DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare and Medicaid Services

Quality, Safety & Oversight Group
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Quality Assurance for the Medicare & Medicaid Programs

FY2019 Mission & Priority Document (MPD)

Quality, Safety & Oversight Group
Survey & Certification Activities

October 2018

Note: The FY19 MPD provides an overview of current activities and priorities and does not provide a full overview of past activities. For an overview of the prior years and more detailed explanations, please refer to the FY18 MPD under the *downloads* section.

CURRENT FACILITY GROWTHS

FY18 of Facility Growth:

For data, please refer to the download section under the MPD Website.

SPECIAL NOTES

A. New Regulations with New Responsibilities

- Proposed Rules:
    - **Burden Reduction for Non Long-Term Care:** This proposed rule would reform Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This proposed rule would increase the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or that divert resources away from furnishing high quality patient care.

    - **Anticipated 1150B Delegation of Authority**: We are looking to publish a proposed rule to fully enforce Section 1150B requirements for reporting crimes to nursing home residents, we are proposing a regulation that will allow Civil Money Penalties (CMPs) to be imposed of up to $200,000 against covered individuals (staff, volunteers, etc.) who fail to report reasonable suspicion of crimes. This proposed regulation would also facilitate a 2-year exclusion for retaliating against individuals who report. Although CMS has the authority to impose CMPs against nursing homes, rule-making is required to facilitate CMPs and exclusions imposed against covered individuals. (Unified Agenda 2018)

- Final Rules:
    - **Home Health Conditions of Participation**: New Conditions of Participation (CoPs) became effective January 13, 2018. Two new CoPs were added, Infection Control and Prevention and Quality Assessment and Performance Improvement. The majority of the previous requirements were retained although reorganized, or were slightly modified with the transition to the new COPs.

B. Past Continued Efforts and Continuing Initiatives

As of FY18 and Continued through FY19:

- ESRD Contract Surveys
  CMS is continuing with ESRD contract surveys to assist those States with seriously overdue survey intervals. DCCP will coordinate with ROs and SAs to select these surveys.

- Non-Deemed ASC 25% surveys

C. Reminders

- The Quality, Safety, Education Division has converted majority of all training online. Training for both providers and suppliers can be accessed at https://surveyortraining.cms.hhs.gov/.
- The Quality, Safety & Oversight Group has converted to public notices for terminations to be online on CMS.gov. Termination Notices can be viewed at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html.
- Provider and Supplier Specific Information can also be found under the left side links at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html.

D. Quality, Safety, Education Division Information

For information related to the QSOG Training opportunities, please refer to the download available which provides all training information.

E. Budget Formulation Guidelines

For information on continued budget and expenditure reporting timing and requirements, CMS Budget Analysis and Adjustment and more, please refer to the Budget Download which will provide additional guidance.

PROVIDER/SUPPLIER SPECIFIC OVERSIGHT

For additional information on past activities or history, please see the "downloads section" which provides an attachment for each provider/supplier type.

- **Deeming Options**

  Initial certifications of all provider/supplier types that have the option to achieve deemed Medicare status by demonstrating compliance with Medicare health and safety standards through a survey conducted by a CMS-approved AO is a Tier 4 priority, with the exception of End Stage Renal Dialysis Facilities that have a statutory requirement to complete initial surveys within 90 days. In light of the Federal Medicare resource constraints, we consider the cost of initial surveys to be the lowest priority for the Medicare program for those provider and supplier types that have a deemed status accreditation option in those States unable to complete the higher-priority Tier 1-3 work. These include:

  - Ambulatory Surgical Centers
  - Critical Access Hospitals (CAHs) (including swing bed services)
  - Home Health Agencies
  - Hospices
  - Hospitals (including swing bed services)
  - Rehabilitation Agencies (OPT and SLP)
  - Rural Health Clinics
  - Psychiatric Hospitals

  All Others: All other newly-applying providers/suppliers not listed in Tier 3 are Tier 4 priorities, unless approved on an exception basis by the CMS RO due to serious healthcare access considerations or similar special circumstances (see "Priority Exception Requests" in part E below). The affected Medicare providers/suppliers include:

  - Comprehensive Outpatient Rehabilitation Facilities
  - Hospital-based Distinct Part Skilled Nursing Facilities
  - Nursing Homes that do not participate in Medicaid
  - Portable X-Ray Suppliers

- **Ambulatory Surgical Centers (ASCs)**

States must continue to use the Infection Control Surveyor Worksheet for each full survey of an ASC to ensure that all areas listed on the worksheet are assessed. However, for FY 2019, CMS will NOT be selecting a random sample of ASCs or collecting infection control worksheets.

- **Providers of Outpatient Physical Therapy and Speech-Language Pathology Services**

Many rehabilitation agencies provide services from extension sites (an additional practice location or sometimes rented space in nursing homes and assisted living facilities) in addition to

their primary site of certification. SAs should ensure extension locations are incorporated into the survey process by selecting a sample of extension locations to survey in addition to the primary site.

- **Comprehensive Outpatient Rehabilitation Facilities (CORFs)**

Existing CORFs may request to open off-site locations for the provision of therapy services. The RO must evaluate the information provided by the CORFs to determine whether or not to recommend approval for those offsite locations. The RO retains discretion on whether to request that a survey be conducted of a requested additional practice location. Currently CMS does not track offsite locations separately. SAs should include off-site locations in the survey process whenever possible. SAs must ensure that offsite locations are meeting the intent of the CoPs.

- **Community Mental Health Centers (CMHCs)**

CMS enters into agreements with CMHCs pursuant to the provision of Partial Hospitalization Services. CMHCs must provide at least 40% of their services to non-Medicare patients. This requirement is monitored by the Medicare Administrative Contractor (MAC).

- **Critical Access Hospitals (CAHs)**

A conversion survey is required for each new CAH. Prospective CAHs must first be certified and enrolled as a hospital, and only thereafter, may seek conversion to CAH status. Requests from a non-deemed hospital to be certified as a CAH are, therefore, not treated as initial surveys but as conversions, and may be surveyed as a Tier 2, 3, or 4, priority at State option. Similarly, conversion back from CAH status to non-deemed acute care hospital status is treated as a conversion rather than an initial survey, and may be treated as a Tier 2, 3 or 4 priority, at State option.

  - Accrediting Organizations (AOs) with a CMS-approved CAH program are able to conduct a CAH conversion survey. There are three AOs with approved CAH accreditation programs: AOA/HFAP, DNV GL, and TJC.

  - In order to routinely re-evaluate the compliance of currently certified CAHs with the status and location requirements at 42 CFR 485.610, CMS developed a *CAH Recertification Checklist: Rural and Distance or Necessary Provider Verification* for use by the CMS RO staff when processing CAH re-certifications. See S&C: 16-08-CAH (REVISED 09.02.16) for additional details and a copy of the checklist.

  - Swing-bed services will be covered under the Hospitals section. See QSO Memo 18-26-Hospital-CAH for additional swing bed guidance.

- **Dialysis (ESRD) Facilities**

States are responsible for being informed about the ESRD programs by using the following:

- CMS S&C data web site for ESRD data reports: the State is responsible for assigning a Master Account Holder, and reviewing the State-specific data which is available on the CMS ESRD data Web site at https://www.dialysisdata.org. States are responsible for using these data reports to inform the survey process. Each State is expected to use the

State rank-ordered Outcomes List with frequency rates; the facility-specific Dialysis Facility Reports (DFR); and the facility-specific pre-populated Pre-Survey DFR Extract for these purposes.

- Previously, the Mission and Priority Document instructed States to survey, as a Tier 2 priority, a 10% targeted sample of ESRD facilities that were identified to be most at risk for non-compliance with the Conditions of Participation. For FY 2019, in order to reduce Tier 2 workload and increase the focus on ESRD facilities identified to have poor clinical outcomes, CMS will develop the ESRD Tier 2 Outcomes List focusing on the top 5% of ESRD facilities with poor clinical outcomes across four defined clinical measures. These measures were chosen based upon their potential to significantly impact patient outcomes and include:
    - Mortality
    - Hospitalizations
    - Hospitalizations related to septicemia
    - Catheter use greater than 90 days

Due to the new methodology for development of the Outcomes list, the Tier 2 workload is expected to be reduced nationally by an estimated 350 surveys in FY 2019. While this reduction varies by State, the vast majority of States will see reductions in their Tier 2 workload with a few states seeing only a slight increase in Tier 2 workload from previous years. States are expected to survey ***all*** identified facilities in their State on the Outcomes List. The annual process for releasing and reviewing the Outcomes List will remain the same.

- The ESRD Core Survey Process has been revised to require that surveyors conduct visits to a minimum of two nursing homes where dialysis patients may be receiving their treatments as home dialysis. This additional task will increase on-site survey time.

- The Bi-Partisan Budget Act of 2018 included a requirement for timing of surveys of new dialysis facilities. An initial survey of a dialysis facility must be initiated not more than 90 days after the applicant's application to the MAC has been determined to be complete by the MAC and the applicant's enrollment status indicates approval is pending a survey.

- **Federally Qualified Health Centers (FQHCs)**

Certification and recertification surveys are not required for FQHCs. However, CMS investigates complaints that make credible allegations of substantial violations of CMS regulatory standards for FQHCs as a Tier 2 priority. States will use most of the same health and safety standards as they do for RHCs when investigating FQHC complaints.

- **Home Health Agencies (HHAs)**

CMS will implement a new survey process for HHAs in FY 2019 and will simplify procedures for moving from standard to partially-extended to extended surveys. Additionally:

- QSOG will continue to fund one OASIS Education Coordinator and one OASIS Automation Coordinator per State Agency. The OECs will provide technical assistance to the HHA providers in the administration of the OASIS data set. The OACs will

provide technical assistance to the HHA providers on the transmission of OASIS data. The Division of Chronic and Post-Acute Care (DCPAC) has assumed responsibility for the technical support to OECs. The Division of Quality Systems for Assessments and Surveys (DQSAS) will provide technical support to the OACs.

- **Hospice Agencies**

Under the IMPACT Act of 2014, each Medicare certified hospice must be surveyed no less frequently than every 36 months. This affects non-deemed facilities which are surveyed by State Agencies, since those that are deemed were already surveyed by their respective accrediting agency on a 3-year basis. Funding provided through the IMPACT Act as well as the QSOG S&C Medicare program management budget will assist States to comply with this requirement.

- **Hospitals and Psychiatric Hospitals**

The below information highlights both hospital and psychiatric hospitals.

Hospitals

Swing-bed requirements will continue to be surveyed as part of a scheduled hospital or CAH survey, and do not need to be targeted for a separate, stand-alone survey, unless:

- There is a swing-bed requirement complaint in a hospital or CAH;
- A non-deemed hospital or CAH is applying for an initial swing-bed approval, in which case, the survey is conducted by the SA; or
- A deemed hospital or CAH is applying for an initial swing bed approval, in which case, the survey is conducted by the AO.

Note - For non-deemed hospitals or CAHs that wish to add swing-beds as a new service, see the "FY19 Survey Frequency and Priority" Tier Status for scheduling those surveys. For swing-bed recertifications, States must include swing-bed recertification during hospital and CAH recertification surveys.

Appendix A (Hospital guidance) and Appendix W (CAH guidance) swing-bed sections have been updated to align with the LTC rules and refer to Appendix PP (LTC guidance). The guidance for Swing-Beds found in Appendix T has been retired. Appendix A and Appendix W will be utilized for surveying hospitals and CAHs, respectively, that have swing-beds. See QSO Memo 18-26-Hospital-CAH for additional details.

Psychiatric Hospitals

- The majority of Medicare-certified psychiatric hospitals participate via deemed status, based on their accreditation by the Joint Commission (TJC). However, a small number of psychiatric hospitals have grandfathered partially deemed status, i.e., they are deemed for the regular hospital CoPs only by the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) or DNV GL Healthcare (DNV GL), leaving States or CMS contractors responsible for surveying them for the two special conditions. This practice stems from a time when no AO had an approved psychiatric

hospital Medicare deeming program. Although CMS no longer permits AOA/HFAP or DNV GL to partially deem any new psychiatric hospital clients, we have grandfathered their existing psychiatric hospital clients. There are less than ten hospitals that remain partially deemed and partially under State jurisdiction.

- CMS granted approval to the Joint Commission (TJC) for a Medicare psychiatric hospital deeming program, including for the two special conditions for psychiatric hospitals under 1861(f) of the Social Security Act and 42 CFR, Section 482.61 and 482.62. (Psychiatric hospitals enrolled in Medicare as of FY 2011 and which were deemed by another AO may continue to be deemed by that AO for the *Conditions of Participation specified in Section 482.1 through 482.23 and Section 482.25 through 482.57* only, since no other AO has yet been approved for the two special conditions. There are less than ten grandfathered, partially deemed psychiatric hospitals. However, any initial psychiatric hospital applicant, including previously terminated psychiatric hospitals, will not be afforded the opportunity to be deemed for the *Conditions of participation specified in section 482.1 through 482.23 and section 482.25 through 482.57* only.)

- At this time, CMS will continue to maintain (under contract) a panel of psychiatric consultant surveyors to conduct representative sample validation surveys of the two special conditions. The SA is responsible for the representative sample validation survey of the regular hospital CoPs. Supplemental funding will be made available to the States for any psychiatric hospital validation surveys they are assigned. In the case of a sample validation survey involving a CMS contract surveyor, States will be required to coordinate with the contractor on the timing of the surveys to assure that both components of the survey take place within 60 days of the completion of the AO survey.

- **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**
  - CMS implemented a focused survey process in FY 2018. The revised process is designed to reduce surveyor time in paperwork review and increase surveyor observations and interactions with the residents and staff.
  - CMS completed pilot a surveyor competency test involving surveyors from ten State Survey Agencies to evaluate the knowledge and skills of ICF/IID surveyors. CMS plans to administer the competency test to surveyors nationally to all ICF/IID surveyors in FY2019.

- **Long Term Care**

  Standard Health Survey Process:

  - All states have converted to the new long-term care survey process to assess compliance with the Requirements for Participation. CMS will continue to make software updates and will update the LTCSP Procedures Guide and Training documents accordingly.

  - Surveyors will use the new F-Tags to cite noncompliance.

- Resources for all of these changes can be found on the Integrated Surveyor Training Website at https://surveyortraining.cms.hhs.gov and at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html.

- **Appendix P:** In FY2018, CMS removed Appendix P and incorporated key policy components into Chapter 7 of the State Operations Manual. The Long-Term Care Survey Procedure Guide will be the reference guide for the survey process and will be available on our website and in the software program.

Other Areas of Importance:

- **National Partnership to Improve Dementia Care:** CMS has established a public goal of reducing the antipsychotic rate by 15% among those facilities that continue to have high rates of antipsychotic usage by the end of 2019.

- **Focused Dementia Care Surveys:** FY2019, CMS plans to have federal contract surveyors conduct additional focused dementia care surveys in some states. Due to concerns about facilities using an inappropriate process to diagnose residents with schizophrenia, we also expect to conduct a limited number of surveys focused on this issue. We welcome States that may want surveyors to observe either of these surveys.

- **Organ Procurement Organizations (OPOs)**

All OPO surveys are conducted by CMS Regional Office Surveyors.

- **Portable X-Ray Suppliers**

CMS plans to release new interpretive guidance for PXR in FY2019.

- **Psychiatric Residential Treatment Facilities (PRTFs)**

PRTFs must be in compliance with the requirements at 42 CFR 441.150-184 and the requirements at 42CFR 483 Subpart G.

- **Religious Nonmedical Health Care Institutions (RNHCIs)**

No new changes or efforts in FY18 to FY19. If changes arise, CMS will update this section as appropriate.

- **Rural Health Clinics (RHCs)**

States will perform surveys on a 5% targeted sample of RHCs, or at least 1, whichever is greater. States will select the sample, focusing on RHCs that have not been surveyed in more than 6 years and/or RHCs that represent a greater risk of having quality problems, based on their recent compliance history or other factors known to the State. States should use their individual history of growth, in addition to any State and local events/initiatives, as a guide to project workloads. This Tier 2 sample is not required for any State that has fewer than 7 RHCs. Since FY2015, RHC initial surveys are a Tier 4 priority since these facilities now have two deeming options. In future years we will, as funding permits, require validation surveys for a representative sample of deemed RHCs.

- **Transplant Centers**

  - The transplant program recertification survey interval has been changed to 5 years maximum to be consistent with the hospital survey interval.

  - CMS Central Office will maintain the responsibility for the review of transplant program outcome data and the review of Mitigating Factors applications.

  - Effective January 1, 2019 all transplant program survey activity including initials, re-approvals, revisits, and complaint investigations will be performed by the applicable State Survey Agency.

MAJOR PRIORITIES FOR S&C WORKLOAD AND PROGRAM REQUIREMENTS

Survey activities must be scheduled and conducted in accordance with the S&C priority ranking provided in this document. The four priority Tiers reflect statutory mandates and program emphases. Planning for lower-tiered items presumes that the State will accomplish higher-tiered workloads. For example, States must assure that Tiers 1 and 2 will be completed as a pre-requisite to planning for subsequent Tiers. It is not necessary to complete Tier 1 or Tier 2 work before beginning Tier 3 if the multi-tier work has been included in the State's submission, has been approved by CMS and the higher Tier work will be completed by the end of the FY. We also refer States to SC-13-60-ALL for guidance on the scheduling of initial certification surveys for new owners of previously certified providers and suppliers when those new owners have rejected assignment of the seller's Medicare provider agreement or supplier approval.
States must not make the scheduling and conduct of such surveys a higher priority than their Tier 1 and 2 workload, nor of their other initial certification survey workload.

In addition to prioritizing work between Tiers 1-4, we suggest States prioritize their work within Tiers and to consult with the ROs in the prioritization process. States must track their workload quarterly by Tier and report the results to the RO 45 days after the close of the quarter and also report for the full fiscal year 60 days after the close of the fiscal year. As part of their oversight and trouble-shooting responsibilities, ROs will monitor and work with States on the performance of the Tiered workload.

We also note that timely, successful uploading to the national system of completed survey kits in ASPEN and ACTS is an essential component of the States' workload in each Tier. States must implement measures to assure that these uploads are completed.

TIER STATUS FOR FY19

Appendix 1 - Table of Survey Frequencies & Priorities – Tier Chart

2019 SURVEY FREQUENCY & PRIORITY				
Category	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
1. Nursing Homes	• **15.9-Mo. Max. Interval:** No more than 15.9 months elapses between completed surveys for any particular nursing home. • **12.9-Mo. Avg:** All nursing homes in the State are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less.			• **Initial Surveys of Nursing Homes that are seeking Medicaid-only** – funded only by Medicaid (not Medicare) and surveyed at state priority • **Initial Surveys of Nursing Homes seeking dual Medicare/Medicaid certification***
2. Home Health Agencies	• **36.9-Mo. Max. Interval**: No more than 36.9 months elapses between completed surveys for any particular agency. • **Complaint investigations triaged as IJ Validation Surveys:** States annually survey a representative sample of deemed HHAs specified by CMS during the year. At least 1 deemed HHA is surveyed, unless the State has no deemed HHAs, or unless CMS makes no assignment, based on AO survey schedules. An extended survey is required for any validation survey which finds that one or more condition-level deficiencies. (*Each State surveys 1 HHA within its standard budget allocation; additional surveys are budgeted for some States via supplemental allocation.)* • **Substantial Allegation Validation (Complaint) Surveys - IJs**: Only when authorized by the RO, complaint surveys are to be initiated and completed within the applicable SOM timeframe and are Tier 1 priority.	• Substantial Allegation (Complaint) Investigations		• **24.9 Mo. Avg:** Add'l surveys (beyond tiers 1-3) done based on State judgment regarding HHAs most at risk of providing poor care so all HHAs are surveyed on avg. every 24 mos. (average of all Tier IV surveys ≤ 24.9 mos. in order to optimize unpredictability of surveys) • Surveys of HHAs de-activated (by the MAC) –for failure to bill Medicare for 12 consecutive months. Initial surveys of HHA's following a CHOW where the provider agreement and billing privileges do not convey to the new owner.
3. ICFs/IID	• **15.9 Mo. Max. Interval: No more than 15.9 months elapses between completed surveys for any particular ICF/IID.** 12.9-Mo. Avg: All ICF-IIDs in the State are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less. Complaint surveys triaged as IJ.			**Initial Surveys**

4. Hospitals, Psychiatric Hospitals, & CAHs-Deemed	• **First (1%) Representative Sample Hospital Validation Surveys:** All States perform at least one survey and selected States perform additional surveys of the States' deemed hospitals, designed to validate the surveys of AOs with CMS identifying the hospitals to be surveyed by each State. *("first" 1% sample funded via the State's regular budget.)(See Appendix 3)* • **Targeted Second (Add'l) Representative Sample Validation Surveys:** Some States conduct add'l surveys from a second sample of deemed hospitals identified by CMS *(Second sample % budgeted separately and allocated as supplemental funding during the year).(See Appendix 3)* • **5% CAH Representative Sample Validation Surveys:** States annually survey a representative sample of deemed CAHs specified by CMS during the year (of the total deemed CAHs, 5% of those deemed CAHs have a validation survey conducted by accrediting orgs, or at least 1 survey in each state - whichever is greater). At least 1 deemed CAH is surveyed in each State, unless the State has no deemed CAHs, or unless CMS makes no assignment, based on AO survey schedules. *(Entirely funded out of each State's regular budget)(See Appendix 3)* • ***Substantial Allegation Validation (Complaint) Surveys:*** Only when authorized by the RO. IJ complaints, including restraint/seclusion death incidents are to ***be initiated or completed within the applicable SOM timeframe*** and are Tier 1 priority. • ***EMTALA Complaint Surveys:*** Only when authorized by the RO. All EMTALA complaints surveys authorized are prioritized as IJs and are to be completed within the applicable SOM timeframe and are a Tier 1 priority. • ***Full Surveys Pursuant to Complaints***: Full surveys may be required by the RO after each complaint investigation that finds condition level non-compliance for deemed hospitals and CAHs. These are a Tier 1 priority.	• **Substantial Allegation Validation (Complaint) Investigations that are prioritized as non-IJ high must be initiated within 45 days of RO authorization**		

	• **Psychiatric Hospital Representative Sample Validation Surveys**: Surveys are conducted in a sample of deemed psychiatric hospitals, specified by CMS during the year, depending on the AO's survey schedules for the FY. If States are not equipped to evaluate compliance with the special conditions, CMS' contractor will perform that component of the validation survey. *(Budgeted separately and allocated as supplemental funding during the year.)*			
5. Hospitals, Psychiatric Hospitals-& CAHs Non-Deemed (1)	• C**omplaint surveys:** Complaint allegations prioritized as IJs and RO-authorized EMTALA and restraint/seclusion death incident surveys, initiated or completed within the applicable SOM timeframes.	• **5-Year Max. Interval:** No more than 5.0 years elapses between surveys for any particular non-deemed hospital, psychiatric hospital or CAH. • **5% Targeted Sample:** States survey at least 1, but not less than 5% of the non-deemed hospitals, 5% of the non-deemed psychiatric hospitals and 5% of non-deemed CAHs in the State, selected by the State based on State judgment regarding those most at risk of providing poor care. Some targeted surveys may qualify to count toward the Tier 3 and 4 priorities. Targeted sample requirements do not apply to States with fewer than 7 non-deemed hospitals, psychiatric hospitals or CAHs.	• ***Re*certs: 4.0-Year Max. Interval**: No more than 4.0 years elapses between surveys for any particular non-deemed hospital or CAH. • **Recerts of Psych Hospitals**: 3.0 yr average recertification surveys of non-accredited/non deemed psychiatric hospitals only. • **New IPPS Exclusions**: All new rehabilitation hospitals/ units & new psychiatric units seeking exclusion from IPPS (2), as well as existing providers newly seeking such exclusion. The SA does not need to conduct an on-site survey for verification of the exclusion requirements but instead may process	3.0-Year Avg.: **Add'l surveys are done (beyond Tiers 2-+3), based on State judgment regarding the non-deemed hospitals and CAHs that are most at risk of providing poor care, such that all non-deemed hospitals/CAHs in the State are surveyed, on avg, every 3.0 years (i.e., total surveys divided by total non-deemed hospitals/CAHs is not more than 3.0 years; separate calculation for hospitals and CAHs). Targeted surveys may count toward the 3.0 yr avg.**

1 Includes critical access hospitals, rehabilitation hospitals, and psychiatric hospitals. IPPS refers to the Inpatient Prospective Payment System.
2 Onsite verifications are to be completed no later than 90 days prior to the beginning of the hospital's cost reporting period.

			an attestation of compliance by the hospital. • **IPPS Exclusion Verification (Existing excluded hospitals/units):** 5% (but at least 2 per State) of providers already IPPS-excluded. These are rehabilitation hospitals, rehabilitation units and psychiatric units that have attested to continued compliance with the IPPS exclusion requirements (3). These surveys verify that the hospital unit continues to meet IPPS exclusion criteria.	
6. ESRD	• **Investigation of complaint allegations triaged as IJ** • Initial surveys within 90 days of the MAC approval of the CMS-855.	• **Complaint Investigations:** non-IJ high • Outcomes List: 100% of the ESRD facilities in the State on the Outcome List	**3.5-Year Max Interval (42.9 months):** Additional surveys are done to ensure that no more than 3.5 years elapses between surveys for any one particular ESRD facility • Complaint Investigations: non-IJ medium.	**3.0-Year Avg:** Additional surveys are done (beyond Tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of 3.0 years or less
7. Hospices	• 36-Month Max. Interval: No more than 36 months between completed surveys for any particular agency. Use the separately-tracked IMPACT hospice funds first.	• **Complaint investigations: High**		**Initial Surveys**

3 Onsite verifications are to be completed no later than 90 days prior to the beginning of the hospital's cost reporting period.

	• **Representative Sample validation surveys of deemed hospices:** States conduct validation surveys of deemed hospices, specified by CMS, during the year, depending on the AOs' survey schedules for FY 2019*(Budgeted separately via supplemental allocation).* • **Complaint investigations prioritized as immediate jeopardy – deemed hospices:** only with RO authorization; survey to be initiated within 2 days of RO authorization.			
8. Comprehensive Outpatient Rehabilitation Facilities	• **Complaint investigations prioritized as immediate jeopardy**:	• **5% Targeted Surveys**: Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.	• 7.0-Year Interval: **Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any one particular provider.**	6.0-Year Avg**: Add'l surveys are done (beyond Tiers 2-3) such that all non-deemed providers in the State are surveyed, on average, every 6 years. (i.e., total surveys divided by total providers is not less than 16.7% = 6.0 years).**
9. Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	• **Complaint investigations prioritized as immediate jeopardy – Deemed RHCs:** only with RO authorization; survey to be initiated within 2 days of RO authorization. • **Complaint investigations prioritized as immediate jeopardy FQHCs:** only with RO authorization; survey to be initiated within 2 days of RO authorization.	• **5% Targeted Surveys:** Each year, the State surveys 5% of non-deemed RHCs (or at least 1, whichever is greater), based on State judgment for those RHCs most at risk of quality problems Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 RHCs of this type are exempt	• **7.0-Year Interval**: Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any one particular RHC.	• **6.0-Year Avg:** Add'l surveys are done (beyond tiers 2-3) such that all non-deemed RHCs in the State are surveyed, on average, every 6 years. (i.e., total surveys divided by total RHCs is not less than 16.7% = 6.0 years). • **Initial Survey-** there is a deemed status option for RHCs. • There is no certification or recertification for FQHCs.

		from this requirement. • **Complaint investigations prioritized as non-IJ high:** to be initiated within 45 days (for deemed RHCs, or FQHCs within 45 days of RO authorization)**.**		
10. Ambulatory Surgery Centers	• **Representative Sample Validation Surveys - Deemed ASCs:** States conduct validation surveys of 5% - 10% of deemed ASCs, assigned by CMS based on AO survey schedules. *(Budgeted separately via supplemental allocation)* • **Complaint investigations prioritized as immediate jeopardy – deemed ASCs:** only with RO authorization; survey to be initiated within 2 days of RO authorization.	• **Targeted Surveys (25%):** The State performs surveys totaling 25% of all non-deemed ASCs in the State (or at least 1, whichever is greater) focusing on ASCs not surveyed in more than 4 years or based on State judgment for those ASCs more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 priority. States with only 7 or fewer non-deemed ASCs must survey at least 1 ASC unless all non-deemed ASCs were surveyed within the prior two years. Included within the targeted surveys is a random sample selected by CMS of roughly 10% of the non-deemed ASCs in the State • **Complaint investigations**	• **6.0-Year Interval**: Additional surveys are done to ensure that no more than 6.0 years elapse between surveys for any one particular non-deemed ASC.	**Initial Surveys**

		prioritized as non-IJ high: to be initiated within 45 days (for deemed ASCs, within 45 days of RO authorization)**.**		
11. Psychiatric Residential Treatment Facilities (Medicaid Psych < 21)	• **Complaint investigations triaged as IJ.**	• **Complaint investigations triaged as non-IJ 5.0-Year Interval:** Survey visits (Validation and Complaint) of 20% of PRTFs).		Initial Surveys
12. Community Mental Health Centers (CMHCs)	• **Complaint investigations triaged as IJ.**	• **5% Targeted Surveys**: Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on CMS judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 priorities. Targeted sample requirements do not apply to States wit.	• **5.0-Year Interval:** Survey visits (Validation and Complaint) of 20% of CMHCs).	**Initial certification of CMHCs unless there is verification of access concerns.**
13. Portable X-Ray Suppliers	• **Complaint investigations triaged as IJ**	• **5% Targeted Surveys**: Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3	• **7.0-Year Interval**: Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any one particular provider.	• **6.0-Year Avg:** Add'l surveys are done (beyond Tiers 2-3) such that all non-deemed providers in the State are surveyed, on average, every 6 years

		and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.		
14. Transplant	• **Complaint – IJ:** Investigation of complaint allegations triaged as IJ.	• **Mandatory Re-approval Surveys:** For transplant programs that do not meet the data submission, clinical experience or outcomes requirements.	• **Initials:** Any initial surveys of programs	
15. New Provider-Initial Surveys	Initial certification of the following: ESRD Facilities	• Relocations of the parent or main location of existing non-deemed providers or suppliers. • Relocations of any provider displaced during a public health emergency declared by HHS.	Initial certification of the following: • Transplant centers • SNF/NFs • Relocations of non-deemed branches or off-site locations. • Note: Conversion of a non-deemed hospital to a CAH, or a non-deemed CAH back to a hospital is a conversion, not an initial certification and at State option may be done as Tier 2, 3, or 4. However, the conversion of a deemed hospital or CAH or the addition of swing beds as a new service in an existing deemed or non-deemed hospital or CAH is a Tier 4 priority.	• Initial certifications of all provider types that have a deemed accreditation option (with the exception of ESRD): hospitals, home health, new home health branches, hospice, expansion of inpatient hospice for a currently certified hospice, ambulatory surgical centers, outpatient physical therapy, and rural health clinics. (While CAHs may also be deemed, these are conversions, not initial certifications; however deemed CAHs are expected to be surveyed by their AOs for their conversion surveys.) • The addition of home health branches are administrative actions thus not a deeming option. (AOs deem compliance with CoPs, not administrative actions.) Though surveys may not be involved, these actions should remain in the Tier structure as they are often resource intensive. • The addition of hospice multiple locations may warrant a survey. These surveys should be scheduled consistent with the Tier structure as they are often resource intensive. • All other newly-applying providers not listed in Tier 3 are Tier 4, unless approved on an exception basis by the CMS RO, due to serious healthcare access considerations or similar special circumstances.

				• Relocations of deemed providers or suppliers
16. Complaint Investigations	• Complaint Investigations triaged as a high potential for immediate jeopardy or, in the case of hospitals, psychiatric hospitals or CAH DPUs, where the RO authorizes investigation of a hospital or CAH DPU restraint/seclusion death incident or an EMTALA complaint. • For all deemed non-LTC provider/supplier types for which one or more condition-level deficiencies is determined to be out of compliance pursuant to a complaint investigation, the RO: ➢ May require a full survey before proceeding to enforcement.	• Complaint Investigations triaged non-IJ high.	• Complaint investigations of non-deemed non-LTC facilities triaged as non-IJ medium are investigated when the next on-site survey occurs. Complaint investigations of LTC facilities triaged as medium	• Complaint investigations of LTC facilities triaged as low • Complaints of non-deemed non-LTC facilities triaged as non-IJ low are not separately investigated but tracked/trended for potential focus areas during the next on-site survey.
17. Core Infrastructure	• Timely ASPEN data entry of survey workload • Attendance at mandatory federal surveyor training • MDS, OASIS, QIES and IRF-PAI systems activities • Maintenance of the nurse aide registry and assessments of nurse aide training and competency evaluation programs • Review of the nurse aide registry to assure that it is being operated in compliance with the requirements. • Maintenance of a home health hotline • Performance Measurement Activities • Implement & promote fulfillment of CMS GPRA goals and Quality Initiative, including collaboration with QIOs on the GPRA goals (pressure ulcer reduction, restraint use reduction). • Training of survey & certification staff, including transcript & qualifications maintenance. (See separate Training Mission Letter) • Emergency preparedness essential functions (see download)			

Statistical Convention: Whenever standards are expressed in months, 0.9 of the succeeding month is included in order to permit completion of any survey in progress. Hence a 12 month average is tracked as 12.9 months. Similarly, a 3.0 year interval is tracked as 36.9 months and a 6.0 year interval is tracked at 72.9 months.