DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/ Quality, Safety & Oversight Group

Admin Info: 18-22-ALL

DATE: September 28, 2018

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Fiscal Year (FY) 2019 State Performance Standards System (SPSS) Guidance

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Memorandum Summary

- **SPSS Framework**: The three dimensions of frequency, quality, and enforcement continue to serve as the Centers for Medicare & Medicaid Services' (CMS) framework to organize and measure the performance of State Survey Agencies. .

Background

Every year, CMS conducts a formal assessment of whether State Survey Agencies (SAs) fulfill their responsibilities to identify and enforce compliance among Medicare/Medicaid certified providers, thereby ensuring the health and safety of Medicare/Medicaid enrollees. The assessment is done through the SPSS, which is a three-dimensional structure (frequency, quality, and enforcement) for organizing and measuring SA performance. In addition, these three dimensions support our efforts to standardize, promote consistency and automate the data that are used in the State performance evaluation process.

In FY 2018 (Admin Info18-02), we placed on hold the scoring of Q2 (Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by Federal Oversight Support Surveys (FOSS)), Q3 (Documentation of Noncompliance in Accordance with Federal Standards for Nursing Home Health FOSS Surveys), and Q4 (Identification of Health and Life Safety Code Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results). In April 2018, CMS launched an initiative to evaluate the entire SPSS program to identify ways to improve State performance. This large-scale effort is focused on improving the efficiency and effectiveness of measuring and improving State performance. The effort supports our ultimate goal of protecting and improving the health and safety of all individuals receiving services from all Medicare/Medicaid providers throughout the country. Since this initiative is still underway, there are no major updates for FY 2019, and the changes implemented in FY 2018 remain in effect. The only change is that we deleted the clarifying guidance for scoring State performance related to the requirements for Non-Deemed Hospices.

Throughout the year, we intend to test new methodologies for revising the program, and plan to implement a new program beginning in FY 2020. We appreciate your efforts to continuously improve the performance of SAs, and improve the health and safety of Medicare/Medicaid enrollees.

Contact: Please contact the SPSS team at SPSS_Team@cms.hhs.gov with any questions or concerns.

Effective Date: Immediately. This information should be communicated to 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 – FY 2018 Consolidate SPSS Guidance
Attachment 2 – Q1 Worksheet
Attachment 3 – Q8 Worksheet,
Attachment 4 – Summary Score Sheet

cc: Survey and Certification Regional Office Management

FY 2019
State Performance Standards System Guidance

Table of Contents

PURPOSE

This guidance sets forth how the Centers for Medicare & Medicaid Services (CMS) will evaluate the overall State Survey Agency's (SA's) compliance with specific responsibilities outlined in the 1864 Agreement.

BACKGROUND

Article V of the 1864 Agreement gives the Secretary the authority to periodically evaluate the State's performance under the Agreement.

In FY 2001, CMS established a set of standards to determine whether the SAs were meeting the requirements for the survey and certification program and to identify areas for improvement in management. In FY 2006, the State Performance Standards System (SPSS), as illustrated below, were redesigned in order to emphasize that the value of the survey program stems not only from completing surveys timely, but also from the quality of the surveys themselves, the proper identification of deficiencies, and the enforcement and remedy of identified problems in Medicare/Medicaid-certified providers/suppliers, preferably through systemic change.

Frequency

Enforcement
and Remedy

Quality of
Surveys

VALUE
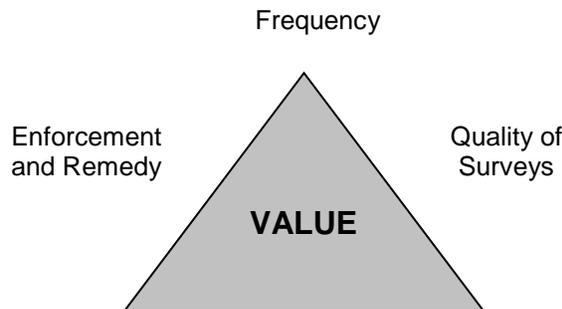
The SPSS is intended to evaluate whether the SAs are meeting key areas of the State survey and certification program. This evaluation does not restrict the CMS Regional Offices (ROs) from performing other oversight activities, to assure that the SAs are meeting the terms of the 1864 Agreement. Furthermore, the SPSS does not create any new policy for the SAs and it does not nullify Federal law, regulations, the State Operations Manual, or formal policy provided by CMS.

GENERAL INSTRUCTIONS

The FY 2019 SPSS Guidance provides instructions to the ROs on how to evaluate the SAs' performance across three Dimensions: Frequency, Quality, and Enforcement and Remedy. Each Dimension is comprised of various Measures.

In order to complete the FY 2019 State Performance Standard review in a timely manner, the ROs should conduct parts of the evaluation semi-annually, especially the Measures that include case documentation review. At this point, the RO may wish to provide the SAs with a report of its findings so that improvements could be facilitated for the remainder of the fiscal year.

Scoring should be conducted according to the Method of Evaluation section that is listed under each Measure. Scoring sheets for the specific Measures are included in the Appendices. In cases where a Threshold Criterion is not applicable to a SA, the RO will note this on the scoring sheet and the SA will not receive a score for that particular Threshold Criterion. The ROs must complete a State Performance Review Summary packet (i.e., scoring sheet, supporting documentation) for each SA in their respective RO.

In order to assure that the SAs are scored in a consistent manner, the RO should not allow for any exceptions as each Measure is scored. If a SA does not meet a Measure, it may provide information in its Corrective Action Plan about any extenuating circumstances that had occurred during the FY.

The ROs should not request information that is already available in CMS systems from States. If more information is needed, it should be transmitted in an electronic format that is usable by the RO whenever possible.

FREQUENCY

F1 Off-Hour Surveys for Nursing Homes

a) Threshold Criterion

   1. *Nursing home off-hour surveys:* At least 10% of standard surveys conducted in the fiscal year under review must begin either on the weekend (Saturday or Sunday), in the early morning hours (before 8:00 am), or in the evening hours (after 6:00 pm), or on holidays. For a survey to count as beginning during off-hours, a health survey team of typical size and composition must enter the facility together. Life Safety Code (LSC) and Emergency Preparedness (EP) surveys are exempt (i.e., LSC and EP surveys are not required to be conducted during off-hours).

b) References: 42 CFR § 488.307, State Operations Manual (SOM) Chapter 7 section 7207B2, and S&C-04-33.

c) Data Source: CASPER State Performance Standard Report-Report 800S.

d) Method of Evaluation: See Appendix 2 - FY 2019 -Discussion of Data.

e) Scoring

   If the percentage of nursing home surveys conducted during the off-hour timeframes is greater than or equal to 10%, this Measure is scored as "Met."

   If the percentage of nursing home surveys conducted during the off-hour timeframes is less than 10%, this Measure is scored as "Not Met."

F2 Frequency of Nursing Home Surveys

a) Threshold Criteria

   1. *Maximum survey frequency requirement:* For 100% of nursing homes, the SA must conduct a standard health survey not later than 15.9 months after the last day of the previous standard health survey.

   2. *Statewide average interval requirement:* The statewide average time interval between consecutive standard health surveys must be 12.9 months or less.

b) References: Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Act and 42 CFR § 488.308.

c) Data Source: CASPER State Performance Standard Reports- Reports 801S, 802D, and 803D. In FY 2010, CASPER was modified so that the survey frequency intervals are calculated from the "Survey Completion Date" (L34).

d) Method of Evaluation: See Appendix 2--FY 2019-Discussion of Data.

e) Scoring

   If the maximum number of months between all standard surveys is less than or equal to 15.9 months and the statewide average interval is less than or equal to 12.9 months, this Measure is scored as "Met."

   If the maximum number of months between any standard survey is greater than 15.9 months or the statewide average interval is greater than 12.9 months, this Measure is scored as "Not Met."

F3.1 Frequency of Non-Nursing Home Surveys – Tier 1

a) Threshold Criterion

   1. *Tier 1 Surveys:* The SA conducts recertification surveys for non-deemed Home Health Agencies (HHAs), ICFs/IID, (non-deemed hospices), and validation surveys for deemed hospitals, according to the Tier 1 Requirements in the FY 2019 Mission & Priority Document and the Final State Medicare Allocations Memorandum.

b) References

   1. HHAs – Section 1891(c)(2)(A) of the Act
   2. ICFs/IID – 42 CFR §§ 442.15, 442.16, and 442.109
   3. Hospices - Improving Medicare Post-Acute Care Transformation Act of 2014 - IMPACT Act (H.R. 4994). Admin Info: 15-09
   4. Validation Surveys -Sections 1864(c) and 1865 of the Act and 42 CFR § 488.7
   5. FY 2019 Survey & Certification Mission and Priority Document
   6. FY 2019 Final State Medicare Allocations Memorandum

c) Data Source: CASPER State Performance Standard Reports for Tier 1 providers-810S, 811D, 812D, 820S, 821D, 822D, 830S, and 831D.

d) Method of Evaluation: See Appendix 2 – FY 2019-Discussion of Data.

Any deemed hospital that is *sampled for a validation survey in* the fiscal year under review is included in the current fiscal year 2019 State Performance Evaluation. Validation surveys are required to be completed within 60 days of the accrediting organization's survey end date.

a) Scoring

If the SA conducts recertification surveys for non-deemed HHAs, ICFs/IID, and non-deemed hospices, and validation surveys for deemed hospitals according to the Tier 1 Requirements, this Measure is scored as "Met."

If the SA does not conduct recertification surveys for non-deemed HHAs or ICFs/IID or non-deemed hospices or validation surveys for deemed hospitals according to the Tier 1 Requirements, this Measure is scored as "Not Met."

NOTE – HHA/ HOSPICE:
If the SA can produce documentation that they received notification that an HHA/ Hospice has dropped their AO status at 60 days or less from the maximum 36 month survey interval date and they were unable to schedule and complete the re-certification survey within the required timeframe as result of that late notification, CMS will not do an associated non-delivery notice nor will the SA be penalized on the SPSS for not making the 36.9 maximum survey interval on that particular survey.

F3.2 Frequency of Non-Nursing Home Surveys – Tier 2

a) Threshold Criterion

1. *Tier 2 Surveys:* The SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities (excluding transplant hospitals), according to the Tier 2 Requirements in FY 2019 Mission & Priority Document and the Final State Medicare Allocations Memorandum.

b) References

1. FY 2019 Survey & Certification Mission and Priority Document
2. FY 2019 Final State Medicare Allocations Memorandum
3. FY 2019 Targeted Sample List for ESRD Facilities
4. FY 2019 Random Sample List for ASCs
5. FY 2019 Targeted Sample List for Non-Deemed Hospitals

c) Data Source: CASPER State Performance Standard Reports for Tier 2 providers/suppliers – 0840S, 0841D, 0842D, 0843D, 0844S, 0845S, and 0846S.

d) Method of Evaluation: See Appendix 2 – FY 2019 - Discussion of Data.

e) Scoring

If the SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities according to the Tier 2 Requirements, this Measure is scored as "Met."

If the SA does not conduct recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, or ESRD facilities according to the Tier 2 Requirements, this Measure is scored as "Not Met."

F3.3 Frequency of Non-Nursing Home Surveys – Tier 3

a) Threshold Criterion

1. *Tier 3 Surveys:* The SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities (excluding transplant hospitals), according to the Tier 3 Requirements in FY 2019 Mission & Priority Document and the Final State Medicare Allocations Memorandum.

b) References

1. FY 2019 Survey & Certification Mission and Priority Document
2. FY 2019 Final State Medicare Allocations Memorandum

c) Data Source: CASPER State Performance Standard Reports for Tier 3 providers/suppliers – 0840S, 0841D, 0842D, 0843D, 0844S, 0845S, and 0846S.

d) Method of Evaluation: See Appendix 2 – FY 2019 - Discussion of Data.

e) Scoring

If the SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities according to the Tier 3 Requirements, this Measure is scored as "Met."

If the SA does not conduct recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, or ESRD facilities according to the Tier 3 Requirements, this Measure is scored as "Not Met."

F4 Timeliness of Upload into CASPER of Standard Surveys for Non-Deemed Hospitals and Nursing Homes

a) Threshold Criterion

1. *Data entry for non-deemed hospitals (including non-deemed CAHs) and nursing homes:* The mean number of days from the latest date of the SA survey completion (L34) to the date of data successful upload into CASPER (National Database) does not exceed 70 calendar days. For hospitals, if condition-level noncompliance is identified, the case should be excluded from the review.

b) References: Article II (J) of the 1864 Agreement and SOM Chapter 5, section 5075 and Chapter 7, section 7410C.

c) Data Source: Providing Data Quickly (PDQ).

d) Method of Evaluation

The universe for this Measure is all nursing home and non-deemed hospital (including non-deemed CAHs) recertification surveys uploaded into CASPER during the fiscal year. Initial surveys are excluded.

1. For nursing homes, enter PDQ and click on "Nursing Home Providers." For non-deemed hospitals, enter PDQ and click on "Hospital Providers."
2. Follow steps #3-5 for both nursing homes and hospitals.
3. Under "Survey Reports," click on "Frequency of Data Entry (F4)" link.
4. Enter the selection criteria for each field as described below and click "Run Report."
   a. Year Type: "Fiscal Year" (default)
   b. Begin Year: "2019" (default)
   c. End Year: "2019" (default)
   d. Display multiple years: "empty" (default)
   e. Define Outliers: "70" days (default)
   f. Provider Type(s): For nursing homes, select all four provider types.
5. After selecting "Run Report," the program then advances to a page providing results separately by RO. The program creates rows below that RO, separating the results by the SAs in that RO. The page will have the following columns:
   a. Region: Click once on your region name to get to the specific SA in your RO. When you click once on the SA name, this provides a listing of all providers within that SA that are outliers.
   b. Number of Surveys Entered
   c. Mean # of Days to Data Entry
   d. Data Entry Exceeds 70 Days (% of Surveys)
   Print this page separating the results by SA. Utilizing this PDQ output from the column marked "Number of Surveys Entered" and "Mean # of Days to Data Entry," record this data for nursing homes and non-deemed hospitals for each SA.

e) Scoring

If the average is less than or equal to 70 calendar days for data entry of both nursing home and non-deemed hospital (including non-deemed CAHs) surveys, this Measure is scored as "Met."

If the average is greater than 70 calendar days for data entry for either nursing home or non-deemed hospital (including non-deemed CAHs) surveys, this Measure is scored as "Not Met."

QUALITY

Q1 Documentation of Deficiencies for Nursing Homes, ESRD Facilities, ICFs/IID and Non-Deemed HHAs and Hospitals

a) Threshold Criteria

1. *Nursing Homes:* The SA achieves a score of 85% or above for each of the seven requirements that evaluate whether the SA documents all deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation and Appendices P and PP of the SOM.
2. *Non-Nursing Homes (Non-Deemed HHAs, ESRD Facilities, ICFs/IID, Non-Deemed Hospitals, including Non-Deemed CAHs)*: The SA achieves a score of 85% or above for each of the six requirements that evaluate whether the SA documents all deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation and relevant Appendices of the SOM.

b) References: 42 CFR § 488.318, the Principles of Documentation of the SOM, relevant sections of the SOM and applicable Survey & Certification Memoranda related to the documentation of deficiencies (e.g., revised surveyor guidance).

c) Data Source: Datasets to identify cases for review will be created by the RO. See Appendix 3. CMS-2567s from recertification and complaint surveys will be used to complete the review.

d) Method of Evaluation

Characteristics of the Sample - Nursing Homes

1. Date range – Based on CMS-2567 date of October 1, 2018 to September 30, 2019
2. Size

Total Number of Surveys Conducted during FY 2018	Sample Size (Number of Surveys)
10 or Less	All
11 to 100	10
101 to 400	10% of the number of surveys
Greater than 400	40

3. The sample should contain 75% recertification surveys and 25% complaint surveys.
4. The sample should contain only surveys that lead to a deficiency at S/S=D or above.

Characteristics of the Sample – ESRD Facilities, ICFs/IID, and Non-Deemed HHAs and Hospitals, including CAHs

1. Date range – Based on CMS-2567 date of October 1, 2018 to September 30, 2019
2. Size

Total Number of Surveys Conducted during FY 2018	Sample Size (Number of Surveys)
10 or Less	All
11 to 100	10
101 to 400	10% of the number of surveys
Greater than 400	40

3. The sample should contain 25% complaint surveys and 75% recertification surveys.
4. The sample should contain at least two surveys from each provider type if possible.
5. The sample should contain only surveys that lead to a deficiency.
6. The sample should exclude surveys for deemed providers and EMTALA cases.

NOTE: The total number of surveys for each provider is derived from the Survey Activity Report in PDQ. The total number of surveys equals the number of standard surveys plus the number of complaint surveys.

Conducting the Review

- The review should be conducted by an individual in the RO who is professionally qualified to evaluate the cases based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements.
- Review four tags for each survey if there are at least that number of tags. Otherwise, review all the tags. If the survey includes both a health LSC and EP component, the RO selects at least one deficiency tag from the LSC component and one deficiency tag from the EP component, if there is a tag cited, to count in the four tags
- For nursing homes, review tags at Severity Level 2 and above only. Do not review Severity Level 1 deficiencies.
- For nursing homes, review at least one quality of care tag, if applicable.
- For non-nursing homes, review at least one condition-level deficiency.
- One person may conduct the review with at least one additional person reviewing all requirements rated "No."

- All "No" ratings must have a specific objective explanation in the comment section.
- The reviewer should base his/her rating on the written documentation on the CMS-2567 without assuming additional information.
- It is recommended that the review be performed semi-annually.
- If the health or LSC or EP Statement of Deficiencies (SOD) has a completion date outside the FY of the review, do not review any deficiencies from that component of the SOD

Note:
- Up to 25% of enforcement cases randomly selected that are referred to the RO may be used. This review should only be conducted on the first survey that began the enforcement case (Long term care - LTC/Non-long term care - NLTC).
- Up to 25% of State surveys that lead to comparative surveys may be used (LTC Only). **Cases should be randomly selected**.

Review Requirements -Principles of Documentation

NOTE: The purpose of the review is to assess whether the tag 1) is consistent with the Federal regulation at which it was cited and 2) contains sufficient information to support the finding of noncompliance.
The RO should include contractor surveys that are arranged by the state, but will need to exclude federal contractor surveys from the sample.

Requirements 1-5 are related to guidance found in the Principles of Documentation.

	Requirement	Guidance and References

1	The findings support and illustrate the entity's non-compliance. (Principle #3)	Score Y when:
		• There is sufficient evidence to support the finding of noncompliance at the cited requirement/condition; and
		• **All** relevant what, who, where, when, and how questions are answered for the evidence that supports the finding of noncompliance:
		   ○ What entity practice was noncompliant;
		   ○ Who were the residents/patients/clients or staff involved;
		   ○ Where the deficient practice occurred, e.g., specific locations in the entity or documents;
		   ○ When (e.g., for how long) the problem occurred;
		   ○ How the deficiency was determined and how the evidence relates to the requirement.
		
		If Score=N, then all other requirements (#2 to 8) are scored N/A.
		
		Additional Guidance:
		
		This is scored "Yes" when there is sufficient evidence to support the findings of noncompliance at the cited requirement/condition and all relevant questions are answered for the evidence that supports the noncompliance. Only focus on the evidence that supports the noncompliance. The findings have to be appropriate for the tag being reviewed, not necessarily what the deficient practice statement DPS indicates the facility failed to do. As long as the relevant questions are answered for the evidence that supports the finding of noncompliance at the cited requirement/condition, this can be scored a "Yes." If there is additional information that does not support the finding of noncompliance (see Requirement #5) or does not contribute to answering the questions, that will not make this a "No." Note that if Requirement 1 is scored a "No", all other criteria (#2 to 7 for LTC and #2 to 5 plus #8 for NLTC) are scored "N/A".

	Requirement	Guidance and References
2	Each Deficient Practice Statement clearly summarizes the provider/supplier's failure(s) and quantifies a relevant extent. (Principle #3B)	This requirement applies to the Deficient Practice Statement only. Score Y when the Deficient Practice Statement contains all of the following: • Specific action(s), error(s), or lack of action (deficient practice), • Outcome(s) relative to the deficient practice, when possible, • Description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases, • The identifier of the individuals or situations referenced in the extent of the deficient practice, and • The source(s) of the information through which the evidence was obtained. <u>Additional Guidance:</u> **Bullet 1:** There needs to be a statement of what the facility failed to do. If the statement is not correct for the tag; is a restatement of the regulation; is not clear as to what the facility failed to do; or is not consistent with the evidence in the findings, Requirement 2 is scored "No." **Bullet 2:** Outcomes relative to the deficient practice should be included, when possible. The POD states that "To the extent possible, especially where described or anticipated in the requirement(s), the deficient practice indicates outcome(s)." If there is a specific outcome, the DPS should include an outcome statement. If harm occurred at the actual harm level or IJ level, this outcome must be noted in the DPS. If there is likely harm at the IJ level, this must also be noted in the DPS. Otherwise, the DPS may include an outcome statement but it is not required. When it is not required, Requirement 2 should not be scored "No" due to the lack of an outcome statement. **Bullet 3:** Extent is addressed in the POD. Extent is not necessarily scope. An extent statement has the number of deficient cases in the numerator and the total number of cases that could be affected by the failed practice in the denominator. The denominator is determined by what the surveyor knows about the failed practice. Could all residents/patients/clients be impacted by the deficient practice? What was the extent of the surveyor's investigation, e.g., did the surveyor only look at this issue in the sample? If so, could the whole sample be impacted or only a subset of the sample? Does the requirement relate only to a subset of the residents/patients/clients? Was the deficient practice determined through only random opportunities for discovery? An extent based on random opportunities for discovery does not have to have a denominator. Extents that use non-person units are permissible. **Bullet 4:** All deficient cases (identifiers of individuals or situations) should be listed in the DPS. **Bullet 5:** The sources of information listed in the DPS MUST MATCH the sources of information used in the findings. If the DPS indicates that the evidence is based on observation and interview but only the interview is part of the findings, this is not acceptable. If the findings have a record review and interview but the DPS only includes record review, this is not acceptable.

	Requirement	Guidance and References
3	Each person referred to in the citation is uniquely identified. (Principle #3)	Score Y when all individuals (e.g., residents, patients, staff) in the citation are identified with a unique identifier that preserves their confidentiality. It is acceptable to refer to a confidential interviewee without providing an identifier. • Confidential identifiers must be unique. • When the person referred to in the report is an entity staff member (and does not wish to remain confidential), the person(s) must be identified by their position, discipline, or job title. If there is only one type of staff member, (e.g., the Administrator, the Director of Nursing (DON)) it is sufficient to refer to that person by their position, discipline or job title alone. If there are more than one of that type of staff member they should be referred to by their position, discipline or job title and an identifying number. For example, "registered nurse #1 confirmed…" or "housekeeper #3 stated…" • This criterion applies only to individuals directly contributing to the survey findings. Additional Guidance: Participants in the group interview or others who contribute to the findings, if applicable or as permitted, should be given a unique identifier. The PODs indicate that "When random observations or recipients/cases/records beyond the original sample(s) are included in a citation, an identifier should be given to the individual so that the entity may evaluate the extent of the problem or patterns and correct the deficient entity practice." The PODs address confidential interviews as follows: "Every effort should be made to protect a recipient's privacy especially regarding information gathered during an in-depth interview. Do not identify recipients or family members without their permission. If the interviewee does not wish the entity to know the source of the information provided to you, that information may be recorded on the Form CMS-2567 without an identifier. The CMS-2567 would state, 'During a confidential interview…'"
4	The citation includes information about the source(s) through which evidence was obtained. (Principle #3)	Score Y when the citation includes information about the sources through which evidence was obtained: • For observations - The date, time, duration (when appropriate), who was observed, and location of the observations. • For interviews - The date and time of the interviews and the identification of who was interviewed. • For record reviews -The types and dates of records/documents used in the identification of the deficient practices (i.e., date of entry, exact title of record, and, if applicable to the deficient practice, verification of a lack of additional records with a knowledgeable staff member). Additional Guidance: Minor errors that do NOT IMPACT the ability to demonstrate noncompliance should not be scored a "NO".

	Requirement	Guidance and References
5	Evidence is written in plain language that is clear, concise and easily understood. (Principle #2)	When scoring, consider whether the deficiency is written clearly, objectively, and in a manner that is easily understood. Score Y when the citation generally has: • An explanation of abbreviations and acronyms when first used in each deficiency citation; common abbreviations may be placed in introductory comments. • Short, concise sentences. • No technical jargon that would not be readily understood by a lay person (e.g., includes an explanation of medical terminology). • An absence of critical spelling errors. • Active voice (subject—verb—object). • An absence of extraneous information, defined as findings that are not relevant to demonstrating noncompliance. • An absence of vague terminology (such as, seems, appears, did not always, only, just, unsatisfactory, unnecessary, or inadequate). • An absence of unsupported conclusions. • The findings organized in a logical order, generally chronological, with the most serious findings first. <u>Additional Guidance:</u> If you can understand how the facility is not in compliance, score this "Yes." However, if an important point is not clear, e.g., part of a crucial sentence is missing or the words are jumbled, Requirement 5 should be scored "No." If there is so much extraneous information that it distracts the reader or if the language is so vague that it leaves doubt as to the nature of the noncompliance, score this a "No." If commonly known acronyms are not explained, that should not be sufficient to score what would otherwise be a "Yes" a "No."

Review Requirements -Assessment of the Level of Deficiencies

NOTE: Requirements 6-8 are related to the categorization of a deficiency as it relates to the documented findings.

	Requirement	Guidance and References
6	(For nursing homes) The severity rating reflects the evidence and the actual and/or potential outcome to residents.	*For nursing homes*, score Y when the facts in the citation support the assigned severity rating (severity is the level of outcome or potential/actual harm to residents). Refer to . Deficiency Categorization, Appendix PP for severity guidance on specific tags, Appendix Q, and the Scope and Severity Grid. Additional Guidance: Find the Scope and Severity Grid by going to the Survey Resource folder at the following link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
7	(For nursing homes) The scope reflects the evidence and the number of residents who are, or may be, affected by the deficient practice.	*For nursing homes*, score Y when the facts in the citation support the assigned scope rating (isolated, pattern or widespread). Refer to the Scope and Severity Grid. Additional Guidance: Find the Scope and Severity Grid by going to the Survey Resource folder at the following link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html This requirement should only be scored Yes if both the DPS and the findings support the cited scope. .
8	(For non-nursing homes) The condition, standard, or element- level cited reflects the evidence and the actual and/or potential outcome to patients/clients. (Principle #8)	*For non-nursing homes*, score Y when the condition, standard, or element identifies noncompliance at the level cited. • A condition-level deficiency is cited when "the deficiencies ... adversely affect the health and safety of patients." 42 CFR §§ 488.24(b) and 488.26(b). • Apply Appendix Q for immediate jeopardy situations. A condition-level deficiency is cited for IJ situations. • If a condition-level deficiency exists, the CMS-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at standards or other subsidiary requirements, the deficient practices and individual findings are cited at the relevant requirements. The findings under these subsidiary requirements may be referenced under the condition-level citation. • For a condition-level deficiency, the findings explain how the degree and manner of the deficient practice justifies a conclusion of noncompliance at the condition-level. • When a condition-level deficiency is reviewed, the RO reviews its accompanying standard or other subsidiary deficiency(ies). Each deficiency tag will be counted individually for this review (e.g., if one condition-level deficiency is reviewed with its two subsidiary deficiencies, this counts as three tags reviewed).

e) Scoring

   If the score for each requirement for nursing homes and non-nursing homes is greater than or equal to 85%, this Measure is scored as "Met." If one or more scores for a requirement is less than 85%, this Measure is scored as "Not Met."

Q2 Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by Federal Oversight Support Surveys (FOSS) - Scoring for FY2019 Placed on Hold

a) Threshold Criterion

    1. *Survey conduct (FOSS):* Nursing home health surveys evaluated by FOSS are satisfactorily conducted, by effectively achieving the desired outcomes of the survey, using Federal standards, protocols, forms, methods, and procedures specified by CMS in manual instructions (i.e., the SA achieves an average rating of 3.0 or greater for each of the six FOSS measures).

b) References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act and 42 CFR § 488.318, and the FOSS Manual.

c) Data Source: Federal Monitoring Survey (FMS) Access Database

d) Method of Evaluation: The following reports are generated from the FMS Access Database.

    Report #1 – Ratings Per Measure: This report shows the average rating for each FOSS measure. This report furnishes an overview of the SA's strengths and weaknesses for outcome achievement within the survey process.

    To meet this Measure, the SA must have an average score of 3.0 ("satisfactory") or greater for each of the six FOSS measures. The score for each FOSS measure is calculated by adding the ratings for that FOSS measure across surveys and dividing the sum by the total number of surveys with ratings for that FOSS measure. This calculation achieves a separate average score for each of the individual FOSS measures.

e) Scoring

    If all six FOSS measures achieve an average score of 3.0 or above, this Measure is scored as "Met."

    If any FOSS measure achieves an average score less than 3.0, this Measure is scored as "Not Met."

Q3 Documentation of Noncompliance in Accordance with Federal Standards for Nursing Home Health FOSS Surveys *- Scoring for FY2019 Placed on Hold*

a) Threshold Criterion

   1. *Survey findings (FOSS):* The unjustified disparity rate is 20% or less between deficiencies identified onsite at Task 6 and deficiencies cited on CMS-2567 for nursing home health FOSS surveys (health).

b) References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act, 42 CFR § 488.318, and the FOSS Manual.

c) Data Source: FMS Access Database.

d) Method of Evaluation: The following reports will be generated from the FMS Access Database.

   Report #2 – Tags where Severity Changed from the Potential Citations completed by the survey team. to Facility Copy of CMS-2567: This report lists the deficiencies for each survey for which there was a variation in the determination of noncompliance made onsite versus the final Form CMS-2567 issued to the facility. The report indicates whether the RO agrees with the revision from Task 6 to the final CMS-2567.

   Example of disparity rate determination: Of the 20 deficiencies a SA decides to cite during Potential Citations, three were not cited on the CMS-2567; although, onsite information indicates that the deficiencies should have been cited. In addition, there are two deficiencies where the scope/severity level changed from "G" to "D;" although, onsite information supports a higher severity level. The unjustified disparity rate is (3+2)/20=25%.

   Calculation:

   Disparity Rate = Number of deficiencies where the RO disagreed with the SA's revisions between Potential Citationsand issuance of the CMS-2567 divided by the total number of deficiencies identified at Task 6

e) Scoring

   If the unjustified disparity rate is 20% or less, this Measure is scored as "Met."

   If the unjustified disparity rate is more than 20%, this Measure is scored as "Not Met."

Q4 Identification of Health, and Life Safety Code (LSC) and Emergency Preparedness (EP) Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results - *Scoring for FY2019 Placed on Hold*

a) Threshold Criteria: This threshold criterion evaluates the SAs identification of onsite findings of noncompliance as measured by comparative survey results. For 90% or more of the deficiencies cited on the RO comparative surveys at immediate jeopardy or actual harm levels or that resulted in substandard quality of care (SQC), the SA did not miss citing the same findings on its survey at the same or higher severity level. NOTE: For SQC at an F, the SA had to cite the same findings at an F or higher.

b) References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act and 42 C.F.R. §488.318.

c) Data Source: FMS database reports.

d) Method of Evaluation

Table 1: Citation Accuracy Chart – FY 2019

RO Comparative Survey cites	Points in Denominator	Points in Numerator				
		SA cites: similar findings at same or different tag; same or higher severity	SA cites: similar findings at same or different tag; lower severity which was appropriate at the time of its survey	SA cites: similar findings at same or different tag;, lower severity; that should have cited at same or higher severity level or SQC	SA cites same tag, no similar findings	SA does not cite tag at all SHF = yes
IJ/SQC	15	15	15	0	0	0
IJ/no SQC	12	12	12	0	0	0
AH/SQC	8	8	8	0	0	0
AH/No SQC	5	5	5	0	0	0
F SQC	3	3	3	0	0	0

NOTE: The following circumstances are not considered in the scoring i.e. (do not count in the numerator or denominator); 1) the SA does not cite tag at all and RO determined the SA should not have found the deficiency (Should Have Found (SHF) =No); 2) RO unable to determine if the deficiency should have been cited by SA (SHF=unable to determine), 3) RO unable to determine if SA understated the severity level (understatement=unable to determine).

NOTE: For "F" SQC, the SA had to cite the same findings at an "F" or higher to be scored as having cited at the same or higher severity

NOTE: Points in numerator columns in priority order - the first column that fits the situation indicates the number of points

NOTE: This analysis is done for each deficiency cited by the RO at an IJ, Actual harm and/or SQC level for both health, LSC and EP deficiencies

NOTE: After adding up the numerator and denominator over all the deficiencies included in the analysis, calculate a percentage.

Lower Severity Includes deficiencies the SA cited at severity levels 1, 2 or 3 that are at a severity level less than what the RO cited and deficiencies that were not cited at all.

Similar findings means that both the Federal and State survey findings included similar issues around the same topic areas, such as falls, pressure ulcers, infection control, etc. For example, both the SA and RO may cite F323. However, the findings would not be similar if the RO identified only failure to prevent elopements and the SA identified only failure to prevent falls.

A FMS database report 4b will identify all the deficiencies cited from health, EP and LSC comparative surveys that the RO identified at IJ, actual harm and/or SQC; at what severity/scope levels the deficiencies were cited by the RO and the SA; and whether the SA should have found the deficiency(ies). For each such deficiency, based on what was written in the FMS analysis report regarding how the SA cited the same findings, the RO will determine which cell on the above table applies and will determine how many points go in the numerator and denominator. The RO will calculate the percentage agreement using the following calculation:

Calculation:

NOTE: There is only one calculation for this measure that includes all the deficiencies that apply, i.e., health, EP and LSC deficiencies are combined into one score.

Numerator   = Sum of numerator values for all deficiencies in the analysis

Denominator = Sum of denominator values for all deficiencies in the analysis

$$\% \text{ Agreement Rate} = \frac{Numerator}{Denominator} X \ 100\%$$

e) Scoring

If the % Agreement Rate is 90% or higher (without rounding up), this Measure is scored as "Met."

If the % Agreement Rate is less than 90%, this Measure is scored as "Not Met."

Q5 Implementation of the Nursing Home Quality Indicator Survey

This measure will not be implemented in FY 2019.

Q6 Prioritizing Complaints and Facility Self-reported Incidents

a) Threshold Criteria

1. *Nursing homes:* In at least 90% of cases sampled, whether or not an onsite survey is conducted, the SA follows CMS guidelines for prioritizing Federal complaints and those incidents that require a Federal onsite survey.

2. *Non-deemed hospitals (including non-deemed CAHs), non-deemed home health agencies, and ESRD facilities*: In at least 90% of cases sampled, whether or not an onsite survey is conducted, the SA follows CMS guidelines for prioritizing Federal complaints and those incidents that require a Federal onsite survey.

b) References: SOM, Chapter 5, sections 5070-5075, and Exhibit 22 of the SOM.

c) Data Source: Datasets to identify cases for review will be created by CO and distributed to the ROs. The ROs are to use ASPEN Complaint/Incidents Tracking System (ACTS) and SA intake documentation in their assessment. The SA may provide additional information that supports their prioritization determination.

d) Method of Evaluation

    Criterion 1- Nursing homes

    Characteristics of the sample:

        1. Date range - Intakes with a received start date of October 1, 2018 to September 30, 2019.
        2. Size

Total Intakes Received in Prior FY	Sample Size
10 or Less	All
11 to 100	10
101 to 400	10% of the number of intakes
Greater than 400	40

    Note: The total number of intakes is derived from data in QIES.

3. The sample includes Federal complaints, regardless of whether an onsite survey is conducted, and those incidents that require a Federal onsite survey.

Note:
- Up to 25% of enforcement cases randomly selected that are referred to the RO may be used. This review should only be conducted on the first survey that began the enforcement case (LTC/ NLTC).
- Up to 25% of State surveys that are associated with comparative surveys may be used (LTC Only). **Cases should be randomly selected**.

Review each sampled case to determine if the SA appropriately prioritized the intake using the criteria for each of the levels listed in Chapter 5, section 5075 of the SOM. This review should be conducted by an individual in the RO who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements. Use the final prioritization rating assigned by the SA after its review of the intake data.

If the SA assigned an equal or higher prioritization level to an intake than the RO, the RO shall score the intake as being appropriately prioritized.

Scoring for Q6 – Criterion 1 – Nursing homes

If at least 90% of sampled intakes are prioritized appropriately, Threshold Requirement 1 is scored as "Met."

If less than 90% of sampled intakes are prioritized appropriately, Threshold Requirement 1 is scored as "Not Met."

Criterion 2 - Non-deemed hospitals (including non-deemed CAHs), non-deemed home health agencies, and ESRD facilities

Characteristics of the sample:

1. Date range - Intakes received October 1, 2018 to September 30, 2019.
2. Size

Total Intakes Received in Prior FY	Sample Size
10 or Less	All
11 to 100	10
101 to 400	10% of the number of intakes
Greater than 400	40

Note: The total number of intakes is derived from data in QIES.

3. The sample includes Federal complaints, regardless of whether an onsite survey is conducted, and those incidents that require a Federal onsite survey.

4. The sample should include at least two ESRD intakes.
5. The sample should include at least two non-deemed home health agency intakes.
6. The sample should include at least two non-deemed hospital intakes. Cases with an allegation of restraint/seclusion death should be excluded.
7. The sample should exclude intakes related to EMTALA.

Review each sampled case to determine if the SA appropriately prioritized the intake using the criteria for each of the prioritization levels in Chapter 5, section 5075 of the SOM. This review should be conducted by an individual in the RO who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements. Use the final prioritization rating assigned by the SA after its review of the intake data.

If the SA assigned a higher prioritization level to an intake than the RO, the RO shall score the intake as being appropriately prioritized.

Scoring for Q6 – Criterion 2 - Non-deemed hospitals (including non-deemed CAHs), non-deemed home health agencies, and ESRD facilities

If at least 90% of sampled intakes are prioritized appropriately, Threshold Criterion 2 is scored as "Met."

If less than 90% of sampled intakes are prioritized appropriately, Threshold Requirement 2 is scored as "Not Met."

e) Scoring (Overall)

If both Threshold Criteria are scored as "Met," this Measure is scored as "Met."
If either Threshold Criterion is scored as "Not Met," this Measure is scored as "Not Met."

Q7 Timeliness of Complaint and Facility Self-reported Incident Investigations *- Scoring for FY2019 Placed on Hold for criteria 1 and 3 - Nursing Homes only*

a) Threshold Criteria

1. *Immediate jeopardy (IJ) within two working days:* For nursing homes, ESRD facilities, non-deemed HHAs, non-deemed ASCs, and non-deemed hospitals (including non-deemed CAHs, excluding EMTALA cases), the SA initiates an investigation within two working days of the received end date for 95% of all complaints and incidents where the intake is prioritized as "IJ."
2. *Immediate jeopardy within two working days for deemed hospitals, deemed ASCs, and deemed HHAs:* For deemed hospitals (including CAHs, excluding

EMTALA cases), deemed ASCs and deemed HHAs, the SA initiates an investigation within two working days of receipt of authorization from the RO for 95% of all complaints and incidents where the intake is prioritized as "IJ."

3. *Non-immediate jeopardy within ten working days for nursing homes:* For nursing homes, the SA initiates an investigation within 10 working days of the received end date for 95% of all complaints and incidents where the SA prioritizes the intake as "Non-IJ High."

4. *Non-immediate jeopardy within 45 calendar days for deemed hospitals (including CAHs):* For deemed hospitals (including CAHs), the SA initiates an investigation within 45 calendar days of receipt of authorization from the RO for 95% of all complaints and incidents.

b) References: Chapter 5, section 5075 of the SOM

c) Data Source: ACTS Federal Investigation Timeframe Reports, or CASPER reports 0836D, 0837D, and 0838D.

d) Method of Evaluation

The procedure for running the ACTS Federal Investigation Timeframe Reports is located in Appendix 5 - Q7 ACTS Report Procedures for FY 2018.

For Threshold Criterion 1 and 3, the time interval is measured from the "Received End Date" which is the date there was sufficient information to prioritize the complaint/incident.

For Threshold Criteria 1, 2, and 3, the RO accounts for State holidays and office closures in its working day calculation.

For Threshold Criteria 1, 2, and 4, if the intake involves a Restraint/Seclusion Death for a hospital, the intake should be removed from the sample.

Include all ACTS generated reports with the report that goes to the SA for comment.

e) Scoring

If all four Threshold Criteria are met, this Measure is scored as "Met."
If any Threshold Criterion is not met, this Measure is scored as "Not Met."

Q8 Quality of EMTALA Investigations

a) Threshold Criterion

EMTALA investigations: The SA's EMTALA complaint investigations meet CMS' guidance. The overall score for the five requirements combined is at least 90%.

b) References: Chapter 5 of the SOM, Article II (A)(2) of the 1864 Agreement, and Appendix V.

c) Data Source: ACTS, CMS-2567, and completed survey packets sent to CMS.

d) Method of Evaluation

Sampling:

A random sample of all EMTALA complaints that were authorized by the RO for investigation will be selected from ACTS. The universe is all intakes with a received start date from October 1, 2018 through September 30, 2019. If the survey for the intake is conducted in FY18, the RO will keep the intake in the sample for the fiscal year under review. If the survey has not been conducted by the time the performance review occurs or it was conducted in the subsequent Fiscal Year, the RO should replace the intake.

The random sample includes intakes received from October 1, 2018 through September 30, 2019. Base the sample on the number of intakes received in the previous year.

Sample Size:

Total Intakes Received in Prior FY	Sample Size
1 to 10	All
11 to 50	10
Greater than 50	20

Review each sampled case to determine if the SA investigated the EMTALA complaint in accordance with CMS policy.

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

Was the onsite complaint investigation completed within five working days from RO Approval Date/Extension Date?

For EMTALA complaints that are granted extensions by the RO, review against the RO approved extension date instead of five working days (for example, if the RO gives the SA an extra five days to complete the EMTALA investigation, review against the extension date). Timeframes are calculated from date of RO EMTALA investigation approval date to the survey exit date. Count the day of RO notification to the SA as day zero. Survey exit date is

obtained from the SA survey packet in the CMS-670. The RO accounts for State holidays and office closures in its working day calculation

1. Was a completed packet sent to the RO within 10 working days following the survey exit date when a suspected violation is identified or 15 working days when no violation was found?

   Timeframes are calculated from the survey exit date to the RO receipt date. Count the day of the survey exit date as day zero. The RO accounts for State holidays and office closures in its working day calculation

NOTE:
For each item listed in 2.1 to 2.8 to be scored "yes," the document(s) being referred to needs to have been submitted timely and be complete. If the item was not submitted timely and/or was not complete, the corresponding element in number 2 should be scored "no."

A complete packet is defined as containing the items listed below:

2.1 CMS-562 sent to RO/Data entered into ACTS;

2.2 CMS-670 sent to RO/Data entered into ACTS;

2.3 A completed CMS-2567;

2.4 CMS-1541B with recommendation for action included or sent in the survey packet;

2.5 Written summary of interviews – can be in the narrative or surveyor notes;

2.6 Copies of pertinent hospital policies and procedures that relate to the identified deficiencies
NOTE:
- If a violation is found, policies and procedures must be submitted with the packet. If they are required but not included, score NO.
- If no violation is found, policies and procedures are not required to be submitted with the packet. If they are not required, score "YES" whether submitted or not.

2.7 Summary listing of all patients comprising the sample (including an explanation of how and why the sample patients were selected for review); and

2.8 Copies of medical records for substantiated cases, medical records of individuals named in complaints and other medical records in accordance with the QIO physician review checklist.

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

4. Did the CMS-2567 require no revisions or only minor revisions by the SA after review by the RO?
   - Score Yes if the CMS-2567 required no revisions or only minor revisions or the only revisions were beyond the SA's control, e.g., as a result of the QIO review
   - Score No if the CMS-2567 required major revisions that were within the SA's control, including failure to follow the Principles of Documentation

5. Was a complete Complaint Investigation Narrative included with the SA packet that was sent to the RO?

   The narrative should summarize significant findings found in medical records, meeting minutes, hospital policies and procedures, staffing schedules, QAPI plans, hospital By-laws, Rules and Regulations, training programs, credential files, personnel files, and contracted services. The narrative should also briefly summarize SA findings in the investigation and the rationale used for the course of action recommended to the RO.

e) Scoring

   Total overall score for all requirements combined must be 90% or above to meet this Measure. The separate Requirement percentages are for analysis purposes only.

   Each requirement is worth 4 points. The eight individual elements of requirement 2 are worth 0.5 points each.

   Total the possible points obtained for each sample case.

   Total the points for all sample cases. Divide number of points obtained by the total number of points possible to determine the final score.

   For example:
   - Sample size = 10
   - Total points obtained = 188
   - Total points possible = 200
   - 188/200 = 94%
   - Measure "Met"

   Small sample size example:
   - Sample size = 4
   - Total points obtained = 68
   - Total points possible = 80
   - 68/80 = 85%
   - Measure "Not Met"

Q10 Triaging of Deemed Facility Complaints (DEVELOPMENTAL)

This measure is under development.

ENFORCEMENT AND REMEDY

E1 Timeliness of Processing Immediate Jeopardy (IJ) Cases

a) Threshold Criterion

IJ processing: The SA adheres to the 23-day termination process in at least 95% of the cases in which it determines there is an IJ that is not removed prior to the end of the survey. (Excludes EMTALA and Medicaid-only cases.)

b) *References*: Sections 1819(h)(1)(A) and 1866(b) of the Act, 42 CFR §§ 488.410 and 489.53, and Chapters 3 and 7 of the SOM.

c) Data Source

   To identify and evaluate nursing home cases, the ASPEN Enforcement Manager (AEM) Immediate Jeopardy Timeline Report is used.

   To identify non-nursing home cases, the following reports may be used:
   - CASPER Report 0017D (Providers with Selected Requirements Out of Compliance) for recertification surveys
   - CASPER Report 0043D (Requirements Out of Compliance) for complaint surveys
   - ASPEN Central Office Tracking Report- CoPs Out of Compliance

   Provider certification files and RO tracking systems may also be used to perform the evaluation.

d) Method of Evaluation: This Measure evaluates the SA's performance for all IJ cases not removed for surveys of all provider/supplier types. The overall evaluation will assess whether the following three actions were completed:

   1. The SA promptly notified CMS of the survey date when IJ was discovered so that the provider can be notified of the 23-day termination action. For nursing homes, the SA notifies the RO no later than two calendar days after the last day of the survey that identified the IJ (SOM Chapter 7, section 7309). For non-nursing homes, the SA notifies the RO no later than two working days after the survey

date (SOM, Chapter 3, section 3010). The RO accounts for State holidays and office closures in its working day calculation

2. The SA conducted a timely revisit upon receipt of a credible allegation of IJ removal.
3. The SA notified CMS of whether or not IJ had been removed. For nursing homes, the notification of whether or not IJ has been removed must be no less than three working days prior to the termination date. For non-nursing homes, the SA follows SOM timeframes and CMS guidance for the notification of IJ and the termination process, so that termination takes effect timely, unless the IJ has been removed. The RO accounts for State holidays and office closures in its working day calculation.

Calculation:

1. Identify all IJ cases that were not removed onsite.
2. Determine in how many of these cases the SA notified CMS of the IJ in a timely manner, conducted a timely revisit upon receipt of a credible allegation of compliance, and notified CMS whether or not the IJ was removed within prescribed timeframes. Determine the total number of acceptable cases.
3. Divide #2 by #1 and convert to a percentage format.

e) Scoring

If the resulting percentage is greater than or equal to 95%, this Measure is scored as "Met."

If the resulting percentage is less than 95%, this Measure is scored as "Not Met."

E2 Timeliness of Mandatory Denial of Payment for New Admissions (DPNA) Notification for Nursing Homes

a) Threshold Criterion

1. *Mandatory DPNA processing:* The SA adheres to the enforcement processing timeframes so that DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. In at least 80% of the cases, the SA transfers the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA to the provider by the 70th day. This excludes cases involving Medicaid-only nursing homes.

b) References: Section 1819(h)(2)(D) of the Act, 42 CFR §488.417(b).

c) Data Source: AEM Reports - Mandatory DPNA Timeline and Surveys Not in AEM Case Reports.

d) Method of Evaluation: This Measure evaluates whether the SA transfers the enforcement case to CMS by the 70th day $\underline{or}$ the SA sends the imposition notice to the provider by the 70th day.

   1. Using AEM, identify all enforcement cases where the nursing home was not in substantial compliance within 70 days of the date of the original survey (as verified by a revisit occurring on or before day 70) $\underline{and}$ all enforcement cases where, on the 70th day, it was not known whether the facility had achieved substantial compliance (e.g., a revisit had not occurred and the SA has not verified compliance). If the RO conducted a Federal Monitoring Survey during the enforcement cycle, then the enforcement case should be excluded from the review. The RO will review enforcement cases where the original survey occurred between July 1, 2018 and June 30, 2019.

   2. CMS will evaluate the following key dates:

      a. Date of SA notification to the RO of continuing noncompliance, no later than 70 days after the original survey that determined noncompliance; $\underline{or}$

      b. Date of SA notification to the provider of imposition of DPNA, no later than 70 days after the original survey that determined noncompliance.

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

   3. Divide #2 by #1 and convert to a percentage format.

e) Scoring

If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met." If the resulting percentage is less than 80%, this Measure is scored as "Not Met."

E3 Processing of Termination Cases for Non-Nursing Home Providers/Suppliers

a) Threshold Criterion

   1. *Termination processing:* The SA adheres to the 90-day termination process in at least 80% of cases in which condition-level noncompliance is cited. This includes cases for all non-nursing home providers/suppliers, except for cases involving deemed providers/suppliers, EMTALA cases, transplant program termination, and Medicaid-only providers/suppliers.

b) References: Section 1866(b) of the Act, 42 CFR § 489.53, and SOM, Chapter 3 section 3012.

c) Data Sources

- QIES Data
    - E3 NLTC Report - QIES workbench report.

- Provider certification files (ACO / ACTS) and RO tracking systems may also be used to perform the evaluation.

d) Method of Evaluation:

If condition-level compliance is not determined at the revisit, the SA sends the 90-day termination packet to CMS by the 55th day from the last day of the survey that found condition-level noncompliance.

Note: The 90-day termination process begins the date the entire survey is completed onsite, regardless of when the exit conference is held. This date is day 0.

Using the User-Defined QIES report - E3 NLTC Report:

1. Determine the size of the universe—all COP-out cases. (Excluding certain cases as indicated in the Protocol.)
2. Determine the number of error cases by reviewing the sample subset, which consists of cases out of compliance or compliance not known at the 55th day.
3. Subtract the errors from the universe to determine the number of correct cases.
4. Divide the correct cases by the universe to determine the percentage score.

Another way of describing the correct scoring method is:

- Universe, which is all 90 day termination cases, minus error cases = correct cases. Correct cases divided by Universe = percentage correct, which is the score.

e) Scoring

If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met." If the resulting percentage is less than 80%, this Measure is scored as "Not Met."

E4 Special Focus Facilities (SFFs) for Nursing Homes

a) Threshold Criterion

1. *SFF surveys:* Each SA shall have the specified number of SFFs identified and conduct a standard survey of those facilities twice during the fiscal year.
2. *Appropriate Enforcement Remedies:* The SA recommends enforcement remedies to the RO/State Medicaid Agency, in accordance with S&C 17-20.

b) References: S&C 17-20, S&C-14-20, and the SFF Procedures Guide.

c) Data Source: RO list of identified SFFs, ACO/AEM, provider certification files, and SA feedback on standard survey data related to facilities on the candidate list.

d) Method of Evaluation:

An active SFF must have two standard surveys per year from the time of selection into the SFF program. Once a facility has been selected for the SFF program, the SA must conduct a standard survey within six months of that selection date, but with an interval of no more than 15.9 months from the last standard survey. A reasonable degree of unpredictability in these surveys must be maintained. For the purposes of the State Performance Standards, States must complete two standard surveys per SFF slot per fiscal year. Slots are determined by the number of SFFs assigned to each State as designated in policy memorandum S&C-14-20.

For example, if a State had five SFF slots, we would expect there would be 10 standard surveys conducted on the SFFs in that State in a given fiscal year. If a State had one SFF slot, we would expect that there would be two standard surveys conducted on that SFF in a given fiscal year. When one SFF is removed either through termination or graduation, then another SFF is selected within 21 days as a replacement so all of the SFFs slots are filled. By way of example, if SFF-A graduates in March and is replaced within two weeks by SFF-B, then the new facility (SFF-B) should have a standard survey no later than early September to meet both the requirements of the SFF program and the State Performance Standards. In this example, there were two standard surveys in the fiscal year and thus would meet the requirement. However, if the second survey was not completed until October it would not meet the performance measure. If the selection of a replacement SFF occurs after 21 days, the SA would not meet the performance measure.

LSC, and EP surveys will be conducted at the same frequency as the health surveys (i.e., twice the number of standard surveys per year). A LSC, and EP finding of actual harm on the most recent survey will preclude graduation from the SFF initiative during that survey cycle.

e) Scoring

If the SA has the required number of SFFS, has conducted the required number of standard surveys for SFFS, and has replaced SFFs within the 21 day period, this threshold criteria is scored as "Met.

If the SA recommends enforcement remedies to the RO/State Medicaid Agency, in accordance with S&C 10-32, this threshold criteria is scored as "Met."

If both Threshold Criteria are met, this Measure is scored as "Met."

If either Threshold Criterion is not met, this Measure is scored as "Not Met."

REPORTING REQUIREMENTS

Timeline

October 1, 2018 to September 30, 2019	Period of evaluation
Week of January 6, 2020	CMS ROs will run the reports for the following Measures: F1, F2, F3, F4
February 10, 2020	CMS ROs send draft reports to SAs.
February 24, 2020	SAs send comments on the draft reports to CMS ROs.
March 09, 2020	CMS ROs send final report to SAs and CMS CO.

CORRECTIVE ACTION PLAN

For each Measure that is scored as "Not Met," the SA will develop and implement a corrective action plan that will address identified problems. The RO will review and follow-up to ensure that the SA is progressing toward making corrections.

If performance was impacted by State law, regulation, or executive action during the FY, the SA should document this information in its corrective action plan. This could include information about the implementation of staff attrition, furloughs, and hiring freezes in the State. In addition, the SA should document any extenuating circumstances which prevented it from meeting the performance measure. This could include a declaration of a public health emergency where the Secretary of the Department of Health and Human Services invokes time-limited statutory authority to permit CMS to waive certain requirements.

RECONSIDERATION

There is no formal appeal of findings relative to this Report of State Survey Agency Performance since the assessment is under the umbrella of the "Evaluation" Article (Article V) of the 1864 Agreement. However, where the SA and CMS cannot come to a final agreement on key findings, the SA may ask CMS for informal reconsideration. The request should be made in writing to the next higher level of line authority above the CMS RO authority issuing the report. The request should be made within 14 calendar days of the date the SA received the draft report.

<u>CONTACTS</u>

SAs- Please contact your CMS RO if you have any questions.

ROs- Please contact one of the members of the State Performance Standards team at Central Office:

CMS SCG SPSS Team SPSS_Team@cms.hhs.gov

Francis Adanuty at Francis.Adanuty@cms.hhs.gov or call (410) 786-9867

Elaine Soong at Elaine.Soong@cms.hhs.gov

Bonnie Reed at Bonnie.Reed@cms.hhs.gov or call 410 786 2187

Appendix 1 – 9

Appendix 1: FY 2019 State Performance Standards System (SPSS) - Dimensional Overview

FREQUENCY	QUALITY	ENFORCEMENT & REMEDY
This dimension tracks the frequency with which survey teams provide on-site, objective, and outcome-based verification that basic standards of quality are met by health care providers.	This dimension measures the quality of the surveys themselves, based on review of survey findings, onsite observations of survey performance and review of complaints and incidents.	This dimension measures the appropriateness and effectiveness of enforcement action by the survey agencies. If conditions and standards needed to assure quality are not met, are remedies promptly devised and implemented.
F1: Off-Hour Surveys for Nursing Homes F2: Frequency of Nursing Home Surveys F3: Frequency of Non-Nursing Home Surveys • Non-Deemed Home Health Agencies • ICFs/MR • Validation Surveys for Deemed Hospitals • Non-Deemed Hospices • ESRD Facilities • Non-Deemed Hospitals • OPTs • CORFs • RHCs • Non-Deemed ASCs F4: Frequency of Data Entry of Standard Surveys	Q1: Documentation of Deficiencies Q2: Conduct of Nursing Home Surveys (FOSS) Q3: Documentation of Noncompliance (FOSS) Q4: Accuracy of Documentation (Comparative Surveys) Q5: Implementation of the Nursing Home Quality Indicator Survey [HOLD] Q6: Prioritizing Complaints and Incidents Q7: Timeliness of Complaint and Incident Investigations Q8: Quality of EMTALA Investigations	E1: Timeliness of Processing Immediate Jeopardy Cases E2: Timeliness of Mandatory DPNA Notification E3: Processing of Termination Cases for Non-Nursing Home Provider/Suppliers E4: Special Focus Facilities for Nursing Homes

Appendix 2: FY 2019 Frequency Measures- Discussion of Data

Pertinent Memoranda
- Admin Info:19-XX.02 - FY 2019 Mission & Priority document (MPD)
- Pending memorandum - Final FY 2019 State Medicare Allocations for Survey & Certification

CASPER Reports Available
- 0800S- Nursing Home Staggered Surveys
- 0801S- Nursing Home Standard Survey Summary
- 0802D- Nursing Home Providers Surveyed
- 0803D- Nursing Home Providers Not Surveyed
- 0810S- HHA Standard Survey Summary
- 0811D- HHA Standard Surveys that Exceed Interval
- 0812D- HHA Providers Not Surveyed
- 0820S- ICF/IID Standard Survey Summary
- 0821D- ICF/IID Standard Surveys that Exceed Agreement
- 0822D- ICF/IID Providers Not Surveyed
- 0830S- Hospital Providers and Validation Survey Counts
- 0831D- Hospital Validation Surveys
- 0840S – Performance Standard Survey Summary
- 0841D – Providers Surveyed
- 0842D – Providers Not Surveyed
- 0843D – Standard Surveys Exceed Interval
- 0844S – Short-Term Acute Care Hospitals
- 0845S – All Hospitals
- 0846S – End Stage Renal Disease Facility

F1- Off-Hour Surveys for Nursing Homes

Data Source: CASPER Report 0800S- Nursing Home Staggered Surveys

a) Calculate the number of providers that were active the entire period (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question)
b) For the providers from (a), calculate the number of surveys conducted
c) From (b), calculate how many surveys were conducted during "Off Hours" (use existing criteria)
d) Calculation

$$\% \text{ Off-Hours} = \frac{(c)}{(b)} \times 100\%$$

e) For FY2019, in order to meet the Performance Measure:
$$\% \text{ Off-Hours} \geq 10\%$$

F2- Frequency of Nursing Home Surveys

Data Sources: CASPER Reports 0801S- Nursing Home Standard Survey Summary

> 0802D- Nursing Home Providers Surveyed
> 0803D- Nursing Home Providers Not Surveyed
> Note - In FY 2010, CASPER was modified so that the survey frequency intervals are calculated from the "Survey Completion Date" (L34).

Calculation based upon a 15.9-month time period, FY 2019, for example, would be 6/1/2018 – 9/30/2019.

a) Calculate the number of providers that were active the entire period (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question).
b) For the providers from (a), calculate how many were surveyed.
c) For the providers from (a), calculate how many were surveyed but the number of months between standard surveys exceeds 15.9 months (use the Current Survey – Prior Survey). Use Report 0802D to identify surveys that exceeded 15.9 months.
d) Calculation

$$\% \text{ Recertified} = \frac{(b) - (c)}{(a)} \times 100\%$$

e) Statewide average is the average number of months between the Prior Survey Date and the Current Survey Date for the providers listed in (a).
f) For FY 2019, in order to meet the Performance Measure:

$$\% \text{ Recertified} = 100\% \text{ \underline{and} Statewide Average} \leq 12.9 \text{ months}$$

Notes:
- In the CASPER Reports, survey intervals are calculated using the Oracle function called "Months_Between." A full description of the function can be found at this site: http://download.oracle.com/docs/cd/B19306_01/server.102/b14200/functions089.htm
- On Report 801S, the "Maximum Interval" column should be ignored, since it is calculated from the "Current Survey Date" (regardless of which year the survey actually occurred).

F3.1- Frequency of Non-Nursing Home Surveys – Tier 1

Home health agencies

Data Sources: CASPER Reports 0810S- HHA Standard Survey Summary

0811D- HHA Standard Surveys that Exceed Interval
0812D- HHA Providers Not Surveyed

Calculation based upon a 36.9-month time period, FY 2019, for example, would be 9/1/2016 – 9/30/2019.

a) Calculate the number of providers that were active the entire period (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question).
b) For the providers from (a), calculate how many were surveyed.
c) For the providers from (a), calculate how many were surveyed in FY 2018, but the number of months between standard surveys exceeds 36.9 months (use the Current Survey – Prior Survey). Use Report 0811 to identify surveys that exceeded 36.9 months.
d) Calculation

$$\% \text{ Recertified} = \frac{(b) - (c)}{(a)} \times 100\%$$

e) For FY 2019, in order to meet the Performance Measure:

$$\% \text{ Recertified} = 100\%$$

NOTE - HHA:
If the SA can produce documentation that they received notification that an HHA has dropped their AO status at 60 days or less from the maximum 36 month survey interval date and they were unable to schedule and complete the re-certification survey within the required timeframe as result of that late notification, CMS will not do an associated non-delivery notice nor will the SA be penalized on the SPSS for not making the 36.9 maximum survey interval on that particular survey.

ICFs/IID

Data Sources: CASPER Reports 0820S- ICF/IID Standard Survey Summary
                   0821D- ICF/IID Standard Surveys that Exceed Agreement
                   0822D- ICF/IID Providers Not Surveyed

Calculation based upon a 15.9-month time period, FY 2019, for example, would be 6/1/2018 – 9/30/2019.

a) Calculate the number of providers that were active the entire period (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question).
b) For the providers from (a), calculate how many were surveyed.

c) For the providers from (a), calculate how many were surveyed but the number of months between standard surveys exceeds 15.9 months (use the Current Survey – Prior Survey). Use Report 0821D to identify surveys that exceeded 15.9 months.

d) Calculation

$$\% \text{ Recertified} = \frac{(b) - (c)}{(a)} \times 100\%$$

g) Statewide average is the average number of months between the Prior Survey Date and the Current Survey Date for the providers listed in (a).

h) For FY 2019, in order to meet the Performance Measure:

$$\% \text{ Recertified} = 100\% \text{ } \underline{\text{and}} \text{ Statewide Average} \leq 12.9 \text{ months}$$

Notes:

- In the CASPER Reports, survey intervals are calculated using the Oracle function called "Months_Between." A full description of the function can be found at this site:
  http://download.oracle.com/docs/cd/B19306_01/server.102/b14200/functions089.htm

Deemed Hospitals

Data Source: CASPER Report 0831D- Hospital Validation Surveys, Form CMS-2802

a) Determine the hospitals sampled for FY 2019.
b) Calculate whether the sampled hospitals were surveyed within 60 days of the accrediting organization's survey.
c) For FY 2019, in order to meet the Performance Measure:

   # Validation Surveys Conducted ≥ # Deemed Hospitals Sampled in FY 2019

Non-Deemed Hospices

Data Source: CASPER Reports 0840S – Performance Standard Survey Summary
                      0841D – Providers Surveyed
                      0842D – Providers Not Surveyed

a) Calculate the number of providers that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question). Deemed providers should be excluded.
b) Calculate the number of providers from (a) that were surveyed during the FY.

c) Calculation

$$\% \text{ Surveyed} = \frac{(b)}{(a)} \times 100\%$$

d) For FY 2019, in order to meet the Performance Measure:

$$\% \text{ Surveyed} \geq 33\%$$

F3.2 and F3.3- Frequency of Non-Nursing Home Surveys – Tiers 2 & 3

OPTs, CORFs, and RHCs

Data Source: CASPER Reports 0840S – Performance Standard Survey Summary
            0841D – Providers Surveyed
            0842D – Providers Not Surveyed
            0843D – Standard Surveys Exceed Interval

a) Calculate the number of providers/suppliers that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question). Deemed providers/suppliers should be excluded.
b) Calculate the number of providers/suppliers from (a) that were surveyed during the FY.
c) Calculate the number of providers/suppliers from (a) where the difference between the Current Survey Date and September 30, 2019 is greater than 7.0 years.
d) Calculation

$$\text{T2 Coverage} = \frac{(b)}{(a)} \times 100\%$$

e) For FY 2019, in order to meet the Performance Measure:
   o F3.2 Measure

$$\text{T2 Coverage} \geq 5\%$$

   o F3.3 Measure

# of Providers/Suppliers that Exceed 7.0-Year Interval = 0

f) If the SA does not have any active providers/suppliers, then both F3.2 and F3.3 for that provider/supplier type would be scored as Nonapplicable.
g) If the SA has *fewer than 7 active providers*, then F3.2 for that provider/supplier type would be scored as Nonapplicable. F3.3 would still be evaluated.

Non-Deemed ASCs

Data Source: CASPER Reports 0840S – Performance Standard Survey Summary
                    0841D – Providers Surveyed
                    0842D – Providers Not Surveyed
                    0843D – Standard Surveys Exceed Interval

a) Calculate the number of providers/suppliers that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question). Deemed providers/suppliers should be excluded.
b) Calculate the number of providers/suppliers from (a) that were surveyed during the FY <u>and</u> are considered to be a Tier 2 facility on the random sample list distributed by CMS, per Admin Info Memo 14-35. The RO should also review whether all non-deemed ASCs that were included in the random sample were surveyed in the last quarter of FY 2017 or FY 2018.
c) Calculate the number of providers/suppliers from (a) where the difference between the Current Survey Date and September 30, 2019 is greater than 6.0 years.
d) Calculation

$$\text{T2 Coverage} = \frac{(b)}{(a)} \times 100\%$$

e) For FY 2019, in order to meet the Performance Measure:
   o F3.2 Measure

$$\text{T2 Coverage} \geq 25\%$$
   o F3.3 Measure

   # of Providers/Suppliers that Exceed 6.0-Year Interval = 0

f) If the SA does not have any active providers/suppliers, then both F3.2 and F3.3 for that provider/supplier type would be scored as Nonapplicable. States that have only 7 or fewer non-deemed ASCs must survey at least 1 facility in FY 2019 unless all such ASCs were surveyed in FY 2017 and FY 2018.

ESRD Facilities

Data Source: CASPER Report 0841D – Providers Surveyed
                    0842D – Providers Not Surveyed
                    0843D – Standard Surveys Exceed Interval
                    0846S – End Stage Renal Disease Facility

        Note: The Tier 3 maximum survey interval is 3.5 years.

a) Calculate the number of ESRD facilities that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and

providers that were terminated from the Medicare/Medicaid program during the period in question).

b) Calculate the number of ESRD facilities from (a) that were surveyed during the FY <u>and</u> are considered to be a Tier 2 facility on the targeted sample list distributed by the University of Michigan.

c) Calculate the number of ESRD facilities from (a) where the difference between the Current Survey Date and September 30, 2019 is greater than 3.5 years.

d) Calculation

$$\text{T2 Coverage} = \frac{(b)}{(a)} \times 100\%$$

e) For FY2019, in order to meet the Performance Measure:
   o F3.2 Measure

$$\text{T2 Coverage} \geq 10\%$$

   o F3.3 Measure

$$\text{\# of ESRDs that Exceed 3.5 -Year Interval} = 0$$

f) If the SA does not have any active ESRDs, then F3.2 and F3.3 are Nonapplicable for ESRDs. However, if the SA has active ESRDs and no surveys were completed, then F3.2 and F3.3 for ESRDs would not be met.

Non-Deemed Hospitals (NDH)

Data Source: CASPER Reports
          0841D – Providers Surveyed
          0842D – Providers Not Surveyed
          0843D – Standard Surveys Exceed Interval
          0844S – Short-Term Acute Care Hospitals
          0845S – All Hospitals
          Note: The Tier 3 maximum survey interval is 4.0 years.

a) Calculate the number of non-deemed short-term acute care hospitals that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the Medicare/Medicaid program during the period in question).

b) Calculate the number of non-deemed short-term acute care hospitals from (a) that were surveyed during the FY.

c) Calculate the number of non-deemed hospitals (includes all hospital subtypes) that were active during the entire FY (this would exclude new providers entering the Medicare/Medicaid program and providers that were terminated from the

Medicare/Medicaid program during the period in question). Religious non-medical health care institutions should be excluded.

d) Calculate the number of non-deemed hospitals from (c) where the difference between the Current Survey Date and September 30, 2019 is greater than 5.0 years.

e) Calculate the number of non-deemed hospitals from (c) where the difference between the Current Survey Date and September 30, 2019 is greater than 4.0 years.

f) Calculation

$$\text{T2 Coverage} = \frac{(b)}{(a)} \times 100\%$$

g) For FY 2019, in order to meet the Performance Measure:
   o F3.2 Measure

   T2 Coverage ≥ 5% <u>and</u> # of NDHs that Exceed 5.0-Year Interval = 0

   o F3.3 Measure

   # of NDHs that Exceed 4.0-Year Interval = 0

g) If the SA does not have any active NDHs, then F3.2 and F3.3 for NDHs are scored as Nonapplicable.

h) If the SA has *fewer than 7* non-deemed short-term acute care hospitals, then the SA is exempt from the requirement of conducting surveys for a 5% targeted sample and this component of this measure should be scored as Nonapplicable. The Tier 2, 5-year maximum interval requirement and F3.3 would still be evaluated.

NOTE: Veterans Affairs providers/suppliers, RNHCIs, and transplant centers should be excluded from the evaluation.

Appendix 3: Q1- Procedures for Obtaining the Random Sample

1. Copy and save into your QIES Workbench Library, the following User-Defined Extracts:

   - <u>Q1 Nursing Homes</u>
   - <u>Q1 Hospital ESRD HHA ICF/MR</u>

   Prior to submitting the report, you may wish to change the RO, SA, and Survey Date range. Submit the report and save the report as a text file.

2. Open Excel. Select Office Button→Open. Select File Type=Text File. Select your file. This will open the Text Import Wizard. Select Delimited File Type. Click "Next."

Text Import Wizard - Step 1 of 3 ? ×

The Text Wizard has determined that your data is Delimited.
If this is correct, choose Next, or choose the data type that best describes your data.

Original data type
Choose the file type that best describes your data:
○ Delimited   - Characters such as commas or tabs separate each field.
○ Fixed width   - Fields are aligned in columns with spaces between each field.

Start import at row: 1   File origin: 437 : OEM United States

Preview of file C:\Documents and Settings\l136\Desktop\QWU_J23331_P1_Data.txt.

```
1 PRVDR_NUM□FAC_NAME□CITY_NAME□STATE_CD□SRVY_CYC_DESC□SRVY_DT
2 075185□ANDREW HOUSE HEALTHCARE□NEW BRITAIN□CT□COMPLAINT SURVEY□20071220
3 075186□HAVEN HEALTH CTR OF ROCKY HILL□ROCKY HILL□CT□STANDARD SURVEY□200710
4 075186□HAVEN HEALTH CTR OF ROCKY HILL□ROCKY HILL□CT□COMPLAINT SURVEY□20080
5 075186□HAVEN HEALTH CTR OF ROCKY HILL□ROCKY HILL□CT□COMPLAINT SURVEY□20080
6 075195□PARKWAY PAVILION HEALTH CARE□ENFIELD□CT□STANDARD SURVEY□20080408
```

Cancel | < Back | Next > | Finish

3. Select Delimiters: **Tab**. Make sure all of the other Delimiters are deselected. Click "Next."

Text Import Wizard - Step 2 of 3 ? ×

This screen lets you set the delimiters your data contains. You can see how your text is affected in the preview below.

Delimiters
☑ Tab   ☐ Semicolon   ☐ Comma
☐ Space ☐ Other:

☐ Treat consecutive delimiters as one

Text qualifier: "

Data preview

PRVDR_NUM	FAC_NAME	CITY_NAME	STATE_CD	SRVY_CYC_DESC
075185	ANDREW HOUSE HEALTHCARE	NEW BRITAIN	CT	COMPLAINT SURV
075186	HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	STANDARD SURVE
075186	HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	COMPLAINT SURV
075186	HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	COMPLAINT SURV
075195	PARKWAY PAVILION HEALTH CARE	ENFIELD	CT	STANDARD SURVE

Cancel | < Back | Next > | Finish

4. In the Data Preview screen, select the **PRVDR_NUM column** (It should already be selected). Select **Text**.

Text Import Wizard - Step 3 of 3

This screen lets you select each column and set the Data Format.

'General' converts numeric values to numbers, date values to dates, and all remaining values to text.

Column data format
- General
- ● Text
- Date: MDY
- Do not import column (skip)

Advanced...

2. Select **Text**.

Data preview

Text	General		General	General	General
PRVDR_NUM	FAC_NAME		CITY_NAME	STATE_CD	SRV
075069	CONNECTICUT HEALTH OF GREENWICH		GREENWICH	CT	COM
075074	FILOSA CONV HOME, INC		DANBURY	CT	STA
075078	WESTVIEW NURSING CARE & REHAB		DAYVILLE	CT	COM
075079	NORWICHTOWN REHABILITATION & C		NORWICH	CT	STA
075084	VILLA MARIA NURSING & REHAB COMMUNITY, INC	PLAINFIELD	CT	STA

1. Select **Column.**

Cancel | < Back | Next > | Finish

5. Select the **SRVY_DATE column**. (You will need to scroll to the right to find this column.) Select **Date: YMD**. Click "**Finish**."

Text Import Wizard - Step 3 of 3

This screen lets you select each column and set the Data Format.

'General' converts numeric values to numbers, date values to dates, and all remaining values to text.

Column data format
- General
- Text
- ● Date: YMD
- Do not import column (skip)

Advanced...

2. Select **Date: YMD**.

Data preview

General	General	General	General	YMD
FAC_NAME	CITY_NAME	STATE_CD	SRVY_CYC_DESC	SRVY_D
ANDREW HOUSE HEALTHCARE	NEW BRITAIN	CT	COMPLAINT SURVEY	200712
HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	STANDARD SURVEY	200710
HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	COMPLAINT SURVEY	200801
HAVEN HEALTH CTR OF ROCKY HILL	ROCKY HILL	CT	COMPLAINT SURVEY	200804
PARKWAY PAVILION HEALTH CARE	ENFIELD	CT	STANDARD SURVEY	200804

1. Select **Column.**

Cancel | < Back | Next > | Finish

6. The data file downloaded from OSCAR/CASPER into EXCEL contains the following data columns.

   o Column A – Provider Number
   o Column B – Provider/Supplier Name
   o Column C – City
   o Column D – State
   o Column E – Survey Type (Complaint or Standard)
   o Column F – Survey Date
   o Column G- Provider Category
   o Column H – Empty. To be used in the process for random number generation.

7. Enter the following formula into cell **H2** :

<div align="center">=rand()</div>

8. Copy the formula into each cell in Column H.
9. Select column H and select Home→Copy (or Ctrl+C).
10. Select column I. Select Home→Paste→Paste Special…. Select **Values**. Click OK.

11. Select all of the cells in the spreadsheet. Select Data→ Sort…. In the box, Sort by State_CD, then Column I. Click OK.
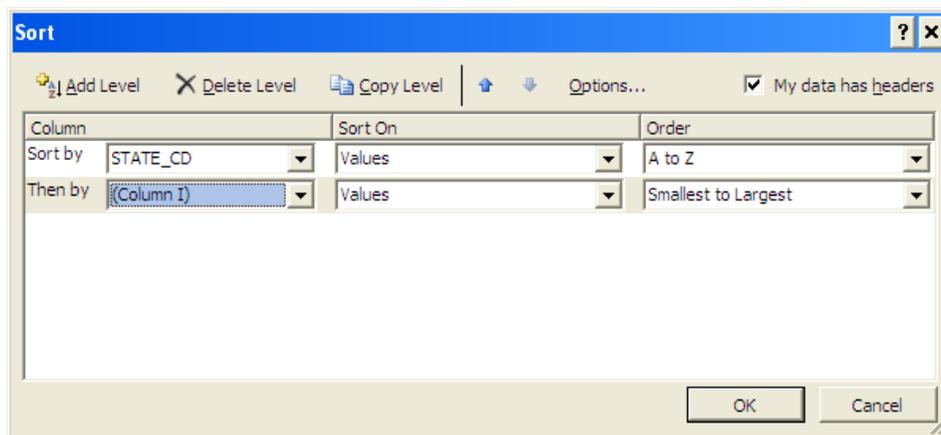
Q4 Identification

State Name:

Appendix 4: Q4 Identification of Health, EP and Life Safety Code (LSC) Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results

Threshold Criterion

This threshold criterion evaluates the State Survey Agency's identification of onsite findings of noncompliance as measured by comparative survey results. For 90% or

more of the deficiencies cited on the Regional Office (RO) comparative surveys at immediate jeopardy or actual harm levels or that resulted in substandard quality of care, the State did not miss citing the same findings on its survey at the same or higher severity level [NOTE: For SQC at an F, the State Agency had to cite the same findings at an F or higher.]

<u>Findings Include</u>
Between October 1, 2012 and March 31, 2013, W health traditional comparative surveys and Z Life Safety Code (LSC) and Emergency Preparedness (EP) comparative surveys were conducted by the Regional Office. For the health surveys conducted, the RO cited B immediate jeopardies (IJs) that were also substandard quality of care (SQC); C IJs that were not SQC; D deficiencies at Level 3 severity (Actual Harm = AH) that were also SQC; E deficiencies at Level 3 that were not SQC; and F deficiencies that were cited at Level 2 severity that were also SQC. For the LSC and EP surveys conducted, the RO cited no IJ or level 3 deficiencies OR the RO cited G IJs and H deficiencies at Level 3. This results in the denominator equal to K points total.
[NOTE: K= ((B*15+C*12+D*8+E*5+F*3)+(G*12+H*5))]

Based on our review of the State Agency CMS-2567 for the same survey as the RO comparative survey for each deficiency cited by the RO in the denominator as enumerated above, the numerator total number of points is L, resulting from the following:

Type of Survey H=Health L= LSC	CCN	Tag FXXX KXXX	Category IJ/SQC IJ/no SQC AH/SQC AH/no SQC F/SQC	Points in Numerator (only one column has an entry for each tag)					
				SA cites same tag, similar finding, same or higher severity	SA cites same tag, similar findings, lower severity	SA cites different tag, similar findings, same or higher severity	SA cites same tag, no similar findings	SA cites different tag, similar findings, lower severity	SA does not cite tag at all, SHF = yes
Total Points									

The comments below summarize issues of particular note:
(Can include whatever you want, both positive and negative. If you have no comments to include, do not include this section.)

The overall score for Q4 is L/K = MM.M%. Q4 was Met / Not Met.

Action Plan
No action plan is required for the midyear analysis.

Measure Q7

Appendix 5: Q7 - Procedures for Obtaining Federal Investigation Timeframe Reports in ACTS

NOTE: Prior to running these reports, deactivate all filters under My Selections (or as an alternative, at the reports filtering screen, make sure that all of the Responsible Teams, Management Units, and appropriate Provider Types are selected). At the main screen in the Facility view, expand the My Selections tree by clicking on the node. Right-click on any selection with a green check and select Deactivate.

IJ Complaints- Non-Deemed Providers

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports→ IJ→ Non-Deemed Provider Complaints.

4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date =10/1/2018
   b. Report Date Range (for Received End Date): End Date = 9/30/2019
   c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151 (Deselect all other types- scrolling across the field may be necessary)
   d. Intake Type = Complaint
   e. Intake Subtype= A Federal COPs, CFCs, RFPs, EMTALA

5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was <u>not</u> initiated within two working days:
   - Total number of federal intakes
   - Total number of federal intakes where the received end and survey start dates are more than 2 working days

IJ Incidents-Non-Deemed Providers

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports→ IJ→ Non-Deemed Provider Incidents.

4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date=10/1/2018
   b. Report Date Range (for Received End Date): End Date= 9/30/2019
   c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151 (Deselect all other types- scrolling across the field may be necessary)
   d. Intake Type = Incident
   e. Intake Subtype = 1 Federally-required, entity-reported
                        2 State-req, potential Fed noncompl, entity-reported
                        3 State-required, all other, entity-reported
                        4 Reported by other agencies
                        5 None of the above
   f. Onsite/Offsite = 1 Onsite Survey Performed
5. Click OK
6. Click the Printer icon, and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was not initiated within two working days:
   - Total number of federal intakes
   - Total number of federal intakes where the received end and survey start dates are more than 2 working days

IJ-Deemed Providers

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports→ IJ→ Deemed Provider.
4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date= 10/1/2018
   b. Report Date Range (for Received End Date): End Date= 9/30/2019
   c. Provider Type= 011, 012, 013, 014, 015, 016, 051, 052, 151 (Deselect all other types- scrolling across the field may be necessary)
5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was not initiated within two working days:
   - Total number of federal intakes
   - Total number of federal intakes where the RO approval and survey start dates are more than 2 working days

Non-IJ High- Nursing Homes

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports→ Long Term Care→ Non-IJ High.
4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date=10/1/2018

b. Report Date Range (for Received End Date): End Date= 9/30/2019
5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was <u>not</u> initiated within 10 working days:
   - **Total number of NIJH triaged federal intakes**
   - **Total number of NIJH triaged federal intakes where the received end and survey start dates are more than 10 working days**

Non-IJ- Deemed Providers

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports→ Deemed Providers- Non-IJ.
4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date=10/1/2018
   b. Report Date Range (for Received End Date): End Date= 9/30/2019
   c. Provider Type= 011, 012, 013, 014, 015, 016 (Deselect all other types- scrolling across the field may be necessary)
   d. Priority= B Non-IJ High
5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. Use the following data to calculate the percentage of intakes where an onsite survey was <u>not</u> initiated within 45 calendar days:
   - Total number of federal intakes
   - Total number of federal intakes where the RO approval through the survey start dates are greater than the Investigation Within values specified (Check to see whether the Investigation Within value for each intake is 45 days.)

The following two reports can assist in identifying intakes that may be outstanding.

NOTE: Prior to running these reports, deactivate all filters under My Selections (or as an alternative, at the reports filtering screen, make sure that all of the Responsible Teams, Management Units, and appropriate Provider Types are selected). At the main screen in the Facility view, expand the My Selections tree by clicking on the node. Right-click on any selection with a green check and select Deactivate.

IJ- Intakes Without a Scheduled Survey

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Intakes without Scheduled Surveys
4. Change the following filters:
   a. Report Date Range (for Received End Date): Start Date=10/1/2018

     b. Report Date Range (for Received End Date): End Date=9/30/2019
     c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151 (Deselect all other types- scrolling across the field may be necessary)
     d. Intake Subtype = 1 Federally-required, entity-reported

2 State-req, potential Fed noncompl, entity-reported

3 State-required, all other, entity-reported

4 Reported by other agencies

5 None of the above- A Federal COPs, CFCs, RFCs, EMTALA

          (Deselect all other types-- scrolling across the field may be necessary)

     e. Priority = IJ (Deselect all other types)
     f. Onsite/Offsite = 2 No survey performed, 3 Offsite survey performed (Deselect 1 Onsite survey performed)
5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. Include these intakes in the calculation of the percentage of intakes where an onsite survey was <u>not</u> initiated within two working days.

Long Term Care- Non-IJ High-Intakes Without a Scheduled Survey

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Intakes without Scheduled Surveys
4. Change the following filters:
     a. Report Date Range (for Received End Date): Start Date=10/1/2018
     b. Report Date Range (for Received End Date): End Date= 9/30/2019
     c. Provider Type = 021, 022, 023, 024(Deselect all other types- scrolling across the field may be necessary)
     d. Intake Subtype = 1 Federally-required, entity-reported

          2 State-req, potential Fed noncompl, entity-reported

          3 State-required, all other, entity- reported

          4 Reported by other agencies

          5 None of the above

          A Federal COPs, CFCs, RFCs, EMTALA

          (Deselect all other types-- scrolling across the field may be necessary)

     e. Priority = Non-IJ High (Deselect all other types)
     f. Onsite/Offsite = 2 No survey performed, 3 Offsite survey performed (Deselect 1 Onsite survey performed)
5. Click OK.
6. Click the Printer icon, and click OK to print the report.
7. Include these intakes in the calculation of the percentage of intakes where an onsite survey was <u>not</u> initiated within 10 working days.

Appendix 6: E2 - How to Identify the Universe of Enforcement Cases for Review

1. In ASPEN, make sure that My Selections filters have either been deactivated, or select for only SNFs, SNF/NFs, and distinct part SNF/NFs.

2. Run the **AEM Mandatory DPNA Timeline Report** with the following filters:
   a. Report Time Period
      i. Date Type- **Date Range**
      ii. First Date- **07/01/2018**
      iii. Last Date- **06/30/2019**
      iv. Based On- **Cycle Start Date**
   b. Report Order – **Cycle Start Date** or **Facility Name**
   c. FMS Surveys- **Exclude**
   d. Compliance within 70 days- **Exclude**
   e. Facility Type
      i. **021 NURSING HOME (NH) SNF/NF DUAL CERT**
      ii. **022 NURSING HOME (NH) SNF/NF DISTINCT PART**
      iii. **023 NURSING HOME (NH) SNF ONLY**
   f. Case Type
      i. **1 Opportunity to Correct**
      ii. **2 No Opportunity to Correct**

AEM Mandatory DPNA Timeline Report

Report Time Period
- Date: Date Range
- First Date: 07/01/2012
- Last Date: 06/30/2013
- Year: [blank]
- Based On: Cycle Start Date

- Report Order: Facility Name
- Fed Case Status: All
- State Case Status: All
- Chain ID: All
- State Region: All
- Initial Transfer to RO: All
- Compliance Status: All

- FMS Surveys: Exclude
- Compliance within 70: Exclude
- Exclude cases Transferred to RO before 70th Day ☐
- Exclude cases with 1st Revisit before 70th Day and DPNA Not In Effect ☐

Case Workers
- SA Primary Worker: All
- RO Primary Worker: All

Do not select Exclude cases with 1st Revisit

Facility Type — De-Select All
- ☑ 021 NURSING HOME (NH) SNF/NF DUAL CERT
- ☑ 022 NURSING HOME (NH) SNF/NF DISTINCT PART
- ☑ 023 NURSING HOME (NH) SNF ONLY
- ☐ 024 NURSING HOME (NH) NF ONLY

Case Type — De-Select All
- ☑ 1 Opportunity to Correct
- ☑ 2 No Opportunity to Correct
- ☐ 3 Past Noncompliance
- ☐ 4 State Licensure

Additional Selection Factors
- ☐ 01 IDR on any Visit in Cycle
- ☐ 02 SQC in any Visit in Cycle
- ☐ 03 Complaint Visit in Cycle
- ☐ 04 1st Visit is Complaint
- ☐ 05 1st Visit is IJ
- ☐ 06 Any IJ in Case
- ☐ 07 Any CMP In Case
- ☐ 08 Per Day CMP
- ☐ 09 Per Instance CMP
- ☐ 10 NATCEP Loss Actual + Poten...
- ☐ 11 Hearing Requested
- ☐ 12 Bankruptcy case
- ☐ 13 Special Focus Facility

Report Settings
- ☐ Save Setting as [blank]
- Stored Settings: [blank]
- ☐ Public (*)
- Delete

May assist with State agency reviews. Report headings indicating Revisit only show the ASPEN REVST survey type (for certification or complaint). Other visit types may have occurred but will not appear on this report (except for the first visit of the cycle).

Print Options: Detail, Summary and Definitions   [OK]   [Cancel]

3. This report identifies the enforcement cycles where
   a. The most recent visit of the enforcement cycle occurred after the 70th day, or
   b. It was not known on the 70th day whether or not the facility was in substantial compliance. (This includes cases in which the compliance date is on or prior to the 70th day, but the compliance date was determined after the 70th day)

4. This report is a list of the universe of cases to be reviewed for E2 of the State Performance Standards. However, the following enforcement cases should be excluded from the universe of cases to be reviewed:
   a. Cases in which a revisit occurred and substantial compliance is determined by the 70th day, but additional visits were added to the enforcement cycle due to State licensure activities.
   b. Cases in which substantial compliance is determined on or before the 70th day and a waived LSC tag is contributing to the compliance. This is legitimate compliance, but the system may not recognize this.
   c. Cases in which an enforcement cycle is prolonged by data entry errors (e.g., surveys are added to enforcement cycle after substantial compliance is achieved). Data entry errors should be identified and corrected.

   NOTE:

Do not select either "Exclude cases Transferred to RO before 70th Day" or "Exclude cases with 1st Revisit before 70th Day and DPNA In Effect," since this will inaccurately reduce the number of cases in the universe. Leave these selection boxes blank. For these two factors, the Report Definitions on the last page of the report should show "Include."

5. The Surveys Not in an AEM Case Report may identify other enforcement cases that should have been included in the review. Run this report with the following filters:
   a. Report Time Period
      i. First Date- **07/01/2018**
      ii. Last Date- **06/30/2019**
      iii. Based on- **Survey Exit Date**
      iv. Survey Type- **Fed. Surveys**
      v. Highest S/S- **D+ Above**
   b. Review these surveys to see if an enforcement case should have been created and whether the enforcement case should have been referred to the RO.

6. In order for a case to be scored as "Met," one of the following three actions must have occurred <u>on or prior to the 70th day</u>,
   a. The SA sent a DPNA imposition letter to the nursing home.
   b. The SA transferred the case to the RO (as indicated by the "Initial Transfer to RO" field).
   c. The RO sent a DPNA imposition letter.

Note: The report and universe will include cases in which the compliance date is on or prior to the 70th day. This is because it is acceptable for a visit occurring after the 70th day to set the compliance date on or before the 70th day. But, for such a case, one of the three actions noted above (#6) must have taken place on or before the 70th day. For these types of cases, the SA does not know on the 70th day whether or not the facility is in substantial compliance, and therefore, must either send a DPNA letter or send the case to the RO.

The key to the review is to assess what the SA knew as of the 70th day and what the SA did as of the 70th day. If the SA knew the facility was in compliance (based on a documented visit), the case is not in the universe. If, on the 70th day, the SA did not know whether or not the facility was in compliance, the case is in the universe and one of the three actions noted above must have taken place.

Continuous Monitoring

Over the course of time, the SAs have the ability to monitor their progress.

1. In ASPEN, make sure that My Selections filters have either been deactivated, or select for only SNFs, SNF/NFs, and distinct part SNF/NFs.

2. Run the **AEM Mandatory DPNA Timeline Report** with the following filters:
   a. FMS Surveys- **Exclude**
   b. Compliance within 70 days- **Include**
   c. Federal Case Status – **Open-Active**
   d. Facility Type
      i. **021 NURSING HOME (NH) SNF/NF DUAL CERT**
      ii. **022 NURSING HOME (NH) SNF/NF DISTINCT PART**
      iii. **023 NURSING HOME (NH) SNF ONLY**
   e. Case Type
      iv. **1 Opportunity to Correct**
      v. **2 No Opportunity to Correct**
   d. Date Range Based on – **Cycle Start Date**

For the SA, this report identifies
   1) Whether a revisit needs to be conducted and entered into ACO/AEM, if the nursing home has not achieved substantial compliance.
   2) Cases that need to be transferred to the RO (or the SA needs to issue an imposition notice), if a revisit has not been conducted by the 70th Day.
   3) Cases that need to be transferred to the RO (or the SA needs to issue an imposition notice), if the Compliance Date is after the 70th Day.

Appendix 7: E3 - Processing of Termination Cases for Non-Nursing Home Providers/Suppliers

12. Copy and save into your QIES Workbench Library, the following User-Defined Extracts:

- E3 NLTC Report

Prior to submitting the report, you may wish to change the RO, and Survey Date range.

13. Open QIES Workbench → Survey & Certification

14. Select Certification & Complaint, All Surveys

15. Select Provider Supplier Categories Deselect Deemed & Medicaid only

16. Select region

17. Field Selection

18. Search Criteria

19. Submit Report

20. Submit to Queue

21. Download Data file to PC (Click Ctrl + J to open up downloaded file if file does not save or open automatically.)

22. The Data file will be delimited by ""

23. Open Excel to Import Data file
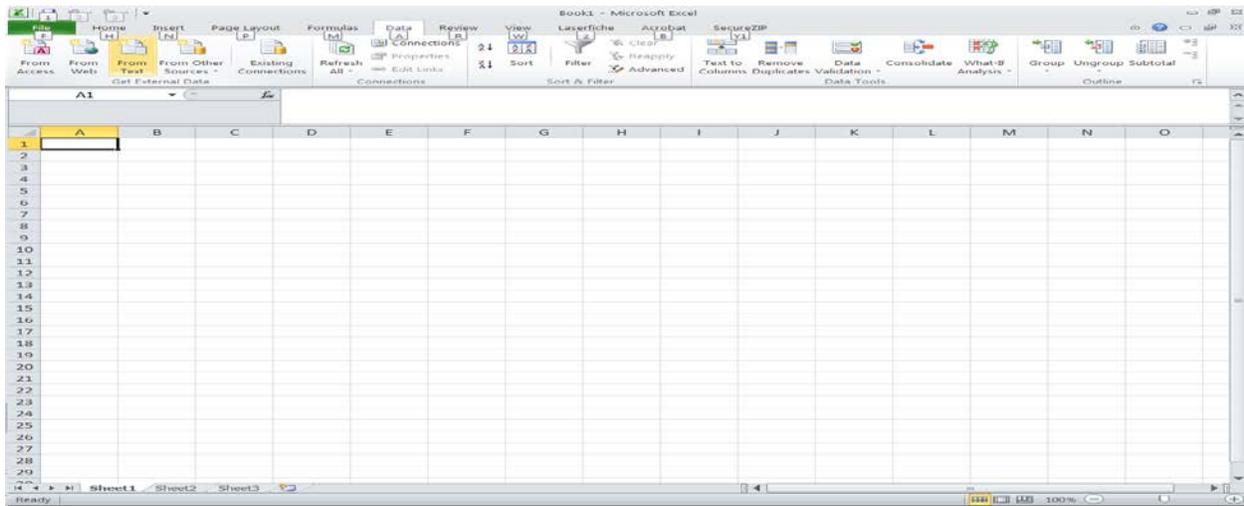
24. Use the Text Import Wizard Select "Delimited"
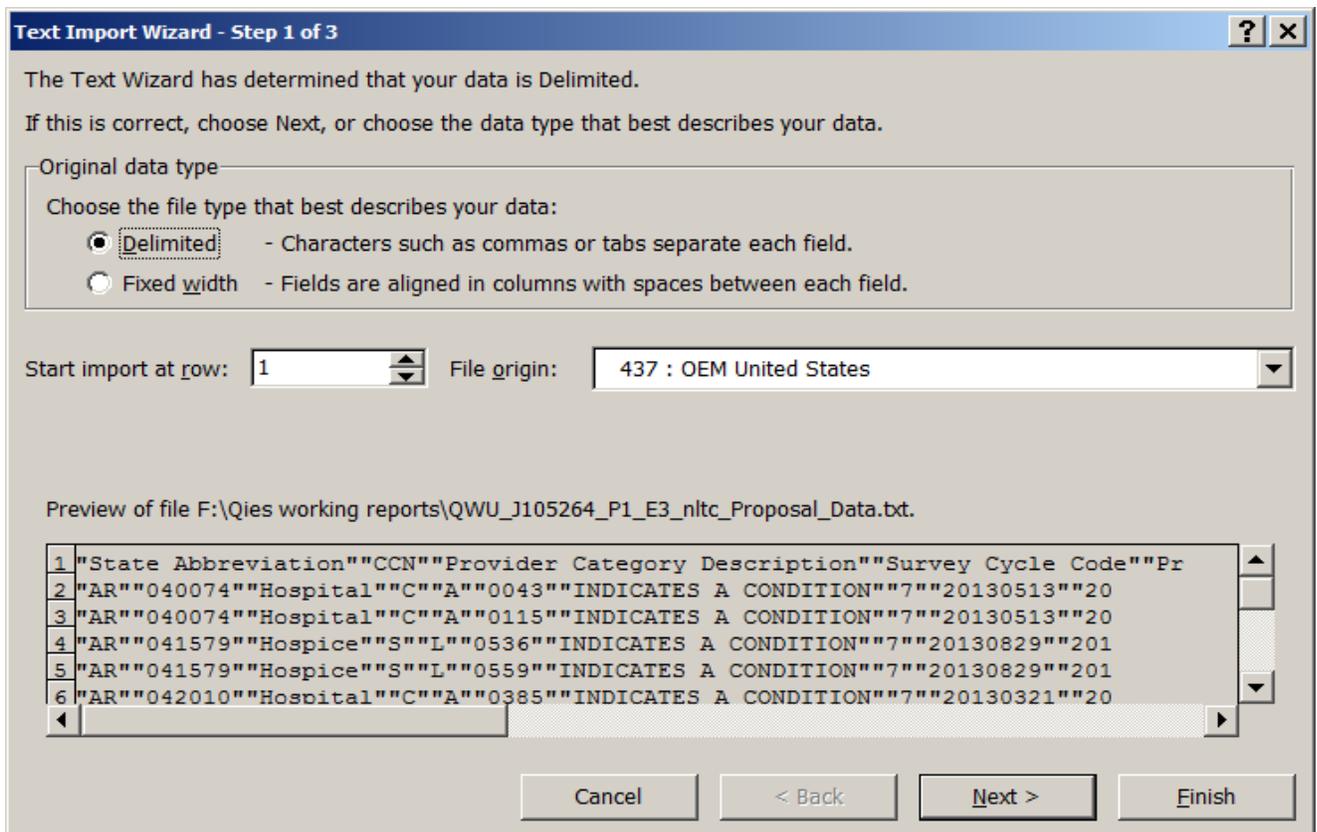
25. Convert CCN and Tags to Text, Select YMD to convert date fields. (You will need to scroll to the right to find columns.)
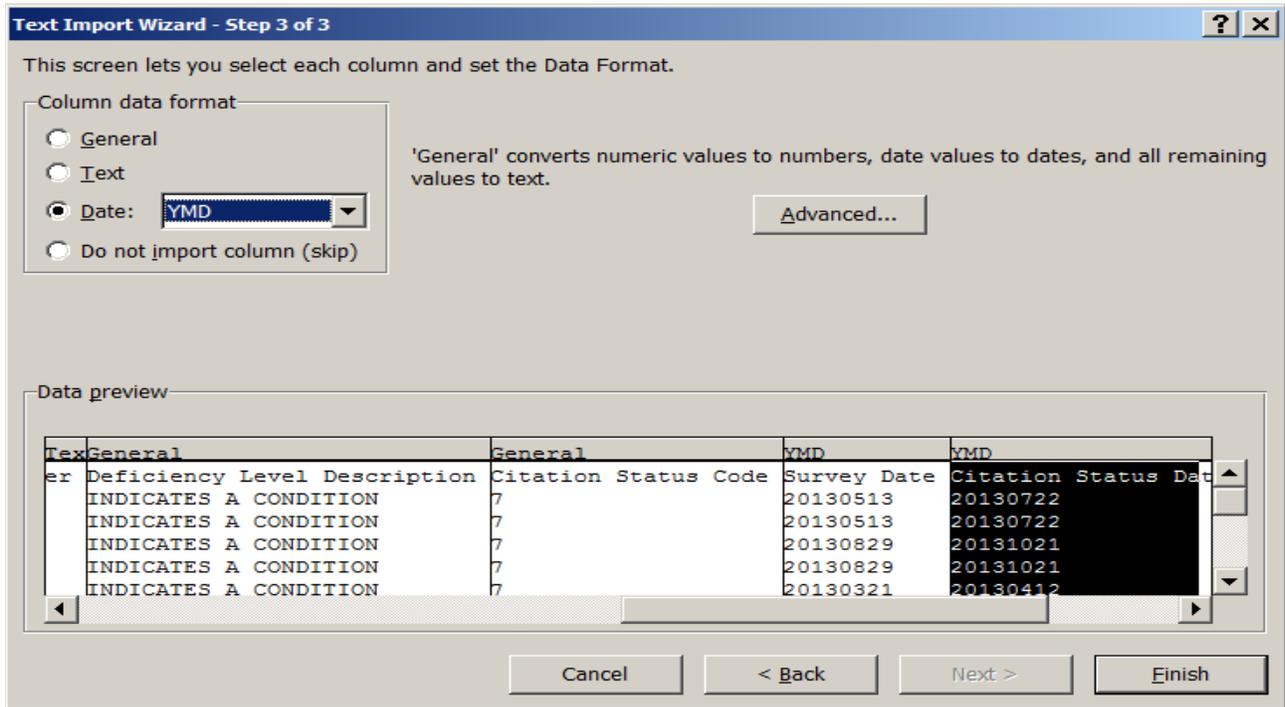
26. Imported data will look like this.

27. Select CCN Prefix Code and Survey Date to remove duplicates

28. Insert formula = K2-J2 (=Citation Status Date - Survey Date) into Column L and drag the formula to the bottom of your data.

29. Select column L and select Home→Copy (or Ctrl+C).
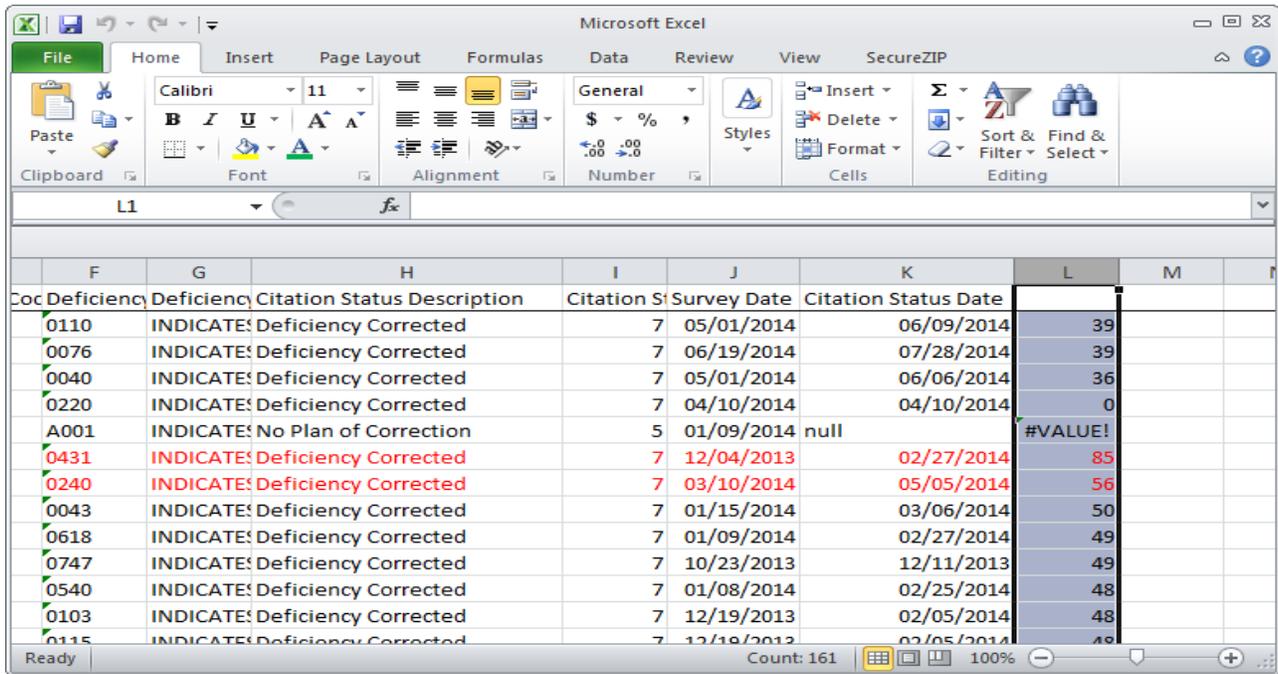
30. Select column L. Select Home→Paste→Paste Special….   Select Values. Click OK.
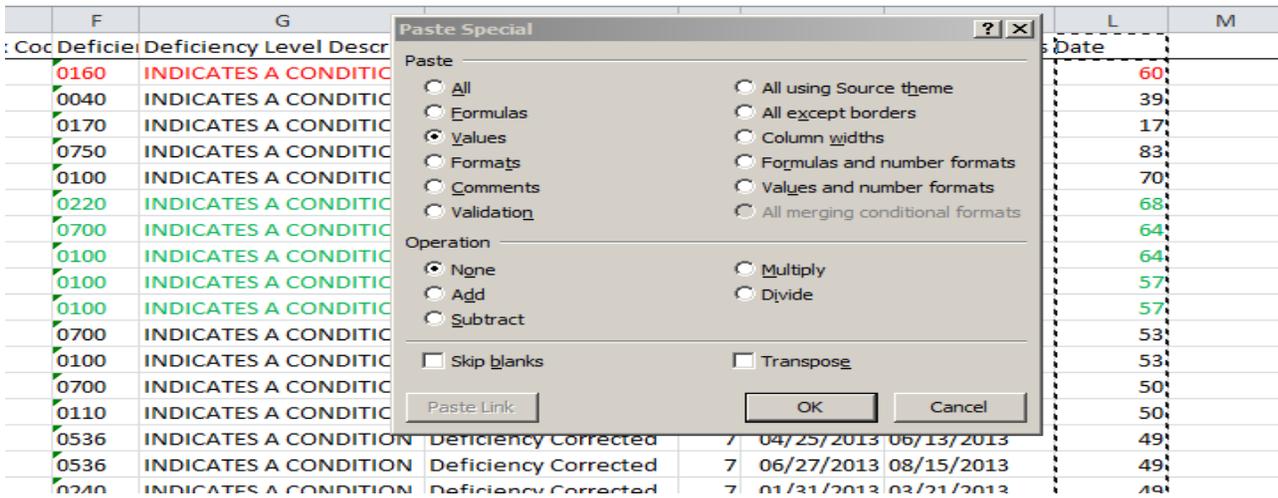
31. Select all of the cells in the spreadsheet. Select Data→ Sort…. In the box, Sort by State Abbreviation, then Column L. Click OK.

	A	B	C	D							K	L
1	State Abb	CCN	Provider (	Survey							Status Date	
2	AR	040027	Hospital	C							04/02/2014	41
3	AR	041323	Hospital	S							04/10/2014	0
4	AR	041522	Hospice	S							06/06/2014	43
5	AR	042501	End Stage	S							02/27/2014	41
6	AR	042527	End Stage	S							06/09/2014	39
7	AR	042564	End Stage	C							07/02/2014	42
8	AR	043460	Rural Heal	S							05/30/2014	42
9	AR	043494	Rural Heal	S							07/28/2014	39
10	AR	047032	Home Hea	C							02/27/2014	44
11	AR	047080	Home Hea	S							04/24/2014	41
12	AR	047083	Home Hea	S	G	0156	INDICATES	Deficiency Corrected	7	01/31/2014	03/17/2014	45
13	AR	047088	Home Hea	S	G	0330	INDICATES	Deficiency Corrected	7	12/05/2013	01/17/2014	43
14	AR	047162	Home Hea	S	G	0156	INDICATES	Deficiency Corrected	7	05/07/2014	06/19/2014	43

Sort dialog:

Sort by: State Abbreviation | Sort On: Values | Order: A to Z
Then by: (Column L) | Sort On: Values | Order: Largest to Smallest

My data has headers ✓

32. Anything above the 55 day line has to be reviewed. Below 55 days are met.

QWU_J115327_P1_E3_NLTC_Report_Data.txt

	A	B	C	D	E	F	G	H	I	J	K	L
1	State Abb	CCN	Provider (	Survey Cy	Prefix Coc	Deficiency	Deficiency	Citation Status Description	Citation S	Survey Date	Citation Status Date	
14	AR	042527	End Stage	S	V	0110	INDICATES	Deficiency Corrected	7	05/01/2014	06/09/2014	39
15	AR	043494	Rural Heal	S	J	0076	INDICATES	Deficiency Corrected	7	06/19/2014	07/28/2014	39
16	AR	04C00010:	Ambulato	S	Q	0040	INDICATES	Deficiency Corrected	7	05/01/2014	06/06/2014	36
17	AR	041323	Hospital	S	C	0220	INDICATES	Deficiency Corrected	7	04/10/2014	04/10/2014	0
18	LA	199801	Hospital	C	X	A001	INDICATES	No Plan of Correction	5	01/09/2014	null	#VALUE!
19	LA	192007	Hospital	S	A	0431	INDICATES	Deficiency Corrected	7	12/04/2013	02/27/2014	85
20	LA	19C000108	Ambulato	S	Q	0240	INDICATES	Deficiency Corrected	7	03/10/2014	05/05/2014	56
21	LA	194074	Hospital	S	A	0043	INDICATES	Deficiency Corrected	7	01/15/2014	03/06/2014	50
22	LA	192029	Hospital	S	A	0618	INDICATES	Deficiency Corrected	7	01/09/2014	02/27/2014	49
23	LA	193079	Hospital	S	A	0747	INDICATES	Deficiency Corrected	7	10/23/2013	12/11/2013	49
24	LA	192708	End Stage	C	V	0540	INDICATES	Deficiency Corrected	7	01/08/2014	02/25/2014	48
25	LA	194083	Hospital	C	B	0103	INDICATES	Deficiency Corrected	7	12/19/2013	02/05/2014	48
26	LA	194083	Hospital	C	A	0115	INDICATES	Deficiency Corrected	7	12/19/2013	02/05/2014	48
27	LA	19C00010:	Ambulato	S	Q	0240	INDICATES	Deficiency Corrected	7	01/23/2014	03/11/2014	47

Appendix 8: Rounding Issues

The conventional rounding methodology (i.e., .1 to .49 = round down; .5 to .99 = round up) does not apply to the State Performance Standards. In general, for purposes of reporting scores, numbers should be rounded to the nearest **tenth** (one decimal point). However, rounding should not be used to determine whether a SA did meet or did not meet a threshold criterion. Examples are provided under F1. In determining sample sizes, numbers should always be rounded up to the nearest whole number. More specifically:

Sample Selection (Q1, Q6, Q8, Q9): When pulling a random sample, the sample size should always be rounded **up** to the nearest whole number. Rounding down in sample selection results in less than the required sample size.

SPS F1 - Off-Hour Surveys for NHs. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

Calculation of the Percentage of Surveys that are Off-Hours	Score to be Reported	Threshold Criterion Met or Not Met?
6.015%	6.0%	Not Met
9.95%	<10.0%	Not Met
10%	10.0%	Met
10.45%	10.5%	Met
13.33333%	13.3%	Met

For the second example, including the "less than" (<) sign indicates that the SA did not meet the threshold criterion for a score of 10.0% that was rounded.

SPS F2 - Frequency of NH Surveys. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion. The requirements are for no more than 15.9 months between surveys and an average statewide interval not to exceed 12.9 months.

SPS F3 - Frequency of Non-NH Surveys. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS F4 - Frequency of Data Entry. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q1 - Documentation of Deficiencies. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q2 - NH Surveys in Accordance with Federal Standards (NH FOSS Surveys). Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q3 - Documentation of Non-Compliance (NH FOSS Surveys). Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q4 - Accuracy of Documentation (NH Comparative Surveys). Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q6 - Prioritizing Complaints and Incidents. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q7 - Timeliness of Complaint and Incident Investigations. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q8 - Timeliness of EMTALA Investigations. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS Q9 - Quality of Investigation. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

SPS E1-E4 - Enforcement. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

Appendix 9: Acronyms

The Act	Social Security Act
ACTS	ASPEN Complaints/Incidents Tracking System
AEM	ASPEN Enforcement Manager System
ASCs	Ambulatory Surgical Centers
ASPEN	Automated Survey Processing Environment System
CASPER	Certification and Survey Provider Enhanced Reporting System
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CO	CMS Central Office
CORFs	Comprehensive Outpatient Rehabilitation Facilities
DPNA	Denial of Payment for New Admissions
ESRD	End-Stage Renal Disease

EMTALA	Emergency Medical Treatment & Labor Act
FMS	Federal Monitoring System
FOSS	Federal Oversight/Support Survey
FY	Federal Fiscal Year
HHAs	Home Health Agencies
ICFs/IID	Intermediate Care Facilities for Individuals who are Intellectually Disabled
IDR	Informal Dispute Resolution
IJ	Immediate Jeopardy
LSC	Life Safety Code
ODIE	Online Data Input & Edit System
OPTs	Outpatient Physical Therapy
OSCAR	Online Survey Certification & Reporting System
PDQ	Providing Data Quickly System
RHCs	Rural Health Clinics
RO	CMS Regional Office
SA	State Survey Agency
SFF	Special Focus Facility
SOM	State Operations Manual
SPSS	State Performance Standards System

Summary
Q1 Worksheet-FY 2019

Nursing Homes

			Total Yes	Total No	Total N/A	Total Tags Scored	Requirement Score
Principles of Documentation	1	The findings support and illustrate the entity's noncompliance.	0	0		0	#DIV/0!
	2	Each Deficient Practice Statement clearly summarizes the provider's failure(s) and quantifies a relevant extent.	0	0	0	0	#DIV/0!
	3	Each person referred to in the citation is uniquely identified.	0	0	0	0	#DIV/0!
	4	The citation identifies the source(s) through which evidence was obtained.	0	0	0	0	#DIV/0!
	5	Evidence is written in plain language that is clear, concise, and easily understood.	0	0	0	0	#DIV/0!
Assessment	6	(NHs only) The severity rating reflects the evidence and the actual and/or potential outcome to residents.	0	0	0	0	#DIV/0!
	7	(NHs only) The scope reflects the evidence and the number of residents who are, or may be, affected by the deficient practice.	0	0	0	0	#DIV/0!

Non-Nursing Homes

			Total Yes	Total No	Total N/A	Total Tags Reviewed	Requirement Score
Principles of Documentation	1	The findings support and illustrate the entity's noncompliance.	0	0		0	#DIV/0!
	2	Each Deficient Practice Statement clearly summarizes the provider/supplier's failure(s) and quantifies a relevant extent.	0	0	0	0	#DIV/0!
	3	Each person referred to in the citation is uniquely identified.	0	0	0	0	#DIV/0!
	4	The citation identifies the source(s) through which evidence was obtained.	0	0	0	0	#DIV/0!
	5	Evidence is written in plain language that is clear, concise, and easily understood.	0	0	0	0	#DIV/0!
Assessment	8	(Non-NHs only) The condition, standard, or element-level cited reflects the evidence and the actual and/or potential outcome to patients/clients.	0	0	0	0	#DIV/0!

Index

	Name	CCN	Survey Date	State	Provider Type	Reviewer	Date of Review
1							
2							
3							
4							
5							
6							
7							
8							
9							
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33							

Q1 Worksheet-FY 2019

Name of Provider			Certification #	Survey Date
0			0	01/00/00
State	Provider Type	Reviewer		Date of Review
Select	Select		0	01/00/00

			Enter Tag	Enter Tag	Enter Tag	Enter Tag
		Requirement	Select	Select	Select	Select
Principles of Documentation	1	The findings support and illustrate the entity's noncompliance.	Select	Select	Select	Select
	2	Each Deficient Practice Statement clearly summarizes the provider/supplier's failure(s) and quantifies a relevant extent.	Select	Select	Select	Select
	3	Each person referred to in the citation is uniquely identified.	Select	Select	Select	Select
	4	The citation identifies the source(s) through which evidence was obtained.	Select	Select	Select	Select
	5	Evidence is written in plain language that is clear, concise, and easily understood.	Select	Select	Select	Select
Assessment	6	(NHs only) The severity rating reflects the evidence and the actual and/or potential outcome to residents.	Select	Select	Select	Select
	7	(NHs only) The scope reflect the evidence and the number of residents who are, or may be, affected by the deficient practice.	Select	Select	Select	Select
	8	(Non-NHs only) The condition, standard, or element-level cited reflects the evidence and the actual and/or potential outcome to patients/clients.	Select	Select	Select	Select

Comments

Double-click to add narrative text. This will take you to a Microsoft Word text box…once you have finished entering text, select a cell outside of the text box.

Q1 Worksheet-FY 2019

Name of Provider			Certification #	Survey Date
0			0	01/00/00
State	Provider Type	Reviewer		Date of Review
Select	Select		0	01/00/00

		Requirement	Enter Tag	Enter Tag	Enter Tag	Enter Tag
			Select	Select	Select	Select
Principles of Documentation	1	The findings support and illustrate the entity's noncompliance.	Select	Select	Select	Select
	2	Each Deficient Practice Statement clearly summarizes the provider/supplier's failure(s) and quantifies a relevant extent.	Select	Select	Select	Select
	3	Each person referred to in the citation is uniquely identified.	Select	Select	Select	Select
	4	The citation identifies the source(s) through which evidence was obtained.	Select	Select	Select	Select
	5	Evidence is written in plain language that is clear, concise, and easily understood.	Select	Select	Select	Select
Assessment	6	(NHs only) The severity rating reflects the evidence and the actual and/or potential outcome to residents.	Select	Select	Select	Select
	7	(NHs only) The scope reflect the evidence and the number of residents who are, or may be, affected by the deficient practice.	Select	Select	Select	Select
	8	(Non-NHs only) The condition, standard, or element-level cited reflects the evidence and the actual and/or potential outcome to patients/clients.	Select	Select	Select	Select

Comments

Double-click to add narrative text. This will take you to a Microsoft Word text box…once you have finished entering text, select a cell outside of the text box.

Summary
Q8 Worksheet: EMTALA Investigation Review - FY 2019

Select

	Requirement	Total Yes	Total No	Total Cases	Percent Yes (for analysis only)	Points for Yes	Max Points for Requirement	Points for Requirement
1	Was the onsite complaint investigation completed within five working days from RO Approval Date/Extension Date?	0	0	0	0%	4	0	0
2	Was a completed packet sent to the RO within 10 working days following the survey exit date when a suspected violation is identified or 15 working days when no violation was found? Timeframes are calculated from the survey exit date to the RO receipt date. Count the day of the survey exit date as day zero. The RO accounts for State holidays and office closures in its working day calculation A complete packet is defined as containing the items listed below. (Scoring for Requirement 2 takes place below. The Yes's and No's tallied here are for analysis purposes only.) NOTE: For each item listed in 2.1 to 2.8 to be scored "yes," the document(s) being referred to needs to have been submitted timely and be complete. If the item was not submitted timely and/or was not complete, the corresponding element in number 2 should be scored "no."	0	0	0	0%			
2.1	CMS-562 sent to RO/Data entered into ACTS;	0	0	0	0%	0.5	0	0
2.2	CMS-670 sent to RO/Data entered into ACTS;	0	0	0	0%	0.5	0	0
2.3	A completed CMS-2567;	0	0	0	0%	0.5	0	0
2.4	CMS-1541B with recommendation for action included or sent in the survey packet;	0	0	0	0%	0.5	0	0
2.5	Written summary of interviews – can be in the narrative or surveyor notes;	0	0	0	0%	0.5	0	0
2.6	Copies of pertinent hospital policies and procedures that relate to the identified deficiencies NOTE: • If a violation is found, policies and procedures must be submitted with the packet. If they are required but not included, score NO. • If no violation is found, policies and procedures are not required to be submitted with the packet. If they are not required, score "YES" whether submitted or not.	0	0	0	0%	0.5	0	0
2.7	Summary listing of all patients comprising the sample (including an explanation of how and why the cases were selected for review); and	0	0	0	0%	0.5	0	0
2.8	Copies of medical records for substantiated cases, medical records of individuals named in complaints and other medical records in accordance with the QIO physician review checklist.	0	0	0	0%	0.5	0	0
3	Was the sample selection based on the case selection methodology outlined in Appendix V, Task 2 of the SOM?	0	0	0	0%	4	0	0
4	Did the CMS-2567 require no revisions or only minor revisions by the SA after review by the RO? • Score Yes if the CMS-2567 required no revisions or only minor revisions or the only revisions were beyond the SA's control, e.g., as a result of the QIO review • Score No if the CMS-2567 required major revisions that were within the SA's control, including failure to follow the Principles of Documentation	0	0	0	0%	4	0	0
5	Was a complete Complaint Investigation Narrative included with the SA packet that was sent to the RO? The narrative should summarize significant findings found in medical records, meeting minutes, hospital policies and procedures, staffing schedules, QAPI plans, hospital By-laws, Rules and Regulations, training programs, credential files, personnel files, and contracted services. The narrative should also briefly summarize SA findings in the investigation and the rationale used for the course of action recommended to the RO.	0	0	0	0%	4	0	0

Maximum Possible Points   0

Total Points for This Review   0

Q8 Score (must be at least 90.0% to be Met)   #DIV/0!

Q8 Index - FY2013

TAB	Name	CCN # / Intake #	Survey Date	State	Reviewer	Date of Review	EMTALA violation found (YES/NO)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							

Q8 Worksheet - FY 2019

Name of Provider		CCN # / Intake #	Survey Date
0		0	01/00/00
State	Reviewer	Date of Review	EMTALA violation found
Select	0	01/00/00	0

	Requirement	Score
1	Was the onsite complaint investigation completed within five working days from RO Approval Date/Extension Date?	Select
2	Was a completed packet sent to the RO within 10 working days following the survey exit date when a suspected violation is identified or 15 working days when no violation was found? Timeframes are calculated from the survey exit date to the RO receipt date. Count the day of the survey exit date as day zero. The RO accounts for State holidays and office closures in its working day calculation A complete packet is defined as containing the items listed below. (Scoring for Requirement 2 takes place below. The Yes's and No's tallied here are for analysis purposes only.) NOTE: For each item listed in 2.1 to 2.8 to be scored "yes," the document(s) being referred to needs to have been submitted timely and be complete. If the item was not submitted timely and/or was not complete, the corresponding element in number 2 should be scored "no."	Select
2.1	CMS-562 sent to RO/Data entered into ACTS;	Select
2.2	CMS-670 sent to RO/Data entered into ACTS;	Select
2.3	A completed CMS-2567;	Select
2.4	CMS-1541B with recommendation for action included or sent in the survey packet;	Select
2.5	Written summary of interviews – can be in the narrative or surveyor notes;	Select
2.6	Copies of pertinent hospital policies and procedures that relate to the identified deficiencies NOTE: • If a violation is found, policies and procedures must be submitted with the packet. If they are required but not included, score NO. • If no violation is found, policies and procedures are not required to be submitted with the packet. If they are not required, score "YES" whether submitted or not.	Select
2.7	Summary listing of all patients comprising the sample (including an explanation of how and why the cases were selected for review); and	Select
2.8	Copies of medical records for substantiated cases, medical records of individuals named in complaints and other medical records in accordance with the QIO physician review checklist.	Select
3	Was the sample selection based on the case selection methodology outlined in Appendix V, Task 2 of the SOM?	Select
4	Did the CMS-2567 require no revisions or only minor revisions by the SA after review by the RO? • Score Yes if the CMS-2567 required no revisions or only minor revisions or the only revisions were beyond the SA's control, e.g., as a result of the QIO review • Score No if the CMS-2567 required major revisions that were within the SA's control, including failure to follow the Principles of Documentation	Select
5	The narrative should summarize significant findings found in medical records, meeting minutes, hospital policies and procedures, staffing schedules, QAPI plans, hospital By-laws, Rules and Regulations, training programs, credential files, personnel files, and contracted services. The narrative should also briefly summarize SA findings in the investigation and the rationale used for the course of action recommended to the RO.	Select

Comments

Double-click to add narrative text. This will take you to a Microsoft Word text box…once you have finished entering text, select a cell outside of the text box.

Name of Provider		CCN # / Intake #	Survey Date
0		0	01/00/00
State	Reviewer	Date of Review	EMTALA violation found
Select	0	01/00/00	0

	Requirement	Score
1	Was the onsite complaint investigation completed within five working days from RO Approval Date/Extension Date?	Select
2	Was a completed packet sent to the RO within 10 working days following the survey exit date when a suspected violation is identified or 15 working days when no violation was found? Timeframes are calculated from the survey exit date to the RO receipt date. Count the day of the survey exit date as day zero. The RO accounts for State holidays and office closures in its working day calculation A complete packet is defined as containing the items listed below. (Scoring for Requirement 2 takes place below. The Yes's and No's tallied here are for analysis purposes only.) NOTE: For each item listed in 2.1 to 2.8 to be scored "yes," the document(s) being referred to needs to have been submitted timely and be complete. If the item was not submitted timely and/or was not complete, the corresponding element in number 2 should be scored "no."	Select
2.1	CMS-562 sent to RO/Data entered into ACTS;	Select
2.2	CMS-670 sent to RO/Data entered into ACTS;	Select
2.3	A completed CMS-2567;	Select
2.4	CMS-1541B with recommendation for action included or sent in the survey packet;	Select
2.5	Written summary of interviews – can be in the narrative or surveyor notes;	Select
2.6	Copies of pertinent hospital policies and procedures that relate to the identified deficiencies NOTE: • If a violation is found, policies and procedures must be submitted with the packet. If they are required but not included, score NO. • If no violation is found, policies and procedures are not required to be submitted with the packet. If they are not required, score "YES" whether submitted or not.	Select
2.7	Summary listing of all patients comprising the sample (including an explanation of how and why the cases were selected for review); and	Select
2.8	Copies of medical records for substantiated cases, medical records of individuals named in complaints and other medical records in accordance with the QIO physician review checklist.	Select
3	Was the sample selection based on the case selection methodology outlined in Appendix V, Task 2 of the SOM?	Select
4	Did the CMS-2567 require no revisions or only minor revisions by the SA after review by the RO? • Score Yes if the CMS-2567 required no revisions or only minor revisions or the only revisions were beyond the SA's control, e.g., as a result of the QIO review • Score No if the CMS-2567 required major revisions that were within the SA's control, including failure to follow the Principles of Documentation	Select
5	The narrative should summarize significant findings found in medical records, meeting minutes, hospital policies and procedures, staffing schedules, QAPI plans, hospital By-laws, Rules and Regulations, training programs, credential files, personnel files, and contracted services. The narrative should also briefly summarize SA findings in the investigation and the rationale used for the course of action recommended to the RO.	Select

Comments
Double-click to add narrative text. This will take you to a Microsoft Word text box…once you have finished entering text, select a cell outside of the text box.

FY 2019 State Performance Evaluation - Summary Score Sheet
FREQUENCY DIMENSION

Select…

F1: OFF-HOUR SURVEYS FOR NURSING HOMES

	Measure Score	Select…
	Percentage	

*In order to meet the Performance Measure: % Off-Hours ≥ 10%

F2: FREQUENCY OF NURSING HOME SURVEYS

	Measure Score	Select…
# of Active Nursing Homes		
# Surveyed		
# Exceeding 15.9 Months		
% Surveyed	#DIV/0!	
Threshold 1 Score	Select…	
Statewide Avg Interval (Months)		
Threshold 2 Score	Select…	

If the maximum number of months between all standard surveys is less than or equal to 15.9 months and the statewide average interval is less than or equal to 12.9 months, this Measure is scored as "Met."

F3.1: FREQUENCY OF NON-NURSING HOME SURVEYS-TIER I

	Measure Score	Select…
HHAs		Select…
# of Active HHAs		
# Surveyed		
# Exceeding 36.9 Months		
% Surveyed	#DIV/0!	
ICFs/IID		Select…
# of Active ICFs/MR		
# Surveyed		
# Exceeding 15.9 Months		
% Surveyed	#DIV/0!	
Threshold 1 Score	Select…	
Statewide Avg Interval (Months)		
Threshold 2 Score	Select…	
NON-DEEMED HOSPICES		Select…
# of Active Hospices		
# Surveyed		
% Surveyed (33% Required)	#DIV/0!	
DEEMED HOSPITALS		Select…
# of Hospitals in Sample (1)		
# of Hospitals in Sample (2)		
# of Hospitals Surveyed		

*If the SA conducts recertification surveys for non-deemed HHAs, ICFs/IID, and non-deemed hospices, and validation surveys for deemed hospitals according to the Tier 1 Requirements, this Measure is scored as "Met."

Select…

F3.2: FREQUENCY OF NON-NURSING HOME SURVEYS-TIER II

	Measure Score	Select…
OPTs		Select…
# of Active OPTs		
# of OPTs Surveyed		
% Surveyed		#DIV/0!
CORFs		Select…
# of Active CORFs		
# of CORFs Surveyed		
% Surveyed		#DIV/0!
RHCs		Select…
# of Active RHCs		
# of RHCs Surveyed		
% Surveyed		#DIV/0!
NON-DEEMED ASCs		Select…
# of Active ASCs		
# of ASCs Surveyed		
% Surveyed		#DIV/0!
ESRDs		Select…
# of Active ESRDs		
# of ESRDs Surveyed from Targeted Sample		
% Surveyed		#DIV/0!
NON-DEEMED HOSPITALS & CAHS		Select…
# of Active Hospitals- STAC		
# of Hospitals Surveyed- STAC		
% Surveyed-STAC		#DIV/0!
Max # of Years between Surveys		
# Exceeding Max Interval (All NAHs)		

*If the SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities according to the Tier 2 Requirements, this Measure is scored as "Met."

FY 2019 State Performance Evaluation - Summary Score Sheet
FREQUENCY DIMENSION

Select…

F3.3: FREQUENCY OF NON-NURSING HOME SURVEYS-TIER III

	Measure Score	Select…

OPTs   Select…

Max # of Years between Surveys
Exceeding Max Interval

CORFs   Select…

Max # of Years between Surveys
Exceeding Max Interval

RHCs   Select…

Max # of Years between Surveys
Exceeding Max Interval

NON-DEEMED ASCs   Select…

Max # of Years between Surveys
Exceeding Max Interval

ESRDs   Select…

Max # of Years between Surveys
Exceeding Max Interval

NON-DEEMED HOSPITALS & CAHS   Select…

Max # of Years between Surveys
Exceeding Max Interval

*If the SA conducts recertification surveys for non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs, and ESRD facilities according to the Tier 3 Requirements, this Measure is scored as "Met."

F4: FREQUENCY OF DATA ENTRY OF STANDARD SURVEYS FOR NON-DEEMED HOSPITALS AND NURSING HOMES

	Measure Score	Select…

Nursing Homes

# of Surveys Entered
Mean # of Days to Data Entry
% of Surveys-Data Entry Exceeds 70 Days

Non-Deemed Hospitals

# of Surveys Entered
Mean # of Days to Data Entry
% of Surveys-Data Entry Exceeds 70 Days

If the average is less than or equal to 70 calendar days for data entry of both nursing home and non-deemed hospital (including non-deemed CAHs) surveys, this Measure is scored as "Met."

FY 2019 State Performance Evaluation - Summary Score Sheet
QUALITY DIMENSION

Select…

Q1: DOCUMENTATION OF DEFICIENCIES ON FORM CMS-2567

Measure Score	Select…	
Threshold 1 Score	Select…	
Threshold 2 Score	Select…	

	Nursing Homes Score	**Non-Nursing Homes Score**
Requirement 1		
Requirement 2		
Requirement 3		
Requirement 4		
Requirement 5		
Requirement 6		
Requirement 7		
Requirement 8		

*If the score for each requirement for nursing homes and non-nursing homes is greater than or equal to 85%, this Measure is scored as "Met."

Q2: CONDUCT OF NH SURVEYS IN ACCORDANCE WITH FEDERAL STANDARDS (FOSS SURVEYS)

Measure Score	Select…
Average Rating #1	
Average Rating #2	
Average Rating #3	
Average Rating #4	
Average Rating #5	
Average Rating #6	

*If all six FOSS measures achieve an average score of 3.0 or above, this Measure is scored as "Met."

Q3: DOCUMENTATION OF NONCOMPLIANCE IN ACCORDANCE WITH FEDERAL STANDARDS (FOSS SURVEYS)

Measure Score	Select…
Unjustified Disparity Rate	

*If the unjustified disparity rate is 20% or less, this Measure is scored as "Met."

Q4: ACCURACY OF DOCUMENTATION DURING (COMPARATIVE SURVEYS)

Measure Score	Select…
Measure Percentage	

* Agreement Rate must be 90% or above to meet this Measure.

Select…

Q5	HOLD

Q6: PRIORITIZING COMPLAINTS AND INCIDENTS

Measure Score	*Select…*
Threshold 1 Percentage	
Threshold 1 Score	*Select…*
Threshold 1 Percentage	
Threshold 2-6 Score	*Select…*

*If both Threshold Criteria are scored as "Met," this Measure is scored as "Met."

Q7: TIMELINESS OF COMPLAINT AND INCIDENT INVESTIGATIONS

Measure Score	Select…
Threshold 1 Percentage	
Threshold 1 Score	Select…
Threshold 2 Percentage	
Threshold 2 Score	Select…
Threshold 3 Percentage	
Threshold 3 Score	Select…
Threshold 4 Percentage	
Threshold 4 Score	Select…

*If all four Threshold Criteria are met, this Measure is scored as "Met."

Q8: QUALITY OF EMTALA INVESTIGATIONS

Measure Score	Select…
Total Possible Points	
Total Point Score	
Percentage Met	#DIV/0!

* Total score on all requirements must be 90% or above to meet this Measure.

Q9: QUALITY OF COMPLAINT/INCIDENT INVESTIGATIONS FOR NURSING HOMES

Measure Score	Select…
Requirement 1 Score	
Requirement 2 Score	
Requirement 3 Score	
Requirement 4 Score	
Requirement 5 Score	

*If the score for each criterion is greater than or equal to 85%, this Measure is scored as "Met."

FY 2019 State Performance Evaluation - Summary Score Sheet
ENFORCEMENT DIMENSION

Select…

E1: TIMELINESS OF PROCESSING IMMEDIATE JEOPARDY CASES

Measure Score	**Select…**

# of Acceptable Cases
# of Cases Reviewed
Percentage   #DIV/0!

*If the resulting percentage is greater than or equal to 95%, this Measure is scored as "Met."

E2: TIMELINESS OF MANDATORY DENIAL OF PAYMENTS FOR NEW ADMISSIONS (DPNA) NOTIFICATION FOR NURSING HOMES

Measure Score	**Select…**

# of Acceptable Cases
# of Cases Reviewed
Percentage   #DIV/0!

*If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met."

E3: PROCESSING OF TERMINATION CASES FOR NON-NURSING HOME PROVIDERS/SUPPLIERS

Measure Score	**Select…**

# of Acceptable Cases
# of Cases Reviewed
Percentage   #DIV/0!

*If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met."

E4: SPECIAL FOCUS FACILITIES FOR NURSING HOMES

Measure Score	**Select…**
Threshold 1 Score	**Select…**
Threshold 2 Score	**Select…**

# of Selected Facilities
# of Standard Surveys for SFFs
# of SFFs replaced after 21 days (If applicable)

*If both Threshold Criteria are met, this Measure is scored as "Met."