support its budget request.
- Budget documents submitted are completed correctly.
- The type and amount of work projected is in accordance with applicable program instructions.
- The justification for each line item and cost, on the budget request, is reasonable and based on applicable program instructions.
- Program cost shares approved by CMS are appropriately applied to all line-items and costs on the budget request.
- The SA submits required expenditure and workload reports in a timely manner. (Quarterly reports are due forty-five (45) days after the close of the quarter and year-end cumulative reports are due sixty (60) days after the close of the fiscal year.)
- The SA submits the required quarterly and cumulative expenditure and workload reports that are completed in accordance with applicable program instructions.
- The SA submits quarterly Title XIX budget estimates in accordance with applicable program instructions.
- The SA provides reasonable assurances to CMS Office that costs shown on all budget/expenditure reports are appropriately applied to the Medicare, Medicaid and State Licensure programs across provider/supplier and program types.

- Reported FTEs and dollar amounts are reasonable and consistent with the State's budget approval. Line item amounts generally conform to the approved budget, except for good cause.

Scoring:

Attached is a score sheet to be used by the reviewer. For each item, a "Met" answer equals a score of one (1) and a "Not-Met" answer equals a score of zero (0). In order for the State to receive an overall "Met" for this emphasis, the State must have a score of ten (10) or above.

Acceptable method for monitoring expenditures (Emphasis B): The SA has an acceptable method for monitoring its current rate of expenditures and planned workload.

a) Threshold Criteria: The SA monitors and analyzes both its spending and workload progress throughout the fiscal year to ensure that the program priorities are accomplished within its approved budget.

b) Data Source: The OSCAR 10, 15, and 25 Reports, the CMS-435 State Survey Agency Budget/Expenditure Report and the CMS-434 State Survey Agency Workload Report.

c) Method of Evaluation:

- Quarterly Analysis: The SA prepares a brief analysis that summarizes the status of its spending and work completion in relation to meeting the budgeted dollar and workload amounts for the fiscal year.
- Annual Analysis: The SA prepares a brief analysis which analyzes the fiscal year and compares actual expenditures and accomplished workload to the amount budgeted and the planned workload.
- The State takes appropriate action to ensure program priorities are accomplished within the approved budget amount.
- If necessary, the SA prepares and justifies a supplemental budget.

Scoring:

This Emphasis is scored as "Met" if CMS Office verifies quarterly and annual analyses.

Timeliness & quality of complaint investigations: (Standard 6)

NOTES:
1) The procedure for running the ACTS Federal Investigation Timeframe Reports is located in Appendix D.
2) In Standard 6, "complaints" and/or "complaints and incidents" refer to "complaints and incidents (that require a Federal onsite visit)".

Prioritizing complaints and incidents (Emphasis A): The SA maintains and follows guidelines for the prioritization of complaints and incidents (that require a Federal onsite visit) for Medicare/Medicaid certified facilities in LTC, Non-accredited Hospitals, HHAs, and ESRD facilities.

a) Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints Medicare/Medicaid certified facilities.

1. Long Term Care

b) Data Source: ACTS Federal Investigation Timeframe Reports.

c) Statutory/Regulatory citations: Sections 1819(g)(1)(c), 1919(g)(1)(c), and the Act, 42 CFR 488.332 and 42 CFR 488.335, and SOM 5020 and 5030.

Sample Size:

Universe	Sample Size
70 or greater	Ten percent (10%) of all Medicare/Medicaid certified provider/supplier complaints with a maximum of forty (40)
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

Sampling Methodology:

(Medicare/Medicaid certified Facilities Only) The sample is drawn from ACTS complaint/incident inputs. Pull a random sample from all complaints received, but if sampled cases do not include immediate jeopardy and actual harm cases, expand the sample until it includes at least a minimum of two (2) immediate jeopardy cases and four (4) actual harm cases, in possible. If the sample is expanded in order to

include immediate jeopardy and actual harm, drop the appropriate number of "other" cases to achieve the required sample size.

The random sample is pulled from complaints received beginning October 01, 2004 through September 30, 2005.

Review Methodology: Review each sampled case to determine if the SA appropriately triaged the complaint using the criteria defined in the S&C 04-09 letter and State policy and procedure criteria. Use the final triage rating assigned by the State after their review of the complaint intake data.

*If there is disagreement between the SA and the RO as to the assigned category, discuss with the SA the factors taken into account when the triage assignment was made. If there is still disagreement between the RO and SA triage assignment, refer the case to the RO for a second independent review.

Scoring for Emphasis A – LTC

- If ninety percent (90%) of all complaints are triaged appropriately score Emphasis A – LTC as "Met".
- If less than ninety percent (90%) of all complaints are triaged correctly score Emphasis A – LTC as "Not Met".

2. Non-Long Term Care Providers

b) Data Source: ACTS.

c) Statutory/Regulatory citations: SOM 3280

Sample Size:

Universe	Sample Size
70 or greater	Ten percent (10%) of all Medicare/Medicaid certified provider/supplier complaints with a maximum of forty (40)
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

Sampling Methodology:

(Medicare/Medicaid non-accredited Certified Facilities Only). The sample is drawn from ACTS complaint inputs. Pull a random sample

from all complaints received. Ensure that a minimum of two (2) complaints from ESRD, non-deemed HHAs, and Non-accredited Hospitals are included in the sample.

The random sample is pulled from complaints received beginning October 01, 2004 through September 30, 2005.

Review Methodology:

Review each sampled case to determine if the SA appropriately triaged the complaint using the immediate jeopardy, and State policy and procedure criteria.

> **Note:** If there is a disagreement between the state and the RO as to the assigned category, discuss with the SA the factors taken into account when the triage assignment was made. If there is still disagreement between the RO and SA triage assignment, take the case to the RO for a second independent review.

Scoring for Emphasis A – Non Long Term Care

- If ninety percent (90%) of all complaints are triaged appropriately, score Emphasis A – NLTC as "Met".
- If less than ninety percent (90%) of all complaints are triaged correctly score Emphasis A – NLTC as "Not Met".

Overall Scoring for Emphasis A

- If Emphasis A – LTC and Emphasis A – NLTC are both scored as "Met" then the overall score for Emphasis A is scored as "Met."
- If Emphasis A – LTC and Emphasis A – NLTC are both scored as "Not Met" then Emphasis A is scored as "Not Met."
- If Emphasis A – LTC is scored as "Met" and Emphasis A – NLTC is scored as "Not Met" then the Emphasis A is scored as "Not Met."
- If Emphasis A – LTC is scored as "Not Met" and Emphasis A – NLTC is scored as "Met" then emphasis A is scored as "Not Met."

Frequency of complaint and incident investigations (Emphasis B): The SA investigates all complaints and incidents (that require a Federal onsite visit) it receives in Medicare/Medicaid certified facilities within the prescribed time limits for LTC, ESRDs, HHAs, non-accredited hospitals and deemed hospitals.

a) Threshold 1 Criterion: The SA investigates one-hundred percent (100%) of complaints and incidents (that require a Federal onsite visit) it receives for Medicare/Medicaid certified facilities where it determines there is a present or ongoing immediate jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA. (LTC, ESRD, Home Health agencies, non-accredited hospitals, deemed hospitals.)

b) Threshold 2 Criterion: The SA investigates all complaints and incidents (that require a Federal onsite visit) in LTC Medicare and Medicaid certified facilities it receives alleging or involving actual harm to individuals within an average of ten (10) working days with all complaints completed by twenty (20) working days. (LTC only.)

c) Threshold 3 Criterion: The SA investigates all certified deemed hospital non-immediate jeopardy complaints and incidents (that require a Federal onsite visit) that allege non-compliance with conditions of participation within an average of forty-five (45) calendar days with all complaints completed by sixty (60) calendar days. (deemed hospitals.)

d) Data Source: ACTS Federal Investigation Timeframe Reports.

e) Statutory/Regulatory citations: Section 1819(g)(4) and Section 1919(g)(4) of the Act, 42 CFR 488.332, and section 7700(G)(1) of the SOM, SOM 3262 and SOM 3281.

Sample Size:

- Set the date filter for complaints received beginning October 1, 2004 through September 30, 2005.
- Run the ACTS Federal Investigation Timeframe Reports.

Review Methodology/Scoring:

- If Threshold 1, Threshold 2, and Threshold 3 are all met - then score Emphasis B as Met.
- If any Threshold is not met (Threshold 1, Threshold 2 and/or Threshold 3) – then score Emphasis B as not met. Include all ACTS generated reports with the report that goes to the SA for comment.

Frequency of EMTALA investigations (Emphasis C): The SA investigates EMTALA complaints referred by the RO according to CMS policy.

a) Threshold Criterion: No less than 80% of approved EMTALA complaints are investigated according to CMS policy.

b) Data Source: RO EMTALA logs and Completed Survey Packets sent to RO.

c) Statutory/Regulatory Citation: Section 3406 (B) of the SOM and Article II (A) (2) of the 1864 Agreement.

Sample Size:

Universe	Sample Size
70 or greater	Ten percent (10%) of all Medicare/Medicaid certified provider/supplier complaints with a maximum of forty (40)
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

Sampling Methodology: A random sample of all EMTALA complaints that were referred by the RO for investigation will be selected from the RO EMTALA log.

The random sample is pulled beginning October 01, 2004 through September 30, 2005.

Review Methodology:

1. Was the complaint investigation completed within five (5) working days from RO approval Date/Extension Date?

2. Was a completed packet sent to the RO within ten (10) working days following survey exit date when a suspected violation is identified or fifteen (15) days when no violation was found? A complete packet is defined as containing the following items listed below:

- CMS-562 sent to RO/Data entered into ACTS;
- CMS-670 sent to RO/Data entered into ACTS;
- CMS-2567 (if applicable);
- CMS-1541B with recommendation for action included or sent in survey packet;
- Written summary of interviews – can be in narrative or surveyor notes;

- ♦ Copies of pertinent hospital policies and procedures that relate to the identified deficiencies (If applicable);
- ♦ Summary listing of all patients comprising the sample (including an explanation of how and why the cases were selected for review); and
- ♦ Copies of medical records for substantiated cases, medical records of individuals named in complaints and any medical records for which a QIO review was requested;

3. Was the sample selection based on the case selection methodology outlined in Appendix V, Task 2 of the SOM?

4. Did the SA documentation support the SA's recommendation?

5. Did the 2567 reflect the SA's documentation/recommendation?

For each case selected, review the complaint investigation packet using the attached worksheet.

Guidance for Question One: For EMTALA complaints that are granted extensions by the RO, review against the RO approved extension date instead of five (5) working days. (*For example, if the RO gives the State an extra five (5) days to complete the EMTALA investigation, review against the extension date).* Time frames are calculated from date of RO notification to the survey end date. Count the day of RO notification to the SA as day zero. Survey end date is obtained from SA survey Packet, CMS 670.

Scoring:

- If eighty percent (80%) of all reviewed EMTALA complaints met the pass criteria of having no more than two (2) "No" answers - then score the emphasis as "MET."
- If less than eighty percent (80%) of all reviewed EMTALA complaints met the pass criteria of having no more that two (2) "No" answers - then score the emphasis as "Not Met."

Quality of Investigation (Emphasis D): The SA investigates complaints and incidents (that require a Federal onsite visit) for Medicare/Medicaid certified LTC Facilities according to CMS general instructions for complaint handling.

a) Threshold: No less than eighty percent (80%) of LTC complaints and incidents (that require a Federal onsite visit) are investigated according to CMS policy.

b) Data Source: ACTS and State documentation.

c) Statutory/Regulatory citations: Sections 1819(g)(1)(c), 1919(g)(1)(c), and the Act, 42 CFR 488.332 and 42 CFR 488.335, and SOM 5020 and 5030.

Sample Size: Use the random sample pulled for emphasis A (LTC).

Review Methodology: Use the worksheets provided and review each LTC complaint or incident (that require a Federal onsite visit) for the following criteria:

1. Was an appropriate sample chosen based on the allegations?

   Guidance for Question One: The sample should include a sufficient number of residents rooms, records, and/or services (as applicable) to evaluate the specific allegation as well as systemic issues that affect the ability of the provider/supplier to maintain compliance with regulations.

2. Was each allegation investigated?

3. If the allegation was substantiated with deficiency, was there a corresponding citation on the 2567? If applicable.

4. Did a qualified surveyor (SMQT Qualified) complete the survey?

5. If the complaint or incident (that require a Federal onsite visit) concerns conditions on a certain day (e.g., weekends) or on a certain shift (e.g., 11-7 shift), the SA investigates the complaint at the relevant time. If applicable (Refer to: Appendix P – Page 74.)

   Note: Some complaints that allege issues that occurred on weekends may be effectively investigated during regular working hours.

6. Was the complainant contacted with the survey results? If applicable.

Scoring:

- If eighty percent (80%) of all LTC complaints and incidents (that require a Federal onsite visit) investigated had no more than two (2) "No" answers then score the emphasis as "MET."
- If less than eighty percent (80%) of all LTC complaints and incidents (that require a Federal onsite visit) investigated had no more than two (2) "No" answers then score the emphasis as "Not Met."

Timeliness & accuracy of data entry (LTC and Nonaccredited Hospitals only): (Standard 7)

ACTS timeliness and accuracy will not be measured in the FY 2005 State Performance Standards analysis.

Frequency of data entry (Emphasis A): Certification kits for recertified non-accredited hospitals, nursing homes, and LSC are entered into the OSCAR/ODIE/ASPEN Central Office system on a timely basis.

a) Threshold Criterion: The mean number of days from the latest date of the SA survey completion date (L34) to the date of data entry into OSCAR/ODIE/ASPEN Central Office does not exceed seventy (70) calendar days. (Use which ever has the latest date: Health or LSC).

b) Data Source: Providing Data Quickly (PDQ) and OSCAR Reports.

Providing Data Quickly (PDQ) is a web enabled reporting application that provides summarized reports of survey and certification program data. The application is designed to let program analysts and managers monitor the data by generating basic queries on different aspects of the data in order to return responses quickly.

Method of Evaluation using PDQ: (When comparing OSCAR Reports to PDQ Reports, please refer to the "HELP for OSCAR USERS" link on the PDQ Report page).

1. For nursing homes, enter PDQ and click on "nursing home providers." For nonaccredited hospitals, enter PDQ and click on "hospital providers."
2. Under "survey reports, click on "State Performance Standard 7A."
3. Enter the selection criteria for each field as described below and click "Run Report. (Repeat this step for SNF/NFs, for NFs, and for nonaccredited hospitals).

    a. **Year Type**: "Fiscal Year" (default)
    b. **Begin Year**: "2005" (default)
    c. **End Year**: "2005" (default)
    d. **Display multiple years**: "*empty*" (default)
    e. **Define Outliers**: "70" days (default)
    f. **Provider & Supplier Type(s)**: All of the selection criteria (filters) are set to meet the requirements of the protocol. As

an option, any of the selection criteria can be changed to meet specific reporting needs.

4. After selecting "Run Report," the program then advances to a page providing results separately by region. The program creates rows below that region, separating the results by the States in that region. The page will have the following columns:

   a. Region: Click once on your region name to get to the specific State in your region. When you click once on the State name, this provides a listing of all providers within that State that are outliers.
   b. Number of Surveys
   c. Mean # of days to data entry
   d. Data Entry Exceed 70 days (% of Surveys)

Print this page separating the results by State. Utilizing this PDQ output from the column marked **"Number of Surveys"** and **"Mean # of days to data entry"**, record this data for SNF/NFs, NFs, and non-accredited hospitals for each State on the worksheet titled Performance Standard 7 Emphasis A Score Sheet."

Method of Evaluation of LSC using OSCAR Reports: To create a report using the OSCAR (User Defined), please utilize the following criteria:

1. The report is for the Federal fiscal year.
2. Include Accepted Records Only
3. RO-flagged cases are included.
4. All provider subtypes are included:
   a. Nursing Homes: SNFs, NFs, and SNF/NFs (dually certified and distinct part).
   b. Hospitals: All hospitals and non-accredited CAH.
5. Record this data for SNF/NFs, NFs, and non-accredited hospitals for each State on the worksheet titled Performance Standard 7 Emphasis A-LSC Score Sheet.

A. Frequency of Review:

CMS will review LTC surveys entered and nonaccredited hospital surveys entered during the annual reviews. Onsite reviews are discretionary.

B. Universe:

The universe for Emphasis A is all non-accredited hospital, SNF, SNF/NF and NF recertification surveys entered/uploaded into OSCAR/ODIE during the fiscal year. Initial surveys are excluded.

C. Scoring:

1. If the score does not exceed seventy (70) calendar days for either LTC or nonaccredited hospitals, Emphasis A is "Met". If either LTC or non-accredited hospitals is scored as Not Met, Emphasis A is scored as "Not Met".

   Enter the score for each subpart reviewed on the "Performance Standard 7 Summary."

2. For States that do not meet Emphasis A, create a list of surveys that exceeded seventy (70) processing days. To generate this listing, click on the State name in the left hand column of the PDQ State Performance Standard 7A report and print the listing of facilities.

D. Feedback to SA:

Send the Emphasis A Scoresheet together with the listing(s) of surveys exceeding seventy (70) processing days, if appropriate, within fifteen (15) of completing the review.

If the SA determines that a recertification kit with an IDR was entered into the data system timely and can submit acceptable evidence to confirm the timeliness, this information will be considered when calculating the data entry interval. It may require the data entry interval to be recalculated without using an existing software program.

Accuracy of data entry (Emphasis B): The SA enters data accurately into OSCAR\ASPEN Central Office for recertified non-accredited hospitals and nursing homes.

a) Threshold Criterion: No less than eighty-five percent (85%) of cases reviewed, demonstrate that data is entered into OSCAR\ASPEN Central Office accurately.

b) Data Sources: OSCAR/ASPEN Central Office, OSCAR user-defined reports; ODIE inquiry screens; hard copy of nursing home and non-accredited hospital recertification kits; CMS-1539 (C&T) for actions subsequent to the certification kit; SA Informal Dispute Resolution (IDR) log or documents; SA staggered survey log.

Method of Evaluation:

Use statistically valid random samples of nursing home and non-accredited hospital recertification surveys to determine the data entry accuracy rate.

Copies of the following documentation should be collected from the SA for each **LTC** provider in the sample:
1) the CMS-1539 associated with the recertification,
2) any CMS-1539s for actions subsequent to the recertification,
3) the CMS-671 associated with the recertification,
4) the CMS-672 associated with the recertification,
5) administrator signature copies of the CMS-2567s associated with the recertification (life safety code, health, and any revisits upon which deficiencies were cited),
6) (if applicable) the CMS-2567b(s) associated with the recertification (life safety code and health),
7) the SA Informal Dispute Resolution (IDR) log or documents, and
8) SA staggered survey log.

Copies of the following documentation should be collected from the SA for each **nonaccredited hospital** in the sample:
1) the CMS-1539 associated with the recertification,
2) any CMS-1539s for actions subsequent to the recertification,
3) the CMS-1514 associated with the recertification,
4) the CMS-2786E associated with the recertification,
5) administrator signature copies of the CMS-2567s associated with the recertification (life safety code, health, and any revisits upon which deficiencies were cited), and
6) (if applicable) the CMS-2567b(s) associated with the recertification (life safety code and health)

Compare all selected forms and/or data fields directly against the ODIE inquiry screens, SA IDR log and SA staggered survey log. Worksheets and substantive data field listings needed for completing this Emphasis may be found in Appendix E. This emphasis will be evaluated in two parts.

A. Subpart Measures:

Subpart B1. For SNF and SNF/NF recertifications entered into ASPEN/ODIE between October 1, 2004 and September 30, 2005, no less than eighty-five per cent (85%) of cases reviewed demonstrate that data is entered accurately.

Subpart B2. For non-accredited hospitals, no less than eighty-five

percent (85%) of recertifications reviewed demonstrate that data is entered into ODIE accurately.

B. Definitions:

Data entry fields: The data entry fields appearing in ASPEN/ODIE for the forms comprising nursing home and non-accredited hospital recertification kits. Refer to Attachments B1 and B2 for forms and fields to be reviewed for each emphasis.

Error case: A case will be considered to not meet Subparts B1 or B2 (i.e., is an error case) if the reviewer finds:

- Two (2) or more data entry errors or omissions in data fields designated as "substantive" **or**
- Five (5) or more data entry errors or omissions in nonsubstantive data fields **or**
- One (1) substantive plus four (4) nonsubstantive errors or omissions in data fields.

NOTE: If there is a discrepancy between the data field information in ODIE and the SA's hardcopy form, mark as an "error" until verified with the SA that the data field in ODIE is the correct information. Once it has been verified that the information in ODIE is correct, the SA should be scored as met for the accuracy of the data in the data field and the RO should record the discrepancy in the comments section of the "Performance Standard 7-Emphasis B, Subpart B_, Random Sample/Review Results" score sheet and indicate that hardcopy forms should be annotated by the SA when changes have been made.

Substantive Data Field: A field that the SA or CMS Office operations deem as important. (See Attachments B1 and B2.)

C. Frequency of Review:

CMS will conduct these reviews annually. Onsite reviews are discretionary.

D. Universe:

For nursing homes, the universe is all recertification surveys entered into OSCAR/ODIE/ASPEN Central Office from October 1, 2004 through September 30, 2005. For non-accredited hospitals, the universe is all recertification surveys entered into OSCAR/ODIE from October 1, 2004 through September 30, 2005. To select a sample for each subpart, copy

and save the OSCAR Report(s), **PS7EB NH** and **PS7EB HOSP**, if needed from GB17's library. The report is **Type: U** and **Suffix: P**

A document containing detailed instructions on how to copy and run the OSCAR report is located in Appendix E. The document, Attachment AB, "Performance Standard 7 – Instructions For Copying User-Defined OSCAR Reports From GB17 Library" describes the procedure for downloading a pre-defined user defined OSCAR extract report.

E. Sample Size:

The sample sizes for nursing homes and for hospitals are as follows:

Universe	Sample Size
70 or greater	Ten percent (10%) with a maximum of forty (40)
7 to 69	Six (6)
1 to 6	Entire universe

For each annual review, the number of recertifications reviewed should not exceed forty (40). If the universe of surveys for any subpart is greater than six, the reviewer must use a random sample to select the surveys to be reviewed for that subpart.

F. Random Sample Selection:

Draw a statistically valid random sample for each review. Detailed instructions are available on Attachment BB in Appendix E. Attachment BB, "Performance Standard 7 – Emphasis B, Instructions for Converting Raw OSCAR Data to an Excel Format and Drawing the Random Sample, contains instructions on how to manipulate the downloaded user defined OSCAR report. It takes the reviewer from formatting the downloaded report in Excel to generating the random sample and transferring the data to the "Random Sample Review Results Worksheet," which generates case/error counts, error ranges, error averages and the score for the Subpart.

Note: For some states a random selection will not have to be selected for non-accredited hospitals since the entire universe of surveys will be less than seven.

G. Sample Review:

Follow the steps below when conducting the review.

1. Check the accuracy of the data entry by comparing each data field on the hardcopy of each required certification form against the ODIE

inquiry screen (or equivalent print screen) and each required data field from the ODIE inquiry screen (or equivalent print screen) against the hard copy form.

2. Refer to the appropriate subpart document titled “List of Data Fields for Review …” (AttachB1_datafields.doc and AttachB2 _ datafields. doc) to identify substantive and all other fields to be reviewed.

3. Complete the “Performance 7 Random Sample Case Review Worksheet” for each case. The results annotated on this form will be used to complete the EXCEL spreadsheets “Performance Standard 7- Emphasis B, Subpart B_, Random Sample/Review Results.” (See scoring, below.)

4. Conduct Informal Dispute Resolution (IDR) and staggered survey reviews as follows:

   a. IDR Review:

      1. For surveys that indicate that an IDR was requested (found on ODIE screen 4.2.2 - CMS-671), compare the IDR request and completion date with the dates in the State's IDR log. Also, check to see that any changes made as a result of the IDR have been entered into ODIE. (**Note:** If a tag has been deleted by IDR, it should **not** appear on the CMS-2567 ODIE screen. Similarly, the ODIE screen should reflect any change(s) made in deficiency tags and scope and severity.)

      2. Determine if ODIE does not indicate an IDR was performed, but the IDR log Indicates otherwise. The omission of IDR entry into ODIE is considered a **nonsubstantive error**.

      3. If a survey does not appear on the State’s IDR log, all deficiencies appearing on the hard copy of the CMS 2567 and/or CMS 2567B should appear in ODIE.

   b. Staggered Survey Review:
      1. Verify that the staggered survey field (ODIE screen 3.2.2 – CMS 671) agrees with the State’s staggered survey log. For example, if the staggered survey field is blank in ODIE, the survey should not appear on the State’s staggered survey log.

2. For Subpart B1 the ODIE screen should contain a **Y** if a staggered survey was performed. (The reviewer may determine if the survey was morning, evening or weekend by reviewing the columns related to staggered surveys (columns I, J and K) on the spreadsheet containing the surveys randomly selected for review.)

H. Scoring:

1. Complete a separate "Random Sample Review Results" report (PS7EB_summary.xls) for each subpart. Results for each subpart will be summarized and **automatically scored.** Enter the following information into the report:
   (6) Basic information at the top of the form, including whether the Threshold Criterion is met (i.e., accurate case score is eighty-five percent (85%) or higher) or not met (i.e., accurate case score is eighty-four percent (84%) or less).
   (7) Number of errors, broken out by substantive and nonsubstantive, for each sample case.
   (8) Error Case or Accurate Case designation for each sample case.
   (9) Universe of cases (count), which is available at the bottom of the randomly sorted Excel sheet by state.

2. Transfer the findings for each Subpart reviewed from the "Random Sample Review Results " to the "Performance Standard 7 Summary" (PS7_FY03summary.doc).

   If both subparts are met (accuracy rate of eighty-five percent (85%) or better), Emphasis B is "Met."

   If one or both of the subparts are not met, Emphasis B is "Not Met."

Feedback to SA:

Send the following documents to the SA, together with any other pertinent data, within fifteen (15) days of completing the review:

- "Random Sample Case Review Worksheet." Forward a copy of the worksheet for each survey reviewed that contained a data entry error. Include screen prints of all data entry errors if the SA has requested them in advance of the review.

- "Performance Standard 7 – Emphasis 2, Random Sample/Review Results" report. This lists and counts all sample cases (including IDR

and staggered survey cases), the number of substantive/nonsubstantive errors per case, the error case and accurate case designation per case, the total number of error and accurate cases, a count of the universe of cases, the total number of errors, minimum/maximum number of errors (i.e., range), average number of errors and the score (%).

Standard 7 Feedback to SA

In addition to the documents specified under each emphasis, send the following documents to the SA:

1. "Performance Standard 7 Review Summary." Complete a 1-page sheet that specifies whether the Standard is met, partially met or not met; whether each Emphasis is met or not met and the score for each Emphasis. Complete this summary after the reviews for both Emphasis A and Emphasis B are completed.

2. A request for a corrective action plan addressing any problems noted. Include the date the plan is due.

Reporting Requirements

Timeline

September 30, 2005	End of Evaluation Period
December 4, 2005	CMS ROs send Draft Report to CO
December 16, 2005	CO sends comments on Draft Reports to CMS ROs
January 4, 2006	CMS ROs send Draft Report to SAs
January 25, 2006	SAs send comments on the Draft Reports to CMS ROs
February 26, 2006	CMS ROs send Final Report to SAs and CO

Reconsideration

There is no formal appeal of findings relative to this Report of State Agency Performance since the assessment is umbrellaed under the "Evaluation" Article (Article V) of the 1864 Agreement. However, where the SA and CMS cannot come to a final agreement on key findings, the SA may ask CMS for informal reconsideration. The request should be made in writing to the next higher level of line authority above the CMS RO authority issuing the report. The request should be made within fifteen (15) calendar days of the date the SA received the draft report.

Contacts

- **Timeliness of survey** (Standard 1): Please direct any questions relative to this standard to Kirsten Jensen or call (410) 786-1095.

- **Documentation of survey results** (Standard 2): Please direct any questions relative to this standard to Kathleen Pozek or call (816) 426-6503.

- **Quality of State Agency investigations & decision-making** (Standard 3): Please direct any questions relative to this standard to Kirsten Jensen or call (410) 786-1095.

- **Timeliness of adverse action procedures** (Standard 4): Please direct any questions relative to this standard to John Thompson (Jthompson2) or call (410) 786-3264.

- **Budget analysis** (Standard 5): Please direct any questions relative to this standard to John Thompson (Jthompson2) or call (410) 786-3264.

- **Timeliness & quality of complaint investigations** (Standard 6): Please direct any questions relative to this standard to Sherrian Pater or call (816) 426-6557.

- **Timeliness & accuracy of data entry** (Standard 7): Please direct any questions relative to this standard to Maria Neff at (312) 886-5203 or Jill Kelly (PDQ only) at 410-786-9359.