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

Center for Clinical Standards and Quality
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Quality Assurance for the Medicare & Medicaid Programs

Fiscal Year 2026
Mission & Priorities Document (MPD)

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Policy Highlights

End-Stage Renal Disease (ESRD) Facilities

Each year, CMS releases the ESRD Facility Outcomes List, which establishes the state's Tier 2 workload. CMS will release the annual Outcomes List at the start of FY2026. CMS and State Agency users will need to log into https://dialysisdata.org/ using their username and password to access the confidential file.

Deferment of a Tier 2 Survey: In the FY2025 MPD, CMS issued guidance for deferring certain Tier 2 surveys when the ESRD Facility is ranked in the bottom 5th percentile for performance across multiple consecutive years. CMS is clarifying two of the conditions (bolded) that must be met to allow deferral of a Tier 2 survey:

1. **The facility was identified in both the FY2025 and FY2026 Outcomes List.**
2. **The Tier 2 survey based on FY2025 results was performed in the last fiscal year.**
3. The prior survey resulted in no citations or standard-only citations with an accepted plan of correction.
4. There are no complaints against the facility triaged as immediate jeopardy (IJ) or non-IJ high since the last reapproval survey.
5. There is no other quality of care concerns. Information about quality of care concerns should be obtained from the ESRD Network that is assigned to the facility location.

Enhancement to the Outcomes List Table: There are two new indicators on the Outcomes List table: one for Tier 3 status and one for whether the facility was surveyed in the last fiscal year. The Tier 3 status indicator will help state agencies (SA) determine which Tier 2 facilities are also due for a standard reapproval survey, i.e. ESRD facilities that have not had a survey in the last 3.5 years. The indicator to show whether the facility was surveyed in the last fiscal year will help state agencies determine whether the Tier 2 ESRD facility is eligible for a deferral. When making a decision about whether to defer a Tier 2 survey, state agencies should use the full deferral criteria outlined above.

Deemed Tier 2 ESRD Facilities: Tier 2 facilities that are deemed by a CMS-approved Accrediting Organization (AO) are not the responsibility of the SA. CMS-approved AO's will implement its procedures for performing Tier 2 surveys.

Hospice Program

CMS continues implementation of the Consolidated Appropriations 2021(CAA), which established new hospice program survey and enforcement requirements and expanded requirements for AOs with deeming authority for hospice programs. These provisions were codified into the CY2022 Home Health Prospective Payment Rate Update Final Rule, released on November 9, 2021.

The CY 2024 Home Health Prospective Payment System Rate Update (CMS-1780-F) includes the Hospice Informal Dispute Resolution process and Special Focus Program (SFP) requirements. The Final rule was published on November 13, 2023, and is available on the Federal Register: https://www.federalregister.gov/public-inspection/2023- 24455/medicare- program-calendar-year-2024-home-health-prospective- payment-system-rate-update-quality

CMS published memorandum QSO-25-02-Hospice on October 4, 2024, which outlines the hospice SFP criteria and the roles and responsibilities for CMS, the SAs, and the AOs. Effective February 14, 2025, implementation of the Hospice SFP for CY 2025 has been temporarily paused while we revise the program. Until the SFP is resumed, survey procedures for all hospices will continue as established. CMS encourages appropriate use of enforcement remedies available for hospices, through the Consolidated Appropriations Act of 2021, to create an emphasis and incentive for hospices to improve their performance.

Hospitals and Critical Access Hospitals (CAHs)

CMS is evaluating Appendix A and Appendix W of the State Operations Manual (SOM) based on new Obstetrical Services requirements. On July 1, 2025, hospitals are required to implement transfer protocols under discharge planning and emergency services readiness under the emergency services requirements. CAHs will also be required to implement emergency services readiness requirements within the same timeframe. Beginning January 1, 2026, hospitals and CAHs will also be required to implement portions of the obstetrical services Condition of Participation related to organization, staffing, and delivery of services (89 FR 93912).

Long Term Care (LTC)

CMS continues to take actions to improve and protect the health and safety of nursing home residents. These include:

CMS continues to test a risk-based survey (RBS) approach. This approach allows facilities that consistently demonstrate higher-quality performance to receive a more focused survey, improving efficiency and resource utilization compared to the traditional standard recertification survey, while still ensuring compliance with health and safety standards. Following completion of the testing phase, CMS will present the next phase.

CMS announced a national campaign to support staffing in nursing homes to make it easier for individuals to enter careers in nursing home workforce, investing over $75 million in financial incentives such as tuition reimbursement and stipends. States can partner with CMS to increase the number of financial incentives available, increase awareness of the program in their state, and improve their nurse aide training competency evaluation program (NATCEP) websites. CMS will also be working with states to streamline and remove potential barriers from their NATCEPs to increase capacity and provide more certified nurse aides to nursing homes. States should email NHSC@cms.hhs.gov to collaborate with CMS or ask questions.

Training and Education

The Surveyor Skills Review (SSR) Assessment is an annual assessment that measures the competency and knowledge required for successful surveys. Surveyors will take the SSR assessment after completing all the prerequisite and basic training courses listed on the training plan for their primary area of expertise and one year of experience surveying health facilities.

SSR competency assessments will be released by provider type and in a phased approach. The list below shows the SSRs available on The Quality, Safety, & Education Portal (QSEP):

- Ambulatory Surgical Center (ASC)
- Clinical Laboratory Improvement Amendments of 1988 (CLIA)
- Community Mental Health Center (CMHC)
- Emergency Medical Treatment and Labor Act (EMTALA)
- End-Stage Renal Disease (ESRD)
- Emergency Preparedness (EP)
- Home Health Agency (HHA)
- Hospice
- Hospital
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Life Safety Code
- Long Term Care (LTC)
- Psychiatric Hospital
- Psychiatric Residential Treatment Facilities (PRTFs)
- Rural Health Clinic (RHCs)

The SSR is available October 1st each year and closes September 30th the following year. Each surveyor will be notified when they are eligible to take the SSR.

CMS is developing a new training for surveyors titled *The Fundamentals of Patient Safety in Hospitals (FPSH),* with an anticipated release in October 2025. The training will focus on ensuring safe delivery of care and adherence to Quality Assurance and Performance Improvement (QAPI) programs. Surveyors will be notified when the training is available.

Transplant Programs

Performance-Based Reapproval Surveys
CMS is implementing a data-driven approach to prioritizing reapproval surveys of Medicare-approved transplant programs. The prioritization system uses metrics derived from the Scientific Registry of Transplant Recipients (SRTR) Program Specific Reports. This data-driven process will continue prioritizing reapproval surveys of certain transplant programs as a Tier 2 priority, while shifting other standard reapproval surveys to a Tier 3 priority. On October 1, 2025, CMS will begin piloting this new prioritization method for transplant program reapproval surveys focusing on adult kidney transplant programs. CMS will communicate survey-specific details with the state agencies.

The Transplant Workbook
The Transplant Program Survey Workbook is available for surveys via QSEP and provides several resources, including worksheets, checklists, and templates that may be used to collect specific information. The use of the workbook will help surveyors systematically document their findings and observations, making it easier to reference information and maintain consistency throughout the survey process. It will also standardize the survey process by ensuring all survey procedures follow a consistent format, reducing the chances of missing critical steps. This workbook can be used for all initial and reapproval surveys. Surveyor use of the workbook is optional at this time. As surveyors utilize this tool, we will refine and evaluate it for future use and standardization across states.

Heart/Lung Transplant Programs
CMS is removing a duplicative process that requires Medicare-approved hospitals to have an approved heart/lung transplant program to perform combined heart/lung transplants. The national surveyor database will be updated to remove "heart/lung" as a selection for initial and reapproval surveys. Survey teams should ensure that any transplant program performing combined heart/lung transplants has a Medicare-approved heart-only and a Medicare-approved lung-only transplant program.

General Information

Purpose & Overview

The MPD is an annual document updated to reflect several key areas: regulatory changes, adjustments in budget allocations, new initiatives, and new statutory requirements. It directs and prioritizes the work of QSOG, SOG, and the SA. The MPD covers survey and certification functions, as well as the Medicare funding allocation process for states to perform these activities. It also directs work prioritization and planning for the required state survey agency workload.

Regulations

The Unified Agenda of Regulatory and Deregulatory Actions reports on the regulations administrative agencies plan to issue in the near and long term. For upcoming regulatory actions undertaken by both QSOG and SOG, please visit the Office of Information and Regulatory Affairs (OIRA) Unified Agenda website: https://www.reginfo.gov/public/do/eAgendaMain.

Survey and Certification

CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers, and long-term care facilities serving Medicare and Medicaid beneficiaries, and makes available to beneficiaries, providers/suppliers, and State surveyors, information about these activities. The survey (inspection) of these facilities is done on behalf of CMS by the individual State Survey Agencies. The functions the States perform for CMS under the agreements in Section 1864 of the Social Security Act (the Act) are referred to collectively as the certification process.

More information about the certification and compliance process, and a link to the State Operations Manual (SOM)[1] chapters and provider/supplier type appendices can be found here.

CMS Quality Safety & Oversight (QSO) memoranda, guidance and clarification and instructions issued to SAs and CMS Locations can be found here.

Surveyor Training

The mission of the Quality, Safety and Education Division (QSED), in partnership with CMS Locations and SAs, ensures there's a knowledgeable and skilled survey workforce as mandated by the Social Security Act (the Act), as well as informed providers and suppliers throughout the United States.

Before any state or federal surveyor may serve on a survey team (except as a trainee), they must complete the requirements outlined in the surveyor training plan on the Quality, Safety and Education Portal (QSEP).

The majority of QSED surveyor training is now available online via QSEP.

[1] The SOM is a document issued by CMS containing survey and certification guidance and instructions to the SAs. The SOM includes 10 chapters covering certification, survey and enforcement processes as well as appendices for each provider/supplier type and CLIA containing sub-regulatory compliance guidance and survey procedures

Priority Tier Structure for Survey & Certification (S&C) Activities Overview

Survey activities must be scheduled and conducted in accordance with the priority tier structure provided in this document (See Appendix 2). The four priority tiers reflect statutory mandates and program emphases, with tier 1 being of the highest priority and tier 4 being lower priority. Planning for lower-tiered items presumes that the state will accomplish, or has a plan to accomplish, higher- tiered items first.

While states may begin lower-tier work before completing tier 1 or tier 2 activities—provided the multi-tier work is included in their approved budget submission outlining Survey and Certification program goals—they must prioritize tier 1 and 2 workloads along with initial certification surveys over the scheduling and completion of lower-tier surveys..

In addition to prioritizing work between tiers 1-4, we suggest states consult with their CMS Location in the prioritization process. States must track their tiered workload quarterly and report the results to the CMS Location 45 days after the close of the quarter. States must also report the full status of the FY completed workload 60 days after the close of the FY. As part of their oversight responsibilities, CMS Locations will monitor and work with states on completion of their tiered workload.

We note that timely and successful uploading of complete survey kits into the designated system is an essential component of the states' workload. States must implement measures to ensure that these uploads are completed for providers/suppliers, including those remaining in the legacy system.

Note on Statistical Convention used throughout provider and supplier certification tier workloads: Whenever standards are expressed in months, 0.9 of the succeeding months is included to permit the completion of any survey in progress. Hence, a 12-month average is tracked as 12.9 months. Similarly, a 3-year interval is tracked as 36.9 months, and a 6-year interval is tracked at 72.9 months.

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 is an important aspect of the legacy system. For the most recent SPSS information for the fiscal year, refer to the CMS Administrative Information Memos webpage here.

Core Infrastructure

All of the following are considered tier 1 S&C activities of Core Infrastructure:

- Timely data entry of survey workload;
- 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 and hospice hotline;
- Performance measurement activities;
- Implement & promote the fulfillment of CMS Government Performance and Results Act (GPRA) goals and quality initiatives as needed;
- Training of S&C staff, including transcript & qualifications maintenance; and
- Emergency preparedness essential functions.

OASIS Coordinators

QSOG will continue to fund OASIS Education Coordinators (OEC) and OASIS Automation Coordinators (OAC). Each State has designated OASIS Coordinators to provide guidance on the administration and submission of the OASIS instrument for home health. Please refer to the CMS QSOG webpage that contains a list of State Agency and CMS Office contacts for both OASIS Education and Automation Coordinators. While, CMS no longer provides in person trainings specifically for OASIS Coordinators in reference to their duties, all trainings old and new, webinars and reference materials involving the OASIS are announced and posted on the Home Health Quality Reporting (QRP) webpage.

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 in accordance with CMS established specifications and time frames. CMS expects the states to continue to provide staff to serve as RAI/MDS educational and technical resources to nursing homes and SA staff. As such, 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:

- Maintaining up-to-date working knowledge of the RAI manual and MDS 3.0 assessment;
- 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, meetings, and conferences;
- Conducting at least two structured provider training courses within the FY, and provide ongoing RAI/MDS education and technical support to SNF/NF and swing bed hospital providers, and SA staff (training courses shall be documented); and

- Educating providers and SA staff on reports from the data system, MDS outcome, or other reports.

For more information on RAI/MDS and a list of all the State RAI and Automation Coordinators, please visit the CMS website here.

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

CLIA regulates the quality and safety of clinical laboratory testing performed on humans located in the U.S. The program ensures the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed.

CLIA is a user-fee funded program that requires surveys to be prioritized throughout the year as needed (See SOM 6102.1). State Agencies should refer to the most recent memo for the CLIA Annual Fiscal Year Budget Call Letter for guidance on developing projected workloads located on the CMS Administrative Information memos webpage here.

Deeming options

For additional information on CMS-approved AOs and providers/suppliers with an accreditation deeming option, please visit: https://www.cms.gov/Medicare/Provider-Enrollment- and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts- for-Prospective-Clients-.pdf

Contact Information for Program Areas:

In most cases, States will initially refer questions to their CMS Location; however, these mailboxes may be used for national policy questions or to gather policy feedback on a pending question between CMS and states.

- Ambulatory Surgical Center (ASC): QSOG_ASC@cms.hhs.gov
- CLIA: LabExcellence@cms.hhs.gov
- Critical Access Hospital (CAH): QSOG_CAH@cms.hhs.gov
- Community Mental Health Center (CMHC): CMHC@cms.hhs.gov
- Comprehensive Outpatient Rehabilitation Facility (CORF): QSOG_CORF@cms.hhs.gov
- End Stage Renal Dialysis (ESRD): QSOG_ESRDQuestions@cms.hhs.gov
- Home Health Agency (HHA): HHAsurveyprotocols@cms.hhs.gov
- Hospice: QSOG_Hospice@cms.hhs.gov
- Hospital (includes EMTALA): QSOG_Hospital@cms.hhs.gov
- Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID): QSOG_ICFIID@cms.hhs.gov
- Nursing Home Regulations: DNH_TriageTeam@cms.hhs.gov
- Nursing Home Survey Process: NHSurveyDevelopment@cms.hhs.gov
- Nursing Home Schizophrenia Audit: DNH_BehavioralHealth@cms.hhs.gov
- Outpatient Physical Therapy (OPT): QSOG_OPT@cms.hhs.gov
- Portable X-Ray (PXR): CMSQSOG_PXR@cms.hhs.gov
- Psychiatric Hospital: QSOG_PsychiatricHospital@cms.hhs.gov
- Psychiatric Residential Treatment Facility (PRTF): QSOG_PRTF@cms.hhs.gov

- Rural Emergency Hospital (REH): QSOG_REH@cms.hhs.gov
- Rural Health Clinic/Federally Quality Health Center (RHC/FQHC): QSOG_RHC-FQHC@cms.hhs.gov
- Training content, direction, and availability: QSOG_QSED@cms.hhs.gov
- Transplant: QSOG_TransplantTeam@cms.hhs.gov

Budget Formulation Guidelines

CMS is requiring the States to evaluate and justify planned Medicare survey workload and budgets, consistent with MPD requirements, at the provided funding level in attachment A. As part of the narrative, please provide information detailing the budgeted workload to be accomplished in each of the four MPD tiers at the funding level provided by your State. Further guidance on final funding allocations will be provided once the final FY 2026 appropriations are enacted

Due Dates:
State materials due to CMS Locations: **10/15/2025**

CMS Location recommendations to HQ:
11/3/2025

CMS report out to CCSQ Leadership:
11/10/2025

Budget Plan for the Fiscal Year:

CMS requests that States carefully review their ongoing Medicare workload and submit an initial budget plan and limited justification materials for FY 2026 at the base funding level provided for each State in Attachment A. Within this detail, please provide information detailing the budgeted workload to be accomplished. To establish the State funding guidelines for FY26, CMS worked with the Location Budget contacts to review the historical spending of the States from the last several FY's and the reasons for those, whether over, under, or on track. The proposed base funding amounts shown in Attachment A are preliminary and may be subject to increase depending on the final FY 2026 funding level approved by Congress. States shall briefly describe the funding level, critical workload, and tier-level completion in accordance with current MPD requirements at the funding level provided, as shown in the attachment, as well as their Hospice funding request. Each Location, in turn, will review and submit their recommendation to CMS for final disposition. CMS will finalize State allocations and request routine budget materials (CMS-435's, 434's, 1465's, etc.) when final appropriations have been enacted. CMS requests that States carefully review their ongoing Medicare workload and submit an initial budget plan and limited justification materials for FY 2026 at the base funding level. Within this detail, please provide information detailing the budgeted workload to be accomplished at the flat-lined funding level.

CMS Locations complete review of the state's submissions and offer recommendations, by state, by the date listed above to the CMS Headquarters staff Shaneka Thompson (Shaneka.Thompson@cms.hhs.gov), Jamil Macklin (Jamil.Macklin@cms.hhs.gov), and Bary Slovikosky (Bary.Slovikosky@cms.hhs.gov).

Consolidated Appropriations Act (CAA)

The FY 2021 appropriations bill provided additional funds for Hospice survey work, beginning in FY 2022. This funding will continue to be utilized to fully fund all Hospice survey work in FY 2026. All CAA funds should be reported separately on the mini-CMS 435 Hospice -CAA form.
However, CAA funding amounts should not be included on the main CMS 435. If a State sees any significant issues with its allocation, or has questions about the allocations or cost accounting, please communicate those promptly to your CMS Location staff. The CAA provides funds for Hospice-related work. Rough estimates for this activity should be included in your budget requests. Further details on this program will be provided by CMS QSOG/SOG program staff.

Continued guidelines from previous FYs

Title XVIII Budget Closeouts

With the passage of the Grants Oversight and New Efficiency Act (GONE, P.L. 114- 117), a focus has been placed on properly following and executing existing FY budgetary closeout processes. This focus is not intended to add existing work to SAs; in fact, this focus should help states close out their financial books sooner rather than sometimes waiting for five years after the close of the FY.

- *Budget Closeout Requirements*: The main goal is to establish a common grants closeout process in line with current Departmental regulations, statutes, and audit recommendations. With respect to the states, this will primarily be a change to the timeframes involved in closeout, the possibility for unilateral closeouts, as well as an increase in emphasis on closing awards in a timely manner. The actual work required to affect a proper closeout will remain substantially the same.
    - The timelines for this process are as follows:
        - Final financial reports, consistent with the terms of the award, are due 90 calendar days from a grant's completion date;
        - Full closeout, meaning that all applicable administrative

actions and all required work of the federal award have been completed and take actions as described in 45 CFR 75.381, is due no later than 270 days from a grant's completion date;

- If the closeout cannot be completed within the 270-day timeframe, CMS may elect to complete a unilateral closeout.

CMS will provide states sufficient notification of upcoming due dates for both report and closeout due dates via written memorandum and email notification and will work with states to meet the due dates noted. CMS will work with states on a case-by-case basis if there are reasons that they are unable to meet the guidelines noted above.

MDS and HHA mini-CMS-435 forms

The MDS mini-CMS-435 includes all MDS-related costs, while the HHA mini-CMS-435 should include all HHA and OASIS costs. This budgeting (and subsequent expenditure reporting) will show the subset of all MDS and HHA-related costs that are included in the full CMS-435 form.

HHA Cost Allocation

States should use a simplified 50% Medicare-50% Medicaid method to share the federal costs (after state licensure costs are accounted for) by:

1. Identifying the total cost of HHA surveys,
2. Subtracting the state-only amount that reflects the state licensure share,
3. Dividing in half the remainder (total federal share of HHA costs) and
4. Assigning one half to Medicare and the other half to Medicaid.

Please refer to S&C Memo 13-31-HHA for more detail.

State Licensure Shares

This information is required to be filled into columns G & H of the CMS-435 as part of the budget reporting package. This information is necessary to adequately review the use of proper cost accounting to ensure appropriate cost-sharing across all funding sources of the S&C program.

NAR/NATCEP Costs

States must continue requesting and reporting all Medicare NAR/NATCEP costs on the Miscellaneous line 19A of the form CMS-435. These expenses are not to be included in salaries/fringe benefits. State budget requests should be tied to the number of nurse aides and/or training programs. All budgets must include NAR/NATCEP expenses

under line 19A (Miscellaneous) on the CMS-435 form (column B).

NAR/NATCEP and competency evaluation costs incurred for Title XIX-only facilities are considered administrative costs and are to be reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (form CMS-64). There are no provisions for covering these expenses in the Medicaid S&C budgets.

- Costs incurred in joint Titles XVIII/XIX facilities for NAR/NATCEP will be charged and reimbursed 50% by Medicare and 50% by Medicaid (50%-50% split). Expenses incurred for Title XVIII should be reported on the form CMS-435; expenses for Title XIX on the form CMS- 64.
- Guidance pertaining to allowable NAR/NATCEP expenditures can be found in Chapter 4 of the SOM.

Training Line on CMS-435

Under most circumstances, the costs reported in the training line on the form CMS-435 should not be zero. As discussed in the SOM, this line item includes any non-salary costs associated with training.

Final Budget Package

In summary, the final budget package should include:

1. Main CMS-435 Budget Request Form; Note: This form should capture all projected expenditures for the FY (including MDS and HHA but not including CAA Hospice costs) spread across the appropriate lines of the CMS-435.
2. Mini CMS-435s for MDS and HHA (subset reports of the main CMS-435);
3. CMS-435 CAA – Hospice (separate report), with projected expenditures spread across the appropriate line items;
4. CMS-434 Planned Workload Report;
5. CMS-1465A Budget List of Positions;
6. CMS-1466 Schedule for Equipment purchases;
7. Budget narrative with work plan and line by line justification;
8. Include a single, all-inclusive tier statement: indicate what tier workloads the state will and will not be able to accomplish. If circumstances allow for only partial completion of a particular tier workload, indicate in the tier statement which work will not be completed in the tier, by provider type, and the extent of the survey work that the state expects it will be unable to accomplish. Please recall that there is a triage level of complaint investigations in each tier, so mention those if they come into play.

   Please make a tier statement as a clearly identified paragraph toward

the top of the budget narrative. It can be as simple as "tiers 1, 2 and 3 will be done, but not initial surveys in tier 3 and tier 4." Or the statement can be more detailed, especially if the state will complete part of a tier, and needs to specify what won't be done in the tier;

9. Most recent Indirect Cost Agreement.

CMS Budget Analysis and Adjustment

CMS' Headquarters will continue to partner with CMS Locations to review and agree upon a final budget amount for FY26 for each state once Congress has finalized a budget. The funding available to states will be allocated based on several factors that are considered such as:

- Historical Spending;
- Workload Requirements;
- State Hiring Challenges.

It is recommended that states make the CMS Locations aware of expected funding shortfalls or overages as soon as possible in the FY to ensure that the most effective funding distribution can be made as soon as Congress passes a budget.

Contact Information

For questions, please contact: Your CMS Location budget staff, Shaneka Thompson (Shaneka.Thompson@cms.hhs.gov), Jamil Macklin (Jamil.Macklin@cms.hhs.gov), or Bary Slovikosky (Bary.Slovikosky@cms.hhs.gov).

Appendix 1 – Fiscal Year Projected Allocations

	A	B1	B2
State	**FY25 Base Budget**	**FY26 PM Funding Amount**	**FY26 Hospice/CAA Budget Amount+ (States are to provide estimates)**
CT	$6,468,994	$6,468,994	
ME	$2,586,600	$2,498,406	
MA	$9,255,998	$8,940,402	
NH	$1,430,025	$1,430,025	
RI	$1,908,710	$1,843,630	
VT	$1,516,211	$1,464,514	
NJ	$8,726,410	$8,428,871	
NY	$16,884,616	$16,884,616	
PR	$493,358	$476,536	
DE	$1,168,301	$1,168,301	
DC	$1,250,213	$1,207,585	
MD	$4,138,141	$3,997,045	
PA	$10,976,663	$10,602,398	
VA	$5,389,044	$5,205,297	
WV	$2,614,588	$2,614,588	
Subtotal	**$74,807,872**	**$73,231,208**	
AL	$5,226,415	$5,226,415	
FL	$12,742,607	$12,742,607	
GA	$6,201,162	$5,989,725	
KY	$5,382,468	$5,198,945	
MS	$2,348,275	$2,268,207	
NC	$9,142,431	$8,830,707	
SC	$2,726,467	$2,726,467	
TN	$4,756,518	$4,594,338	
Subtotal	**$48,526,343**	**$47,577,411**	
IL	$17,580,637	$16,981,201	
IN	$7,571,208	$7,313,057	
MI	$12,891,235	$12,451,690	
MN	$9,559,106	$9,233,175	
OH	$16,561,971	$15,997,267	
WI	$7,198,896	$6,953,440	
Subtotal	**$71,363,053**	**$68,929,830**	
AR	$6,278,918	$6,278,918	
LA	$7,320,484	$7,070,882	
NM	$2,509,881	$2,424,303	
OK	$7,070,882	$7,070,882	

Appendix 1 – Fiscal Year Projected Allocations, continue

	A	B1	B2
State	**FY25 Base Budget**	**FY26 PM Funding Amount**	**FY26 Hospice/CAA Budget Amount+ (States are to provide estimates)**
TX	$34,823,549	$33,636,191	
Subtotal	**$58,003,714**	**$56,481,176**	
IA	$5,643,968	$5,643,968	
KS(AG)	$3,586,227	$3,463,950	
KS(H)	$1,550,059	$1,497,208	
MO	$12,126,747	$11,713,269	
NE	$3,145,519	$3,038,268	
CO	$5,748,884	$5,552,868	
MT	$1,883,046	$1,818,841	
ND	$1,784,489	$1,723,644	
SD	$1,574,063	$1,520,393	
UT	$2,505,801	$2,420,362	
WY	$1,234,750	$1,234,750	
Subtotal	**$40,783,553**	**$39,627,521**	
AZ	$3,775,250	$3,646,528	
CA	$47,211,331	$45,601,595	
HI	$1,799,027	$1,737,687	
NV	$1,858,297	$1,794,936	
AK	$1,140,240	$1,101,362	
ID	$1,827,243	$1,764,941	
OR (Health)	$1,301,685	$1,257,302	
OR (HR)	$3,401,245	$3,285,275	
WA(H)	$2,373,561	$2,292,631	
WA(SS)	$4,973,007	$4,803,445	
Subtotal	**$69,660,886**	**$67,285,702**	
Blank	**$363,145,421**	**$353,132,848**	

Additional Funding levels to be considered after Congress approves the Fiscal Year Budget.

Appendix 2: Priority tier structure for survey & certification activities for providers and suppliers

Provider and Supplier Oversight

Note on statistical convention used throughout provider and supplier certification tier workloads: Whenever standards are expressed in months, 0.9 of the succeeding months is included to permit the completion of any survey in progress. Hence, a 12-month average is tracked as 12.9 months. Similarly, a 3-year interval is tracked as 36.9 months and a 6- year interval is tracked at 72.9 months.

For reference, Tiered Complaint Investigations listed within each program table, the timeframes for completion are found within Chapter 5 of the SOM (5075.9 - Maximum Time Frames Related to the Federal Onsite Investigation of Complaints/Incidents). This document provides the guiding prioritization of the aggregate workload.

Priority Tier Structure for **Complaint Investigations** of Acute and Continuing Care & Long-Term Care

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized as IJ for acute and continuing care (ACC) providers/suppliers (deemed and non-deemed) and Long-Term Care (LTC) facilities. **EMTALA** **Complaint Surveys**: Only when authorized by the CMS Location. All EMTALA complaints surveys authorized are prioritized as IJs or Non-IJ High **Full Surveys Pursuant to Complaints**: Full surveys may be required by the CMS Location after each complaint investigation that finds condition level non-compliance for deemed providers/suppliers. **Restraint/seclusion death incidents** (hospitals, psychiatric hospitals, PRTFs or CAH DPUs), where the CMS Location authorizes investigation.	Complaint Investigations prioritized as **Non-IJ High.**	Complaint investigations of non-deemed ACC providers/suppliers and LTC facilities prioritized as **Non-IJ Medium** are investigated when the next on-site survey occurs.	Complaints of non-deemed ACC providers/suppliers and LTC facilities triaged as Non-IJ Low are not investigated separately but tracked/trended for potential focus areas during the next onsite survey.

Priority Tier Structure for **Standard Survey Activities** of Acute and Continuing Care & Long-Term Care:

Ambulatory Surgical Centers (ASCs)

Tier 1	Tier 2	Tier 3	Tier 4
	Initial certification Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information) **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 seven or fewer non-deemed ASCs must survey at least one ASC unless all non-deemed ASCs were surveyed within the prior two years.	**6-Year Interval:** Additional surveys are done to ensure that no more than six years elapse between surveys for any one particular non-deemed ASC. **Initial certification**- All others not listed under Tier 1 or 2 **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	

Community Mental Health Centers (CMHCs)

Tier 1	Tier 2	Tier 3	Tier 4
	5% Targeted Surveys: Each year, the state surveys 5% of the providers in the state (or at least one, whichever is greater), based on CMS Location 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 with fewer than seven CMHCs. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	**5-Year Interval** **Initial certification-** All others not listed under Tier 1 or 2.	

Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Tier 1	Tier 2	Tier 3	Tier 4
	Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)- If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 2 priority. This would also include cases where CMS has determined an access to care issue. **5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, 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 seven providers of this type are exempt from this requirement.	**7-Year Interval:** Additional surveys are done to ensure that no more than seven years elapse between surveys for any one particular provider. **Initial certification-** All others not listed under Tier 1 or 2.	**6-Year Avg:** Additional surveys are done (beyond tiers 2 and 3) such that all non-deemed providers in the state are surveyed on average, every six years. (i.e., total surveys divided by total providers are not less than 16.7% = six years).

End-Stage Renal Dialysis (ESRD) Facilities

Tier 1	Tier 2	Tier 3	Tier 4
Initial surveys: States must conduct initial certification surveys within 90 days of the MAC approval of the CMS- 855, unless the supplier has elected a deeming option.	**Outcomes List**: 100% of the ESRD facilities on the state Outcomes 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. **Relocations, expansion of service(s)*, and/or addition of station(s) requests**, as needed.	**3-Year Average:** Additional surveys are done (beyond tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of three years or less.

**Addition of home dialysis services may be processed in a higher Tier on a case-by-case basis. See "Policy Spotlight for the Fiscal Year" section for more information.*

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Tier 1	Tier 2	Tier 3	Tier 4
	Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option- If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**7-Year Interval:** Additional surveys are done to ensure that no more than seven years elapse between surveys for any RHC. **Initial certification**- All others not listed under Tier 1 or 2	**6-Year Average**: Additional surveys are done (beyond tiers 2-3) such that all non-deemed RHCs in the state are surveyed on average, every six years. (i.e., total surveys divided by total RHCs are not less than 16.7%). **There is no certification or re-certification requirement for FQHCs.**

Home Health Agencies (HHAs)

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapse between completed surveys for any particular agency.	**Initial certification -** Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	**Initial certification Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 3 priority. **Initial certification**- All others not listed under Tier 1 or 2	**24.9 Mo. Avg**: Additional 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 average every 24 mos. (average of all tier 4 surveys ≤ 24.9 mos. to optimize the unpredictability of surveys. **Surveys of HHAs de-activated (by the MAC)–**for failure to bill Medicare for 12 consecutive months.

Hospice

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapsed between completed surveys for any particular agency.	**Initial certification -** Provider/Supplier with a CMS- determined access to care issue (the provider is responsible for providing the information)	**Initial certification**- All others not listed under Tier 1 or 2 **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 3 priority.	

Hospitals, Psychiatric Hospitals, & Critical Access Hospitals (CAHs) - Deemed

Tier 1	Tier 2	Tier 3	Tier 4
		N/A	The conversion of a deemed hospital or CAH or the addition of swing beds as a new service in an existing deemed hospital or CAH is a tier 4 priority. Deemed CAHs are expected to be surveyed by their AOs for their conversion surveys.

Hospitals, Psychiatric Hospitals-& Critical Access Hospitals (CAHs) - Non-Deemed

Tier 1	Tier 2	Tier 3	Tier 4
5% Targeted Sample: States survey at least one, 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 count toward the tier 3 and 4 priorities. Targeted sample requirements do not apply to states with fewer than seven non-deemed hospitals, psychiatric hospitals or CAHs.	**5-Year Recertification Max. Interval**: No more than five years elapse between surveys for any particular non- deemed hospital, psychiatric hospital, or CAH. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**4-Year Recertification Max. Interval:** No more than four years elapse between surveys for any particular non- deemed hospital or CAH. **Recertifications of Psych Hospitals**: 3-year average recert surveys of non- accredited/non-deemed psychiatric hospitals only. **New IPPS Exclusions:** All new rehabilitation hospitals/units & new psychiatric units seeking exclusion from IPPS 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 an attestation.	**3-Year Recertification Avg**.: Additional surveys are done (beyond tiers 2 and 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 three years (i.e., total surveys divided by total non- deemed hospitals/CAHs is not more than three years; separate calculation for hospitals and CAHs). Targeted surveys may count toward the three-year average. *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.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Tier 1	Tier 2	Tier 3	Tier 4
15.9 Mo. Recertification Max. Interval: No more than 15.9 months elapse between completed surveys for any particular ICF/IID. **12.9-Mo. Recertification 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.		**Initial certification**- Surveyed at state priority	**N/A**

Outpatient Physical Therapy and (OPT) & Speech-Language Pathology (SLP) services

Tier 1	Tier 2	Tier 3	Tier 4
	Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information) **5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, 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 seven providers of this type are exempt from this requirement.	**7-Year Interval**: Additional surveys are done to ensure that no more than seven years elapse between surveys for any one particular provider. **Initial certification**- All others not listed under Tier 1 or 2 **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option -** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 3 priority.	**6-Year Avg:** Additional surveys are done (beyond tiers 2-3) such that all non-deemed providers in the state are surveyed on average, every six years. (i.e., total surveys divided by total providers is not less than 16.7% = six years). There is a deemed status option for OPTs.

Portable X-Ray (PXR) Suppliers

Tier 1	Tier 2	Tier 3	Tier 4
	5% Targeted Surveys: Each year, the state surveys 5% of the providers in the state (or at least one, whichever is greater), based on state judgment for those providers more at risk of quality problems. Some of the targeted surveys may count toward the tier 3 and 4 priorities. States with fewer than seven providers of this type are exempt from this requirement.	**7-Year Interval**: Additional surveys are done to ensure that no more than seven years elapse between surveys for any particular provider. **Initial certification-** All others not listed under Tier 2. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS- determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	**Initial Certification Surveys** **6-Year Avg:** Additional surveys are done (beyond tiers 2-3) such that all non-deemed providers in the state are surveyed on average, every six years

Psychiatric Residential Treatment Facilities (PRTFs) - (Medicaid Psych < 21) Initial certification is achieved by the facility submitting attestation to the State Medicaid Agency (SMA).

Tier 1	Tier 2	Tier 3	Tier 4
	5-Year Recertification Interval: In States with five or more PRTFs, 20% of PRTFs must be surveyed at least annually to meet the 5-year interval (Complaint investigations do not count towards 20%).		

Rural Emergency Hospitals (REHs) - Non-Deemed

Tier 1	Tier 2	Tier 3	Tier 4
Targeted Sample: Because all REHs are a new non-deemed provider type, States should survey 100% of REHs within 12 months of the REH certification date. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days - determined access to care issue (the provider is responsible for providing the information)**- If more than 150 days has passed since the MAC has recommended approval of the application, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue. Initial certification of eligible facilities that subsequently closed and require an initial on-site survey.	**5-Year Recertification Max. Interval**: No more than five years elapse between surveys for any non- deemed REH.	**4-Year Recertification Max. Interval:** No more than four years elapse between surveys for any non- deemed REH.	**3-Year Recertification Avg**.: Additional surveys are done (beyond tiers 2 and 3), based on state judgment regarding the non-deemed REHs that are at most risk of providing poor care. Targeted surveys may count toward the three-year average.

Transplant Programs

Tier 1	Tier 2	Tier 3	Tier 4
Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)- If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	**All Transplant Programs-** Performance-Based Reapproval Surveys **Standard Reapproval Surveys (5-year interval)—**applicable to transplant programs in states with fewer than two transplant programs identified in Performance-Based Reapproval Surveys. Reapproval surveys are for all organ transplant types.	**Initial certification-** All others not listed under Tier 1. **Standard Reapproval Surveys (5-year interval)—** applicable to transplant programs in states with two or more transplant programs identified in Performance-Based Reapproval Surveys. Reapproval surveys are for all organ transplant types.	

Long-Term Care (LTC) Facilities

Tier 1	Tier 2	Tier 3	Tier 4
15.9-Month Recertification Max. Interval: No more than 15.9 months elapsed between completed surveys for any particular nursing home. **12.9-Mo. Recertification Avg:** All nursing homes in the state are surveyed on average, once per year. The statewide average interval between consecutive standard surveys should be 12.9 months or less **"Off-Hours" Surveys:** States are required to conduct at least 10% of the standard health surveys on the weekend or before 8:00 a.m. or after 6:00 p.m. (i.e., "off- hours). States shall conduct at least 50% of their required off- hours surveys on weekends using the list of facilities with potential staffing issues provided by CMS. **Special Focus Facility Surveys:** Each State Survey Agency shall conduct one standard recertification survey of each designated Special Focus Facility (SFF) at least once every 186 days.	**Initial certification- Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS- determined access to care issue (the provider is responsible for providing the information):** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 2 priority. This would also include cases where CMS has determined an access to care issue.	**Initial Surveys of Nursing Homes that are seeking Medicaid-only funding**–funded only by Medicaid (not Medicare) and surveyed at state priority. **Initial certification-** All others not listed above or under Tier 1 or 2.	

**Note: Conversion of a Medicaid-only Nursing Facility (NF) to dual-certification (SNF/NF) does not require an initial Medicare certification survey provided all of the following are met:*
(a) the Medicaid survey has been completed within the prior six months, (b) the majority of beds in the facility will remain Medicaid-certified and (c) the procedures in SOM 7002 are followed for SNFs.

Version	Date	Changes/Notes
1.0	2025-09-12	Initial draft
1.1	2025-09-26	Added OASIS coordinators and RAI/MDS under General Information
1.2	2025-11-24	Added missing information to the Tier 2 columns for CORF and FQHC/RHC in Appendix 2.