DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Survey & Certification Group

Admin Info: 18-01-ALL
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DATE: **October 17, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: FY 2018 Mission & Priority document (MPD) – Action

****Revised Appendix 1- Nursing Home Tier 4 to Tier 3 Status****

Memorandum Summary

FY 2018 MPD: Enclosed is the final FY 2018 MPD. The final document is improved as a result of the feedback from AHFSA and the Regional Offices. Due to the separate IMPACT funding available, we are requesting each State's FY 2018 Hospice funding requests by November 17, 2017.

Hospice Funding Requests

Funding for hospice surveys will follow the same approach in FY 2018, as in FY 2015, FY 2016 and FY 2017(communicated via AdminInfo 15-26). In short, all survey and certification work in FY 2018 regarding both non-deemed and deemed hospices is to be funded first by IMPACT funds (after subtracting that portion of costs properly assigned to the State's usual licensure share of the costs). Medicare S&C funds will be used after the State's allocation of IMPACT Act funds have been committed. We are requesting that States send their request for total FY 2017 hospice funding to their RO budget contacts by November 17, 2017 and copy Bary Slovikosky (Bary.Slovikosky@cms.hhs.gov). We have left Column B2 and D2 of Appendix 2 of the MPD blank until we have more time to review requests for hospice funding. We will issue a separate memorandum conveying the IMPACT funds allotted to each State.

S&C Medicare Funding Allocation Process

We have projected a 0.5% increase in Medicare funds as a target for this FY for all States. However, when Congress passes a final budget, we will engage in a process similar to the process used in FY2013-17; that is, we will ask each State to submit a budget request based on the State's needs and amount that the State actually expects to use. Due to State hiring limitations and the timing of federal appropriations, both we and States have found it more challenging to project funding availability and actual funding use in advance of the FY. We will

therefore continue to provide a projected funding target, but will follow up later in the year with a more specific process.

Training Curriculum Catalog: To access the curriculum map for FY18, please refer to https://projects.aha-llc.com/cms/catalog/v10/index.html.

Contact: For questions or concerns, please contact your RO.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment(s):
Attachment 1- FY2018 MPD
Attachment 2- FY2018 Training Schedule

cc: Survey and Certification Regional Office Management

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

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Center for Clinical Standards and Quality
7500 Security Boulevard
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Quality Assurance for the Medicare & Medicaid Programs

FY2018 Mission & Priority Document (MPD)

Survey and Certification

October 17, 2017

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SECTION ONE: INTRODUCTION

The mission of the survey and certification (S&C) program is to assure basic levels of quality and safety for all patients, residents and clients receiving care from Medicare and Medicaid certified institutional providers.

Survey and certification is the system that provides onsite, objective and outcome-based verification by knowledgeable and trained individuals to assure that basic standards of quality are being met by healthcare providers across the nation or, if not met, that appropriate remedies are promptly applied and implemented effectively. More than 200,000 providers, suppliers and laboratories are subject to survey & certification. Approximately 85,000 onsite, unannounced recertification surveys are conducted each year, and more than 85,000 onsite complaint investigations. The system covers the following:

- Ambulatory Surgical Centers
- Comprehensive Outpatient Rehab
- Dialysis (ESRD) Facilities
- Clinical Laboratories
- Home Health Agencies
- Hospices
- CMHCs
- Hospital –Acute
- Hospitals–Critical Access
- Hospitals–Rehabilitation
- Hospitals–Long Term Care
- Hospitals-Psychiatric
- Hospitals–Organ Transplant Programs
- ICFs-IID
- Nursing Homes
- Outpatient PT and SLP (Rehab Agency)
- Portable X-Ray Suppliers
- Religious Non-Medical Healthcare Institutions
- Rural Health Clinics
- Federally Qualified Health Centers
- Psychiatric Residential Treatment Facilities
- Organ Procurement Organizations.

The Centers for Medicare & Medicaid Services (CMS) accomplishes these quality assurance functions under specific direction from the Social Security Act (the Act) and jointly with States, accrediting organizations (AOs) and contracts with qualified organizations.

When significant problems are determined, through onsite observation during periodic comprehensive surveys or complaint investigations, CMS is backed by legislated authority to impose remedies on the provider or supplier. Failure to implement appropriate remedial action for serious deficiencies on the part of any provider can result in termination of the Medicare (and where applicable, also Medicaid) provider agreements or supplier approval (which also terminates funding from those sources).

In the case of clinical laboratories, failure to implement corrective action may also result in sanctions including revocation of the CLIA certificate. Once revoked, the laboratory can no longer perform any human specimen testing, including waived, provider performed microcopy, and moderate or high complexity testing, used for healthcare purposes, as delineated in the Clinical Laboratory Improvement Amendments of 1988.

The Act mandates the establishment of minimum health and safety standards that must be met by participating providers and suppliers. For laboratories, Section 353 of the Public Health Service Act is the basis for such standards. The Secretary of the Department of Health and Human Services (DHHS) has designated CMS to administer the standards compliance aspects of these programs.

Agreements between the Secretary and States, territories and the District of Columbia stipulate that State Survey Agencies (SAs) designated by the Governors are responsible for the performance of the certification functions created by §1864 of the Act.

The Secretary agrees to provide funds for the reasonable and necessary costs to the States to perform the functions authorized by the agreements. Payments to States under §1864 of the Act are made from the Federal Hospital and Supplementary Medical Insurance Trust Funds to cover the costs of services performed under the agreement as authorized by §1864 of the Act. However, expenditures from the Trust Funds for S&C functions are authorized only through the regular appropriation process of Congress.

If the SA is also performing Medicaid certification activities pursuant to an approved State Plan, the Federal financial grant mechanisms are used to pay the State for a percentage of the cost of those activities during each quarter of the year. The matching grants come from appropriated general revenues of the United States. The Secretary is authorized to pay a percentage of these costs for the proper and efficient administration of the State Plan. Whereas the Title XVIII trust funds are controlled under terms of the State agreement, the grant funds are controlled by the established rules of Federal grant laws and regulations. Among the responsibilities of the parties to the §1864 agreements are obligations imposed upon the Federal government (delegated to CMS) dealing with the States' program administration, which include:

- Setting policy and providing policy interpretations on the provider and supplier certification program standards;
- Providing consultation to agencies involved in administering the Federal requirements;
- Paying the appropriate and allowable costs of the SA functions relating to administration of regulations and provisions of the agreement and State Plan;
- Making determinations of allowable State costs to submit for Federal payment;
- Controlling payment of Federal trust funds and grant awards to appropriate SAs for S&C costs incurred in administering Title XVIII and Title XIX programs; and
- Training and qualifying Federal and State personnel to conduct Medicare and Medicaid surveys and provider certification.

Major Survey & Certification Functions – Examples			
	S&C Major Function	**Focus**	**Frequency – CMS Policy**
1	Comprehensive ("Standard") Surveys	Survey all the major requirements for quality that are specified in regulation.	Nursing Homes – average every year Home Health Agencies and Hospices– every 3 years, every provider Hospitals – every 3 years, on average IFC/IID – average every year Others – 3-6 year averages, depending on provider type.
2	Complaint Investigations	Investigate complaints & providers' compliance with CMS requirements.	Frequency varies by provider type. In FY2016 approximately 56,522 nursing home and 3,420 hospital/CAH complaints were investigated.
3	Minimum Data Set (MDS) (Nursing Homes)	Monitor assessments that nursing homes are required to conduct for every nursing home resident and educating providers. Investigate problems in the MDS coding by NHs during surveys.	
4	Outcome & Assessment Information Set (OASIS)	CMS uses OASIS assessment data to inform oversight of home health agencies.	
5	Validation of State Surveys	CMS conducts validation surveys to verify the accuracy of State surveys. Two main types of validation surveys are done: (a) comparative surveys, in which a CMS team or contractor conducts an independent survey within 60 days of the State survey (to compare results) and (b) observational surveys, in which a CMS team or contractor accompanies the State team to observe the process of the State team. Sample size varies with provider type, from 5% in nursing homes, to 1% for all other provider types.	
6	Validation of Accrediting Organization (AO) Surveys	Two main types of validation surveys of AOs are done: (a) Representative Sample Validation surveys, in which the SA conducts a survey within 60 days of the AO survey and, less frequently (b) "mid-cycle" or Substantial Allegation complaint validation surveys that are not tied to the timing of an AO survey but are designed to assess the extent of accredited provider/supplier compliance, for particular purposes, usually in comparison to non-accredited providers/suppliers. Sample size varies according to the budget, and provider/supplier type. CMS must report annually to Congress on the performance of all CMS-approved national accreditation programs in assuring the compliance with Medicare health and safety standards of accredited, deemed providers/suppliers. In addition, complaint surveys are conducted in response to substantial allegations of non-compliance in accredited, deemed facilities.	
7	Accrediting Organization Approvals & Oversight	CMS reviews the applications of national accrediting organizations (AOs) for initial approval as well as renewal of Medicare-approved accreditation programs under which providers/suppliers may be "deemed" by CMS to meet required health and safety standards. The statute requires that the AO standards meet or exceed those of Medicare and that the AO requirements for accreditation, survey procedures, ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, monitoring procedures for provider entities found out of compliance with the conditions or requirements, and ability to provide CMS with necessary data for validation be comparable to those of Medicare. Representative Sample and Substantial Allegation Validation surveys represent an important aspect of CMS' on-going AO oversight once CMS-approval has been granted.	
8	Public Information	CMS and States provide high quality content on public websites regarding a variety of provider types. For example, CMS' *Five-Star Quality Rating System* offers consumers easy-to-understand information about the quality of care in the nation's nursing homes, on the CMS *Nursing Home Compare* website. The website offers key information about quality measures, staffing and survey results. As a service to the public, the website improves the ability of consumers to make informed decisions and to ask pertinent questions of providers. As a tool for quality, the website provides incentives for nursing homes to improve their quality. CMS also publishes nursing home survey reports (Form 2567s) in a searchable database available to the public via the internet, as well as hospital complaint investigation surveys.	

SECTION TWO: SPECIAL CHALLENGES

A. New Responsibilities

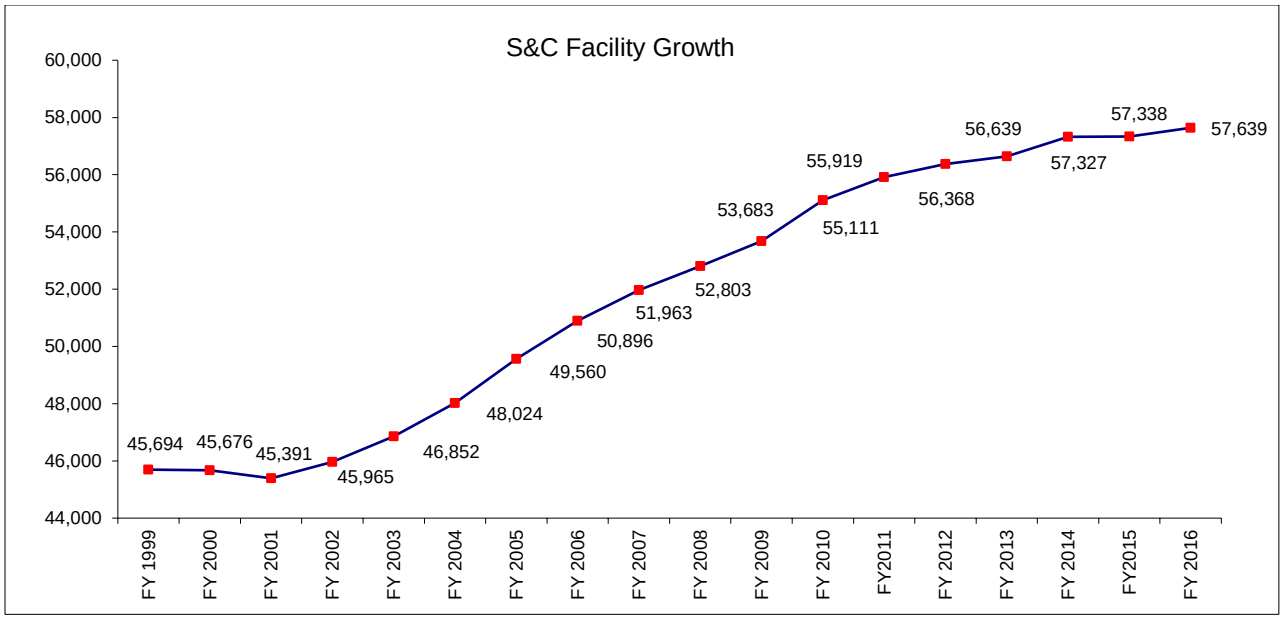
Major New Regulation Affecting All Providers/Suppliers:

The Emergency Preparedness Final Rule: In FY 2017, CMS released Appendix Z of the State Operations Manual (SOM), Emergency Preparedness Interpretive Guidelines for All Providers and Suppliers. On September 1, 2017, CMS' Emergency Preparedness Online Training was released to surveyors and providers. This training is available on demand, on the Integrated Surveyor Training Website (https://surveyortraining.cms.hhs.gov/). Surveyors should begin surveying for compliance with the new EP Tags for the new Condition for Participation/Condition for Coverage/Requirement. CMS will also continuously update the SCG Emergency Preparedness website (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html) to provide additional resources and guidance to surveyors, stakeholders and the general public.

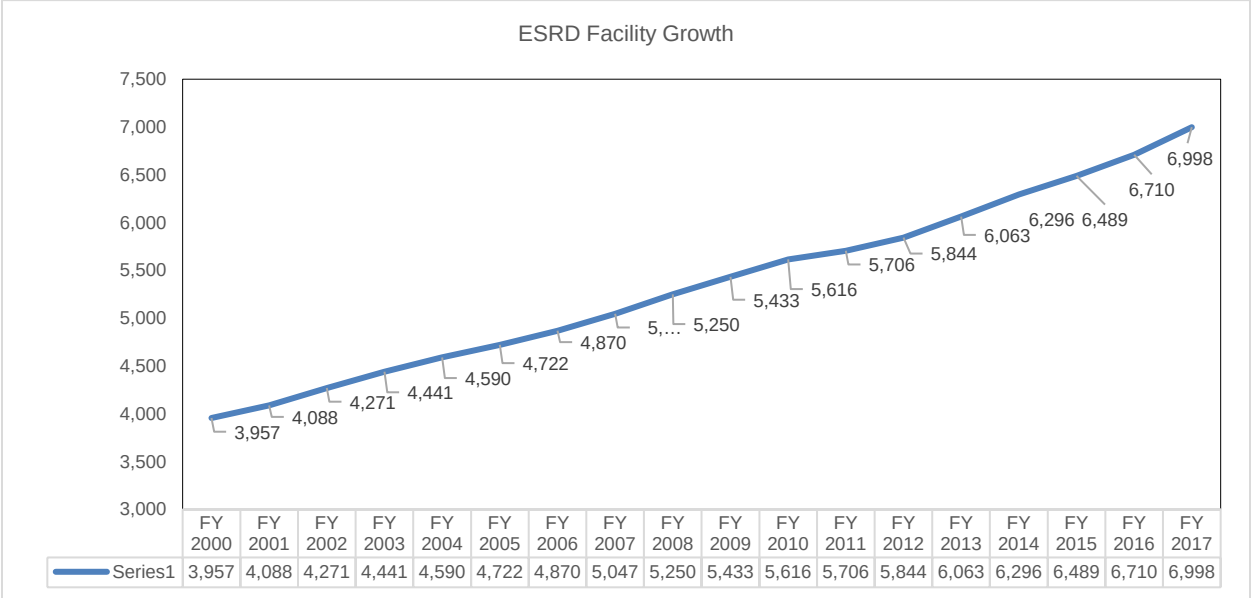
B. Continuing Challenges

B.1 The IMPACT Act of 2014: 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 will assist States to comply with this requirement. By FY2018 all hospices should have been surveyed within the past three years and be scheduled for survey every 36 months.

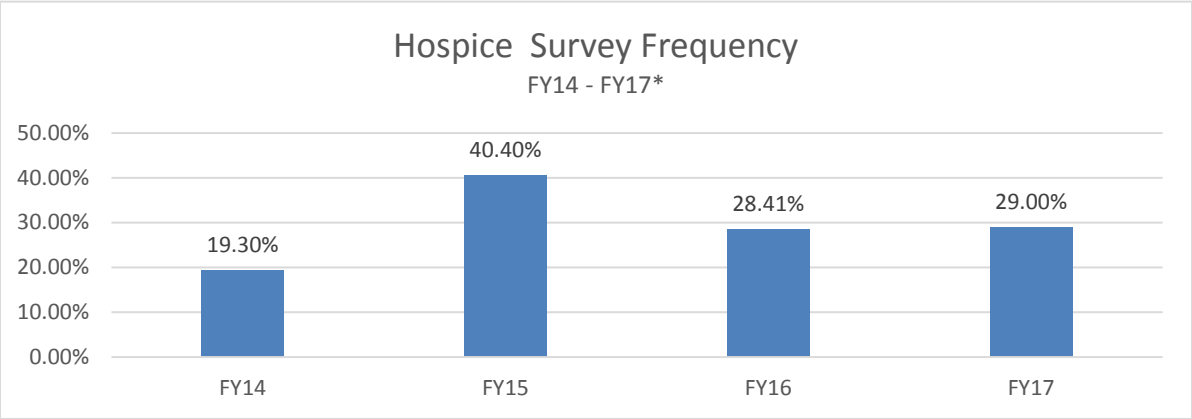
B.2 More Facilities: There is a consistent increase in the number of providers that must be surveyed. This is one of the strongest drivers of the Medicare survey & certification budget, since more providers will stretch out the average time between surveys unless additional resources are available. While the availability of the deemed status option reduces states' surveyor workload, the certification and enforcement processing workload continues to increase. The following graph illustrates the total cumulative effect of increased numbers of all types of providers that are subject to Medicare and Medicaid survey and certification requirements, excluding clinical laboratories.

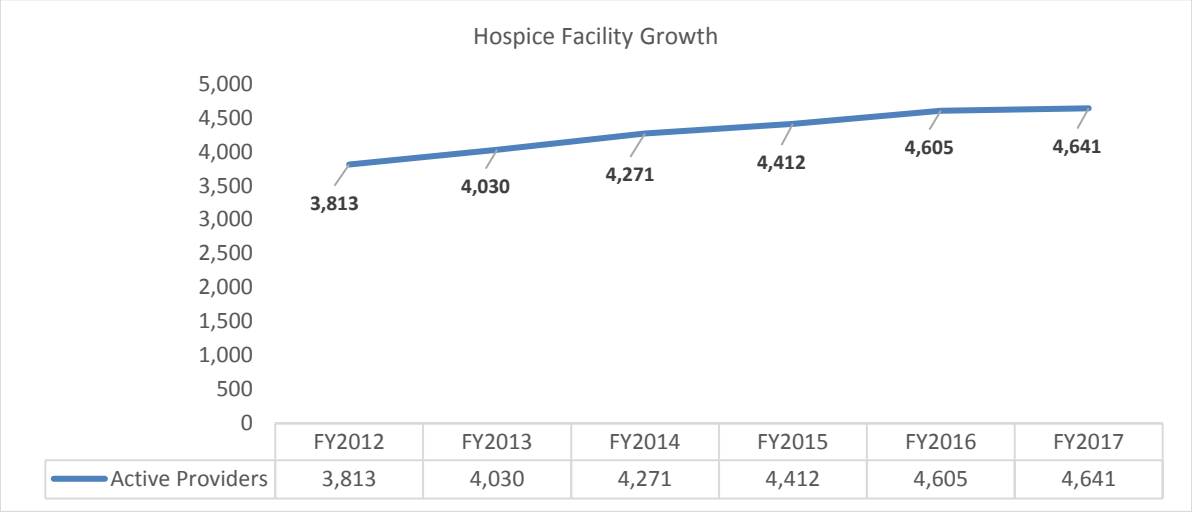


End-stage renal disease (ESRD) facilities are also growing significantly in number. The following graph portrays the rise in ESRD facilities from 4,441 in FY2003 to 6,998 in FY2017, a 57.6% increase.



B.3 Sustaining Improved Survey Coverage: Federal and State efforts to improve efficiency, provide clearer guidance, implement State performance standards and accomplish other improvements have resulted in a survey system that is both improved and more reliable. The graph on this page, for example, shows the percentage of Hospices surveyed from FY14 – FY17 (*please note that the FY17 numbers are not final). And we have included a chart showing the growth in the number of hospices since FY2012.


Hospice Survey Frequency
FY14 - FY17*
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
19.30%
40.40%
28.41%
29.00%
FY14
FY15
FY16
FY17


Hospice Facility Growth
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,813
4,030
4,271
4,412
4,605
4,641
FY2012 FY2013 FY2014 FY2015 FY2016 FY2017
Active Providers 3,813 4,030 4,271 4,412 4,605 4,641

SECTION THREE: SPECIAL NOTES

In this section we describe some of the notable changes from recent years.

Changes to the MPD or Survey Processes in Recent Years, or New Opportunities in FY2018

Please see the discussion in Section Two for special challenges. With respect to many of the new regulations that are discussed in Section Two, States can expect a variety of new, required trainings in FY2018, particularly in relation to the following:

- Adoption of the 2012 Life Safety Code (anticipated availability in December 2017)
- Emergency Preparedness (available now)
- Nursing Home Requirements for Participation and New Survey Process (anticipated availability in March 2018)
- Home Health Conditions of Participation (Anticipated training availability in January 2018)

Specific information regarding training can be found in Section Six (CMS SCG Training Program).

Continued from the Recent Past

A. Home Health Focused Survey: During FY2018 CMS plans to implement a focused standard survey for Home Health Agencies (HHA). The revised HHA survey process will reduce the time on site for surveyors, and will better focus surveyors' activities while onsite.

B. ESRD Contract Surveys: CMS began using a National Contractor starting in 2013, to assist States with surveying facilities that have not been surveyed in a significant period of time. The contractor provides survey team members to conduct a limited number of state surveys of ESRD facilities in areas of high priority. Regional office staff in conjunction with State survey agencies will identify facilities to be surveyed under the contract. States which take advantage of this resource will be required to provide administrative support to the contract survey teams and will be responsible for the necessary follow-up actions (such as revisits) related to contract survey findings.

C. Home Health Agency Conversions (From Deemed Status to SA Responsibility) – Impact on Non-Delivery Deductions: When Home Health Agencies, initially certified under deemed status by a CMS-approved Accreditation Organization, elect to drop their deemed status and resume State oversight, the State Survey Agency (SA) must ensure that the statutory 3 year survey interval is maintained. However, in some cases, the SA does not receive notification of the intent of the Home Health Agency to convert back to SA oversight with sufficient notice to schedule a timely survey. Because this timely notification is not within the control of the SA, CMS will not identify a non-delivery deduction or penalize the SA on State Performance Standards when it can produce evidence that it did not receive at least 60 days notification of such a conversion.

D. Ambulatory Surgical Centers (ASCs): All States that have non-deemed ASCs are required to survey at least 25% of their non-deemed ASCs using the enhanced survey process. States that have only **7** or fewer non-deemed ASCs must survey at least 1 facility unless all such ASCs were surveyed within the prior two fiscal years. For FY 2018, CMS will NOT be selecting a random sample of ASCs or collecting infection control worksheets. This is scheduled to resume in FY 2019.

E. One-Time Funding Opportunities: We suggest that States conduct a clear analysis of one-time investments that may raise productivity or otherwise lead to a reduction in the rate of growth in future expenses. Such analysis will position the State to take advantage of funds that may be reallocated from other States that are not able to use the monies. In addition, we request that States review the infrastructure they have in place that enable surveyors to conduct surveys using computers that can be then linked among members of the survey team (e.g., tablet computers, mobile hotspots) and participate effectively in online training courses and similar distance learning (e.g., headset availability, preferably ones that can plug into telephones and have noise cancelling capability). Computer based infrastructure is of particular concern given the move towards an electronic LTC survey process which is planned to begin in early FY2018.

F. Interagency Agreement with Centers for Disease Control – Reducing Infections and Improving Care Transitions between Hospitals and Nursing Homes

The Centers for Disease Control and Prevention (CDC) provides funding for CMS to address joint priorities related to assessing the continuum of infection prevention efforts between hospitals and nursing homes in order to prevent transmission of infections in both settings.

Thirty five of the forty nursing homes that received a pilot survey in FY17 have agreed to continue to participate in the Infection Control Pilot. After the educational surveys were performed, a team of infection control professionals used the findings to develop an action plan for improvement and organized technical assistance. In FY18, the QIN QIOs will provide technical assistance based on the survey findings and action plan. Twenty four of the 35 facilities that agreed to participate, along with four that did not, will receive a one day educational survey using the same survey tool. The survey results for each facility will be compared with their original results to determine if the technical assistance improved their infection control program performance. We will keep States informed along the way as to where these educational surveys will be conducted and all of the surveys will be performed by the National Contractor.

SECTION FOUR: 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 prioritizing 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.

A. Nursing Homes (Health and Life Safety Code)

1. Mission Highlights for FY2018

Standard Health Survey Process:

On November 28, 2017, there will be 4 major changes:

- All states will be converting the new long-term care survey process to assess compliance with the Requirements for Participation. Training will be completed at the end of October 2017.
- Surveys will include review of Phase 2 requirements for the new Requirements for Participation.
- New Interpretive Guidance that CMS released on June 30, 2017 will be effective.
- 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 (https://surveyortraining.cms.hhs.gov/) and at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

2. Updates for Other Recent Activities

- **Appendix P:** In FY2018, CMS will be removing Appendix P and will incorporate 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.

- **Basic Long-Term Care Surveyor Training (Health and Life Safety Code):** CMS will be converting the Basic Long-Term Care Survey Process and all Life Safety Code courses to the online, self-paced format. Please refer to Section Six of this document and the Training Schedule for when these courses are expected to be available.

- **MDS Focused Surveys:** CMS has integrated an evaluation of the MDS into the standard survey process. We will not be conducting separate focused MDS surveys for FY2018.

- **Focused Dementia Care Surveys:** FY2017, 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 this process.

- **National Partnership to Improve Dementia Care:** CMS will be establishing 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.

- **Enforcement and Civil Money Penalty Tool:** CMS will be continuing work on policies related to the imposition of remedies and availability of the CMP Tool.

- **Special Focused Facility program:** CMS will continue to partner with States to operate the SFF program. We do not expect programmatic changes to this program for FY 2018 and will continue policies such as the "last chance survey", and reviewing progress of all other facilities that have been on the SFF list for more than 12 months.

- **Life Safety Code Surveys:** CMS will gather data on the surveys conducted under the 2012 Life Safety Code. We will review this data to establish a framework for conducting the Life Safety Code Short Form expected to start in FY2019.

- **Emergency Preparedness Surveys:** Please refer to the Emergency Preparedness website for additional information for these requirements and surveys starting November 15, 2017. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

- **State Reinvestment of Civil Money Penalty (CMP) funds**: States are required to reinvest CMP funds to improve and protect the health and safety of nursing home residents. They are also required to maintain a plan of how the funds are intended to be

reinvested, and report certain metrics about projects funded. CMS will continue to work with States to monitor and ensure the appropriate use of CMP funds.

3. Continued Guiding Program and Budget Requirements

- **Statutory Timeframes:** All skilled nursing facilities (SNFs) and nursing facilities (NFs) are subject to a standard survey that is completed no later than 15.9 months after the previous standard survey, with a statewide average between standard surveys of 12.9 months.

- **Staggered Surveys:** States must continue to stagger a set number of nursing home inspections (to be started mornings, evenings and/or weekends).

- **State Medicaid funding:** States must secure the necessary Medicaid State share for funding those activities attributable to Medicaid facilities or dually-certified facilities.

- **Maintenance of Nurse Aide Training Registry:** States are required to maintain a registry of all individuals who have completed a nurse aide training course and have passed a competency evaluation test. States must also investigate allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide or other individuals. See 42 CFR Subpart D, and Section 4132 and 4141 of the State Operations Manual for additional requirements.

- **Resident Assessment Instrument/Minimum Data Set (RAI/MDS):** Nursing homes and swing bed hospitals are required to encode and transmit MDS records to CMS according to established record specifications and time frames. As such, CMS expects the States to continue to provide staff to serve as RAI/MDS educational and technical resources to the nursing homes and SA in each State and attend CMS-required training. States must continue to adequately fund and staff the positions of a RAI coordinator and a RAI/MDS automation coordinator. A description of expected responsibilities can be found at: Section 4145 of the State Operations Manual, and Chapter 2 and Appendix B of the Resident Assessment Instrument (RAI) Manual.

- **Fire Inspector 1 Training:** The Fire Inspector 1 training is a pre-requisite for the Basic LSC Training. This training must be based on the National Fire Protection Agency requirements but does not have to be presented by the NFPA. Courses that rely only on the International Building Code are not sufficient.

PRIORITY

Nursing Homes			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **Nursing Homes- 15.9 Month Max. Interval:** No more than 15.9 months elapses between completed surveys for any particular nursing home. • **Nursing Homes - 12.9 Month 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***	

***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.*

B. Non-Deemed Home Health Agencies (HHAs)

1. Basic Expectations: Under Section 1891(b) of the Act, the Secretary is responsible for assuring that Conditions of Participation (CoPs) and the resulting enforcement are adequate to protect the health and safety of individuals under the care of an HHA and to promote the effective and efficient use of Medicare funds. In accordance with Sections 1861(o), 1864 and 1891(c) of the Act, SAs conduct surveys of HHAs to determine whether they are complying with the CoPs.

HHAs must be surveyed via a standard survey at least every 36.9 months. This is not an average of 36.9 months; it is a maximum interval between surveys for any one particular HHA. The Medicare statute established the 36-month interval commensurate with the need to assure the delivery of quality home health services. Comprehensive State performance standards for compliance with the 36.9-month statutory requirement continue to apply.

2. Activation, De-activation, and CHOWs: Since January 1, 2010, a provider or supplier who does not submit any Medicare claims for 12 consecutive calendar months is subject to having its Medicare billing privileges deactivated. Deactivated agencies remain certified and must continue to be surveyed at least every 36.9 months. A standard survey is conducted and entered into the Automated Survey Processing Environment (ASPEN) system as a recertification survey with a note that this is an early recertification due to a request for reactivation of Medicare billing.

In addition to the requirements outlined under 42 CFR §489.18, if an HHA undergoes a CHOW within 36 months of the effective date of the provider's enrollment into Medicare, or subsequent asset sale, stock transfer or CHOW the provider agreement and Medicare billing privileges do not convey to the new owner. An initial survey will be required. The initial surveys will be considered Tier 4 of the survey priorities, and the HHA may utilize an approved AO for a deeming survey and follow existing procedures. It is the responsibility of the HHA to arrange the Medicare survey with the AO.

3. Surveyor Qualifications: Before any State or Federal surveyor may serve on a survey team (except as a trainee) for an HHA survey, he/she must attend the Basic HHA course.

NON-DEEMED HOME HEALTH AGENCIES			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **36.9-Month Max. Interval**: No more than 36.9 months elapses between completed surveys for any particular agency. • **Complaints triaged as possible Immediate Jeopardy.**	• Substantial Allegation (Complaint) Investigations – non-IJ: complaints prioritized as non-IJ high must be initiated within 45 days.		• **24.9 Month Avg:** Add'l surveys (beyond Tiers 1-3) done based on State judgment regarding HHAs more at risk of providing poor care so all HHAs are surveyed on avg. every 24.9 mos (all Tier IV surveys divided by total agencies ≤ 24.9 mos.in order to optimize unpredictability of surveys) • Initial surveys of HHA's following a CHOW where the provider agreement and billing privileges do not convey to the new owner. • Initial surveys.

C. Deemed Home Health Agencies

States will continue to be responsible for conducting two types of validation surveys for deemed HHAs: substantial allegation complaint surveys and representative sample validation surveys in FY2018. **Each SA should budget for one representative sample validation survey of its deemed HHAs from its standard allocation, unless it does not have any deemed HHAs located in its State.**

Depending on the AOs' actual survey schedules, there may be States with deemed HHAs for which no representative sample validation survey can be assigned within the FY. Each month a sample of scheduled AO surveys is selected for validation. We will inform the SAs promptly if they have been assigned a validation survey. Some States with larger numbers of deemed HHAs have been designated to perform more of these representative sample validation surveys once they have completed the one survey provided for in the standard allocation. For these States, a supplemental budget allocation will be made for surveys completed beyond the first representative sample validation survey.

DEEMED HOME HEALTH AGENCIES			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **Representative Sample Validation Surveys:** States annually survey a representative sample of deemed HHAs specified by CMS during the year. At least 1 deemed HHA is surveyed in each State, unless the State has no deemed HHAs, or unless CMS makes no assignment, based on AO survey schedules. *(Each State surveys 1 HHA within its standard budget allocation; additional surveys are budgeted for most 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 – non-IJ:** complaints prioritized as non-IJ high must be initiated within 45 days of RO authorization		

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

States have a regulatory obligation to conduct annual surveys of ICFs/IID. These facilities must be surveyed, on average, every 12.9 months with a maximum 15.9 month survey interval (please see S&C: 12-29-ALL). The comprehensive State performance standards monitor to what extent States are recertifying ICFs/IID on a timely basis.

The President's budget requests Federal funds for the Medicaid portion of LTC survey & certification activities, including recertification surveys and related revisits of ICFs/IID once per year. States are reminded to secure the necessary Medicaid State share for funding those LTC survey and certification activities attributable to Medicaid facilities and dually-certified facilities.

Before any State or Federal surveyor may serve on a survey team (except as a trainee) for an ICF/IID survey, he/she must attend the Basic ICF/IID surveyor training course (reference: see S&C-03-05, which clarified the intent of Section 4009C of the SOM).

ICFs/IID – Priority			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **15.9 Month Max. Interval:** No more than 15.9 months elapses between completed surveys for any particular ICF/IID. 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. • Complaints triaged at an Immediate Jeopardy (IJ) level	• **Complaints triaged at a non-IJ level**.	Initial Surveys	

E. Deemed Hospitals – Representative Sample Validation Surveys

The following represents CMS policy:

1. Each State will conduct representative sample validation surveys on approximately 1% of deemed hospitals (or at least 1 in each State, whichever is greater) as part of the State's baseline budget. CMS will select the sample each month from AO survey schedules. The projected number of surveys for each State is shown in Appendix 3. Each State should budget for the number of validation surveys indicated under the base budget in Appendix 3 from its standard allocation.

2. Selected States will conduct representative sample validation surveys on a second targeted sample (an additional 1.0-1.5% nationally). The expected number of supplemental hospital surveys for each State is shown in Appendix 3. We will notify each affected State as supplemental validation surveys are assigned for this "second sample %." Appendix 3 indicates those States that are likely to be assigned additional hospital validation surveys and the projected additional numbers.

F. The Joint Commission Deemed Psychiatric Hospitals-Representative Sample Validation Surveys

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 regular hospital CoPs only, since no other AO has yet been approved for the two special conditions. There are only a handful of such 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 regular hospital CoPs only.)**

CMS recognizes that many States do not maintain the psychiatric expertise necessary to assess compliance with the two special psychiatric provisions. As a result, 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.

G. Deemed CAHs – Representative Sample Validation Surveys

Each State should budget for sample validation surveys of 5% of its deemed CAHs (or at least one survey, whichever is greater) unless it does not have any deemed CAHs located in its State. States with very small numbers of deemed CAHs may not have any that are surveyed by an AO during the FY, but we will not be able to determine this fact until well into the fiscal year**.** Nonetheless, all States should tentatively plan for at least one sample validation survey.

H. Complaints in Deemed Hospitals and CAHs – Substantial Allegation Validation Surveys

Substantial allegation validation surveys (i.e., complaint investigations of deemed providers and suppliers, including hospitals and CAHs), are conducted only when authorized by CMS in accordance with longstanding statutory requirements and CMS regulations. Complaints triaged as IJ and authorized by the RO for survey as a possible IJ represent a Tier 1 priority. In addition, if the RO requires a full standard survey of a deemed hospital or CAH subsequent to a complaint investigation that resulted in citation of condition-level deficiencies, the full standard survey is also prioritized as Tier 1.

Complaints triaged as non-IJ high and authorized for investigation by the RO are a Tier 2 priority.

Complaints triaged as non-IJ medium or low are not authorized for a Federal survey by the SA. For complainants that are not authorized for a Federal survey, States must provide information to the complainant indicating the facility remains under the jurisdiction of an AO and that the complainant has the option to file a complaint directly with the appropriate AO. Contact information for each AO can be found in Memorandum AdminInfo 13-25.02. Accrediting Organizations Complaint Contacts Attachment.

DEEMED HOSPITALS AND CAHS – VALIDATION SURVEYS			
Tier 1	**Tier 2**	**3**	**4**
• **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 accrediting organizations, with CMS identifying the hospitals to be surveyed in each State (*"first 1%" sample funded via the State's regular budget). (See Appendix 3)*	**Substantial Allegation Validation (Complaint) Investigations** that are prioritized as non-IJ high must be initiated within 45 days of RO authorization.		

DEEMED HOSPITALS AND CAHS – VALIDATION SURVEYS			
Tier 1	**Tier 2**	**3**	**4**
• **Targeted Second (Additional) Representative Sample Validation Surveys:** Some States conduct additional 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 (5% of surveys conducted by AOs, or at least 1 survey, 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 reported to the RO are to be initiated within the applicable SOM timeframe and are Tier 1 priority. • **EMTALA Complaint Surveys:** Only when authorized by the RO. All EMTALA complaint 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 a complaint investigation that finds CoPs out of compliance for deemed hospitals and CAHs, and are a Tier 1 priority • **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 schedule 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.)*	**Substantial Allegation Validation (Complaint) Investigations** that are prioritized as non-IJ high must be initiated within 45 days of RO authorization.		

I. Non-Deemed Hospitals, Psychiatric Hospitals and CAHs

CMS policy is to achieve a national recertification coverage level that ultimately achieves 33% coverage each year for non-deemed hospitals, psychiatric hospitals and CAHs. To accommodate resource limitations, we have spread that expectation across multiple tiers rather than just one tier.

The CMS coverage policy applies to all types of non-deemed hospitals, including short-term acute care, children's, long term care, and rehabilitation hospitals, as well as to non-deemed psychiatric hospitals and CAHs.

The priorities apply to recertification surveys, associated revisits and initial surveys when the State expects to complete all of its higher tier work.

1. 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 is only a handful of hospitals that remain partially deemed and partially under State jurisdiction.

In addition, roughly 11% of all psychiatric hospitals are completely non-deemed. CMS recognizes that many States do not maintain the expertise necessary to assess compliance with the two special conditions. As a result, CMS will continue to maintain (under contract) a panel of psychiatric consultant surveyors to conduct upon request from the CMS Regional Office, recertification and complaint surveys of the two special conditions in partially deemed psychiatric hospitals and initial, recertification and complaint surveys of these two conditions in non-deemed psychiatric hospitals.

When deficiencies are identified by CMS contract surveyors during a recertification or complaint survey of the two psychiatric conditions, CMS Central Office will authorize up to two revisits by the contract surveyors if recommended by the CMS Regional Office. A third revisit may be conducted only if recommended by the CMS Regional Office and will be conducted either by the State or the RO survey staff.

CMS has begun the development of a web-based basic training course to assist those State and Regional surveyors who either have not surveyed psychiatric hospitals for an extended period of time or have been unable to attend an on-site training course.

For those States that have the requisite professional resources available and wish to assume the responsibility for the survey of the special conditions for partially deemed or non-deemed psychiatric hospitals in their State, CMS may make contract staff available upon request for either on-site training or a partnership survey. In order to conduct these surveys, State surveyors must have experience in the psychiatric hospital setting (psychiatric nurse, psychiatrist or psychologist). If a State assumes responsibility for the two special conditions for non-deemed psychiatric hospitals in their State, it must adhere to the average time interval between surveys (3 years) as stated in this document and survey approximately 33% of non-deemed psychiatric hospitals each year. A budget adjustment will be made for initial and recertification surveys conducted by the State Agency.

2. 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.

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..

3. Inpatient Prospective Payment System (IPPS) - Excluded Hospitals/Units

3.1. Sampling Surveys for Existing IPPS-Excluded Hospitals/Units: States will also be responsible for conducting an onsite re-verification of IPPS exclusion criteria for at least 5% (but not less than 2 hospitals/units) of rehabilitation hospitals and rehabilitation and psychiatric units within short-term acute care hospitals, when those units have already qualified for IPPS exclusion. This number can be 5% of the combined total of IPPS-excluded facilities/units, rather than 5% of each type, so long as the State varies the proportion from each type each year so that, over time, all types are addressed. These surveys must be scheduled at least 90 days prior to the beginning of the hospital cost reporting period.

3.2. IPPS-Exclusion Applications: Based on guidance provided via S&C-08-03 (dated November 5, 2007), the requirement for States to conduct first time onsite verification surveys of all new rehabilitation hospitals and or all new rehabilitation or psychiatric units of short term acute care hospitals seeking exclusion from IPPS will continue to be waived. Such hospitals newly seeking IPPS exclusion will instead be required to self-attest to their compliance with the exclusion criteria. These first-time attestations must be processed prior to the beginning of the hospital cost reporting period. Once approved, the newly-approved hospitals/units are placed by the State into the pool of existing IPPS-excluded hospitals/units from which the annual 5% onsite verification sample is drawn.

We continue to suspend the requirement that deemed IPPS-excluded rehabilitation hospitals/excluded units be validated for compliance with exclusion criteria at least once every six years. The suspension will continue unless the IPPS requirements are codified in the Conditions of Participation.

NOTE: *For non-deemed hospitals, IPPS-exclusion verifications or re-verifications should always be conducted concurrently when a regular hospital survey is being conducted, as long as the cost-reporting period timeframes are observed.*

NON-DEEMED HOSPITALS AND CAHS			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
Complaint Surveys: Complaint allegations prioritized as IJs and RO-authorized EMTALA and restraint/seclusion death incident surveys, initiated and completed within the applicable SOM timeframe.	• **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 the 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 Tier 3 + 4 priorities. Targeted sample requirements do not apply to States with fewer than 7 non-deemed hospitals, psychiatric hospitals CAHs.	• **Recerts: 4.0-Year Max Interval:** No more than 4.0 years elapse between surveys for any particular non-deemed hospital or CAH • **Recerts of Psych Hospitals:** 3.0 year average recertification surveys of non-deemed psychiatric hospitals only. • **New IPPS**: 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 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 (1). These surveys verify that the hospital/unit continues to meet IPPS exclusion criteria.	• **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 or 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.

J. Solid Organ Transplant Programs

On March 30, 2007, the final regulation establishing new Conditions of Participation for solid organ transplant programs was published in the Federal Register. This regulation was effective June 28, 2007. The CMS policy for transplant program recertification survey interval will be 5 years maximum to be consistent with the hospital survey interval. CMS Central Office also conducts periodic review of individual transplant program outcomes (for patient and graft survival one year after transplant), and recommends enforcement action to the Regional Office when there is a condition level deficiency related to outcomes.

Changes to Transplant Program S&C Activities:

All transplant program initials, re-approvals, and revisit surveys will be performed by the National Contractor during all of FY 2018 and FY 2019 October through December 2018. Beginning in January, 2019 SAs will resume all survey activities in transplant programs.

SAs have already resumed investigation of all complaints received against transplant programs.

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

Transplant Centers			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **Complaint – IJ:** Investigation of complaint allegations triaged as IJ.	• **Re-approval Surveys (performed by national contractor in FY2018):** For transplant programs that do not meet the data submission, clinical experience or outcomes requirements. • **Complaint Investigations** o Investigation of complaints not categorized as potential IJ.		• **Initials:** Any initial surveys of programs

K. End Stage Renal Disease (ESRD) Facilities

Notable aspects of the ESRD survey responsibilities include:

- **Information Responsibilities**: **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.

Overall Responsibilities: States are responsible for conducting initial, recertification, complaint and revisit surveys of ESRD facilities.

Survey Priorities

- **Tier 1:**
  Complaint investigations triaged as immediate jeopardy.

  Targeted Surveys: Survey 10% of ESRD facilities using the CMS-generated, rank-ordered Outcomes Lists with frequency rates. The Outcomes List identifies the poorest ranked 20% of the facilities in each State based on a composite score of outcome indicators. States are responsible for selecting half of the 20% facilities from their respective Outcomes List to determine the final 10% targeted sample. The Outcomes List is a confidential list for use only within the specific State survey agency for determining survey priorities. This list is distributed to each State through a secure Web site at: https://www.dialysisdata.org.

- **Tier 2:**
  3.5 Year Max Interval: The Tier 3 priority is an interval measure identifying a maximum period of 3.5 years (42.9 months) between surveys for any one particular facility. Complaint investigations triaged as non-immediate jeopardy.

Tier 3: ***3.0 Year Average:*** Conduct additional surveys (beyond Tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of 3.0 years or less.

- **Tier 4: Initial Surveys**

Requirements for ESRD Surveyors:

- Prior to inclusion on an ESRD survey team (except as an observer or trainee/orientee), the surveyor must complete the following requirements:
    - Visit an ESRD facility to observe the environment and processes involved in dialysis care;
    - Successfully complete the CMS ESRD Basic Surveyor Training Course.

ESRD FACILITIES			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
Complaint-IJ Investigation of complaint allegations triaged as IJ • **Targeted Sample (10%):** States survey a 10% targeted sample of ESRD facilities, selected from a CMS list that identifies those facilities most at risk of providing poor care. Some of the targeted surveys may qualify to count toward the Tiers 3 and 4 priorities. ***If the proposed legislation for deemed status for ESRD becomes final initial ESRD surveys must be completed within 90 days.**	***3.5 Year Max Interval:*** The Tier 3 priority is an interval measure identifying a maximum period of 3.5 years (42.9 months) between surveys for any one particular facility. **Complaint Investigation:** Complaints not categorized as potential IJ	• ***3.0 Year Average****:* Conduct additional surveys (beyond Tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of 3.0 years or less.	

L. Psychiatric Residential Treatment Facilities (PRTFs)

The regulation defines a PRTF as "a facility other than a hospital, that provides psychiatric services as described in 42 CFR, Section 441, Subpart D, to individuals under age 21, in an inpatient setting." The rule also establishes one Condition of Participation (CoP), at 42 CFR Subpart G, for the use of restraint and seclusion that PRTFs must meet in order to continue to provide Medicaid inpatient psychiatric services to patients under 21. The CoP requires that restraint or seclusion be used only during emergency safety situations, and requires each facility that provides services to individuals under 21 under a Medicaid provider agreement, to attest in writing to the State Medicaid Agency, that the facility is in compliance with the requirements set forth in the rule.

PRTF general requirements, at 42 CFR Subpart D, address the treatment team and person-centered active treatment plan; and requirements to protect the residents against the improper use of restraint or seclusion that include, but are not limited to: parental/guardian notification when a restraint or seclusion is used; reporting of deaths and serious occurrences; requirements for licensed practitioner's order for the use of restraint or seclusion; requirements for staff education and training on the use of emergency safety intervention; and requirements for monitoring a resident during and immediately after the use of restraint or seclusion.

States should conduct surveys of 20% of the PRTFs in their state annually to ensure that PRTF recertification surveys are conducted at least every five years. Note: State survey costs (Federal funds) for this activity are provided through mandatory Medicaid funds. States should enter all PRTF attestations received from the State Medicaid Agency into the ASPEN system upon receipt.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES *for* CHILDREN			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
5-Year <u>Interval</u>: **Recertification** visits (20% of PRTFs.)			

M. Ambulatory Surgical Centers (ASCs)

In FY2018, States must continue to survey at least 25% of the non-deemed ASCs in each State (subject to minor adjustments). In addition to the Tier 3 requirements of a 6.0-year survey interval, we emphasize the following:

1. Deemed ASCs **-** SAs will perform representative sample validation surveys on a 3% - 10% CMS-specified sample of deemed ASCs, nationally. Appendix 3 provides a projection of the ASC validation workload for each SA. SAs will receive a supplemental allocation for these validation surveys. The ASCs to be surveyed will be selected by CMS based on the AOs' survey schedule of deemed ASCs that are surveyed in this FY. SA representative sample validation surveys must be completed within 60 days of completion of the AO survey.

2. Tier 2 Targeted 25% Sample Surveys for Non-Deemed ASCs – States, with greater than 7 ASCs, will perform surveys totaling 25% of all non-deemed ASCs, or at least 1, <u>whichever is greater, unless all non-deemed ASCs were surveyed in the prior FY</u>. All States that have non-deemed ASCs are required to survey at least 25% of their non-deemed ASCs using the enhanced survey process. States that have only **7** or fewer non-deemed ASCs <u>must survey at least 1 facility.</u> States select ASCs for survey, focusing on ASCs that have not been surveyed in more than 4 years and/or ASCs that represent a greater risk of having quality problems, based on their recent compliance history and any other important factors known to the State.

3. Infection Control: States must continue to use the Infection Control Surveyor Worksheet for each survey of an ASC to ensure that all areas listed on the worksheet are assessed. CMS is not

collecting worksheets in FY 2018. Random sample selection and worksheet collection is targeted to resume in FY 2019.

NOTE: *In contrast to other Tier 2 targeted surveys, the Tier 2 targeted sample requirement for ASCs does apply to a State that has fewer than 7 ASCs.*

Ambulatory Surgical Centers (ASCs)			
Tier 1	**Tier 2**	**Tier 3**	**T-4**
Representative Sample Validation Surveys-Deemed ASCs: States conduct validation surveys of 3%-10% of deemed ASCs, assigned by CMS based on AO survey schedules.	**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 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 ASCs must survey at least 1 ASC unless all non-deemed ASCs were surveyed within the prior two yearsto ensure all non-deemed ASCs are surveyed within the required 4 year period,.	**6.0-Year Interval**: Additional surveys are done to ensure that no more than 6.0 years elapses between surveys for any one particular non-deemed ASC.	Initial Surveys

N. Recertification Surveys of All Other Facility Types

CMS is targeting national annual recertification coverage priorities for the other non-LTC providers, including:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Rehabilitation agency providers;
- Portable X-ray suppliers; and
- Rural Health Clinics (RHCs).

1. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Due to budgetary constraints, CORF applicants may be unable to receive initial surveys. However, existing CORFs may request to open off-site locations for the provision of therapy services. This may create an additional work load for the SAs as they must evaluate the information provided by the CORFs to determine whether or not to recommend approval for those offsite locations to the ROs. The RO retains discretion on whether to conduct a survey 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.

2. Rehabilitation Agencies (Outpatient Physical Therapy (OPT) 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. In FY2006 CMS began issuing identifiers to rehabilitation agency extension locations to ensure that CMS and SAs were aware of the existence of such locations. It is important for the SAs to verify that the rehabilitation agencies with extension locations are providing oversight (administrative and supervisory) for all their locations.

Surveys of new OPTs are a Tier 4 priority, since these facilities have a deeming option.

3. Portable X-Ray

Portable X-ray suppliers may request additional locations. SOM guidance for approval of additional practice locations is expected in FY 2018. There are also issues with Portable X-Ray suppliers providing services across State lines and not always reporting additional practice locations to the MAC. DCCP is working with Provider Enrollment to clarify rules on Portable X-Ray enrollment and will provide clarification as to whether each supplier must be certified in every State in which they provide services.

4. 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.

CORFs, Rehabilitation Agency Providers, Portable X-Ray, Rural Health Clinics			
T-1	**Tier 2**	**Tier 3**	**Tier 4**
Complaint investigations triaged as possible immediate jeopardy.	• **5% Targeted Surveys:** Each year, the State surveys 5% of CORFs, non-deemed Rural Health Clinics, and Rehabilitation Agencies and non-deemed Portable X-rays (or at least 1 of each type, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some targeted surveys may qualify to count toward the Tier 3 and 4 priorities. • **Complaint investigations prioritized as non-IJ high:** to be initiated within 45 days (for deemed OPTs and RHCs, within 45 days of RO authorization)**.**	• **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. **Complaint investigations of non-deemed RHCs, all CORFs, Rehabilitation Agency Providers, Portable X-ray:** prioritized as non-IJ medium.	• **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). • Initial surveys of Rehabilitation Agencies • Initial surveys of RHCs

5. 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.

6. Hospices

The IMPACT Act of 2014 requires that each hospice be surveyed no less frequently than every 36 months. Special funds have been appropriated by Congress to increase the frequency of hospice surveys. The IMPACT Act funds must be accounted for separately. States should use their IMPACT funds first, and then use the Medicare S&C funds for expenses that exceed their IMPACT fund allocation.

The SA is expected to have a system in place for nursing home surveyors to report to the SA those nursing facilities which are providing hospice services to residents and any concerns they have about the provision of hospice services in a specific facility. SAs are expected to follow-up and initiate enforcement action against a hospice when they identify hospice non-compliance issues associated with care to nursing home residents who have elected the hospice benefit.

Before any State or Federal surveyor may serve on a survey team (except as a trainee) for a hospice survey, he/she must attend the Basic Hospice course.

NON-DEEMED HOSPICES			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• 36-Month Max. Interval: No more than 36 months elapses between completed surveys for any particular agency. Use the separately-tracked IMPACT funds first. • Substantial Allegation (Complaint) Investigations – IJ	Substantial Allegation (Complaint) Investigations – non-IJ.		Initial Surveys

Each hospice must be surveyed on a 36 month survey interval, such that by April, 2018 all hospices will have been surveyed in the prior 36 months.

7. Deemed Hospices

State agencies will perform representative sample validation surveys of hospices selected by CMS, based on the AOs survey schedules of deemed hospices in FY 2018. A limited number of States with deemed Hospices will be required to perform these validation surveys, for which a supplemental allocation will be provided.

DEEMED HOSPICES			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
• **Representative Sample Validation Surveys**: States conduct validation surveys of deemed hospices, selected by CMS, depending on the AOs' survey schedules for FY2018. *(Budgeted separately via supplemental allocation)* • **Complaint investigations prioritized as immediate jeopardy:** only with RO authorization; survey to be initiated within 2 days of RO authorization.	• **Complaint investigations prioritized as non-IJ high:** only with RO authorization; survey to be initiated within 45 days of RO authorization		

7. Swing Beds

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

- A complaint investigation of the hospital or CAH Swing bed is being conducted;
- 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 AO must conduct the survey.

States must include swing bed recertification during hospital and CAH recertification surveys. Hospitals newly approved for swing beds are transitioned to SNF/PPS for swing bed payment starting on the first day of the hospital's first cost reporting period, following approval of the swing beds. States must provide technical assistance and training to hospitals on both clinical and systems aspects of swing bed assessment submissions. See Section 5.C for the scheduling of surveys for non-deemed hospitals or CAHs that wish to add swing beds as a new service.

8. Community Mental Health Centers (CMHC)

The survey interval for the CMHCs is every five years and fall into a Tier 3 workload. CMS provides national training annually for the survey of the CMHCs. The initial surveys of the CMHCs under the regulations will be implemented over a 4-5 year period, beginning after the effective date above, as a Tier 3 workload. Targeted surveys may be assigned to achieve faster application of the CoPs, (faster than 20% of the CMHCs completed each year) but we will provide a 3-6 month advance notice in such a case.

CMHCs			
Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
5.0 Year survey interval. Complaints triaged as IJ	• Complaints investigations triaged as non-IJ.	Initial surveys	

O. Complaint and Facility Self-Reported Incident Investigations

We place continued high priority on complaint investigations. The budget contains funds for conducting complaint investigations consistent with expectations contained in Federal regulation and the SOM, including the use of the ACTS application and the timely input of information.

In situations where a complaint or incident is appropriately triaged as suggesting an immediate jeopardy may be present, the SA is required to investigate within two working days of receipt of the information except:

1) ***RO Authorization for Deemed Provider/Supplier-Potential IJs:*** For all Medicare deemed providers/suppliers complaint and incident intakes, the SA investigates a complaint within two working days of receipt from the RO authorization via ACTS of the Form CMS-2802, Request for Validation of Accreditation Survey, if the RO finds that the complaint involves potential immediate jeopardy to patient health and safety;
2) ***EMTALA:*** For hospital and CAH EMTALA complaints, the investigation is completed within five working days after receipt from the RO authorization date in ACTS;
3) ***Hospital (or CAH DPU) Restraint/Seclusion (R/S):*** For restraint/seclusion death reports from hospitals or CAH distinct part units, the SA completes the investigation within five working days of receipt of authorization from the RO via ACTS.
4) ***Hospice R/S Deaths:*** For restraint/seclusion death reports of *unexpected* deaths of hospice patients receiving inpatient care by a hospice that provides care directly in its own facility, the State Agency will complete the investigation within five working days of receipt of authorization from the RO. (Note: Examples of unexpected deaths may be those which occur while the patient is in restraints or seclusion. If a patient has an unexpected death that occurs while in restraints or seclusion, or an unexpected death occurs within 24 hours after discontinuation of restraints or seclusion the death must be reported to CMS RO. See Hospice death reporting requirements at 418.110 (o). An unexpected death could be anything not related to the terminal illness. In this instance most likely an injury/trauma. Additional examples may include, medication error or if medication is used as a means of restraint.)

All fires in Medicare/Medicaid-certified healthcare facilities that result in serious injury or death must be entered into ACTS as a complaint or self-reported incident. In these cases, the fire is to be triaged as a possible IJ for investigation.

For nursing homes only, if the SA triages a complaint as non-IJ high, i.e., the complaint suggests that actual harm of significant consequence may be present, the investigation is to be initiated within 10 working days of its receipt. The initiation of these types of investigations is generally defined as the SA beginning an onsite survey.

When a nursing home surveyor identifies a resident who is receiving poor quality care from another provider type (e.g., Medicare hospice providing care in a nursing home, or an ESRD supplier providing dialysis supplies or service in a nursing home) a complaint should be conveyed to the appropriate survey component to investigate. Likewise, a hospice surveyor who

identifies a resident of a nursing home who is receiving poor care should refer the situation to the appropriate survey component to investigate care being provided in the nursing home.

For substantial allegations of noncompliance for non-EMTALA and non-immediate jeopardy complaints for providers/suppliers with deemed status, an onsite survey is required within 45 calendar days after authorization by the RO. The RO may require the SA to conduct a full survey after a complaint survey that identifies condition-level noncompliance in a deemed provider/supplier, consistent with the criteria discussed in SOM Section 5110. When a full survey is authorized, it represents a Tier 1 priority.

All other Medicare and Medicaid complaint investigations must be conducted promptly, according to the minimum timeframes specified in the SOM, Section 5075.9. If the intake information received requires an onsite survey and the allegation may involve both Federal and State licensure requirements, at a minimum, an onsite survey is completed to investigate the Federal requirements.

For ICFs/IID, after each complaint investigation in which there are CoPs that are substantiated as being out of compliance, extended surveys are required. If the complaint findings require a full survey it would become a Tier 1 priority

For non-deemed HHAs in which a complaint investigation finds a CoP to be out of compliance, an extended survey must be conducted. These are Tier 1 priorities.

For all other non-deemed provider types in which complaint investigations find that CoPs are out of compliance, surveys should be expanded as necessary in accordance with the SOM. These are Tier 2 priorities.

To support management operations, the SA must enter required data elements in the ACTS in a timely manner, as specified by CMS (see Chapter 5 of the SOM).

The level of Federal matching payments for Medicaid complaint survey activity will be sufficient to meet all CMS expectations. States must secure the necessary Medicaid State share for funding those complaint investigation activities attributable to Medicaid facilities and/or dually-certified facilities.

P. Miscellaneous Tier 4 Workload

Inpatient Rehabilitation Facilities Prospective Payment System (IRF-PPS)

CMS developed a patient-centered assessment instrument (IRF-PAI) to assess short stay patients for inpatient rehabilitation facilities to support the Prospective Payment System for reimbursement. IRF-PAI data is collected on all Medicare patients who receive inpatient services from an inpatient rehabilitation facility (free standing rehabilitation hospital or rehabilitation unit in an acute care hospital) certified for Medicare payments. SAs will have access to this information through the CMS system for monitoring quality of care issues. The system is Web-based and there will be a plug-in that must be downloaded to the workstation. The States are not responsible for training or technical assistance to providers.

SECTION FIVE: CMS PRIORITIES for INITIAL SURVEYS of PROVIDERS and SUPPLIERS NEWLY ENROLLING in MEDICARE, CAH CONVERSIONS, or for RELOCATIONS OF EXISTING PROVIDERS/SUPPLIERS

Below we summarize CMS' long-standing policy for Medicare initial surveys. Those long-standing policies were re-affirmed and further clarified via S&C-08-03 (November 5, 2007) and 08-13 (March 7, 2008). We also clarify special provisions that apply in the case of conversions, access-to-care issues, reinstatement of terminated providers and distinct part units (see parts D-F of this section for details).

A. Tier 2 Priority for Relocation Surveys

Relocation surveys of existing providers and suppliers are not initial surveys, but the RO may require a survey of a new main campus, remote location or satellite, as applicable, of an existing hospital or CAH, or of the parent of an HHA, or of any other provider or supplier if in the RO's judgment a survey is needed. If a survey is required, it is a Tier 2 priority. This does not extend to relocation of HHA branches, OPT extensions, hospice multiple locations (which are Tier 3 priorities, described below). Generally the RO will not require a relocation survey of an off-site provider-based department of a non-deemed hospital or CAH unless it provides surgical services. Relocation surveys of any providers or suppliers displaced during the period of a public health emergency declared by the Secretary may be treated as a Tier 2 priority, at State discretion.

B. Tier 3 Priority for Initial or Relocation Surveys

Most surveys of providers or suppliers newly seeking Medicare participation are prioritized as Tier 4. However, the provider/supplier types below are surveyed as a Tier 3 priority. States may prioritize within Tier 3 to address their unique circumstances and general availability of any one particular provider type.

1. **Nursing Facilities or Hospitals-Medicaid-Only:** Costs for initial surveys or hospitals are funded through Medicaid without Medicare expenses. They are not subject to CMS' initials policy of Medicare surveys and may be surveyed at State priority discretion. See part D below with respect to potential conversions of Medicaid-certified facilities to dually-certified (Medicare and Medicaid) facilities.

2. **Relocation of Branches and Extensions:** Relocation of non-deemed HHA branches, OPT extensions, hospice multiple locations are Tier 3 priorities, if a survey is required.

SA directors may consider a variety of factors in setting priorities for initial surveys within Tier 3 and Tier 4. Such factors may include unprecedented State growth in specific provider type applicants without commensurate need or corroborated concerns in your State related to Medicare or Medicaid program integrity.[2]

2 On August 15, 2001, CMS issued S&C-01-22 which outlined new procedures for issuance of the CMS-855A and B. Under these procedures, Fiscal Intermediaries or Carriers are responsible for distributing, reviewing and recommending approval of CMS-855s. These procedures were designed to streamline the provider enrollment process and minimize significant time lapses between application and certification.

C. Tier 4 Priorities for Initial Surveys

1. **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. 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 addition of swing bed services)
    - Home Health Agencies
    - Hospices
    - Hospitals (including addition of swing bed services)
    - Rehabilitation Agencies (OPT and SLP)
    - Rural Health Clinics
    - Psychiatric Hospitals

    States may establish priorities within Tier 4, except for certain provider or supplier types affected by the high-impact fraud area provided in C. 3 below.

2. **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

Existing non-deemed hospitals and CAHs seeking approval for swing-bed services also are a Tier 4.

D. Conversions of Previously Certified Providers

Conversion of an existing provider under the same provider agreement is not considered an initial application and the priority policy for initial surveys does not apply. The provider/supplier types in this circumstance are:

- ***Hospital - CAH:*** 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, if the facility is currently non-deemed, at State option may be done as Tier 2, 3, or 4. Deemed hospitals seeking to convert to CAH or vice versa status remain a Tier 4 priority.

- An AO may conduct a conversion survey for a deemed hospital seeking to convert to CAH or vice versa status. However, prior to conducting a conversion survey for a deemed hospital seeking to convert to CAH status, the AO must consult with the RO to confirm that the hospital meets all CAH distance and location requirements.

E. Priority Exception Requests

1. ***Access to Care Reasons:*** Providers or suppliers may apply to CMS via the SA requesting consideration for an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for beneficiaries served by the provider or supplier. The SA may choose whether to make a recommendation to CMS before forwarding the request to the RO.

   There is no special form required to make a priority exception request. The burden is on the applicant to provide data and other evidence that effectively establishes the probability of serious, adverse beneficiary healthcare access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's request. We expect that such exceptions will be infrequent.

2. ***Voluntary Termination: Acquisition of a Provider/Supplier by a new Owner who Rejects Assignment of Provider/Supplier Agreement:*** When an acquisition occurs, CMS presumes that the new owner accepts assignment of the previous owner's provider agreement or supplier approval. However, new owners may reject assignment of the agreement/approval. In such cases the transaction is no longer considered a CHOW for Medicare purposes and the seller's agreement with Medicare is terminated as a voluntary termination. The new owner is treated as an initial applicant and there is a break in Medicare's payment for services between the date of termination of the old agreement/approval and the effective date of the new owner's agreement/approval. We also refer States to S&C-13-60-ALL and SOM 2003B, issued via S&C 14-24, 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 workloads, nor of their other initial certification survey workload.

F. Initial Applications Based on Deemed Status under a CMS-approved Accreditation Program

States continue to collect and forward to the RO the certification packets for facilities wishing to participate in Medicare through deemed status based on a CMS-approved Medicare accreditation program. The packets include AO letters indicating accreditation effective dates and recommendations of deemed status, attestation documents for those hospitals seeking first-time IPPS exclusion, and any other required documentation. The RO will electronically forward to the State for inclusion in the certification packet documentation received from the AO that is recommending deemed status; the facility applicant may also supply the State with this documentation.

G. Special Provisions for Compliance with IPPS-Exclusion Requirements

With respect to rehabilitation hospitals and short-term acute care hospitals with excluded rehabilitation or psychiatric units, please note the following policy refinements:

IPPS-Excluded Rehabilitation Hospitals and IPPS-excluded Rehabilitation or Psychiatric Units ***of a Hospital:*** As noted in part B, AOs do not have authority to verify a Rehabilitation hospital's or a hospital excluded unit's compliance with the IPPS exclusion criteria at 42 CFR 412. Currently, annual re-verification of IPPS-exclusion for such excluded hospitals or units in already-certified hospitals is handled by provider self-attestation.

We are continuing the suspension of the requirement for an onsite IPPS-exclusion survey of all rehabilitation hospitals and short-term acute care hospitals with units for which they are seeking first-time IPPS-exclusion (SOM Section 3100 - 3108B); except for providers whose IPPS exclusion has previously been removed. See number 2 below for discussion of providers that lose exclusion status. Instead, such providers will be required to submit an attestation and completed Form CMS-437, CMS-437A, or CMS-437B, whichever is applicable, indicating that all CMS exclusion requirements are met. Note that these annual attestation procedures apply to all rehabilitation hospitals and all short-term acute care hospital units that are IPPS-excluded. Annual self-attestation to the exclusion criteria is no longer required for IPPS excluded rehabilitation hospitals and rehabilitation units. These may self-attest to the exclusion criteria once every three years (see S&C 13-04-IRF). IPPS excluded psychiatric units must continue to self-attest to the exclusion criteria annually.

In addition to the attestation and applicable Form CMS-437, rehabilitation hospitals and excluded rehabilitation units must also submit evidence of compliance with the medical director requirement. Psychiatric units must submit evidence of compliance with patient assessment and staffing requirements.

For initial certification, the following process is used for IPPS-exclusion attestation and documentation:

(a) The SA sends to the provider the attestation statement and appropriate CMS-437, along with the standard packet of certification forms and documents, within 10 working days of the earlier of the following two dates:
- Receipt of the provider's letter of intent to open for service and to seek IPPS exclusion; or
- Receipt of the Medicare Administrative Contractor's recommendation for approval of the CMS Form 855A application.

(b) In the case of rehabilitation hospitals or excluded rehabilitation units, the SA requests that the provider include with its attestation and other required materials documentation that permits verification that the provider has a qualified medical director who meets the regulatory standards at 42 CFR 412.29(f).

(c) In the case of excluded psychiatric units, the SA requests that the provider include with its attestation and other required materials the following information:

- Medical record protocols to permit verification that each patient receives a psychiatric evaluation within 60 hours of admission; that each patient has a comprehensive treatment plan; that progress notes are routinely recorded; and that each patient has discharge planning and a discharge summary.
- A description of the type and number of clinical staff, including a qualified medical director of inpatient psychiatric services and a qualified director of psychiatric nursing services, registered nurses, licensed practical nurses and mental health workers to provide care necessary under their patients' active treatment plans.

(d) The provider should return all requested materials to the SA no less than 90 days prior to the start of the facility's first or next cost reporting period, as applicable, in order for the RO to have sufficient time to make a determination to approve or deny the provider's IPPS exclusion status. The SA transmits the completed attestation statement and worksheet, along with its recommendation for re-verification, to the RO at least 60 days prior to the end of the hospital's cost reporting period for inclusion with other information necessary for determining exclusion from PPS.

(e) The SA will act promptly to review the completed packet and will forward it to the RO as soon as possible in order to permit a final certification determination prior to the start of the provider's cost reporting period.

2. ***Psychiatric Unit or Rehabilitation Hospital/Unit IPPS Exclusion Removal***: If CMS removes the IPPS exclusion status of a psychiatric unit, rehabilitation hospital, or unit, the hospital may subsequently seek excluded status again. In such cases, the hospital is required to operate for at least twelve months under the IPPS while continuing to provide the applicable psychiatric or rehabilitation services that comply with the exclusion requirements. In addition, rehabilitation hospitals and hospitals seeking exclusion for a rehabilitation unit are required to wait at least five calendar years before applying for excluded status again. [3] The facility must apply for IPPS exclusion status in the same way as a provider seeking first-time exclusion. **However, in the case of a hospital or unit that has had its IPPS-exclusion status removed, the requirement for <u>onsite</u> verification by the SA of compliance with the exclusion criteria for psychiatric or rehabilitation services will remain in force and such surveys will be a Tier 4 priority.**

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3 The twelve month requirement refers to the cost reporting period, and may be found at 42 CFR 412.25(c) and 412.25(f) for IPPS-excluded units of a hospital, and 42 CFR 412.23(h) and 412.23(i) for rehabilitation hospitals. The requirements for new rehabilitation hospitals or excluded units is found at 42 CFR 412.29(b) and (c)(1).

SECTION SIX: TRAINING PROGRAM

A. Survey and Certification Training Overview

1. Background

The Social Security Act obliges the Department of Health and Human Services (HHS) Secretary to "provide for the comprehensive training of State and Federal Surveyors in the conduct of standard and extended surveys…" and requires that "No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary." The SCG Training Division plans, manages, and executes instructional courses for approximately 8000 surveyors who survey 18 different types of providers and suppliers. This includes:

- Ambulatory Surgery Centers (ASC)
- Community Mental Health Centers (CMHC)
- Critical Access Hospitals (CAH)
- Dialysis (ESRD)
- Home Health Agencies
- Hospice
- Hospitals
- Laboratories
- Life Safety Code
- Nursing Homes
- Psychiatric Hospitals
- Psychiatric Residential Treatment Facilities
- Outpatient Rehabilitation
- Inpatient Rehabilitation
- Comprehensive Outpatient Rehabilitation Facilities
- Rural Health Clinics
- Religious Nonmedical Health Care Institutions
- Transplant

In 2016, the SCG Training Division held 17 webinars, 41 in-person trainings, and 37 online courses. This training resulted in 20,223 Certificates of Completion being issued to surveyors across the nation.

2. Mission and Goal

The CMS SCG Training Division provides leadership, oversight, development and delivery of all surveyor training to actively support the mission of HHS. Our mission is to protect the health and safety of all Americans and to provide essential human services - especially for those who are least able to help themselves. This mission is what guides and drives the design, development, and delivery of high-quality training to our surveyors.

The SCG Training Division, in partnership with both the CMS Regional Offices (RO) and State Survey Agencies (SA), provides training to ensure a knowledgeable and skilled survey

workforce throughout the United States. SA and RO Survey and Certification staff play an important role in protecting America's most vulnerable citizens. To support them in their role, the Training Division works directly with the SCG clinical divisions: Division of Acute Care Services, Division of Continuing Care Providers, Division of Nursing Homes, and the Division of Laboratory Services to design and develop training programs to assist SA and RO staff. Our courses provide a foundation of knowledge to help surveyors learn the survey process and CMS regulations. The training plan includes continuing education, prerequisite, basic, and advanced training.

The goal is to empower SAs and ROs with the knowledge and skills needed to survey a provider- or supplier-type in accordance with the CMS SCG conditions and standards. The SCG Training Division provides a full curriculum of training, from beginning to advanced concepts, including guidance on health care facility regulations and survey processes. See https://projects.aha-llc.com/cms/catalog/v10/index.html.

B. The Survey and Certification Training System

Integrated Surveyor Training Website (ISTW)

The ISTW provides a training platform to support surveyors with custom courseware training, archived webinars, videos, webcasts, and informational materials. Students can log on to ISTW to enroll in training, view courseware and training completed, and complete pre- and post-tests. The ISTW allows administrators to create and export statistical reports for analysis. It also allows courseware developers to review materials; and create and edit pre- and post-tests. All surveyor training on the ISTW can be accessed by the public as well.

C. State Responsibilities for Training and the Role of the State Training Coordinator (STC)

As defined in Exhibit 42 of the State Operations Manual (SOM), it is mandatory that each SA identify an STC and a backup person who will be available when needed for training purposes. The STC is the liaison with the CMS Regional Training Administrator (RTA) and the CMS Central Office (CO) regarding training concerns, logistics, etc. Overall, the STC or their backup is responsible for the supervision of precepting, mentoring, training, and assessment of their SA Surveyors.

1. Training Needs Assessment (TNA)

Since almost 100% of the training is now on-demand and online, there will no longer be an annual TNA exercise. Training needs should be communicated by the STCs directly to the SCG Training Division.

2. SA Participation in Workgroups

The SCG Training Division continues to develop various surveyor and certification training courses. To create job-focused training, we utilize frontline expertise from SA staff to assist with content review and input. Periodically, the SCG Training Division may request assistance with training development projects.

The SCG Training Division may ask the SA to nominate select SA Surveyors to participate in workgroups to Pilot or Beta Test as Subject Matter Experts (SMEs) on critical areas. These SMEs will help with development of new training content. We ask that $15,000 be placed in each SA budget for this purpose.

3. Training Requirements

In addition to the basic orientation and training that each SA must provide, the SA Surveyors must attend a sequence of training courses in their specialty survey area. The STC should utilize the SCG Training Division 1) Curriculum Maps and 2) Training

Schedules to understand the training requirements for each provider type and assure optimal training support for each surveyor **(See Attachments 1 and 2)**.

- Annually, the SCG Training Division publishes **Curriculum Maps** for each specialty. STCs and preceptors use the curriculum map to guide new surveyors training and field survey observations. These maps are located as an attachment to the MPD, inserted within the Preceptor Manual, and are also available on the ISTW. Staff may access the online Preceptor Manual by selecting the link to it on the ISTW at: https://surveyortraining.cms.hhs.gov.
- Monthly, the SCG Training Division publishes the SCG **Training Schedule** to announce all available courses by course-offering date.

4. SA Orientation

Newly hired surveyors and certification staff attend an SA-led orientation and training program and is the very first part of every surveyor training experience. During this time, new hires must successfully complete the CMS required prerequisites and begin their participation on Field Survey Observations with experienced preceptors. The purpose of these activities is to lay a foundation of knowledge regarding the CMS SCG mission, the survey process, and the regulations (conditions and standards). The number of survey operations required is specified by each specialty. These surveys must be a team survey in the designated survey discipline (e.g. Long Term Care (LTC) Standard Survey).

5. Required Prerequisites

SA's should schedule time near the beginning of the SA Orientation for their surveyors to take the two required prerequisite online courses: a) Basic Health Facility Surveyor: Introduction to Surveying, and b) Principles of Documentation.

a. Basic Health Facility Surveyor: Introduction to Surveying (3 versions)

This is the first required prerequisite course for all survey types. It lays a foundation of knowledge for surveyors. It introduces Federal and State Surveyors to the basic terminology and processes associated with surveying health care facilities. It also introduces surveyors to essential tools used throughout the survey process. This includes observation, investigation, and interview skills.

In addition, there are three different versions of this course, which include specific examples of documentation that relate to a particular provider type:

- Basic Health Facility Surveyor Course: Introduction to Surveying for Long Term Care
- Basic Health Facility Surveyor Course: Introduction to Surveying for Non-Long Term Care
- Basic Life Safety Code: The Survey Process

b. Principles of Documentation (4 versions)

This is the second required prerequisite course for all survey types. This course adds another layer to the foundation of knowledge for surveyors in creating formal documentation required for Federal surveys. It provides training to Federal and State Surveyors who will use the comprehensive principles of documentation when completing the Form CMS-2567 (Statement of Deficiencies). By the end of the course, surveyors and reviewers will be able to identify statements of compliance and noncompliance that adhere to the principles of documentation, and write statements adhering to the guidelines presented in this course. Again, there are separate versions of this course:

- Principles of Documentation for Long Term Care (POD-LTC)
- Principles of Documentation for Non-Long Term Care (POD-NLTC)
- Principles of Documentation for Life Safety Code (POD-LSC)
- Principles of Documentation for Clinical Laboratory Improvement Amendments (POD-CLIA)

The CMS training courses are designed to provide surveyors with the basic knowledge and skills needed to accomplish their role as a surveyor for a variety of survey processes in accordance with CMS Medicare regulations and policy. This CMS training is only the first part of the learning process for newly hired surveyors.

6. Field Survey Observations

SA field survey experience is an important part of the learning process for the new surveyor candidate. This post-course training is the second part of the learning process for new staff to gain proficiency during an SA field survey experience. After successfully completing a training course, it is recommended that the STC speak with the new surveyor and schedule opportunities to complete observations and hands-on experience, as well as mentoring with an experienced preceptor.

The post-course field survey experience (with an experienced mentor) ranges from approximately three to six months depending on the survey type, level of experience of the new surveyor candidate, and available opportunities for survey observations and experiences in the field. This experience provides opportunities for mentoring, reinforcement of knowledge, and demonstration of on-the-job skills learned during the training. It provides opportunities for guided experience and feedback, preparing the surveyor to be able to survey independently.

The field survey experience is strongly recommended for all newly-trained surveyors.

- The field survey experience is an SA-led training function.
- Field experiences should ideally occur after the learner completes all course requirements and successfully passes the post-tests with a score of 80% or higher.
- Given the unpredictable nature of initial or complaint surveys however, field experience may need to be concurrent with the course.

The SA should provide an experienced preceptor to progressively mentor the newly trained surveyor for at least two surveys following the completion of the online training component and prior to the new surveyor conducting a survey independently. Additional mentored surveys may be necessary before the preceptor is satisfied that the student is ready to perform survey tasks independently.

- This mentoring process should be documented in SA surveyor training records.

7. **Prerequisite Waivers**

The STC contacts the RTA to request waiver of one or more prerequisites listed above.

- STC submits information, documentation (e.g. vetting information), and other justification to the RTA.
- RTA submits the request for waiver to CMS CO Training Director.
- CMS SCG Training Director makes the decision, and advises the STC and RTA by email. CMS SCG Training Director may discuss the situation with relevant program staff and may also request to discuss the situation with the SA Director.
- All waivers will be considered and determined on a case-by-case basis.

8. **Training Expectations**

Surveyors who have successfully completed the SA's Orientation Program and the relevant CMS Basic Courses must also attend other specific training as required by CMS. Surveyors must keep up with official Survey and Certification Memos and Administrative Information Memos. . To assure an adequately trained, effective surveyor workforce, the CMS SCG Training Division has established the following training expectations:

- All students are expected to have completed all prerequisites prior to registration of a training course or event.
- States are required to release staff from other work responsibilities during online training, just as they would with in-person trainings.
- All students are required to attend all individual training sessions within a course, whether the course is online or in-person. For in-person training, STCs will be notified of student absences from one or more individual training sessions.
- STCs should notify the CMS Training Division in the event of unusual or unexpected training needs (e.g. a group of newly hired LTC Surveyors requiring training).

- Students are expected to complete all curriculum requirements in a timely manner. For unexpected delays in completing curriculum requirements (e.g. surveyor illness, emergencies), the STC should notify the assigned CMS Training Coordinator (TC) who will reschedule the post-requisites.
- The CMS SCG Training Division is continuously improving our courseware. Training assessments in learning are measured via pre- and post- tests. The goal is to measure how well the learner has met the course objectives. Not all CMS trainings currently have student tests. Where such tests exist, they are mandatory and must be passed to obtain a "Completion" in ISTW.

In order to successfully complete the course, learners must pass the post-test with a score of 80% or higher* within 3 attempts. *Some continuing education and advanced courses have a higher required passing score. Individuals who do not pass the post-test must repeat the course. . In a course where a test exists, they are mandatory and must be passed to obtain a successful "Completion" in the ISTW.

In addition, some trainings offer a follow-up assessment a few months after the course ends. This helps the SCG program leads evaluate the long-term retention of knowledge received during the class and also assess any specific areas that may require additional attention in future offerings. There is no pass/fail for the follow-up assessment and the information is not stored in ISTW.

The following terms apply and are defined below as they pertain to testing and the records maintained in ISTW:

Term	**Definition**
Attended	A student has attended the entire (online or in-person) training.
Passed	A test is required of students in this type of course/class. In addition to having "attended," students must "pass" the final examination.
Completed	A student has either "attended" (without being required to test) or "attended and passed" (for those courses requiring a posttest). And, they must have also successfully satisfied all other prerequisites and, in some cases, all curriculum requirements Then, the course is successfully "Completed" and a Certificate of Completion will be made available to the student as well as updating the ISTW to show "Completion."
Students who fail to "Complete" a class	Typically, a student fails to "Complete" a class because they have attempted and failed the final examination. [There are exceptions which will be handled on an individual basis]. In any of the cases below, the SA Director will be advised of a failing student's status.
Students who fail the final examination	All students will be given three attempts at the final examination. If they fail the first two attempts, they are required to complete remediation as specified by the assigned CMS TC. Remediation will vary with the class involved. Both the first and second attempts at the tests must be completed within the timeframe specified by the CMS TC.

Term	Definition
Remediation	Remediation may include the requirement that the student review online or text training materials again and participate in an observed survey under the watchful eye of an experienced surveyor/preceptor. The STC would then submit a vetting form through their RTA. Other methods of remediation may also apply, as specified by the CMS TC and previously approved by the CMS program lead SME and CO Training Director. Students who fail to successfully complete the post-test on the third attempt are required to retake the CMS Basic Course.
Advanced Classes	Students in Advanced classes will often be asked to complete a Comprehensive Knowledge Check. A knowledge check allows such students to receive feedback on their performance, but those scores are not retained.

9. Training Facilitation, Coordination and Communication

Currently, the STC and/or SA Director serve(s) as a liaison with RO and CO training contacts and provide(s) the needs assessment feedback and logistical support for the remaining courses that use traditional training methods (e.g. classroom instruction, videos, etc.). The STC and/or the SA Director also participate(s) in training budget development and allocation of training resources. The Training Division's new directive to develop the majority of the training courses into online, interactive, self-paced courses (available 24 hours per day) will help to create less burden in this role.

D. 2018 Training Updates

1. Learning Systems Integration

Phase I of the data migration and consolidation of the learning systems (i.e. Enterprise Learning Management System™ (ELMS), Blackboard™ (Bb), and the Surveyor Training Website (STW)) was completed on May 1, 2017. Learners are now able to log into a single portal on the ISTW to register for and access their pre-requisite courses and other training. All transcripts from the former learning system (ELMS) have been relocated to the ISTW. Tests and evaluations from ELMS are also housed on the ISTW. Additional phases of the system development process are scheduled to be conducted throughout FY2018 and beyond.

2. Training Course Student Evaluations

Training evaluations were previously administered using several different delivery methods or learning platforms (e.g. on paper, SurveyMonkey™, Bb, ELMS, STW). As a result, training evaluation reports containing feedback were not readily available following training, and students were required to access different learning platforms to complete training evaluations.

Students began completing training evaluations completely online in TotalLMS as of September 1, 2015, and subsequently began completing the evaluations in ELMS as of May 16, 2016, after the completion of a course. Course evaluations are now completed

and stored in ISTW and are kept secure, offer anonymity, and are beneficial because evaluation results can be reported immediately. Course feedback is then made available to instructors quickly so necessary to improvements can be made for future course offerings.

3. Upcoming Online Course Developments

Over the past several years, the CMS SCG Training Division has been working to build an online environment where Surveyors and Certification Specialists have increased access to our training 24/7. Prior to 2006, all of the CMS SCG Basic Surveyor Training courses were offered in a traditional in-person classroom setting. Over time, the numbers of learners trained in online courses have been steadily increasing. Listed below are the many self-paced, online courses that have been developed and are currently available for training 24 hours/day, 7 days per week, and 365 days per year.

As of 2nd Quarter 2017:

Number of Students Trained in Online Courses Per Fiscal Year	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017***	**Total Trained Per Class**
Basic Life Safety Code	0	22	57	0	0	32	31	37	27	47	65	0	**318**
EMTALA Basic Training	0	0	0	221	538	179	71	80	95	53	169	100	**1506**
OCR Clearance Process for Medicare Part A Applicants	0	0	0	0	112	77	9	24	10	7	24	1	**264**
Fundamentals of Patient Safety in Hospitals	0	0	0	0	0	0	407	52	80	24	103	174	**840**
Ambulatory Surgery Centers Basic Training	0	0	0	0	0	0	0	153	96	147	157	111	**664**
Hospital Basic Training (Part 1)	0	0	0	0	0	0	0	0	0	354	295	135	**784**
Hospital Basic Training (Part 2)	0	0	0	0	0	0	0	0	0	231	243	160	**634**
Pharmaceutical Compounding	0	0	0	0	0	0	0	0	0	0	160	480	**640**
Life Safety Code Transition Course	0	0	0	0	0	0	0	0	0	0	244	542	**786**
Critical Access Hospitals Training	0	0	0	0	0	0	0	0	0	0	0	74	**74**
Total Number Students Trained Per Year	**0**	**22**	**57**	**221**	**650**	**288**	**518**	**346**	**308**	**863**	**1460**	**1777**	**6510**

**2017 numbers are for the 1st and 2nd quarter only*

There are also numerous new online courses that are currently under development and are on the horizon for release in FY2018.

COMING SOON
Basic Life Safety Code (2012) - *December 2017*
Home Health Agency Basic Training - *January 2018*
Psychiatric Residential Treatment Facilities (PRTF) - *February 2018*
ICF/IID - *February 2018*
End Stage Renal Disease (ESRD) Basic - *February 2018*
End Stage Renal Disease (ESRD) STAR - *February 2018*
Basic Long Term Care - New Survey Process (BLTCC) - *March 2018*
Hospice Basic Training - *April 2018*
Community Mental Health Centers (CMHC) - *April 2018*
NFP99 - *May 2018*
Fire Safety Evaluation System - Health Care Surveyor Training- *July 2018*
New Long Term Care Survey Process (LTCSP) Application Technical Training – *August 2018*
Fire Safety Evaluation Safety - Board and Care - *November 2018*
Transplant Basic Training – *January 2019*
Outpatient Physical Therapy / Outpatient Speech Language Pathology Services - *TBD*
CLIA Basic Training – *TBD*
CLIA Orientation Manual – *TBD*
CLIA Principles of Documentation – *TBD*
CLIA State Operations Manual (SOM) – *TBD*
CLIA Proficiency Testing – *TBD*

Future SCG Training Initiatives

Phase 1A: Conversion of all basic training (in-person, webinar and instructor-led online) to self-paced, online training, to meet the immediate training needs of all new hires. (90% completed, the remaining 10% will be completed by May 2018)

Phase 1B: CMS Training Support (for surveyors) with SMEs, to allow Q & A and discussion opportunities for new learners, and supplement online learning (starting January 2018).

Phase 2: Development of Refresher Training, as a means of providing continuing education, for all surveyors (starting January 2018).

Phase 3: Development of Competency Testing for all surveyors, who have completed the basic and refresher courses (Starting January 2018).

There are several ways that the STC can facilitate success for surveyors during their online training:

- Schedule uninterrupted time for the learner to complete the course.
- Ensure there is a quiet room or space available for learners to participate.
- Consider a work-at-home arrangement to better support learning.
- Provide headsets and upgraded technology to access training.
- Treat online courses just like you would an in-person training - with no other work assigned.
- Provide surveyors with laptops or computers that meet online course requirements.

E. Online Training: Training Equipment and Technology

1. Integrated Surveyor Training Website (ISTW)

The following computer configuration is required to access your online classroom via the ISTW. If your computer does not have the proper hardware, the courses may run slowly or may not run at all. Prior to running the course on your computer, compare your current system configuration with the system requirements below:

Hardware Minimum Requirements

- 1.5 GHz CPU or greater with minimum of 1GB RAM
- Network adapter: LAN (Ethernet) or wireless (Wi-Fi)
- DSL or cable broadband Internet (Dial-up is not compatible)
- 3G and 4G connections is not recommended when taking tests
- Speakers may be required; refer to course requirements

Operating Systems Requirements

- Windows Vista, 7, 8, or 10
- MAC OSX 10.7 or later

Browser Requirements:

The following tables highlight the new platform and browser configurations tested for using the following support terms:

Microsoft Windows Operating Systems

Microsoft	Internet Explorer 9	Internet Explorer 10	Internet Explorer 11	Edge	Firefox	Google Chrome
Windows Vista (32-bit)	Supported	Unsupported by Microsoft	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Supported
Windows Vista (64-bit)	Supported	Unsupported by Microsoft	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Supported
Windows 7 (32-bit)	Supported	Supported	Supported	Unsupported by Microsoft	Supported	Supported
Windows 7 (64-bit)	Supported	Supported	Supported	Unsupported by Microsoft	Supported	Supported

Windows 8 (32-bit)	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Unsupported by Microsoft	Supported	Supported
Windows 8 (64-bit)	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Unsupported by Microsoft	Supported	Supported
Windows 10 (32-bit)	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Supported	Supported	Supported
Windows 10 (64-bit)	Unsupported by Microsoft	Unsupported by Microsoft	Supported	Supported	Supported	Supported

Apple Mac Operating Systems

Apple Mac	Safari 6	Safari 7	Safari 8	Firefox	Google Chrome
Mac OSX 10.7	Supported	Unsupported by Apple	Unsupported by Apple	Supported	Supported
Mac OSX 10.8	Supported	Unsupported by Apple	Unsupported by Apple	Supported	Supported
Mac OSX 10.9	Unsupported by Apple	Supported	Unsupported by Apple	Supported	Supported
Mac OSX 10.10	Unsupported by Apple	Unsupported by Apple	Supported	Supported	Supported

Videos within the online training modules are often used for scenario-based learning activities.

- Windows Media Player will also need to be installed for access of videos within the ISTW.

Operating Systems Requirements

- Windows Vista, 7, or 8
- MAC OSX 10.7 or later

Software Requirements

- Windows Media Player 9+
- Participants need active computer speakers with volume control.
- If the participants are in a cubicle environment, separate headsets may be needed to prevent disturbance to individuals working in close proximity.

Headsets

General headset specifications:

- The headsets should be capable of being plugged into the desk phone.

CMS does not currently support Voiceover Internet Protocol (VoIP), which allows audio to be heard through the computer speakers, you must obtain a headset that works with your current telephone system.

- Style considerations: over the head, over the ear, behind the neck, wired or wireless - any adjustable style conducive to all-day wearing comfort.
- Wireless headphone devices should include rechargeable capabilities.

- Volume control: Audio performance and a microphone to allow the participants to speak Should not be audio only; noise-cancelling microphone recommended; select a model/brand ideal for telephone intensive users: including call-center, help-desk, and customer service organizations.

- Also download the link for Adobe Flash Player from the Adobe's site. https://get.adobe.com/flashplayer/.

2. Adobe Connect

The current widely used platform for webinars is Adobe Connect. No software purchase is needed for the webinar platform; however an up-to-date version of Adobe Flash Player may need to be downloaded.

Adobe Connect Version 9.1 specifications:

Windows

- 1.4GHz Intel® Pentium® 4 or faster processor (or equivalent) for Microsoft® Windows® XP, Windows 7, Windows 8; 2GHz Pentium 4 or faster processor (or equivalent) for Windows Vista®
- Windows 8 (32-bit/64-bit), Windows 7 (32-bit/64-bit), Windows Vista, Windows XP
- 512MB of RAM (1GB recommended) for Windows XP, Windows 7, Windows 8; 1GB of RAM (2GB recommended) for Windows Vista
- Browser options: Microsoft Internet Explorer 8, 9, 10, 11; Mozilla Firefox; Google Chrome
- Adobe® Flash® Player 10.3+ (11.2+ recommended)

Mac OS

- 1.83GHz Intel Core™ Duo or faster processor
- 512MB of RAM (1GB recommended)
- Mac OS X 10.6, 10.7.4, 10.8
- No Adobe Connect Add-in support for Mac OS X 10.5 (Leopard). Users on Leopard can attend meetings in the browser.
- Mozilla Firefox; Apple Safari; Google Chrome
- Adobe Flash Player 10.3+ (11.2+ recommended)

Linux

- Ubuntu 11.04, 12.04; Red Hat Enterprise Linux 6; OpenSuSE 11.3
- No Add-in support for Linux. Users on Linux can attend meetings in the browser.
- Mozilla Firefox
- Adobe Flash Player 10.3+ (11.2+ recommended)

Mobile

- Apple supported OS versions summary: iOS 6 and higher
- Android supported OS versions summary: 2.3.4 and higher
- Note - not all courseware will be viewable on mobile devices, especially courseware that is Flash based or older videos that use Windows Media Video formats.

Other Considerations

- On Android devices, the Adobe Connect Mobile 2.1 app no longer requires the Adobe AIR Runtime to be installed.
- All features of Adobe Connect Mobile are supported when attending meetings on Adobe Connect Server version 8.2 and higher, from a supported mobile device.
- New features added in Adobe Connect Mobile 2.1 may not be enabled in all Adobe Connect Server meetings running on an 8.1 or older server.
- Meeting server must be Adobe Connect 7.5.1 or higher in order to use Adobe Connect Mobile 2.1.

Virtual environments

- Citrix XenApp 6.5
- VMware View 5.1

Additional requirements

Bandwidth: 512Kbps for participants, meeting attendees, and end users of Adobe Connect applications. Connection: DSL/cable (wired connection recommended) for Adobe Connect presenters, administrators, trainers, and event and meeting hosts.

3. WebEx

Operating System and Browser Support

	Windows	Mac OS X	Linux
Operating Systems	2003 Server, Vista 32-bit/64-bit, Windows 7 32-bit/64-bit, Windows 8 32-bit/64-bit, Windows 8.1 32-bit/64-bit	10.6, 10.7, 10.8, 10.9, 10.10	Ubuntu 10x and 11x (Gnome), Red Hat 5, 6, Open SuSE 11.4 Fedora 15, 16 (all 32-bit)

	Windows	Mac OS X	Linux
Available WebEx Services	All services	Meeting Center Training Center Event Center Sales Center Remote Support	Meeting Center Event Center Training Center Remote Support
Minimum System Requirements			
Processor	Intel Core2 Duo CPU 2.XX GHz or AMD processor (2 GB of RAM recommended)	Intel (512 MB of RAM or more recommended)	Intel or AMD x86
JavaScript	JavaScript and cookies enabled	JavaScript and cookies enabled	JavaScript and cookies enabled
Other	Active X enabled (unblocked for IE is recommended) Java 6 or later		Java 6, libstdc++ 6.0, GNOME/KDE windowing system
Browsers			
Internet Explorer	7, 8 (32-bit/64-bit), 9 (32-bit/64-bit), 10 (32-bit/64-bit), 11 (32-bit/64-bit)		
Mozilla			
Firefox	Latest	Latest	Latest
Safari		5, 6, 7, 8	
Chrome	Latest 32-bit/64-bit	Latest 32-bit/64-bit	

SECTION SEVEN: CORE INFRASTRUCTURE – STANDARD REQUIREMENT MUST BE DONE

A. Additional Information regarding Training

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

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

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

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

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

   2. Leadership Training: State survey agency Directors and Deputy Directors are required to attend and participate in the annual CMS Leadership Training (Survey

Executives Training Institute). This event typically requires 2.5 days of attendance and usually occurs in the Spring each year. Please refer to the Training Schedule for confirmed dates. Travel and lodging expenses are paid 100% from federal funds as an addition to the State's survey budget allocation.

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

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

C. CMS Quality Improvement Initiative

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

D. Performance Measurement Activities

State budget submissions must include thorough and well-structured action plans for effecting Survey and Certification program goals and objectives. The plans should outline effective strategies for achieving performance targets and conforming to CMS' State performance standards and priorities. States should also identify how national goals and standards are being translated into individual performance objectives. If CMS finds that the SA does not meet the performance standards, the SA will be expected to develop and implement a corrective action plan.

E. Home Health Toll-Free Hotline and Investigative Unit

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

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

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

States should note that OASIS expenditures are reflected as non-LTC costs on the form CMS-435. For more reporting instructions, please refer to the General Budget Formulation Guidelines section.

All certified HHAs are required to encode and transmit OASIS records for Medicare and Medicaid beneficiaries to Assessment Submission and Processing System (ASAP), in accordance with CMS-established record specifications and time frames. States will continue to play an active role in providing HHAs with Outcome Based Quality Improvement (OBQI)

reports, using CMS developed software as well as interpreting and using the report. HHAs will use these reports to inform the survey process.

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

Overall responsibility for fulfilling requirements to operate the CMS State QIES rests with the SA. However, the SA may enter into an agreement with the State Medicaid Agency, another component, or a private contractor to perform day-to-day operations of the system. Prior to entering into an agreement with subcontractors, SAs must receive RO approval if the State QIES is operated by an entity other than the SA. The State must ensure that the SA is provided real-time access to this system to fully support all QIES driven functions which will be required of the survey agency (e.g., quality indicator reporting, survey targeting, etc.). Off-site operation of the QIES will require high capacity, fault tolerant network connections to ensure reliable support for the SA's daily operations, which will be affected by this system.

CMS will continue to add software applications to States' standardized hardware environments to support evolving needs for MDS and related survey and certification functions in the States under the QIES initiative discussed below.

CMS will continue to provide travel training funds and mandate attendance at training events for State personnel responsible for administrative and technical aspects of the MDS and Swing Bed (SB)-MDS operation. States should reference the training schedule (Training Program document) for a listing of proposed MDS and SB-MDS conferences and training courses.

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

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

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

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

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

H. Reimbursement for MDS and OASIS Costs

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

CMS will continue to fund any needed upgrades to the State MDS and OASIS systems and related software, as well as the cost of upgrading client computers needed to access the MDS and OASIS servers (discussed under Information Systems Hardware). CMS will also continue to fund the cost of transmitting MDS data from the State to the CMS central repository. Provider costs for hardware and software to maintain and transmit MDS, SB-MDS and OASIS data from their facility to the States will continue to be the provider's responsibility.

However, States are, again, expected to incur some costs associated with operating the MDS, SB-MDS and OASIS systems, specifically for staff time, training and supplies to support the automated QIES.

When States use MDS data in administering the Medicaid program, Federal costs associated with automating MDS and the operating data system should be apportioned by the States between two funding sources: the Medicare and Medicaid Survey and Certification program and the Medicaid program (under administrative costs). States should apportion MDS costs to these programs based on the States' determination of each program's utilization of the MDS system. Costs charged to the Medicare and Medicaid Survey and Certification Program will be prorated in terms of the portion of SNFs and NFs in the States that participate in the Medicare and Medicaid program. Similarly, costs associated with downloading and transferring SB-MDS data to the Medicaid program should be apportioned by the State between these two funding sources. The Federal match for the Medicaid Survey and Certification Program will be 75 percent. Budget estimates should be prepared and submitted as part of each State's FY2018 Survey and Certification budget request.

Costs related to the publication, dissemination and validation of software vendors' ability to comply with State specifications for any added MDS, SB-MDS, or OASIS sections or data (i.e., that portion of the MDS or OASIS that may be added to the State's RAI or HHA instrument at the State's discretion) will not be funded through the Survey and Certification budget. To the

extent that a State develops customized applications for information maintained in the OASIS database (e.g., to support Medicaid payment), the costs of developing and maintaining these additional software applications (and any related hardware components) will not be funded through the Survey and Certification budget.

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

I. The Quality Improvement and Evaluation System (QIES)

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

- Extension of the MDS/OASIS/SB-MDS systems to include new provider types in future years;
- Continued development of the ASPEN suite of products, ASPEN Survey Explorer-Quality (ASE-Q), ASPEN Central Office (ACO), ASPEN Enforcement Manager (AEM), ASPEN Scheduling and Tracking (AST) and ACTS, integrated with State standard systems;
- Further integration of the learning management system that supports most day-to-day operations of the survey and certification training program; and

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

CMS also plans to conduct one, 3-4 day session focusing on prototyping testing and training for a new release in Baltimore; including representatives from 10 States (selectees will be announced.)

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

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

FTE

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

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

These FTEs should be allocated approximately as follows:

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

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

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

1. ***High Speed Internet Access (i.e., DSL, broadband, cable modem, T1)***
   The amount of data moved during each workday increases each year. Surveyor time is a precious asset and the amount of time involved in accessing information electronically is directly affected by the type of internet connection available. Back and forth communications between servers and clients can consume many megabytes per transaction. High speed connections also foster an environment where CMS and the SAs can optimize use of future uses of technology to improve survey efficiency, e.g., computer- based training. Industry studies show that cost benefit analyses favor high speed connections and that is the direction in which the industry is progressing.

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

If State Survey Agencies (SA) need to move the CMS QIES state servers to an alternate location, the **SA** will need to work with their ROs to include a $12,000 line item in their budget plan **at the time of the move request** (i.e., not waiting until the time of the move). So if a move is to take place at the beginning of the following FY, the funds would have to be made available in the preceding FY. This fee covers the move of the circuits and network support. The SA must submit a written request to the QIES Technical Support Office at a minimum of 90 days prior to the scheduled move date.

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

a. Existing State machines that meet the minimum requirements, as described below, are used to provide user access to the standard system. This includes desktop systems connected to an internal network, as well as laptop/tablet systems used mainly for ASPEN Survey Explorer–Quality (ASE-Q).

b. To the extent that existing State systems do not meet the minimum requirements (e.g., insufficient RAM memory), the State submits a plan and budget request to support upgrading of these systems to the recommended performance levels, which includes the type of equipment to be purchased and associated costs. Upgrading an existing computer can include adding more RAM and disk capacity and purchasing processor upgrades. States should also include in the budget those costs associated with upgrading current computer operating systems to the prescribed Windows operating systems. The costs associated with upgrading equipment should not exceed the cost for actual replacement. Finally, it is also appropriate for States to include a budget for additional staff/contractor costs incurred to manage the computer and operating system upgrade process.

c. To the extent that a State does not possess sufficient systems that are currently capable or able to be upgraded to the minimum standard, the State should submit a plan and budget request to support the acquisition of the number of new systems that are necessary to provide appropriate access. The budget request must include the number of each type of machine to be purchased and associated costs.

d. Nursing Home Survey Process – This budget note is directed toward States considering a purchase of computers for their LTC surveyors. CMS seeks to move towards a nursing home survey process and focused survey processes through the use of Tablet technology which allows ready access to data and information onsite by the surveyors and allows documentation of non-compliance to be easily transferred to the

CMS-2567 form. Unless the SA has already procured tablet computers for their LTC surveyors, we recommend that the SA submit a budget request for any equipment needed (e.g., the computers). CMS highly recommends that States plan for future survey process implementations as part of their hardware procurement process recognizing the need for Tablet PC configurations as a future need. The hardware that is budgeted by the SA is in addition to the hardware provided as part of the startup process, with the understanding that equipment costs will be distributed in the usual manner against Medicare/Medicaid/Licensure.

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

Equipment purchases for LTC surveyors should include: one Tablet laptop (described in the table below, Minimum and Recommended Client Requirements) for each surveyor. There will be paper materials that are needed for the LTC survey process to hand to the facilityQI. Surveyor may either bring copies with them or carry a portable printer. States may want to consider portable printers that are lightweight, capable of printing 17 pages or more per minute and capable of running on battery power alone.

e. Surveyor Technical Assistant for Renal Disease (STAR) - Prior to attending a STAR training course, surveyors are expected to have access to specified tablet PCs. The STAR training will be provided in an online format. Surveyors will be able to use the same Tablet equipment for the Long-Term Care Survey Process (or remaining QIS surveys) and STAR.

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

Laptops:
Recommended field system is any Windows 8 or Windows 10 computer designed for light-weight portability and provides both a keyboard option and an option to operate the device as a flat tablet. ASPEN software operates on traditional laptop computers with no flat tablet mode but this is less optimal for field use, especially for Long-Term Care and STAR surveyors. Any selected surveyor computer must also meet the required technical specification provided.

3. Encryption Policy

CMS' encryption policy requires all agency data be protected from unauthorized access. There may be various levels of protection for agency data, but for personally identifiable information (PII), the policy states that dissemination of such data using any portable

devices or recordable media, (e.g., CDs, DVDs, Cartridges, Diskettes, Laptops, External Hard Drives, USB Memory Sticks or thumb drives, etc.), requires encryption. Whole disk encryption of the hard-drive for Laptops or Tablet PCs must be employed. Encryption is the process of protecting stored or transmitted information with a password (key) so that it is indecipherable until the intended recipient uses the password to access it.

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

- IA-7 Cryptographic Module Authentication (Specifies acceptable encryption type – FIPS 140-2 compliant (http://csrc.nist.gov/groups/STM/cmvp/documents/140-1/140val-all.htm) NIST validated module. (http://csrc.nist.gov/groups/STM/cmvp/index.html)
- IA-2 User Identification and Authentication
- AC-3 Access Enforcement
- AC-4 Information Flow; specifically CMS-2
- AC-19 Access Control for Portable and Mobile Systems (encryption requirement only)
- MP-5 Media Transport
- SC-8 Transmission Integrity
- SC-12 Cryptological Key Establishment and Management

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

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

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher** **Required for LTC Survey Process Implementation** **Recommended for Other**
Processor	Pentium Class (or equivalent) @ 1.2 GHz	Pentium Class (or equivalent) @ 2.0 GHz

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher** **Required for LTC Survey Process Implementation** **Recommended for Other**
Memory (RAM)	2 GB	4 GB
Available Disk Space	4 GB	10 GB on SATA 2 drive at 7200 RPM
Monitor	13" Color	Desktop 19": Color Flat Panel ≥1024x768 screen resolution Flat Panel for laptop or tablet
*Operating System**	Windows 8.1 – 32 bit Windows 8.1 – 64 bit	Windows 8.1 – 32 bit Windows 8.1 – 64 bit Windows 10 – 32 bit Windows 10 – 64 bit
Secure Access/Encryption (See Encryption Policy)	Required – See Encryption Policy	Required – See Encryption Policy
Anti-virus	Current License	Current License
Universal Serial Bus Port	One	Two
Removable Media (see Encryption Policy)	USB Drive 2.0	USB Drive 3.0
Pointing Device	Mouse or equivalent (e.g. trackball or touchpad)	Mouse or equivalent (e.g. trackball or touchpad) and Pen/Stylus for tablet
Network Interface Card *(See CMS ARS security guidelines for acceptable wireless configurations)*	Wired for network connectivity; and Wireless network cards must support WPA-2 level encryption	Wired for network connectivity; and Wireless network cards must support WPA-2 level encryption
Optical Drive	2 external USB sockets	3 external USB sockets
Audio	Standard built-in speakers	Attachable microphone and standard built-in speakers
Battery (laptop or tablet)	6-cell lithium-ion	6-cell lithium-ion
*Browser***	Internet Explorer v 11.0 compatibility mode with TLS 1.2 settings	Internet Explorer v 11.0 compatibility mode with TLS 1.2 settings
Integrated Software	.Net Framework 4.6.x	.Net Framework 4.6.x or higher
Firewall Configuration	The Following Ports Must Be Allowed to Contact Client PC 901 (UDP) 910 (TCP)	The Following Ports Must Be Allowed to Contact Client PC 901 (UDP) 910 (TCP) 2638 (TCP)

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher** **Required for LTC Survey Process Implementation** **Recommended for Other**
	2638 (TCP) 8443 (TCP)***	8443 (TCP)***

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

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

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

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

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

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

***Port 8443 is the default used by LTCSP, but can be reconfigured through the software. Whichever port is chosen to be used is the one that must be allowed through firewalls.

K. Emergency Preparedness:

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

The items identified below are key elements that have been developed based on the recommendations of the S&C Emergency Preparedness Stakeholder Communication Forum. While we realize some States already have very well-developed systems that far exceed the elements described here, we appreciate that for many States enhanced IT reporting capabilities require additional time to implement.

1. SA Continuity of Operations (COOP)

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

a. Essential S&C business functions, including:

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

- Provision of monitoring and enforcement of healthcare providers. Even in widespread or significant disasters where reduced S&C activities may occur, key activities (such as complaint investigations, provider communications, communication with CMS regarding any advisable adjustment to previously-imposed enforcement actions that might impede evacuee placement, etc.) will still need to occur in order to ensure the health and safety of patients and residents.
- Conducting timely surveys or re-surveys in the aftermath of a disaster.

b. Identification of strategies to ensure maintenance and protection of S&C critical data.

c. A program of COOP exercises, conducted at least annually by designated staff to ensure State, Regional, Tribal and Federal responsiveness, coordination, effectiveness and mutual support.

2. Effective Communication & Coordination with CMS

a. Point of Contact: A State S&C emergency point of contact (and back-up) is available 24 hours per day and 7 days per week to the CMS RO when the State declares a widespread disaster. The contact:

- Coordinates State S&C activities with CMS;
- Addresses questions and concerns regarding S&C essential functions;
- Provide status reports; and
- Ensures effective communication of federal S&C policy to local constituencies (see details below).

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

b. Policy Communications: The SA maintains capability for prompt dissemination of CMS policy and procedures to surveyors, providers and affected stakeholders. During a disaster, the capability is operative 24/7. The SA capability includes back-up communication strategies, such as websites and hotlines and emergency capability that enable functional communication during energy blackouts. A designated person is available for responding to healthcare providers' questions and concerns related to federal survey and certification. These functions may be performed by a person within the State ICS, who has been clearly assigned to perform these functions.

c. Information and Status Reports: The SA or the State ICS maintains capability and operational protocols to provide the CMS RO with (a) State policy actions (such as a Governor's emergency declarations or waiver of licensure requirements) and (b) an electronic provider tracking report, upon request, regarding the current status of healthcare providers affected by a disaster. The capability includes:

Provider Contacts	Provider Status	Provider Plans
• Provider's name	• For profit/ or not-for-profit agency, or government agency status	• Estimated date for restored operations

• CMS Certification Number (CCN) • National Provider Number (NPI) • Provider type • Address (Street, City, ZIP Code, County) • Current emergency contact name • Contact's Telephone number and alternate (e.g., cell phone) • Contact's email address	• Provider status (evacuated, closed, damaged) • Provider census • Available beds • Emergency department contact information (name, telephone number, FAX number) if different than provider contact information • Emergency department status (if applicable) • Loss of power and/or provider unable to be reached	• Source of information • Date of the status information

3. Recovery Functions

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

4. Funding

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

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

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

States are still required to submit electronic affected provider status reports to the CMS RO during emergency events, which include the data elements identified above. An *Affected Provider Status Report* template is available on the S&C Emergency

Preparedness website for this purpose: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

5. Relationship to State Performance Standards System

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

L. Alignment with State Performance Standards System (SPSS)

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

Table: Providers for Which Tier 1-3 Performance is Measured by SPSS

Statutory Providers	Other Providers
• Nursing Homes • Home Health Agencies • Hospices • Validations – all types of deemed providers/suppliers • ICFs/IID	• Hospitals (all types) • ESRD facilities • • Comprehensive Outpatient Rehabilitation Facilities (CORFs) • Rural Health Clinics (RHCs) • ASCs • OPTs (Rehabilitation Agencies)

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

SECTION EIGHT - BUDGET FORMULATION GUIDELINES

A. Updated Mission Directive for FY18

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 in any way intended to add existing work to State Agencies, in fact, this focus should help States be able to close out their financial books sooner rather than sometimes waiting for 5 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, statute 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 effect a proper closeout will remain substantially the same.

  The timelines for this process are as follows:

  - Final financial reports, consistent with terms of 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 takes 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 Central Office will provide States ample 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. CO will work with States on a case-by-case basis if there are reasons that they are unable to meet the guidelines noted above.

B. Continued Budget and Expenditure Reporting Timing and Requirements

The S&C program will operate under a Continuing Resolution, with funding based on the previous FY base budget as noted in Appendix 2, column A, until such time that Congress passes the funding appropriation which contains the S&C funding. For planning purposes, anticipated timeframes for the budget process are as follows:

Jan - March – States submit, with justification, requested changes to their proposed FY budget amount listed in Appendix 2 to the Regional Office, in accordance with the AdminInfo Memo issued each year.

Jan - March – Regional Offices complete review of the States appeal submissions and offer recommendations, by State, to the Central Office (Bary.Slovikosky@cms.hhs.gov).
Jan - April – Central Office staff will hold conference calls with the Regional offices to discuss and make final decisions regarding the FY18 Allocations.
Feb - April – Final allocations are determined and communicated to States.
March - May – States submit the final budget package and plans to CMS Regional Offices, including updates to the CMS 434-Planned Workload form, using the CMS Tier priorities. For the final budget package, each State's budget should be based on a specific dollar amount expected for Medicare funding (rather than a general estimate of what the State believes is needed).

Again, these timelines are for planning purposes and may be subject to change based when Congress passes a final budget appropriation.

- **IMPACT Act Budget:** A form CMS-435 mini-budget for IMPACT ACT-Hospice is required to be submitted. However, in contrast to the HHA and MDS mini-budgets, the figures included in the IMPACT ACT-Hospice budget refer to a separate funding source and thus **are not** to be included in the main CMS-435.

- **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, dated May 17, 2013, 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 Survey & Certification 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. States' 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 form CMS-435 (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 Survey and Certification budgets.

Costs incurred in joint Titles XVIII/XIX facilities for NAR/NATCEP will be charged and reimbursed 50 percent by Medicare and 50 percent 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.

- **Training Line on CMS-435:** Under no circumstance, should the costs reported in the training line on the form CMS-435 be zero. As discussed in the SOM, this line item includes **any** non-salary costs associated with training.

In summary, the final budget package should include:

1. Main CMS-435 Budget Request Form. *Note: This form should capture all projected FY 2017 expenditures (including MDS and HHA/OASIS, but not including IMPACT Act Hospice costs) spread across the appropriate lines of the CMS-435.*
2. 2 mini CMS-435s for MDS and HHA/OASIS (subset reports of the main CMS-435)
3. CMS-435 IMPACT Act – 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; and
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 indicating 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. Submittal of most recent Indirect Cost Agreement.

C. CMS Budget Analysis and Adjustment

- Central Office will continue to partner with the Regional offices to review and agree upon a final budget amount for FY18 for each state once Congress has finalized a budget. The funding available to states will be allocated based on several factors that are taken into account such as:

    1. Historical Spending
    2. Workload Requirements
    3. State Hiring Challenges

- It is recommended that States make the Regional offices aware of expected funding shortfalls or overages as soon as possible in FY18 to ensure that the most effective funding distribution can be made as soon as Congress passes a budget.

A. Subaccounts in the CMS Payment Management System (PMS): Instructions concerning the use of PMS subaccounts as well as frequently asked questions can be found at the link:
http://www.dpm.psc.gov/grant_recipient/hhs_subaccounting/hhs_subaccounting.aspx

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

2017 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 – non-IJ: complaints prioritized as non-IJ high must be initiated within 45 days of RO authorization		• **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 de-activated HHA's – Surveys are required of HHA's that have not billed Medicare for 12 consecutive months prior to re-activating their billing privileges. • 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 (5% of surveys conducted by accrediting orgs, or at least 1 survey, 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	• **Substantial Allegation Validation (Complaint) Investigations that are prioritized as non-IJ high must be initiated within 45 days of RO authorization**		

	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 CoP out of compliance for deemed hospitals and CAHs. These are a Tier 1 priority. • **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 FY 2015. 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 (4)	• 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.	• ***Recerts*: 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	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.**

4 Includes critical access hospitals, rehabilitation hospitals, and psychiatric hospitals. IPPS refers to the Inpatient Prospective Payment System.

			new rehabilitation hospitals/ units & new psychiatric units seeking exclusion from IPPS (5), 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 of compliance by the hospital. **<u>IPPS Exclusion Verification (Existing excluded hospitals/units)</u>: 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 (6).**	

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

			These surveys verify that the hospital unit continues to meet IPPS exclusion criteria.	
6. ESRD	• **Investigation of complaint allegations triaged as IJ** • **Targeted Sample (10%):** States survey a 10% targeted sample of ESRD facilities, selected from a CMS list that identifies those facilities most at risk of providing poor care. Some of the targeted surveys may qualify to count toward the Tiers 3 and 4 priorities.	• **Complaint Investigations:** not categorized as potential IJ • **3.5-Year Max <u>Interval (42.9 months)</u>:** Additional surveys are done to ensure that no more than 3.5 years elapses between surveys for any <u>one</u> particular ESRD facility.	• **Relocations** • **Expansion of Stations/Services** • **3.0-Year <u>Avg</u>:** Additional surveys are done (beyond Tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an <u>average frequency of 3.0 years or less</u> (Facilities/Surveys<u>≤</u> 3.0yrs).	**Initial Surveys**
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. • **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 FY20153 *(Budgeted separately via supplemental allocation)*. • **Complaint investigations prioritized as immediate jeopardy – deemed hospices:** <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u>	• **Complaint investigations of deemed hospices prioritized as non-IJ**		**Initial Surveys**
8. Outpatient Physical Therapy Providers	• **Complaint investigations prioritized as immediate jeopardy – deemed OPTs:** <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u>	• **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	• **7.0-Year <u>Interval</u>**: Additional surveys are done to ensure that no more than	• **6.0-Year <u>Avg</u>:** Add'l surveys are done (beyond tiers 2-3) such that all non-deemed providers in the State are

	•	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. • **Complaint investigations prioritized as non-IJ high:** to be initiated within 45 days (for deemed, within 45 days of RO authorization)**.**	7.0 years elapse between surveys for any <u>one</u> particular provider.	surveyed, on average, every 6 years. (i.e., total surveys divided by total providers is not less than 16.7% = 6.0 years). Initial Surveys: **There is now a deemed status option for OPTs**
9. Comprehensive Outpatient Rehabilitation Facilities	•	• **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 <u>Interval</u>: **Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any <u>one</u> particular provider.**	6.0-Year <u>Avg</u>**: 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).**
10. Rural Health Clinics	• **Complaint investigations prioritized as immediate jeopardy – deemed RHCs:** <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u> •	• **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 from this requirement. • **Complaint investigations prioritized as non-IJ high:** to be initiated within 45 days (for deemed RHCs, within 45 days of RO authorization)**.**	• **7.0-Year <u>Interval</u>**: Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any <u>one</u> particular RHC.	• **6.0-Year <u>Avg</u>:** 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.
11. 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, with	• **Targeted Surveys (25%):** The State performs surveys totaling 25% of all non-deemed ASCs in the State (or at least 1, whichever is greater)	• **6.0-Year <u>Interval</u>**: Additional surveys are done to ensure that no more than	**N/A**

	infection control worksheets submitted to CMS' contractor. *(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.	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 prioritized as non-IJ high:** to be initiated within 45 days (for deemed RHCs, within 45 days of RO authorization)**.**	6.0 years elapse between surveys for any one particular non-deemed ASC.	
12. Psychiatric Residential Treatment Facilities (Medicaid Psych < 21)	• **5.0-Year Interval:** Survey visits (Validation and Complaint) of 20% of PRTFs). • **Complaint investigations triaged as IJ**	**Complaint investigations triaged as non-IJ**		Initial Surveys
13. Community Mental Health Centers (CMHCs)		• **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.**
14. Portable X-Ray Suppliers		• **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	• **7.0-Year Interval**: Additional surveys are done to ensure that no	• **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

		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.	more than 7.0 years elapse between surveys for any <u>one</u> particular provider.	average, every 6 years. (i.e. total surveys divided by total providers is not less than 16.7% = 6.0 years).
15. New Provider-Initial Surveys		• 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: • ESRD Facilities • Transplant centers • SNF/NFs • Relocations of non-deemed branches or off-site locations. • <u>Note</u>: 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 <u>addition of swing beds as a new service in an existing deemed or non-deemed hospital or CAH is a Tier 4 priority</u>**.**	• Initial certifications of all provider types that have a deemed accreditation option: 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			

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.

Appendix 2 - FY 2018 Projected State Allocations

State	A	B1	B1a	B2	B3	B4	B5	C1	C2	C3	D1	D2
	FY17 Base Budget	Base inc over FY17 Budget	% inc. vs FY17	FY17 Hospice Budget	Non-Bench-marked $	Bench-marked $	Sub-Total FY18 not incl. Hospice	Special Projects/ One-Time awards	Non Delivery Deduc-tions	Estimated Supple-mental Validation Funding *	FY18 State Alloc. Incl Supplements and Addtl. One-Time Awards	FY18 Hospice Alloc.)
CT	$6,404,146	$32,021	0.5%	By Request	$6,436,167	$0	$6,436,167			$0	$6,436,167	By Request
ME	$2,473,361	$12,367	0.5%	By Request	$2,485,728	$0	$2,485,728			$0	$2,485,728	By Request
MA	$8,850,779	$44,254	0.5%	By Request	$8,895,033	$0	$8,895,033			$98,000	$8,993,033	By Request
NH	$1,409,719	$7,049	0.5%	By Request	$1,416,768	$0	$1,416,768			$0	$1,416,768	By Request
RI	$1,885,685	$9,428	0.5%	By Request	$1,895,113	$0	$1,895,113			$0	$1,895,113	By Request
VT	$1,148,651	$5,743	0.5%	By Request	$1,154,394	$0	$1,154,394			$0	$1,154,394	By Request
NJ	$8,211,043	$41,055	0.5%	By Request	$8,252,098	$0	$8,252,098			$145,800	$8,397,898	By Request
NY	$16,616,113	$83,081	0.5%	By Request	$16,699,194	$0	$16,699,194			$153,900	$16,853,094	By Request
PR	$464,044	$2,320	0.5%	By Request	$466,364	$0	$466,364			$0	$466,364	By Request
DE	$1,156,589	$5,783	0.5%	By Request	$1,162,372	$0	$1,162,372			$10,300	$1,172,672	By Request
DC	$1,145,728	$5,729	0.5%	By Request	$1,151,457	$0	$1,151,457			$0	$1,151,457	By Request
MD	$3,956,977	$19,785	0.5%	By Request	$3,976,762	$0	$3,976,762			$61,600	$4,038,362	By Request
PA	$10,496,114	$52,481	0.5%	By Request	$10,548,595	$0	$10,548,595			$92,000	$10,640,595	By Request
VA	$5,153,116	$25,766	0.5%	By Request	$5,178,882	$0	$5,178,882			$69,300	$5,248,182	By Request
WV	$2,588,378	$12,942	0.5%	By Request	$2,601,320	$0	$2,601,320			$0	$2,601,320	By Request
AL	$5,174,023	$25,870	0.5%	By Request	$5,199,893	$0	$5,199,893			$20,300	$5,220,193	By Request
FL	$12,614,869	$63,074	0.5%	By Request	$12,677,943	$0	$12,677,943			$240,500	$12,918,443	By Request
GA	$5,889,961	$29,450	0.5%	By Request	$5,919,411	$0	$5,919,411			$125,200	$6,044,611	By Request
KY	$5,107,109	$25,536	0.5%	By Request	$5,132,645	$0	$5,132,645			$0	$5,132,645	By Request
MS	$2,245,469	$11,227	0.5%	By Request	$2,256,696	$0	$2,256,696			$53,300	$2,309,996	By Request
NC	$8,702,465	$43,512	0.5%	By Request	$8,745,977	$0	$8,745,977			$61,300	$8,807,277	By Request
SC	$2,659,416	$13,297	0.5%	By Request	$2,672,713	$0	$2,672,713			$12,300	$2,685,013	By Request
TN	$4,358,503	$21,793	0.5%	By Request	$4,380,296	$0	$4,380,296			$43,000	$4,423,296	By Request
IL	$16,771,256	$83,856	0.5%	By Request	$16,855,112	$0	$16,855,112			$136,600	$16,991,712	By Request
IN	$7,218,399	$36,092	0.5%	By Request	$7,254,491	$0	$7,254,491			$143,300	$7,397,791	By Request
MI	$12,299,065	$61,495	0.5%	By Request	$12,360,560	$0	$12,360,560			$158,900	$12,519,460	By Request
MN	$9,111,334	$45,557	0.5%	By Request	$9,156,891	$0	$9,156,891			$10,300	$9,167,191	By Request
OH	$16,091,718	$80,459	0.5%	By Request	$16,172,177	$0	$16,172,177			$181,900	$16,354,077	By Request
WI	$6,855,932	$34,280	0.5%	By Request	$6,890,212	$0	$6,890,212			$43,200	$6,933,412	By Request

	A	B1	B1a	B2	B3	B4	B5	C1	C2	C3	D1	D2
State	FY17 Base Budget	Base inc over FY17 Budget	% inc. vs FY17	FY17 Hospice Budget	Non-Bench-marked $	Bench-marked $	Sub-Total FY18 not incl. Hospice	Special Projects/ One-Time awards	Non Delivery Deduc-tions	Estimated Supple-mental Validation Funding *	FY18 State Alloc. Incl Supplements and Addtl. One-Time Awards	FY18 Hospice Alloc.
AR	$6,001,075	$30,005	0.5%	By Request	$6,031,080	$0	$6,031,080			$30,700	$6,061,780	By Request
LA	$7,000,000	$35,000	0.5%	By Request	$7,035,000	$0	$7,035,000			$112,700	$7,147,700	By Request
NM	$2,400,000	$12,000	0.5%	By Request	$2,412,000	$0	$2,412,000			$0	$2,412,000	By Request
OK	$7,000,000	$35,000	0.5%	By Request	$7,035,000	$0	$7,035,000			$20,300	$7,055,300	By Request
TX	$33,100,000	$165,500	0.5%	By Request	$33,265,500	$0	$33,265,500			$371,600	$33,637,100	By Request
IA	$5,686,196	$28,431	0.5%	By Request	$5,714,627	$0	$5,714,627			$18,300	$5,732,927	By Request
KS(AG)	$3,429,226	$17,146	0.5%	$0	$3,446,372	$0	$3,446,372			$0	$3,446,372	By Request
KS(H)	$1,192,004	$5,960	0.5%	By Request	$1,197,964	$0	$1,197,964			$12,300	$1,210,264	By Request
MO	$11,536,273	$57,681	0.5%	By Request	$11,593,954	$0	$11,593,954			$102,300	$11,696,254	By Request
NE	$3,007,811	$15,039	0.5%	By Request	$3,022,850	$0	$3,022,850			$10,300	$3,033,150	By Request
CO	$5,367,851	$26,839	0.5%	By Request	$5,394,690	$0	$5,394,690			$48,900	$5,443,590	By Request
MT	$2,099,115	$10,496	0.5%	By Request	$2,109,611	$0	$2,109,611			$0	$2,109,611	By Request
ND	$1,714,898	$8,574	0.5%	By Request	$1,723,472	$0	$1,723,472			$0	$1,723,472	By Request
SD	$1,505,152	$7,526	0.5%	By Request	$1,512,678	$0	$1,512,678			$0	$1,512,678	By Request
UT	$2,346,348	$11,732	0.5%	By Request	$2,358,080	$0	$2,358,080			$12,300	$2,370,380	By Request
WY	$1,212,423	$6,062	0.5%	By Request	$1,218,485	$0	$1,218,485			$0	$1,218,485	By Request
AZ	$3,559,042	$17,795	0.5%	By Request	$3,576,837	$0	$3,576,837			$132,900	$3,709,737	By Request
CA	$45,109,637	$225,548	0.5%	By Request	$45,335,185	$0	$45,335,185			$475,900	$45,811,085	By Request
HI	$1,265,244	$6,326	0.5%	$0	$1,271,570	$0	$1,271,570			$0	$1,271,570	By Request
NV	$1,539,407	$7,697	0.5%	By Request	$1,547,104	$0	$1,547,104			$48,900	$1,596,004	By Request
AK	$862,925	$4,315	0.5%	By Request	$867,240	$0	$867,240			$0	$867,240	By Request
ID	$1,696,502	$8,483	0.5%	By Request	$1,704,985	$0	$1,704,985			$22,600	$1,727,585	By Request
OR (Health)	$1,234,748	$6,174	0.5%	By Request	$1,240,922	$0	$1,240,922			$20,600	$1,261,522	By Request
OR (HR)	$3,172,739	$15,864	0.5%	$0	$3,188,603	$0	$3,188,603			$0	$3,188,603	By Request
WA(H)	$2,063,679	$10,318	0.5%	By Request	$2,073,997	$0	$2,073,997			$0	$2,073,997	By Request
WA(SS)	$4,739,373	$23,697	0.5%	$0	$4,763,070	$0	$4,763,070			$30,900	$4,793,970	By Request
	$346,901,630	**$1,734,508**			**$348,636,138**	**$0**	**$348,636,138**			**$3,332,500**	**$351,968,638**	

Appendix 3 - FY 2018 Projected Validation Survey Workload

	CAHS		HOSPITALS				PSYCH HOSPITALS			HOME HEALTH AGENCIES				HOSPICES			AMBULATORY SURGERY CTRS		
State	Total Deemed	Est Sample (Base)	Total Deemed	Est Sample (Base)	Est.Sup Wk-load	Est. Sup $ Award	Total Deemed	Est Sup Wk-load	Est. Sup $ Award	Total Deemed	Reg. Budget Wk-load	Est Sup Wk-load (Base)	Est. Sup $ Award	Total Deemed	Est. Sup Wk-load	Est. Sup $ Award	Total Deemed	Est. Sup Wk-load	Est. Sup $ Award
CT	0	0	31	1	0	$0	5	0	$0	21	1	0	$0	5	0	$0	8	0	$0
MA	2	0	75	2	1	$30,700	9	1	$30,700	189	1	2	$16,000	19	0	$0	23	2	$20,600
ME	1	0	18	1	0	$0	3	0	$0	1	1	0	$0	0	0	$0	2	0	$0
NH	1	0	14	1	0	$0	2	0	$0	2	1	0	$0	2	0	$0	10	0	$0
RI	0	0	11	1	0	$0	2	0	$0	13	1	0	$0	3	0	$0	2	0	$0
VT	1	0	5	0	0	$0	2	0	$0	0	0	0	$0	1	0	$0	1	0	$0
R1	**5**	**0**	**154**	**6**	**1**	**$30,700**	**23**	**1**	**$30,700**	226	5	2	$16,000	30	0	$0	46	2	$20,600
NJ	0	0	74	2	1	$30,700	10	1	$30,700	19	1	0	$0	35	1	$12,300	114	7	$72,100
NY	9	1	139	2	1	$30,700	25	2	$61,400	14	1	0	$0	7	0	$0	98	6	$61,800
PR	0	0	32	1	0	$0	4	0	$0	21	1	0	$0	11	0	$0	6	0	$0
VI	0	0	1	0	0	$0	0	0	$0	1	1	0	$0	0	0	$0	1	0	$0
R2	**9**	**1**	**246**	**5**	**2**	**$61,400**	**39**	**3**	**$92,100**	55	4	0	$0	53	1	$12,300	219	13	$133,900
DC	0	0	11	1	0	$0	1	0	$0	2	1	0	$0	2	0	$0	0	0	$0
DE	0	0	9	1	0	$0	3	0	$0	12	1	0	$0	5	0	$0	12	1	$10,300
MD	0	0	50	1	1	$30,700	6	0	$0	11	1	0	$0	11	0	$0	46	3	$30,900
PA	3	0	153	3	1	$30,700	17	1	$30,700	76	1	1	$8,000	39	1	$12,300	15	1	$10,300
VA	7	0	80	2	1	$30,700	9	0	$0	114	1	2	$16,000	44	1	$12,300	15	1	$10,300
WV	9	1	32	1	0	$0	4	0	$0	2	1	0	$0	1	0	$0	1	0	$0
R3	**19**	**1**	**335**	**9**	**3**	**$92,100**	**40**	**1**	**$30,700**	217	6	3	$24,000	102	2	$24,600	89	6	$61,800
AL	1	0	77	2	0	$0	5	0	$0	68	1	1	$22,200	16	1	$12,300	8	0	$0
FL	5	0	195	3	2	$61,400	19	1	$30,700	696	1	8	$99,900	19	1	$12,300	125	7	$72,100
GA	20	1	116	2	1	$30,700	13	1	$30,700	15	1	0	$0	30	1	$12,300	98	5	$51,500
KY	16	1	72	2	0	$0	9	0	$0	7	1	0	$0	4	0	$0	2	0	$0
MS	9	1	47	1	1	$30,700	4	0	$0	9	1	0	$0	16	1	$12,300	16	1	$10,300
NC	18	1	93	1	1	$30,700	9	0	$0	71	1	1	$22,200	36	1	$12,300	13	1	$10,300
SC	3	0	64	2	0	$0	8	0	$0	24	1	0	$11,100	26	1	$12,300	11	0	$0
TN	9	1	102	2	1	$30,700	9	0	$0	21	1	0	$11,100	14	1	$12,300	11	0	$0
R4	**81**	**5**	**766**	**15**	**6**	**$184,200**	**76**	**2**	**$61,400**	911	8	10	$166,500	161	7	$86,100	284	14	$144,200
IL	29	1	134	3	1	$30,700	13	1	$30,700	275	1	4	$32,000	55	1	$12,300	40	3	$30,900
IN	27	1	95	3	1	$30,700	19	2	$61,400	70	1	1	$8,000	36	1	$12,300	32	3	$30,900
MI	25	1	107	2	1	$30,700	11	1	$30,700	368	1	5	$40,000	91	3	$36,900	34	2	$20,600
MN	20	1	50	1	0	$0	6	0	$0	19	1	0	$0	11	0	$0	20	1	$10,300
OH	31	1	160	4	1	$30,700	25	2	$61,400	230	1	3	$24,000	71	2	$24,600	64	4	$41,200
WI	33	1	71	2	0	$0	7	0	$0	27	1	0	$0	21	1	$12,300	43	3	$30,900
R5	165	6	617	15	4	$122,800	81	6	$184,200	989	6	13	$104,000	285	8	$98,400	233	16	$164,800

	CAHS		HOSPITALS				PSYCH HOSPITALS			HOME HEALTH AGENCIES				HOSPICES			AMBULATORY SURGERY CTRS		
State	Total Deemed	Est Sample (Base)	Total Deemed	Est Sample (Base)	Est.Sup Wk-load	Est. Sup $ Award	Total Deemed	Est Sup Wk-load	Est. Sup $ Award	Total Deemed	Est Sample (Base)	Est.Sup Wk-load	Est. Sup $ Award	Total Deemed	Est. Sup Wk-load	Est. Sup $ Award	Total Deemed	Est. Sup Wk-load	Est. Sup $ Award
AR	5	0	34	2	0	$0	10	1	$30,700	5	1	0	$0	2	0	$0	8	0	$0
LA	10	1	92	2	1	$30,700	21	2	$61,400	9	1	0	$0	15	0	$0	18	2	$20,600
NM	6	0	34	2	0	$0	3	0	$0	11	1	0	$0	10	0	$0	10	0	$0
OK	6	0	68	2	0	$0	6	0	$0	43	1	1	$8,000	20	1	$12,300	10	0	$0
TX	18	1	393	5	3	$92,100	52	4	$122,800	578	1	7	$56,000	341	4	$49,200	122	5	$51,500
R6	45	2	621	13	4	$122, 00	92	**7**	$214,900	646	5	8	$64,000	388	5	$61,500	168	7	$72,100
IA	10	1	27	1	0	$0	2	0	$0	33	1	1	$8,000	14	0	$0	14	1	$10,300
KS	5	0	44	2	0	$0	4	0	$0	26	1	0	$0	22	1	$12,300	10	0	$0
MO	10	1	78	1	1	$30,700	13	1	$30,700	47	1	1	$8,000	35	1	$12,300	17	2	$20,600
NE	5	0	21	2	0	$0	2	0	$0	11	1	0	$0	12	0	$0	13	1	$10,300
R7	**30**	**2**	**170**	**6**	**1**	**$30,700**	**21**	**1**	**$30,700**	**117**	**4**	**3**	**$16,000**	**83**	**2**	**$24,600**	**54**	**4**	**$41,200**
CO	6	0	52	2	0	$0	7	0	$0	93	1	2	$16,000	31	1	$12,300	30	2	$20,600
MT	4	0	8	1	0	$0	1	0	$0	2	1	0	$0	4	0	$0	1	0	$0
ND	4	0	9	1	0	$0	3	0	$0	2	0	0	$0	0	0	$0	3	0	$0
SD	0	0	12	1	0	$0	0	0	$0	0	0	0	$0	3	0	$0	4	0	$0
UT	1	0	34	2	0	$0	6	0	$0	20	1	0	$0	27	1	$12,300	9	0	$0
WY	1	0	10	1	0	$0	1	0	$0	2	0	0	$0	0	0	$0	4	0	$0
R8	**16**	**0**	**125**	**8**	**0**	**$0**	**18**	**0**	**$0**	**119**	**3**	**2**	**$16,000**	**65**	**2**	**$24,600**	**51**	**2**	**$20,600**
AZ	5	0	71	2	1	$30,700	14	1	$30,700	67	1	2	$16,000	69	2	$24,600	47	3	$30,900
CA	19	1	299	3	3	$92,100	32	3	$92,100	893	1	10	$80,000	750	8	$98,400	363	11	$113,300
HI	3	0	12	1	0	$0	1	0	$0	6	1	0	$0	3	0	$0	5	0	$0
NV	2	0	28	2	0	$0	6	0	$0	69	1	2	$16,000	31	1	$12,300	24	2	$20,600
R9	**29**	**1**	**411**	**8**	**4**	**$122,800**	**53**	**4**	**$122,800**	**1,035**	**4**	**14**	**$112,000**	**853**	**11**	**$135,300**	**439**	**16**	**$164,800**
AK	7	1	8	1	0	$0	2	0	$0	4	1	0	$0	2	0	$0	4	0	$0
ID	10	1	15	1	0	$0	3	0	$0	16	1	0	$0	21	1	$12,300	20	1	$10,300
OR	14	1	33	2	0	$0	2	0	$0	12	1	0	$0	14	0	$0	18	2	$20,600
WA	10	1	47	2	0	$0	3	0	$0	11	1	0	$0	5	0	$0	44	3	$30,900
R10	**41**	**4**	**103**	**6**	**0**	**$0**	**10**	**0**	**$0**	**43**	**4**	**0**	**$0**	**42**	**1**	**$12,300**	**86**	**6**	**$61,800**
Tot.	**440**	**22**	**3,548**	**91**	**25**	**$767,500**	**455**	**25**	**$767,500**	**4,358**	**50**	**54**	**$432,000**	**2,062**	**39**	**$479,700**	**1,669**	**86**	**$885,800**

FY2018 COMPREHENSIVE TRAINING SCHEDULE
CMS SURVEY & CERTIFICATION GROUP
Updated as of October 10th, 2017

COURSE NAME	DATE	LOCATION	PROGRAM LEAD	TRAINING COORDINATOR	BACKUP	CEUs
OCTOBER (2017)						
LTC Survey Process (RO6)*	2-5	Webinar	K. Jakaitis	M. Segres	J. Claiborne	N/A
LTC Survey Process*	10-13	Webinar	K. Jakaitis	L. Byrd	P. Payne	N/A
LTC Survey Process*	16-19	Webinar	K. Jakaitis	L. Byrd	P. Payne	N/A
Primarily Engaged New Guidance for Appendix A (Hospitals)*	19	Webinar	L. Marunycz	P. Payne	L. Byrd	N/A
LTC Survey Process*	23-26	Webinar	K. Jakaitis	P. Payne	D. Marshall	N/A
Emergency Preparedness Requirements - All Surveyor Call 2:30 - 3:30pm ET Dial in: 1-877-267-1577 Meeting ID:994723328	**26**	**Teleconference**	**C. Blondiaux**	**A. Acheampong**	**S. Schaeffer**	**N/A**
Basic ICF/IID*	30 - 11/3	Webinar	M. Rice	P. Payne	L. Byrd	2.8
NOVEMBER (2017)						
DECEMBER (2017)						
HHA Update*	7	Webinar	J. O'Malley	M. Segres	P. Payne	N/A
JANUARY (2018)						
ICF/IID New Focused Fundamental Survey Process*	**30**	Webinar	M. Rice	TBD	TBD	N/A
APRIL (2018)						
State Agency Director Orientation Course (SADOC)	16 - 17	Baltimore, MD	N/A	L. Byrd	P. Payne	N/A
Survey Executives Training Institute (SETI)	18 - 20	Baltimore, MD	N/A	L. Byrd	P. Payne	N/A
MAY (2018)						
JUNE (2018)						
Resident Assessment Instrument (RAI)	TBD	Baltimore, MD	C. Teague	L. Byrd	P. Payne	N/A
CLIA Partners Meeting	5-6	Baltimore, MD	C. Weaver	C. Weaver	D. Cajigas	N/A
CLIA RO/CO Meeting	6-7	Baltimore, MD	C. Weaver	C. Weaver	D. Cajigas	N/A
Advanced EMTALA	19-21	Baltimore, MD	M. Palowitch	P. Payne	L. Byrd	2.1
JULY (2018)						
SEPTEMBER (2018)						
CMHC QA Review of 2567s*	TBD	Webinar	D. Howard	P. Payne	L. Byrd	N/A

*Students have the option to take Introduction to Webinar Basics prior to the start of this webinar

Introduction to Webinar Basics can be accessed here

FY2018 ON-DEMAND TRAINING SCHEDULE

https://surveyortraining.cms.hhs.gov

EXISTING SELF-PACED ONLINE TRAINING
Ambulatory Surgical Centers (ASC) Basic Training
Basic Health Facility Surveyor Course: Introduction to Surveying for LTC
Critical Access Hospitals (CAH) Training
Emergency Medical Treatment and Labor Act (EMTALA) Basic Training
Emergency Preparedness
Foundational Investigative Skills
Fundamentals of Patient Safety in Hospitals
Hospital Basic Training Part 1
Hospital Basic Training Part 2
Introduction to Webinar Basics (access course here)
Life Safety Code Transition Course
Pharmaceutical Compounding
Principles of Documentation (LTC)
Principles of Documentation Learning Activity - Long Term Care (optional for Non LTC Surveyors)
Rural Health Clinic / Federally Qualified Healthcare Center (RHC/FQHC)

UPCOMING SELF-PACED ONLINE TRAINING
Basic Life Safety Code (2012) - *December 2017*
Home Health Agency Basic Training - *January 2018*
Hospice Basic Training - *Feburary 2018*
Psychiatric Residential Treatment Facilities (PRTF) Basic Training - *February 2018*
ICF/IID Basic Training - *February 2018*
End Stage Renal Disease (ESRD) Basic Training - *February 2018*
End Stage Renal Disease (ESRD) STAR Basic Training- *February 2018*
Basic Long Term Care - New Survey Process (BLTCC) - *March 2018*
Community Mental Health Centers (CMHC) - *April 2018*
NFPA 99 - *May 2018*
Fire Safety Evaluation System - Health Care Surveyor Training- *July 2018*
New Long Term Care Survey Process (LTCSP) Application Technical Training - *August 2018*
Fire Safety Evaluation System - Board and Care - *November 2018*
Transplant Basic Training - *January 2019*
Outpatient Physical Therapy / Outpatient Speech Language Pathology Services Basic Training - *TBD*
CLIA Basic Training - *TBD*
CLIA Orientation Manual - *TBD*
CLIA Principles of Documentation - *TBD*
CLIA State Operations Manual (SOM) - *TBD*
CLIA Proficiency Testing - *TBD*

Online trainings are available 24 hours a day / 365 days a year

For questions about the Training Schedule please contact the assigned Training Coordinator or SCG_Training@cms.hhs.gov

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Hotel Reservation	**Surveyor Training Website Help Desk**	**SCG Training**
http://tdpsvs.com/cms/	1-855-791-8900 cmstraininghelp@hendall.com	scg_training@cms.hhs.gov