

CORE INFRASTRUCTURE STANDARD REQUIREMENT MUST BE DONE

A. Key Developments in Training:

Section Six described the more complete description of SA responsibilities for training and ensuring the on-going competency of surveyors and certification/enforcement staff to perform all tasks relating to the Federal workload under the 1864 agreement.

To facilitate SA planning, we have provided updates below on key developments that will affect planning for training activities.

- 1. *Prerequisite for Basic Life Safety Code (BLSC) training:*** New SA Life Safety Code Surveyors will be required to obtain a “Certified Fire Inspector I (CFI-1)” certificate through the National Fire Protection Association (NFPA) certification program in order for SA LSC surveyor candidates to attend the CMS BLSC course. Specific information on obtaining a NFPA CFI-1 certification can be found at:
<http://www.nfpa.org/training/certification-programs/certified-fire-inspector-i>

The purpose of the CFI-1 is to ensure that all surveyor candidates have a basic knowledge of fire protection and the LSC as necessary to participate effectively in the BLSC course. The CFI-1 is based upon the NFPA Standard 1301, “Standards for Professional Qualification for Fire Inspector and Plan Examiners,” which identifies the professional levels of performance required for fire inspectors, specifically identifying the job performance requirements necessary as a fire inspector.

A candidate for NFPA CFI-1 certification must, at a minimum, have a high school diploma or equivalent. The NFPA CFI-1 certification program requires an exam and practicum to determine whether individuals have the requisite skills and knowledge. Passing the examination and completing the practicum are all that is required to obtain a CFI-1 certification, therefore training is optional for qualified applicants. The NFPA offers a paper and pencil as well as a computer-based version of the examination. After successfully passing the examination, candidates will need to complete the practicum phase of the program in order to demonstrate the application of skills and knowledge. The practicum phase includes the completion of two mandatory and five elective occupancy survey exercises. It is possible that multiple practicum exercises can be completed during a LSC survey, depending upon the size and type of facility.

CMS does not require existing SA LSC surveyors to obtain a CFI-1. SA BLSC training candidates who already have a NFPA CFI-1 certification are not required to take any action, except to make sure that a copy of the certification is provided to their SA and to CMS for entry into the Learning Management System. SA BLSC training candidates who have a CFI-1 certification that was not issued by NFPA must submit a program transfer application to NFPA in order to receive an NFPA certification. CMS does not require recertification of the CFI-1.

CMS will not manage the acquisition of the NFPA CFI-1 certification for SA LSC surveyor candidates. SAs are responsible for addressing all matters necessary to obtain CFI-1 certifications for all SA LSC surveyor candidates who plan to attend CMS BLSC training.

4. Leadership Training: State survey agency Directors and Deputy Directors are required to attend and participate in the annual CMS Survey Executives Training Institute. This event typically requires 2.5 days of attendance and usually occurs in the Spring/Summer each year. Travel and lodging expenses are paid 100% from federal funds as an addition to the State's survey budget allocation.

B. ASPEN Data Entry of Survey Information (e.g. Completion and Use of the CMS-670)

States must continue to ensure accurate and timely input and upload of information for the ASPEN system, including completion of the CMS-670 according to current ASPEN guidelines and CMS SOM Chapter 2, Section 2705 and evaluate their own surveyor times.

C. CMS Quality Improvement Initiative

In FY2003, CMS began publicly reporting nursing home, ESRD and home health quality measures and implemented a nationwide quality improvement effort in nursing homes and HHAs by Quality Improvement Organizations (QIOs). QIOs/ESRD Networks and SA partnerships are critical to the improvement of nursing home, ESRD and home health quality. In 2013, Networks and State Agencies collaborated in two new areas, the Infection Control Initiative and the Involuntary Discharge Initiative. Networks and State Agencies will continue to work together on the Fistula First Initiative.

Beginning in August of 2012, CMS launched a National Nursing Home Collaborative that focuses on preventable healthcare acquired conditions (HACs). As part of that initiative, the QIOs and their nursing home partners will work to strengthen the building blocks of change in order to help nursing homes make meaningful gains in the residents' quality of life and clinical outcomes. These building blocks may include but are not limited to staffing, operations, finance, and leadership among others. We fully support the QIOs in this endeavor and will continue to strengthen our partnership by aligning resources, encouraging collaborative participation and ensuring that each SA is a collaborative partner. The QIO 11th Scope of work began August 2014. The 11th Scope continues these efforts, as well as add to efforts to train nursing homes in quality assessment and performance improvement (QAPI) in anticipation of a forthcoming regulation that will make QAPI a basic requirement for all nursing homes (as required by section 6102 of the Affordable Care Act).

The core infrastructure requirement for quality improvement initiatives, applicable to all SAs, is focused on the following:

1. Restraints, Pressure Ulcers and Immunization Rates in Nursing Homes – Our mutual goal is to reduce the prevalence of pressure ulcers, reduce the incidents of restraints and increase the immunization rates in nursing homes. The SA's role is to:
 - i. Assure that State surveyors are adequately trained on the regulatory requirements and pertinent SOM interpretive guidelines;
 - ii. Make sure that surveyors follow the survey protocols and processes;
 - iii. Provide suitable enforcement remedies when nursing homes are cited;
 - iv. Provide appropriate communications and education for providers regarding the importance of these three priority areas, CMS' goals and resources available to nursing homes; and
 - v. Coordinate S&C activities with those of the QIOs, make appropriate referrals to the QIOs and encourage systemic quality improvement in nursing home plans of correction.

1. Working with Nursing Homes with Systemic Problems
 - a. Meet requirements of the Special Focus Facility (SFF) initiative:
 - Select facilities to be designated as an SFF from the candidate list released periodically by CMS;
 - Survey SFFs twice every 12 months beginning from the date it is selected as an SFF;
 - Monitor SFF to determine if they meet graduation criteria or require more robust enforcement strategies.
 - b. Coordinate with QIOs to provide nursing homes, which have systemic problems with possible tools to assist them.
2. Staffing Data and Quality Measures (QMs) - With the help of SAs we are striving toward improving the adequacy of reported data for nursing home staffing data and QMs. The SA's role is to:
 - Ensure that surveyors follow survey protocols and processes in comparing survey and MDS information during the survey; and
 - Ensure that the RAI coordinator provides support and technical assistance for nursing homes in the coding of the MDS.
 - Monitor the accuracy of MDS coding and ensure that onsite surveys include a review of such coding.
3. National Partnership to Improve Dementia Care in Nursing Homes: Launched in March 2012, the Partnership set a national goal of reducing the use of antipsychotic medications in nursing home residents by 15 percent. After achieving this goal in December 2013, CMS established new goals for reducing the use of antipsychotic medications in long-stay nursing home residents by 25 percent by the end of CY2015, and a 30 percent reduction by the close of CY2016 (using the original baseline rate established in Quarter 4, 2011). CMS is now working with a subset of nursing homes, identified as late adopters, who have had little to no improvement in their long-stay antipsychotic medication utilization rates. The current Partnership goal involves a 15 percent reduction in the prevalence of antipsychotic medication use for those homes identified as late adopters. This goal is to be achieved by the end of CY2019 (using the original baseline rate established in Quarter 4, 2011). This multidimensional initiative includes transparency through public reporting; consumer, provider, prescriber, and surveyor education; research, interpretative guidance revisions, as well as quality improvement efforts involving partnerships with QIOs, National Nursing Home Quality Improvement Campaign. State Dementia Care Coalitions play a major role in sharing information, resources, data, and tools, conducting outreach with individual nursing homes, and engaging in educational programs with other agencies.

Additional emphasis applies to working with nursing homes and QIOs on the implementation of culture change that improves quality of life, through the use of individualized, person-centered care approaches, without compromising quality of care.

D. Performance Measurement Activities

State budget submissions must include thorough and well-structured action plans for effecting Survey and Certification program goals and objectives. The plans should outline effective strategies for achieving performance targets and conforming to CMS' State performance standards and priorities. States should also identify how national goals and standards are being

translated into individual performance objectives. If CMS finds that the SA does not meet the performance standards, the SA will be expected to develop and implement a corrective action plan.

E. Nurse Aide Registry (NAR)/Nurse Aide Training and Competency Evaluation Program (NATCEP)

States are required to maintain a registry of all individuals who have completed a nurse aide training course and have passed a competency evaluation test. States must also investigate allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide or other individuals.

The State must assure that the nurse aide registry is operated in compliance with the Federal requirements. This includes assuring that:

- The SA reports findings of resident abuse, neglect and misappropriation of resident property to the registry and these findings are included in the registry within ten working days of the findings;
- In the case of a singular finding of neglect, the State has established a procedure so that a nurse aide can petition to have his or her name removed from the registry. (The employment and personal history of the nurse aide must not reflect a pattern of abusive behavior or neglect and the nurse aide must wait one year from the substantiation of the finding before petitioning to have his or her name removed from the registry.)

The allowable costs that can be charged to the Medicare State Certification program are outlined in Sections 1819(e) (1) and (2) of the Social Security Act. These costs relate to the State requirements to specify and review nurse aide training and competency evaluation testing programs together with the establishment and maintenance of the nurse aide registry. States are required to conduct these activities as part of the 1864 Agreement as authorized by Section 1864(d) of the Social Security Act. The actual training and competency evaluation testing of nurse aides are not payable as part of this Agreement.

See the General Budget Formulation Guidelines section of this letter for instructions on the reporting of NAR/NATCEP expenses and associated full-time equivalent amounts.

In September 2003, a final rule was published that creates a category of nursing home employee who may assist residents in eating and hydration. The SA may be involved with implementation if the State decides to allow the use of eating and hydration assistants. There may be State costs associated with implementation of this regulation.

F. Home Health Toll-Free Hotline and Investigative Unit

States must maintain a toll-free hotline to receive complaints and to answer questions about HHAs. States must also maintain a unit to investigate complaints. CMS only pays for the maintenance of the hotline and complaint unit and for necessary survey or survey-related activity to follow-up on complaints regarding Federal home health agency requirements.

With the national implementation of ACTS in FY2004, States must ensure that complaints from the HHA hotline are effectively captured in ACTS.

G. Resident Assessment Instrument/Minimum Data Set (RAI/MDS)

All certified nursing homes and swing bed hospitals are required to encode and transmit MDS records to CMS via the Assessment Submission and Processing System (ASAP) in accordance with CMS established record specifications and time frames. As such, CMS expects the States

to continue to provide staff to serve as RAI/MDS educational and technical resources to the nursing homes and SA in each State during the fiscal year, States must continue to adequately fund and staff the positions of a RAI coordinator and a RAI/MDS automation coordinator. The State RAI coordinator and the RAI/MDS automation coordinators will be responsible for the following tasks:

- Attending all mandatory training sessions and demonstrating competency and skills in the RAI process, including coding and transmitting the MDS 3.0;
- Participating in CMS-sponsored workgroups and training including WebEx conferences, and satellite training programs for RAI Coordinators on the RAI process and the MDS 3.0.
- Conducting ongoing RAI/MDS education and training and providing technical support to SNF/NF and swing bed hospital providers and SA staff that--
 - Addresses the RAI process and proper coding of MDS elements to assist providers in meeting OBRA MDS and PPS requirements;
 - Incorporates the MDS 3.0, including any changes to the RAI, manual and survey processes.
- Includes at least two provider training courses annually, which may focus on basic RAI training for new providers or on topics identified either by the State or CMS as important for existing providers; administrative, educational and technical support to providers that will assist in the accuracy in coding of resident assessments; and the transmission of MDS data;
- The collection and housing of MDS data in order that States can develop and test a wide range of program improvement initiatives;
- Coordinating with CMS, SAs, FIs, A/B Medicare Administrative Contracts (MACs) and associations in their education of SNF/NF and swing bed hospital providers and surveyors regarding the MDS 3.0 and changes to the RAI, manual and survey processes;
- Conducting any follow-up training in conjunction with CMS national RAI/MDS educational offerings;
- Educating providers and SA staff on reports from the data system, MDS outcome reports, RAI Manual revisions and any revisions to the RAI process;
- Assist in promoting State-wide consistency with national policies and procedures; and
- Completing semi-annually reporting of the CMS MDS training worksheet in the QIES system in order to report the educational offerings that were conducted in the State during the year.
- Providing comprehensive education to RO & SA RAI and nursing home field-surveyor preceptors (RAI coordinators' conference and MDS 3.0 educational offerings – details to be announced in the MPD training addendum) so that these individuals can successfully manage provider and surveyor inquiries and issues related to the RAI and survey processes and the MDS 3.0. States should budget for the travel for this conference(s). See the MPD training addendum for greater detail on the intended audiences, timing and locations of the educational offerings; and
- Providing training and training aids for SA and RO training coordinators, field-surveyor preceptors and surveyors so that these individuals can successfully understand, interpret and implement the changes to the MDS and related survey processes.

As States will be responsible for assuring that their SA staff are trained in the use of the RAI process, including the MDS 3.0, as well as the changes to the SOM and survey reports and processes as a result of changes to the MDS 3.0, each SA will be responsible for its RAI and Automation Coordinators, as well as a nursing home field-surveyor preceptor, participating in the RAI Coordinators' Conference and MDS 3.0 educational offerings in the fiscal year, which may also include a series of webinars. States will also be responsible for ensuring that its RAI

Coordinator(s) and survey and certification staff members collaborate in order to ensure that their SA staff are adequately prepared to perform their roles as surveyors or RAI coordinators. This is particularly important as the MDS 3.0 significantly impacts both the RAI and survey processes.

States should note that MDS expenditures are reflected as long-term care Medicare and Medicaid costs on form CMS-435. For more reporting instructions, please refer to the General Budget Formulation Guidelines section.

H. HHA/Outcome and Assessment Information Set (OASIS)

All certified HHAs are required to encode and transmit OASIS records for Medicare and Medicaid beneficiaries to Assessment Submission and Processing System (ASAP), in accordance with CMS-established record specifications and time frames. CMS expects the States to continue to play a key role in providing the educational and technical resources (CASPER) to the HHAs in each State. States will continue to fund the positions of the OASIS Educational Coordinator (OEC) and the OASIS Automation Coordinator (OAC) and will continue with the responsibilities outlined below:

The role of OECs includes:

- Basic OASIS training for new and existing providers;
- Educating providers and SA staff on reports from the data system and OASIS outcome reports;
- Provide CMS approved training materials as part of training activities for new and existing HHAs;
- Participating in CMS-sponsored workgroups and training when funding is available;
- Completing an annual OASIS training worksheet in the QIES system by October 15th of each year; and,
- Referring unresolved issues to the Home Health Quality Helpdesk for additional assistance.

The role of OACs includes:

- Facilitate the initial transmission of test data for new HHAs.
- Providing ongoing technical assistance to HHA providers on the transmission of OASIS data.
- Referring unresolved issues to the QTSO Helpdesk for additional assistance.

I. Quality Improvement and Evaluation System (QIES) Automation and Related Activities

In order to assess how information about OASIS, MDS and SB-MDS is disseminated across the nation, the States will report semi-annually on training and technical assistance that they have provided. Instructions for reporting training activity using the MDS and HHA Training Worksheets are found on the secure website: <https://web.qiesnet.org/qiestosuccess/training.html>. The worksheets are accessed via the QIES-To-Success website and are available to State personnel who have rights to see the MDS or HHA reports. The information entered on the worksheets is stored in the National Database. CMS Central and RO personnel can retrieve this data via the CASPER reports: MDS Training Reports or HHA Training Reports.

With CMS technical support and guidance, States will be expected to continue to work closely with the provider community and their MDS, SB-MDS and OASIS software vendors to provide information on specific requirements related to the submission of MDS, SB-MDS and OASIS assessments especially with the move toward national implementation of the MDS 3.0, to the appropriate State or CMS repository. CMS expects that a facility's private sector software vendor will provide primary support to the facility in terms of MDS, SB-MDS and OASIS encoding and transmission. State personnel, however, will be required to work with facilities and software vendors to educate them about this process. CMS has converted SNF and HHA providers to a virtual private network (Verizon Services) to meet confidentiality and security requirements. However, each State must have one line accessible by CMS systems maintainers to ensure their system can be updated.

State personnel will continue to work with facilities and their software vendors in troubleshooting any difficulties facilities experience as they transmit records and implement MDS 3.0.

Each State should review its staffing requirements experience for support of State automation functions and recommend changes as needed. Staffing recommendations for systems support are listed in the "MDS/SB-MDS/OASIS/QIES System Support" section that follows further in this letter.

Each State should also review its State MDS and OASIS Automation Project Plans submitted with its prior year budget requests and provide any updates detailing continuing activities such as facility training, vendor and provider education and technical assistance to providers.

J. Reimbursement for MDS and OASIS Costs

Provider costs for MDS, SB-MDS and OASIS are compensated through the Medicare and Medicaid programs according to the rules for such reimbursement effective for Medicare and Medicaid.

CMS will continue to fund the cost of upgrading state computers needed to access the MDS and OASIS servers (discussed under Information Systems Hardware). Provider costs for hardware and software to maintain and transmit MDS, SB-MDS and OASIS data from their facility to the States will continue to be the provider's responsibility. States are expected to incur some costs associated with operating the MDS, SB-MDS and OASIS systems, specifically for staff time, training and supplies to support the automated QIES.

When States use MDS data in administering the Medicaid program, Federal costs associated with automating MDS and the operating data system should be apportioned by the States between two funding sources: the Medicare and Medicaid Survey and Certification program and the Medicaid program (under administrative costs). States should apportion MDS costs to these programs based on the States' determination of each program's utilization of the MDS system. Costs charged to the Medicare and Medicaid Survey and Certification Program will be prorated in terms of the portion of SNFs and NFs in the States that participate in the Medicare and Medicaid program. Similarly, costs associated with downloading and transferring SB-MDS data to the Medicaid program should be apportioned by the State between these two funding sources. The Federal match for the Medicaid Survey and Certification Program will be 75 percent. Budget estimates should be prepared and submitted as part of each State's FY2017 Survey and Certification budget request.

Costs related to the publication, dissemination and validation of software vendors' ability to comply with State specifications for any added MDS, SB-MDS, or OASIS sections or data (i.e., that portion of the MDS or OASIS that may be added to the State's RAI or HHA instrument at the State's discretion) will not be funded through the Survey and Certification budget. To the extent that a State develops customized applications for information maintained in the OASIS database (e.g., to support Medicaid payment), the costs of developing and maintaining these additional software applications (and any related hardware components) will not be funded through the Survey and Certification budget.

We do not anticipate that any State will allocate more than a minimal amount of its MDS and OASIS costs to the Medicaid Program as administrative costs. The Federal match for costs apportioned as Medicaid administrative costs will be 50 percent and should be reported by the State on line 14 (Other Financial Participation) of the quarterly form CMS-64. Also, where State licensure programs benefit from the automation of the MDS and OASIS, the State itself should also share in the MDS and OASIS automation costs.

K. The Quality Improvement and Evaluation System (QIES)

CMS goals for the standardized MDS/OASIS/SB-MDS system go well beyond providing States with the ability to collect assessment data from providers and transmit that data to a central repository for analysis and support of prospective payment systems. CMS has always intended that the MDS/OASIS/SB-MDS data management system would support a suite of applications/tools designed to provide States and CMS with the ability to use performance information to enhance onsite inspection activities, monitor quality in an ongoing manner and facilitate providers' efforts related to continuous quality improvement. This overall initiative, known as the Quality Improvement and Evaluation System, also includes:

- Extension of the MDS/OASIS/SB-MDS systems to include new provider types in future years;
- Continued maintenance of the ASPEN suite of products (ASPEN Survey Explorer-Quality, ASPEN Central Office, ASPEN Enforcement Manager, ASPEN Scheduling and Tracking, and ASPEN Complaints and Tracking) and their integration with the state standard systems and support the migration to the new Internet Quality Improvement and Evaluation System (iQIES) that will replace the ASPEN suite of products; and,
- Further integration of the learning management system that supports most day-to-day operations of the survey and certification training program; and

CMS provides travel/training funds to assure that States are able to send two or three staff members to two, three-day train-the-trainer sessions for QIES/ASPEN systems releases and ASPEN each FY. These are mandatory training events and once trained, these trainers are expected to perform comparable, hands-on training for agency staff in each of these areas.

L. QIES/SB-MDS/MDS/OASIS STATE SYSTEMS SUPPORT

Each State must continue to provide adequate staff for technical systems support based on the staffing recommendations provided below.

FTE		
Rank*	FTE	All Provider Types/State (Excluding CLIA)
1	4.0	<600
2	4.5	600-1500
3	5.0	>1500

*These ranks may be adjusted upward if the RO believes the volume of a State's complaints warrant more staff.

These FTEs should be allocated approximately as follows:

- MDS/SB-MDS/OASIS Automation Coordinator - 1 FTE
- Systems Administrator - 0.5 to 1 FTE
- Technical operations/system management support - 0.5 FTEs
- Technical support/training for providers, vendors and SA staff - 1-3 FTEs distributed among MDS/SB-MDS/OASIS.
- ASPEN/QIES Coordinator - 1 FTE

These estimates reiterate CMS' staffing recommendations from prior MPD guidance. They do not represent new staffing requirements.

States should also examine their privacy and security controls and determine if optimum protections, as required by federal and State standards, will necessitate any software, hardware, training, security protocols or budgetary adjustments.

1. High Speed Internet Access (i.e., DSL, broadband, cable modem, T1)

The amount of data moved during each workday increases each year. Surveyor time is a precious asset and the amount of time involved in accessing information electronically is directly affected by the type of internet connection available. Back and forth communications between servers and clients can consume many megabytes per transaction. High speed connections also foster an environment where CMS and the SAs can optimize use of future uses of technology to improve survey efficiency, e.g., computer based training. Industry studies show that cost benefit analyses favor high speed connections and that is the direction in which the industry is progressing.

2. Information Systems Hardware

The Quality Improvement and Evaluation System (QIES) system and components (ASPEN) are comprised of technologies that have been selected to deliver the most powerful access to a broad range of information related to facility quality monitoring and to support State agency survey operations within a user-friendly interface. While the core server components of the QIES system (i.e., hardware and software) are provided and installed by CMS within each State, additional computers for State agency end-users will be required to access this core system. These end-user systems are referred to as clients and include computers for users who work onsite within the State agency office as well as off-site users including facility survey staff. As the State QIES server assumes a larger role in day-to-day State operations, States should ensure that it is integrated into their existing systems infrastructure such as State LANs.

If State Survey Agencies (SA) need to move the CMS QIES state servers to an alternate location, the **SA** will need to work with their ROs to include a \$27,600 line item in their budget plan **at the time of the move request** (i.e., not waiting until the time of the move). So if a move is to take place at the beginning of the following FY, the funds would have to be made available in the preceding FY. This fee covers the move of the circuits and network support. The SA must submit a written request to the QIES Technical Support Office at a minimum of 90 days prior to the scheduled move date.

SAs currently vary in the number of laptop/notebook systems they have available for field surveyors' use in accessing ASPEN. Internally, most agencies provide network based computing support for in-house staff managers. Furthermore, over the past few fiscal years, many States have included extensive system upgrades as part of their budget requests. CMS expects that States will use their existing systems to the fullest extent possible to provide client access to the standard system components. To provide users with access to the standard system, States should follow one (or a combination) of the following approaches:

- a. Existing State machines that meet the minimum requirements, as described below, are used to provide user access to the standard system. This includes desktop systems connected to an internal network, as well as laptop/tablet systems used mainly for ASPEN Survey Explorer–Quality (ASE-Q).
- b. To the extent that existing State systems do not meet the minimum requirements (e.g., insufficient RAM memory), the State submits a plan and budget request to support upgrading of these systems to the recommended performance levels, which includes the type of equipment to be purchased and associated costs. Upgrading an existing computer can include adding more RAM and disk capacity and purchasing processor upgrades. States should also include in the budget those costs associated with upgrading current computer operating systems to the prescribed Windows operating systems. The costs associated with upgrading equipment should not exceed the cost for actual replacement. Finally, it is also appropriate for States to include a budget for additional staff/contractor costs incurred to manage the computer and operating system upgrade process.
- c. To the extent that a State does not possess sufficient systems that are currently capable or able to be upgraded to the minimum standard, the State should submit a plan and budget request to support the acquisition of the number of new systems that are necessary to provide appropriate access. The budget request must include the number of each type of machine to be purchased and associated costs.
- d. Nursing Home Survey Process – CMS has moved towards a nursing home survey process, which utilizes Tablet technology. This technology allows ready access to data and information onsite by the surveyors and allows documentation of non-compliance to be easily transferred to the CMS-2567 form. CMS highly recommends that States plan for future survey process implementations as part of their hardware procurement process recognizing the need for Tablet PC configurations as a future need. The hardware that is budgeted by the SA is in addition to the hardware provided as part of the startup process, with the understanding that equipment costs will be distributed in the usual manner against Medicare/Medicaid/Licensure.

Costs for equipment purchases that will be used in conjunction with any LTC survey process must be included on Form CMS-435 State Survey Agency Budget/Expenditure Report and CMS-1466 Survey and Certification State Agency Schedule for Equipment Purchases.

Equipment purchases for LTC surveyors should include: one Tablet laptop (described in the table below, Minimum and Recommended Client Requirements) for each surveyor and one portable printer for every three such surveyors. The portable

printers should be lightweight, capable of printing 17 pages or more per minute and capable of running on battery power alone.

- e. Surveyor Technical Assistant for Renal Disease (STAR) - Prior to attending a STAR training course, surveyors are expected to have access to specified tablet PCs. Surveyors will be able to use the same Tablet equipment for QIS and STAR.

Guidelines for the recommended system configuration and State size based estimates for the number of systems required are found below. For planning purposes, it is expected that at least 10 client systems will be required for in-office access to the standard system and related components, based on State size (i.e., small, average, large). In other words, a large State should have 30 client systems that meet the minimum standards for agency staff. For field systems, States should seek to maintain a ratio of at least one laptop/tablet system per two surveyors.

Laptops:

Recommended field system is any Windows 7 or Windows 8 computer designed for light-weight portability and provides both a keyboard option and an option to operate the device as a flat tablet. ASPEN software operates on traditional laptop computers with no flat tablet mode but this is less optimal for field use, especially for QIS and STAR surveyors. Any selected surveyor computer must also meet the required technical specification provided.

3. Encryption Policy

CMS' encryption policy requires all agency data be protected from unauthorized access. There may be various levels of protection for agency data, but for personally identifiable information (PII), the policy states that dissemination of such data using any portable devices or recordable media, (e.g., CDs, DVDs, Cartridges, Diskettes, Laptops, External Hard Drives, USB Memory Sticks or thumb drives, etc.), requires encryption. Whole disk encryption of the hard-drive for Laptops or Tablet PCs must be employed. Encryption is the process of protecting stored or transmitted information with a password (key) so that it is indecipherable until the intended recipient uses the password to access it.

In accordance with the CMS encryption policy, all workstations with installed QIES components must have encryption software installed that meets or exceeds the standards set forth in the "CMS Information Security Acceptable Risk Safeguards (ARS)" This includes all QIES components installed on Laptop/Tablet PCs as well as any removable media and/or cloud computing used to disseminate PII/PHI. Specifically, the following sections of the ARS should be referenced:

- IA-7 Cryptographic Module Authentication (Specifies acceptable encryption type – FIPS 140-2 compliant (<http://csrc.nist.gov/publications/PubsFIPS.html>) NIST validated module. (<http://csrc.nist.gov/groups/STM/cmvp/index.html>)
- IA-2 User Identification and Authentication
- AC-3 Access Enforcement
- AC-4 Information Flow; specifically CMS-2
- AC-19 Access Control for Portable and Mobile Systems (encryption requirement only)
- MP-5 Media Transport
- SC-8 Transmission Integrity

- SC-12 Cryptological Key Establishment and Management

Please note, in addition to these encryption sections, agencies are encouraged to review the entire ARS as a guideline for enterprise-wide security practices. States are responsible for ensuring that encryption software has the capability of creating encrypted files that are self-extracting with a password key.

Additionally, many agencies have home-based staff using QIES software installed on home workstations. Such home-based systems must be protected with encryption software as described above and comply with CMS controls as defined in the ARS.

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	Minimum	Minimum or Higher Required for LTC Survey Process Implementation Recommended for Other
<i>Processor</i>	Pentium Class (or equivalent) @ 1.2 GHz	Pentium Class (or equivalent) @ 2.0 GHz
<i>Memory (RAM)</i>	2 GB	4 GB
<i>Available Disk Space</i>	4 GB	10 GB on SATA 2 drive at 7200 RPM
<i>Monitor</i>	13" Color	Desktop 19": Color Flat Panel ≥1024x768 screen resolution Flat Panel for laptop or tablet
<i>Operating System*</i>	Windows 7 – 32 bit Windows 7 – 64 bit	Windows 7 – 32 bit Windows 7 – 64 bit Windows 8.1 – 32 bit Windows 8.1 – 64 bit Windows 10 – 32 bit Windows 10 – 64 bit
<i>Secure Access/Encryption (See Encryption Policy)</i>	Required – See Encryption Policy	Required – See Encryption Policy
<i>Anti-virus</i>	Current License	Current License
<i>Universal Serial Bus Port</i>	One	Three
<i>Removable Media (see Encryption Policy)</i>	USB Drive	USB Drive
<i>Pointing Device</i>	Mouse or equivalent (e.g. trackball or touchpad)	Mouse or equivalent (e.g. trackball or touchpad) and Pen/Stylus
<i>Network Interface Card (See CMS ARS security guidelines for acceptable wireless configurations)</i>	Wired for network connectivity; and Wireless network cards must support WPA-2 level encryption	Wired for network connectivity; and Wireless network cards must support WPA-2 level encryption
<i>Optical Drive</i>	CD –ROM	CD/DVD-ROM (External for tablet)

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	Minimum	Minimum or Higher Required for LTC Survey Process Implementation Recommended for Other
<i>Audio</i>	Standard built-in speakers	Attachable microphone and standard built-in speakers
<i>Battery (laptop or tablet)</i>	6-cell lithium-ion	6-cell lithium-ion
<i>Browser**</i>	Internet Explorer v 11.0	Internet Explorer v 11.0

* States considering implementing Windows 10 should carefully evaluate CMS software with this Operating System before full scale deployment.

Note: Operating systems need to be current with all Windows security updates.

**Internet Explorer v 11 will need to operate in compatibility mode in order for the software to operate properly.

Per the Internet Explorer Support Lifecycle Policy FAQ (<https://support.microsoft.com/en-us/gp/microsoft-internet-explorer>), beginning January 12, 2016, only the most current version of Internet Explorer available for a supported operating system will receive technical support and security updates.

Internet Explorer v 9.0 and v 10.0 is no longer supported as of January 1st 2016. Only Internet Explorer v 11.0 running in compatibility mode is currently supported.

Due to new CMS security requirements, all browsers must have the TLS 1.2 setting enabled.

M. Emergency Preparedness:

SAs operate in a larger context of State emergency preparedness and often play important roles within a State Incident Command System (ICS) that extend far beyond Federal survey and certification functions. In such cases States have cost accounting systems in place to allocate expenses properly and ensure that the cost of non-Federal activities is not charged against Federal accounts. Nonetheless, some emergency preparedness *and* emergency response activities are vital to the effective conduct of Federal quality assurance and, as such, are properly included in the State's S&C mission, priority and budget document.

The items identified below are key elements that have been developed based on the recommendations of the S&C Emergency Preparedness Stakeholder Communication Forum. While we realize some States already have very well-developed systems that far exceed the elements described here, we appreciate that for many States enhanced IT reporting capabilities require additional time to implement. In September 2007 CMS therefore provided considerable advance notice for States to establish the electronic tracking and reporting capability no later than July 1, 2009 that includes the data elements identified under “2. *Effective Communication & Coordination with CMS.*”

1. SA Continuity of Operations (COOP)

The SA maintains a coordinated, emergency Continuity of Operations Plan (COOP), updated at least annually, which is submitted to the CMS RO. The COOP addresses:

a. Essential S&C business functions, including:

- Provision of prompt responses to complaints regarding patients/residents who are in immediate jeopardy.

- Provision of monitoring and enforcement of healthcare providers. Even in widespread or significant disasters where reduced S&C activities may occur, key activities (such as complaint investigations, provider communications, communication with CMS regarding any advisable adjustment to previously-imposed enforcement actions that might impede evacuee placement, etc.) will still need to occur in order to ensure the health and safety of patients and residents.
 - Conducting timely surveys or re-surveys in the aftermath of a disaster.
- b. Identification of strategies to ensure maintenance and protection of S&C critical data.
- c. A program of COOP exercises, conducted at least annually by designated staff to ensure State, Regional, Tribal and Federal responsiveness, coordination, effectiveness and mutual support.

2. Effective Communication & Coordination with CMS

- a. Point of Contact: A State S&C emergency point of contact (and back-up) is available 24 hours per day and 7 days per week to the CMS RO when the State declares a widespread disaster. The contact:
- Coordinates State S&C activities with CMS;
 - Addresses questions and concerns regarding S&C essential functions;
 - Provide status reports; and
 - Ensures effective communication of federal S&C policy to local constituencies (see details below).

These functions may be fulfilled by a person within the State ICS who has been clearly assigned to communicate with CMS and provide data for S&C functions.

- b. Policy Communications: The SA maintains capability for prompt dissemination of CMS policy and procedures to surveyors, providers and affected stakeholders. During a disaster, the capability is operative 24/7. The SA capability includes back-up communication strategies, such as websites and hotlines and emergency capability that enable functional communication during energy blackouts. A designated person is available for responding to healthcare providers' questions and concerns related to federal survey and certification. These functions may be performed by a person within the State ICS, who has been clearly assigned to perform these functions.
- c. Information and Status Reports: The SA or the State ICS maintains capability and operational protocols to provide the CMS RO with (a) State policy actions (such as a Governor's emergency declarations or waiver of licensure requirements) and (b) an electronic provider tracking report, upon request, regarding the current status of healthcare providers affected by a disaster. The capability includes:

Provider Contacts	Provider Status	Provider Plans
• Provider's name • CMS Certification Number (CCN) • National Provider Number (NPI) • Provider type	• For profit/ or not-for-profit agency, or government agency status • Provider status (evacuated, closed, damaged) • Provider census • Available beds	• Estimated date for restored operations • Source of information • Date of the status information

• Address (Street, City, ZIP Code, County) • Current emergency contact name • Contact's Telephone number and alternate (e.g., cell phone) • Contact's email address	• Emergency department contact information (name, telephone number, FAX number) if different than provider contact information • Emergency department status (if applicable) • Loss of power and/or provider unable to be reached	
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3. Recovery Functions

Recovery functions will be determined on a case-by-case basis between the SA and the CMS RO. In the context of survey & certification, recovery functions represent those activities that are required to ensure that a provider has re-established the environment and systems of care necessary to comply with Federal certification requirements.

4. Funding

We believe that the types of actions that we are specifying are currently underway or in place based on State-level initiatives and/or prior informal arrangements between States and ROs formed on an ad hoc basis. In many of these cases, implementation costs will be very low. We, therefore, encourage SAs to seek other available sources of emergency services funding or grants to promote emergency preparedness coordination wherever possible and to share information and expertise with other States.

To the extent that routine work cannot be accomplished during a significant disaster, unobligated S&C funds may be available to provide fiscal resources that otherwise could not be budgeted for the above activities. Depending on the nature of the disaster, the CMS RO may also authorize expenditures for certain recovery efforts that would not normally be covered, when such activities advance the subsequent recovery and the continued or resumed certification of providers. An example is the conduct of pre-survey site visits in the aftermath of a disaster, prior to the reopening of a healthcare facility, particularly when the result of the site visit is a conclusion that a subsequent survey is not required (such as a finding that damage is so light that a new life-safety code survey is not needed).

If a very significant emergency occurs in a State and it calls upon extra SA resources to meet the resulting needs, the State can submit a supplemental budget request, which we will consider for priority funding depending on the severity and extent of the emergency.

States are still required to submit electronic affected provider status reports to the CMS RO during emergency events, which include the data elements identified above. An *Affected Provider Status Report* template is available on the S&C Emergency Preparedness website for this purpose: <http://www.cms.hhs.gov/SurveyCertEmergPrep/Downloads/AffectedProviderReportTool.pdf>.

5. Relationship to State Performance Standards System

If a significant emergency occurs in a State that disrupts normal survey and certification activity and that is well outside the level that can typically be expected in the State, CMS will take such circumstances into account so as to avoid penalizing the State for SA Performance issues unavoidably caused by the emergency.

N. Energy Productivity

Consistent with the President's policies and executive direction, CMS seeks to improve the energy productivity of survey & certification operations. Insofar as transportation and fuel costs are significant items of S&C expense, we encourage States to lease or modernize their automobile fleets with highly efficient vehicles that meet or exceed 40 miles per gallon in combined city/highway EPA mileage ratings. An increasing array of vehicles meets this level of efficiency. We will continue CMS incentives to enlarge upon transportation and other energy productivity improvements. In the event that one-time funding becomes available later in the FY, we suggest that States conduct some advance analysis of what would be feasible to take advantage of such funds and how the State would accomplish appropriate cost-accounting among affected funding sources if Medicare one-time funds were available.

O. Alignment with State Performance Standards System (SPSS):

States must maintain documentation and information systems to ensure accurate and timely provision of information on survey activities, findings, enforcement and surveyor performance. Timely uploading of surveys is an important aspect of such a system. With regard to performance of surveys within the required frequencies, most non-LTC provider types continue to be part of the SPSS for frequency of surveys specified in Tiers 1-3. The SPSS includes all of the following with regard to survey frequency.

Table: Providers for Which Tier 1-3 Performance is Measured by SPSS	
Statutory Providers	Other Providers
• Nursing Homes • Home Health Agencies • Hospices • Validations – all types of deemed providers/suppliers • ICFs/IID	• Hospitals (all types) • ESRD facilities • • Comprehensive Outpatient Rehabilitation Facilities (CORFs) • Rural Health Clinics (RHCs) • ASCs • OPTs (Rehabilitation Agencies)

States must track their Tier workload on a quarterly and annual frequency. During the course of the year, States must report the quarterly results to the Regional Offices by the end of the month following the end of the quarter. As part of their oversight and trouble-shooting responsibilities, Regional Offices will be monitoring and working with the States on the performance of the Tiered workload.