



**Center for Clinical Standards and Quality/Quality, Safety & Oversight Group**

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**Admin Info: 20-03-ALL**

**DATE:** December 11, 2019

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality, Safety & Oversight Group

**SUBJECT:** Fiscal Year (FY) 2020 Mission & Priority document (MPD) – Action

**Memorandum Summary**

**FY 2020 MPD:** Based on our commitment to increased transparency, innovation and strengthening oversight, we continue to:

1. Provide updates to the MPD on a public facing website <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/QSOG-Mission-and-Priority-Information.html>
2. Update the download section of the above site to reflect ongoing initiatives and priorities of Survey & Certification work.

As priorities may change throughout the year, we aim to have the MPD be a living and continuous document which can be updated on a timely basis.

**Background**

The MPD is an annual document which directs and outlines the work of the Quality, Safety & Oversight Group, the CMS Regional Offices, and the State Survey Agencies based on regulatory changes, adjustments in budget allocations, and new initiatives, as well as new requirements based on statutes such as the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The MPD discusses survey and certification functions as well as the Medicare funding allocation process for states, which directly impacts the work prioritization and planning for the required survey workload in the fiscal year the MPD is issued. In addition, the MPD provides background information for each of the 17 provider and supplier types, accreditation/deemed surveys, and CMS priorities for initial surveys of providers and suppliers enrolling in Medicare. It also outlines the priorities for surveying relocations of existing providers and suppliers, projected validation survey workload, system requirements, and state performance standards, and provides the upcoming surveyor training schedule.

Every fiscal year, the Quality, Safety & Oversight Group releases the MPD to the CMS Regional Offices and State Survey Agencies.

### **Continuous Improvement of the MPD**

Based on our commitment to increased transparency, innovation and initiatives for human-centered design, we continue to:

1. Provide updates to the MPD on a public facing website <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/QSOG-Mission-and-Priority-Information.html>
2. Update the download section of the above site to reflect ongoing initiatives

As priorities may change throughout the year, we aim to have the MPD be a living document, which can be updated on a timely basis. Such updates will be communicated via an Admin Info memo. For ease of notification, updates will be made to the MPD and/or download(s) in red, italicized font.

### **S&C Medicare Funding Allocation Process**

The S&C program may operate under the terms and conditions of a Continuing Resolution, with funding based on the previous FY base budget as noted in Appendix 2, column A, until such time that Congress passes a final appropriation containing S&C funding. For additional information, please refer to the Budget Download which for additional guidance.

**Contact:** For questions or concerns, please contact your CMS Regional Office.

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

/s/  
David R. Wright

cc: Survey and Certification Regional Office Management



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

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## **Quality Assurance for the Medicare & Medicaid Programs**

**FY2020 Mission & Priority Document (MPD)**

**Quality, Safety & Oversight Group**  
**Survey & Certification Activities**

## CURRENT FACILITY GROWTHS

### **FY18 of Facility Growth:**

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

## SPECIAL NOTES

### **A. New Regulations with New Responsibilities**

- Proposed Rules:
  - **Medicare Program; Accrediting Organizations- Change of Ownership Requirements:** This proposed rule would add requirements and a specified process to address changes of ownership as they relate to the sale, transfer, and/or purchase of assets of Accrediting Organizations (AOs) with the Centers for Medicare & Medicaid Services (CMS)-approved accreditation programs. This change is intended to provide CMS with advance notice when an AO considers a change of ownership. This will allow CMS the opportunity to review the AO's capability to perform its tasks after a change of ownership has occurred to ensure the ongoing effectiveness of the approved accreditation program(s) and minimize risk to patient safety.
  - **Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency”** (CMS-3347-P). The proposed rule would remove requirements for participation identified as unnecessary, obsolete, or excessively burdensome on long-term care (LTC) facilities, also known as “nursing homes.” The rule is part of the agency's five-part approach to ensuring a high-quality LTC facility system that focuses on strengthening requirements for such facilities, working with states to enforce statutory and regulatory requirements, increasing transparency of facility performance, and promoting improved health outcomes for facility residents. CMS expects the provisions in the rule, if finalized, to achieve \$616 million in savings annually for these facilities. Many of the proposed provisions would simplify and/or streamline the Medicare health and safety standards long-term care facilities must meet in order to serve their residents. Importantly, in identifying opportunities for reducing burden, CMS would maintain resident health and safety standards. Once finalized, CMS will provide guidance to state agencies for surveying for compliance with the new regulations.
- Final Rules:
  - **Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (Non Long-Term Care):** This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This proposed rule would increase the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or that divert resources away from furnishing high quality patient care.

**This would affect RNCHIs, CAHs, Hospitals, ASCs, Home Health, Hospice, Transplant, ESRD, CORFs, and Portable X-Ray. It would also change requirements under the Emergency Preparedness Conditions for Participation/Conditions for coverage for all affected providers and suppliers; the effective date for this rule is November 29, 2019. Additional information regarding implementation is forthcoming.**

- **Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements:** CMS has issued a final rule updating the requirements nursing homes must meet to use binding arbitration agreements. CMS is allowing binding arbitration agreements, but will prohibit nursing homes from requiring residents to sign binding arbitration agreements as a condition for receiving care, and will require nursing homes to inform residents or their representatives that they are not required to sign a binding arbitration agreement. Finally, CMS is prohibiting nursing home arbitration agreements from including language preventing residents or anyone else from communication with federal, state, or local officials. We will issue guidance to state agencies for surveying for compliance with the finalized rule.
- **Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care:** This proposed rule would empower patients to be active participants in the discharge planning process. It complements efforts around interoperability that focus on the seamless exchange of patient information between health care settings by revising the discharge planning requirements that Hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Rehabilitation Hospitals, Psychiatric Hospitals, Children's Hospitals, and Cancer Hospitals), Critical Access Hospitals (CAHs), and Home Health Agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014, which would give patients and their families access to information that will help them to make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences, which may ultimately reduce their chances of being re-hospitalized. It also updates one proposed provision regarding patient rights in hospitals, intended to promote innovation and flexibility and to improve patient care.

## **B. Continuing Initiatives**

- ESRD Contract Surveys  
Continued ESRD contract survey assistance to States with seriously overdue survey intervals. However, the availability of these surveys will decrease annually. The

Division of Continuing Care Providers (DCCP) will coordinate with ROs and SAs to select these surveys.

- Surveys of 25% of non-deemed ASCs annually as Tier 2 priority
- Validation Redesign Pilot
  - The Validation Redesign Pilot, which started in early 2018, will continue as a pilot for FY2020. The VRP is a redesign from the traditional validation process. It incorporates the State Agencies (SA) observing the Accrediting Organizations (AO) surveys to evaluate the AO surveyors' performance and their ability to assess compliance with CMS Conditions of Participation (CoP) and Conditions of Coverage (CfCs) for deemed programs. The VRP surveys have included Acute Care Hospitals, Psychiatric Hospitals, Ambulatory Surgical Centers, Home Health Agencies, and Hospice. CMS will work with AOs and States as we continue this pilot.
  - The Validation Redesign Pilot (VRP) will include approximately 15 VRP hospital surveys and 15 VRP non-hospital surveys. Selected states will perform a VRP survey per Appendix 3, via state regular budget. Some states will receive supplemental payment for VRP surveys at a discounted reimbursement amount to reflect the decreased time needed for the VRP surveys using FY2018 CMS-670 hours for VRP surveys.
- State Performance Standards System (SPSS): Through FY2019, CMS has been working on revisions to the SPSS. These revisions include changes to all domains (Frequency, Quality, and Enforcement) for long-term care and non-long term care providers, and will significantly change the way state performance is monitored and assessed. CMS will continue to work with states to finalize the revisions, and anticipates implementing these changes in FY 2020.

## C. Reminders

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

## D. Quality, Safety, Education Division Information

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

## E. Budget Formulation Guidelines

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

## **PROVIDER/SUPPLIER SPECIFIC OVERSIGHT**

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

### **1. Deeming Options**

Due to ongoing Survey and Certification resource constraints, initial certifications of providers/suppliers with the option to achieve deemed Medicare status through accreditation by an Accrediting Organization with CMS-approved deeming authority are a Tier 4 priority for State Agencies. Despite the option for accreditation, End State Renal Dialysis Facilities initial surveys will be a Tier 1 priority because of the statutory requirement that initial surveys begin within 90 days after the Medicare Administrative Contractor approves the CMS-855. Providers/Suppliers with an accreditation option include:

- Ambulatory Surgical Centers
- Critical Access Hospitals (CAHs) (including swing bed services)
- Home Health Agencies
- Hospices
- Hospitals (including swing bed services)
- Rehabilitation Agencies (OPT and SLP)
- Rural Health Clinics
- Psychiatric Hospitals
- End-Stage Renal Disease (ESRD) Facilities\*

### **2. All Others:**

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

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

### **3. Ambulatory Surgical Centers (ASCs)**

States must continue to use the Infection Control Surveyor Worksheet for each full survey of an ASC to ensure that all areas listed on the worksheet are assessed. However, for FY 2020, CMS will NOT be selecting a random sample of ASCs or collecting infection control worksheets.

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

Many rehabilitation agencies provide services from extension sites (an additional practice location or rented space in nursing homes and assisted living facilities) or in other off-premises locations, in addition to their primary site of certification. SAs should ensure extension locations are incorporated into the survey process by selecting a sample of extension locations to survey, in addition to the primary site.

#### **5. Comprehensive Outpatient Rehabilitation Facilities (CORFs)**

A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician

#### **6. Community Mental Health Centers (CMHCs)**

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

#### **7. Critical Access Hospitals (CAHs)**

A conversion survey is required for each new CAH. Prospective CAHs must first be certified and enrolled as a hospital, and then may seek conversion to CAH status. Requests from a non-deemed hospital to be certified as a CAH are, therefore, not treated as initial surveys but as conversions, and may be surveyed as a Tier 2, 3, or 4 priority, at State discretion. Similarly, conversion back from CAH status to non-deemed acute care hospital status is treated as a conversion rather than an initial survey. Generally, CAH's are permitted 12 months to convert back to a non-deemed acute care hospital. CMS expects the states to treat as a Tier 2 or 3 priority.

- Accrediting Organizations (AOs) with a CMS-approved CAH program are able to conduct a CAH conversion survey. There are three AOs with approved CAH accreditation programs: AOA/HFAP, DNV GL, and TJC.
- In order to routinely re-evaluate the compliance of currently certified CAHs with the status and location requirements at 42 CFR 485.610, CMS developed a *CAH Recertification Checklist: Rural and Distance or Necessary Provider Verification* for use by CMS RO staff when processing CAH re-certifications. See S&C: 16-08-CAH (REVISED 09.02.16) for additional details and a copy of the checklist.
- CMS recently clarified the process in the State Operations Manual for adding a provider-based location. See QSO Memo 19-16.
- Swing-bed services will be covered under the Hospitals section. See QSO Memo 18-26-Hospital-CAH for additional swing bed guidance.

#### **8. Dialysis (ESRD) Facilities**

The Bi-Partisan Budget Act of 2018 included a requirement for timing of surveys of new dialysis facilities. An initial survey of a dialysis facility must be initiated not more than 90 days after the applicant's application has been determined to be complete by the MAC and the applicant's enrollment status indicates approval is pending a survey. See Admin Memo 18-15-ESRD for

additional guidance relating to ESRD initial certification. This Act also extended the option for ESRD facilities to be deemed by CMS-approved accrediting organizations.

As updated in the State Operations Manual, Chapter 2 for ESRD, requests for relocations, expansion of services, and/or addition of stations no longer automatically require an onsite survey. ROs are to use the information available to them to determine whether an onsite survey or a desk review is most appropriate to process the request. As a result, requests of this type were removed from the FY19 MPD. If a RO or SA receives a request for the above actions and determines that an onsite survey is needed, this should be treated as a Tier 3 priority and completed as such. See State Operations Manual, Chapter 2, Section 2280 for additional guidance.

States are responsible for monitoring ESRD programs by using the following:

- CMS S&C data web site for ESRD data reports: the State is responsible for assigning a Master Account Holder, and reviewing the State-specific data, which is available on the CMS ESRD data Web site at <https://www.dialysisdata.org>. States are responsible for using these data reports to inform the survey process. Each State is expected to use the State rank-ordered Outcomes List with frequency rates; the facility-specific Dialysis Facility Reports (DFR); and the facility-specific pre-populated Pre-Survey DFR Extract for these purposes.
- The ESRD Outcomes List: focus of the outcomes list continues to be on the top 5% of ESRD facilities with poor clinical outcomes across four defined clinical measures. These measures were chosen based upon their potential to significantly impact patient outcomes and include:
  - Mortality
  - Hospitalizations
  - Hospitalizations related to septicemia
  - Long-term catheter use

States are expected to survey *all* identified facilities in their State on the Outcomes List. The annual process for releasing and reviewing the Outcomes List will remain the same.

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

#### **9. Federally Qualified Health Centers (FQHCs)**

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

## **10. Home Health Agencies (HHAs)**

CMS will implement a new survey process for HHAs in FY 2020 and will simplify procedures for moving from standard to partially extended to extended surveys. Home health surveys should include a sample of extension locations.

Additionally:

- a. QSOG will continue to fund OASIS Education Coordinators (OEC) and OASIS Automation Coordinators (OAC). The OECs will provide technical assistance to the HHA providers in the administration of the OASIS data set. The Division of Chronic and Post-Acute Care (DCPAC) has assumed responsibility for the technical support to OECs.
- b. The OACs will provide technical assistance to the HHA providers on the transmission of OASIS data. The Division of Quality Systems for Assessments and Surveys (DQSAS) will provide technical support to the OACs.

## **11. Hospice Agencies**

Under the IMPACT Act of 2014, each Medicare certified hospice must be surveyed by the State Agency or Accrediting Organization no less frequently than every 36 months. Funding provided through the IMPACT Act as well as the QSOG S&C Medicare program management budget will assist States in meeting this requirement.

Hospice surveys should include a sample of multiple locations in the survey process. This sample should be included minimally in the record reviews and onsite visits when possible.

CMS is working on revisions to the hospice survey process with a target release date of late 2020.

## **12. Hospitals and Psychiatric Hospitals**

The below information highlights both hospital and psychiatric hospitals.

### **a. Hospitals**

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

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

Note - For non-deemed hospitals or CAHs that wish to add swing-beds as a new service, see the "FY20 Survey Frequency and Priority" Tier Status for scheduling those surveys. For swing-bed recertifications, States must include swing-bed recertification during hospital and CAH recertification surveys.

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

### EMTALA Investigations

The timeline for investigations in hospitals and critical access hospitals (CAH) for complaints specific to EMTALA and deaths associated with restraint or seclusion has been changed from *completion* in five working days to *initiation* within two business days. This change brings these two categories of complaint investigations in line with other potential immediate jeopardy (IJ) investigations in Medicare-participating non-long term care facilities.

For EMTALA complaints, the RO is currently able to triage the complaint investigation as IJ but may now triage the complaint as Non-IJ High, based on their review of the allegations. The Non-IJ High prioritization will require the survey to be initiated within 45 days.

The changes to SOM Chapter 5 and Appendix V will align complaint investigative timelines in non-long term care facilities for IJ prioritization. See QSO Memo 19-14 for additional details.

### c. Psychiatric Hospitals

- The majority of Medicare-certified psychiatric hospitals participate via deemed status, based on their accreditation by The Joint Commission (TJC). However, a small number of psychiatric hospitals have grandfathered partially deemed status, i.e., they are deemed for the regular hospital CoPs only by the Accreditation Association for Hospitals/Health Systems Healthcare Facilities Accreditation Program (AAHHS/HFAP) or DNV GL Healthcare (DNV GL), leaving States or CMS contractors responsible for surveying them for the two special conditions. This practice stems from a time when no AO had an approved psychiatric hospital Medicare deeming program. Although CMS no longer permits AAHHS/HFAP or DNV GL to partially deem new psychiatric hospital clients, we have grandfathered their existing psychiatric hospital clients. There are less than ten hospitals that remain partially deemed and partially under State jurisdiction. While TJC is currently the only approved accreditation program for psychiatric hospitals, there has been interest by other accrediting organizations. Please continue to check the CMS website for a current listing [[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.html)].
  
- CMS currently maintains contracted cadre of psychiatric consultant surveyors to conduct surveys of the two special conditions. However, this contract is ending on March 31, 2020, and the SAs will then assume full responsibility for conducting these surveys. The states will conduct the psychiatric surveys for the two special conditions at the same time they conduct surveys for the regular hospital conditions in psychiatric hospitals. CMS will be providing

training to the SA surveyors specific to the two psychiatric special conditions in the beginning of FY 2020.

### **13. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**

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

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

### **14. Long Term Care**

#### **a. Standard Health Survey Process:**

- All states have converted to the new long-term care survey process (LTCSP) to assess compliance with the Requirements for Participation. CMS will continue to make software and guidance updates to existing and new regulations. We will update the LTCSP Procedures Guide and Training documents accordingly.
- Resources for all of these changes can be found on the Integrated Surveyor Training Website at <https://surveyortraining.cms.hhs.gov> and at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>.
- **Appendix P:** In FY2018, CMS removed Appendix P and incorporated key policy components into Chapter 7 of the State Operations Manual. The Long-Term Care Survey Procedure Guide (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Procedure-Guide.pdf>) will be the reference guide for the survey process and will be available on our website and in the software program.

#### **b. Other Areas of Importance:**

- **National Partnership to Improve Dementia Care:** CMS has established a public goal of reducing the antipsychotic rate by 15% among those facilities that continue to have high rates of antipsychotic usage (i.e., late adopters) by the end of CY 2019. CMS will continue to focus on are reducing the use of antipsychotics in late adopters throughout FY 2020. New targets have not been set yet, but we will communicate updates once they are.

- **Focused Dementia Care Surveys:** In FY2020, CMS plans to have federal contract surveyors conduct additional focused dementia care surveys in some states. Due to concerns about facilities using an inappropriate process to diagnose residents with schizophrenia, we also expect to conduct a limited number of surveys focused on this issue. We welcome States that may want surveyors to observe either of these surveys.
- **Investigation of Sufficient Staffing:** States are required to conduct 10 percent of surveys “off-hours” (i.e., starting before 8am, after 6pm, or on weekends or holidays). In FY 2020, states shall conduct at least 50% of their required off-hours surveys on weekends using the list of facilities with potential staffing issues provided by CMS. We anticipate this standard continuing for future years.
- **Facility Reported Incidents and Complaint Investigations:** States should prepare for the release of guidance in Chapter 5 of the State Operations Manual related to the management of facility reported incidents and complaints. This would include the development and implementation of policies and procedures that are consistent with Federal guidelines, adherence to Federal timeframes for investigation, the collection of mandated elements from the initial and investigation reports, and the collection of data to support the tracking of facility reported incidents.

#### **15. Organ Procurement Organizations (OPOs)**

All OPO surveys are conducted by CMS Regional Office Surveyors.

#### **16. Portable X-Ray Suppliers**

CMS plans to release new interpretive guidance for PXR in FY2020.

#### **17. Psychiatric Residential Treatment Facilities (PRTFs)**

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

#### **18. Religious Nonmedical Health Care Institutions (RNHCIs)**

No new changes or efforts in FY2020. If changes arise, CMS will update this section as appropriate.

#### **19. Rural Health Clinics (RHCs)**

States will survey a 5% targeted sample of RHCs, with at least one in those states where 5% is less than one RHC. States will select the sample, focusing on RHCs that have not been surveyed in more than 6 years and/or RHCs that represent a greater risk of quality problems, based on their recent compliance history or other factors known to the State. States should use their individual history of growth, in addition to any State and local events/initiatives, as a guide to project workloads. This Tier 2 sample is not required for any State that has fewer than 7 RHCs. Since FY2015, RHC initial surveys are a Tier 4 priority, as these facilities now have two deeming options. As of FY 2020, states will perform validation surveys as specified by CMS. (See Appendix 3) States with less than 10 deemed RHCs are exempt from performing validation surveys.

## **20. Transplant Centers**

- The transplant program recertification survey interval has been changed to 5 years maximum to be consistent with the hospital survey interval.
- Effective January 1, 2019 all transplant program survey activity, including initials, re-approvals, revisits, and complaint investigations will be performed by the applicable State Survey Agency.

## ***MAJOR PRIORITIES FOR S&C WORKLOAD AND PROGRAM REQUIREMENTS***

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

- In addition to prioritizing work between Tiers 1-4, we suggest States prioritize their work within Tiers and consult with their ROs in the prioritization process. States must track their workload quarterly by Tier and report the results to the RO 45 days after the close of the quarter. States must also report for the full fiscal year 60 days after the close of the fiscal year. As part of their oversight and trouble-shooting responsibilities, ROs will monitor and work with States on the performance of the Tiered workload.
- We note that timely, successful uploading of completed survey kits in ASPEN and ACTS is an essential component of the States' workload in each Tier. States must implement measures to assure that these uploads are completed.

## TIER STATUS FOR FY20

Category	Tier 1	Tier 2	Tier 3	Tier 4
<b>1. Nursing Homes</b>	<ul style="list-style-type: none"> <li>• <b>15.9-Mo. Max. <u>Interval</u>:</b> No more than 15.9 months elapses between completed surveys for any particular nursing home.</li> <li>• <b>12.9-Mo. <u>Avg</u>:</b> All nursing homes in the State are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less.</li> <li>• Complaint investigations triaged as IJ</li> </ul>	<ul style="list-style-type: none"> <li>• <b>“Off-Hours” Surveys:</b> States are required to conduct at least 10 percent of the standard health surveys on the weekend or before 8:00 a.m. or after 6:00 p.m. (i.e., “off-hours”). States shall conduct at least 50% of their required off-hours surveys on weekends using the list of facilities with potential staffing issues provided by CMS.</li> <li>• Complaint investigations triaged as Non-IJ High</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Initial Surveys of Nursing Homes that are seeking Medicaid-only</b> – funded only by Medicaid (not Medicare) and surveyed at state priority</li> <li>• <b>Initial Surveys of Nursing Homes seeking dual Medicare/Medicaid certification*</b></li> <li>• Complaint investigations triaged as Non-IJ Medium</li> </ul>	<ul style="list-style-type: none"> <li>• Complaint investigations triaged as Non-IJ Low</li> </ul>

<p><b>2. Home Health Agencies</b></p>	<ul style="list-style-type: none"> <li>• <b>36.9-Mo. Max. Interval:</b> No more than 36.9 months elapses between completed surveys for any particular agency.</li> <li>• <b>Complaint investigations triaged as IJ</b></li> <li>• <b>Validation Surveys:</b> States annually survey a representative sample of deemed HHAs specified by CMS during the year. At least 1 deemed HHA is surveyed, unless the State has no deemed HHAs, or unless CMS makes no assignment. An extended survey is required for any validation survey, which finds one or more condition-level deficiencies. <i>(Each State surveys 1 HHA within its standard budget allocation; additional surveys are budgeted for some States via supplemental allocation.)</i></li> <li>• <b>Substantial Allegation Validation (Complaint) Surveys - IJs:</b> Only when authorized by the RO, complaint surveys are to be initiated and completed within the applicable SOM timeframe and are Tier 1 priority.</li> </ul>	<ul style="list-style-type: none"> <li>• Substantial Allegation (Complaint) Investigations</li> </ul>		<ul style="list-style-type: none"> <li>• <b>24.9 Mo. Avg:</b> Add'l surveys (beyond tiers 1-3) done based on State judgment regarding HHAs most at risk of providing poor care so all HHAs are surveyed on avg. every 24 mos. (average of all Tier IV surveys ≤ 24.9 mos. in order to optimize unpredictability of surveys)</li> <li>• Surveys of HHAs de-activated (by the MAC) –for failure to bill Medicare for 12 consecutive months. Initial surveys of HHA’s following a CHOW where the provider agreement and billing privileges do not convey to the new owner.</li> </ul>
<p><b>3. ICFs/IID</b></p>	<p>15.9 Mo. Max. <b>Interval: No more than 15.9 months elapses between completed surveys for any particular ICF/IID.</b> 12.9-Mo. <b>Avg:</b> All ICF-IIDs in the State are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less. Complaint surveys triaged as IJ.</p>			<p><b>Initial Surveys</b></p>

<p><b>4. Hospitals, Psychiatric Hospitals, &amp; CAHs- Deemed</b></p>	<ul style="list-style-type: none"> <li>• <b>Representative Sample Hospital Validation Surveys:</b> All States perform at least 1 survey and selected States perform additional surveys of the States’ deemed hospitals, designed to validate the surveys of AOs with <u>CMS identifying the hospitals to be surveyed by each State.</u> <i>(Entirely funded via the State’s regular budget)(See Appendix 3)</i></li> <li>• <b>Targeted Second (Add’l) Representative Sample Validation Surveys:</b> Some States conduct add’l surveys from a second sample of deemed hospitals identified by CMS <i>(Second sample % budgeted separately and allocated as supplemental funding during the year).</i> <i>(See Appendix 3)</i></li> <li>• <b>5% CAH Representative Sample Validation Surveys:</b> States annually survey a representative sample of deemed CAHs specified by CMS during the year (of the total deemed CAHs, 5% of those deemed CAHs have a validation survey conducted by accrediting orgs, or at least 1 survey in each state - whichever is greater). At least 1 deemed CAH is surveyed in each State, unless the State has no deemed CAHs, or unless CMS makes no assignment. <i>(Entirely funded out of each State’s regular budget)(See Appendix 3)</i></li> <li>• <b>Substantial Allegation Validation (Complaint) Surveys:</b> Only when authorized by the RO. IJ complaints, including restraint/seclusion death incidents are to <b><i>be initiated or completed within the applicable SOM timeframe</i></b> and are Tier 1 priority.</li> <li>• <b>EMTALA Complaint Surveys:</b> Only when authorized by the RO. All EMTALA complaints surveys authorized are prioritized as IJs or non-IJ high and are to be completed within the applicable SOM timeframe and are a Tier 1 priority.</li> <li>• <b>Full Surveys Pursuant to Complaints:</b> Full surveys may be required by the RO after each complaint investigation that finds condition level non-compliance for deemed hospitals and CAHs. These are a Tier 1 priority.</li> <li>• <b>Psychiatric Hospital Representative Sample Validation Surveys:</b> Surveys are conducted in a sample of deemed psychiatric hospitals,</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Substantial Allegation Validation (Complaint) Investigations that are prioritized as non-IJ high must be initiated within 45 days of RO authorization</b></li> </ul>		
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	<p>specified by CMS. If States are not equipped to evaluate compliance with the special conditions, CMS' contractor will perform that component of the validation survey. <i>(Budgeted separately and allocated as supplemental funding during the year.)</i></p>			
<p><b>5. Hospitals, Psychiatric Hospitals- &amp; CAHs Non-Deemed (1)</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint surveys:</b> Complaint allegations prioritized as IJs and RO-authorized EMTALA and restraint/seclusion death incident surveys, initiated or completed within the applicable SOM timeframes.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>5-Year Max. Interval:</b> No more than 5.0 years elapses between surveys for any particular non-deemed hospital, psychiatric hospital or CAH.</li> <li>• <b>5% Targeted Sample:</b> States survey at least 1, but not less than 5% of the non-deemed hospitals, 5% of the non-deemed psychiatric hospitals and 5% of non-deemed CAHs in the State, selected by the State based on State judgment regarding those most at risk of providing poor care. Some targeted surveys may qualify to count toward the Tier 3 and 4 priorities. Targeted sample requirements do not apply to States with fewer than 7 non-deemed hospitals, psychiatric hospitals or CAHs.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Recerts: 4.0-Year Max. Interval:</b> No more than 4.0 years elapses between surveys for any particular non-deemed hospital or CAH.</li> <li>• <b>Recerts of Psych Hospitals:</b> 3.0 yr average recertification surveys of non-accredited/non deemed psychiatric hospitals only.</li> <li>• <b>New IPPS Exclusions:</b> All new rehabilitation hospitals/ units &amp; new psychiatric units seeking exclusion from IPPS (2), as well as existing providers newly seeking such exclusion. The SA does not need to conduct an on-site survey for verification of the exclusion requirements but instead may process an attestation</li> </ul>	<p>3.0-Year <u>Avg.</u>: Add'l surveys are done (beyond Tiers 2-+3), based on State judgment regarding the non-deemed hospitals and CAHs that are most at risk of providing poor care, such that all non-deemed hospitals/CAHs in the State are surveyed, on avg, every 3.0 years (i.e., total surveys divided by total non-deemed hospitals/CAHs is not more than 3.0 years; separate calculation for hospitals and CAHs). Targeted surveys may count toward the 3.0 yr avg.</p>

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

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

			<p>of compliance by the hospital.</p> <p><b><u>IPPS Exclusion Verification (Existing excluded hospitals/units):</u></b> 5% (but at least 2 per State) of providers already IPPS-excluded. These are rehabilitation hospitals, rehabilitation units and psychiatric units that have attested to continued compliance with the IPPS exclusion requirements (3). These surveys verify that the hospital unit continues to meet IPPS exclusion criteria.</p>	
<b>6. ESRD Facility</b>	<ul style="list-style-type: none"> <li>• <b>Investigation of complaint allegations triaged as IJ</b></li> <li>• <b>Initial surveys:</b> States must conduct initial certification surveys within 90 days of the MAC approval of the CMS-855 unless the supplier has elected a deeming option.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Complaint Investigations:</b> non-IJ high</li> <li>• <b>Outcomes List:</b> 100% of the ESRD facilities in the State on the Outcome List</li> </ul>	<ul style="list-style-type: none"> <li>• <b>3.5-Year Max Interval (42.9 months):</b> Additional surveys are done to ensure that no more than 3.5 years elapses between surveys for any <u>one</u> particular ESRD facility</li> <li>• <b>Complaint Investigations:</b> non-IJ medium.</li> <li>• Relocations, expansion of service(s), and/or addition of station(s) for which an on-site survey is required.</li> </ul>	<p><b>3.0-Year Average:</b> Additional surveys are done (beyond Tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an <u>average frequency of 3.0 years or less</u></p>
<b>7. Hospices</b>	<ul style="list-style-type: none"> <li>• 36-Month Max. Interval: No more than 36 months between completed surveys for any</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations: High</b></li> </ul>		<b>Initial Surveys</b>

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

	<p>particular agency. Use the separately-tracked IMPACT hospice funds first.</p> <ul style="list-style-type: none"> <li>• <b>Representative Sample validation surveys of deemed hospices:</b> States conduct validation surveys of deemed hospices, specified by CMS, (<i>Budgeted separately via supplemental allocation</i>).</li> <li>• <b>Complaint investigations prioritized as immediate jeopardy – deemed hospices:</b> <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u></li> </ul>			
<p><b>8. Providers of Outpatient Physical Therapy and Speech Language Pathology (OPT / Rehab Agencies)</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations prioritized as immediate jeopardy:</b></li> <li>• <b>OPT Representative Sample Validation Surveys:</b> Surveys are conducted in a sample of deemed OPT's specified by CMS. (Budgeted separately and allocated as supplemental funding during the year.)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>5% Targeted Surveys:</b> Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.</li> <li>• <b>Complaint investigations prioritized as non-IJ high: to be initiated within 45 days (for deemed, within 45 days of RO authorization).</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>7.0-Year Interval:</b> Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any one particular provider.</li> </ul>	<p><b>6.0-Year Avg:</b> Add'l surveys are done (beyond Tiers 2-3) such that all non-deemed providers in the State are surveyed, on average, every 6 years. (i.e., total surveys divided by total providers is not less than 16.7% = 6.0 years). There is now a deemed status option for OPTs</p>
<p><b>9. Comprehensive Outpatient Rehabilitation Facilities</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations prioritized as immediate jeopardy:</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>5% Targeted Surveys:</b> Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk</li> </ul>	<ul style="list-style-type: none"> <li>• <b>7.0-Year Interval:</b> Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any <u>one</u> particular provider.</li> </ul>	<p>6.0-Year <u>Avg:</u> Add'l surveys are done (beyond Tiers 2-3) such that all non-deemed providers in the State are surveyed, on average, every 6 years. (i.e., total surveys divided by</p>

		of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.		<b>total providers is not less than 16.7% = 6.0 years).</b>
<b>10. Rural Health Clinics and Federally Qualified Health Centers (FQHCs)</b>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations prioritized as immediate jeopardy. Deemed RHCs:</b> <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u></li> <li>• <b>Complaint investigations prioritized as immediate jeopardy FQHCs:</b> <u>only with RO authorization; survey to be initiated within 2 days of RO authorization.</u></li> <li>• <b>Validation surveys are conducted in a sample of deemed RHCs, specified by CMS.</b> <i>(Budgeted separately and allocated as supplemental funding during the year.)</i></li> </ul>	<ul style="list-style-type: none"> <li>• <b>5% Targeted Surveys:</b> Each year, the State surveys 5% of non-deemed RHCs (or at least 1, whichever is greater), based on State judgment for those RHCs most at risk of quality problems Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 RHCs of this type are exempt from this requirement.</li> <li>• <b>Complaint investigations prioritized as non-IJ high:</b> to be initiated within 45 days (for deemed RHCs, or FQHCs within 45 days of RO authorization).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>7.0-Year Interval:</b> Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any <u>one</u> particular RHC.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>6.0-Year Avg:</b> Add'l surveys are done (beyond tiers 2-3) such that all non-deemed RHCs in the State are surveyed, on average, every 6 years. (i.e., total surveys divided by total RHCs is not less than 16.7% = 6.0 years).</li> <li>• <b>Initial Survey-</b> there is a deemed status option for RHCs.</li> <li>• There is no certification or recertification for FQHCs.</li> </ul>
<b>11. Ambulatory Surgery Centers</b>	<ul style="list-style-type: none"> <li>• <b>Representative Sample Validation Surveys - Deemed ASCs:</b> States conduct validation surveys of 5% - 10% of deemed ASCs, assigned by CMS. <i>(Budgeted separately via supplemental allocation)</i></li> <li>• <b>Complaint investigations prioritized as immediate jeopardy – deemed ASCs:</b> <u>only</u></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Targeted Surveys (25%):</b> The State performs surveys totaling 25% of all non-deemed ASCs in the State (or at least 1, whichever is greater) focusing on</li> </ul>	<ul style="list-style-type: none"> <li>• <b>6.0-Year Interval:</b> Additional surveys are done to ensure that no more than 6.0 years elapse between surveys for any <u>one</u> particular non-deemed ASC.</li> </ul>	<b>Initial Surveys</b>

	<p><u>with RO authorization; survey to be initiated within 2 days of RO authorization.</u></p>	<p>ASCs not surveyed in more than 4 years or based on State judgment for those ASCs more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 priority. States with only 7 or fewer non-deemed ASCs must survey at least 1 ASC unless all non-deemed ASCs were surveyed within the prior two years.</p> <ul style="list-style-type: none"> <li>• <b>Complaint investigations prioritized as non-IJ high:</b> to be initiated within 45 days (for deemed ASCs, within 45 days of RO authorization).</li> </ul>		
<p><b>12. Psychiatric Residential Treatment Facilities (Medicaid Psych &lt; 21)</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations triaged as IJ<sub>2</sub></b></li> </ul>	<p><b>Complaint investigations triaged as non-IJ</b></p> <ul style="list-style-type: none"> <li>• <b>5.0-Year Interval:</b> In States with 5 or more PRTFs, 20% of PRTFs must be surveyed at least annually to meet 5-year interval. (Complaint investigations don't count towards 20%).</li> </ul>		<p>Initial Certification Surveys</p>

<p><b>13. Community Mental Health Centers (CMHCs)</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations triaged as IJ.</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>5% Targeted Surveys:</b> Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on CMS judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 priorities. Targeted sample requirements do not apply to States with fewer than 7 CMHCs.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>5.0-Year <u>Interval</u></b></li> </ul>	<p><b>Initial certification of CMHCs unless there is verification of access concerns.</b></p>
<p><b>14. Portable X-Ray Suppliers</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint investigations triaged as IJ</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>5% Targeted Surveys:</b> Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>7.0-Year <u>Interval</u>:</b> Additional surveys are done to ensure that no more than 7.0 years elapse between surveys for any <u>one</u> particular provider.</li> </ul>	<ul style="list-style-type: none"> <li>• Initial Certification Surveys</li> <li>• <b>6.0-Year <u>Avg</u>:</b> Add'l surveys are done (beyond Tiers 2-3) such that all non-deemed providers in the State are surveyed, on average, every 6 years</li> </ul>
<p><b>15. Transplant</b></p>	<ul style="list-style-type: none"> <li>• <b>Complaint – IJ:</b> Investigation of complaint allegations triaged as IJ.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Mandatory Re-approval Surveys: 5 year survey interval.</b></li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Initials:</b> Any initial surveys of programs</li> </ul>
<p><b>16. New Provider-Initial Surveys</b></p>	<p>Initial certification of the following: ESRD Facilities</p>	<ul style="list-style-type: none"> <li>• Relocations of the parent or main location of existing non-deemed providers or suppliers.</li> <li>• Relocations of any provider displaced</li> </ul>	<p>Initial certification of the following:</p> <ul style="list-style-type: none"> <li>• Transplant centers</li> <li>• SNF/NFs</li> </ul>	<ul style="list-style-type: none"> <li>• Initial certifications of all provider types that have a deemed accreditation option (with the exception of ESRD): hospitals, home health, new</li> </ul>

		<p>during a public health emergency declared by HHS.</p>	<ul style="list-style-type: none"> <li>• Relocations of non-deemed branches or off-site locations.</li> <li>• <u>Note:</u> Conversion of a non-deemed hospital to a CAH, or a non-deemed CAH back to a hospital is a conversion, not an initial certification and at State option may be done as Tier 2, 3, or 4. However, the conversion of a deemed hospital or CAH or the <u>addition of swing beds as a new service in an existing deemed or non-deemed hospital or CAH is a Tier 4 priority.</u></li> </ul>	<p>home health branches, hospice, expansion of inpatient hospice for a currently certified hospice, ambulatory surgical centers, outpatient physical therapy, and rural health clinics. (While CAHs may also be deemed, these are conversions, not initial certifications; however deemed CAHs are expected to be surveyed by their AOs for their conversion surveys.)</p> <ul style="list-style-type: none"> <li>• The addition of home health branches are administrative actions thus not a deeming option. (AOs deem compliance with CoPs, not administrative actions.) Though surveys may not be involved, these actions should remain in the Tier structure as they are often resource intensive.</li> <li>• The addition of hospice multiple locations may warrant a survey. These surveys should be scheduled consistent with the Tier structure as they are often resource intensive.</li> <li>• All other newly-applying providers not listed in Tier 3 are Tier 4, unless</li> </ul>
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				<p>approved on an exception basis by the CMS RO, due to serious healthcare access considerations or similar special circumstances.</p> <ul style="list-style-type: none"> <li>• Relocations of deemed providers or suppliers</li> </ul>
<b>17. Complaint Investigations</b>	<ul style="list-style-type: none"> <li>• Complaint Investigations triaged as a high potential for immediate jeopardy or, in the case of hospitals, psychiatric hospitals or CAH DPUs, where the RO authorizes investigation of a hospital or CAH DPU restraint/seclusion death incident.</li> <li>• For all <u>deemed non-LTC provider/supplier types</u> for which one or more condition-level deficiencies is determined to be out of compliance pursuant to a complaint investigation, the RO: <ul style="list-style-type: none"> <li>➤ May require a full survey before proceeding to enforcement.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Complaint Investigations triaged non-IJ high.</li> </ul>	<ul style="list-style-type: none"> <li>• Complaint investigations of non-deemed non-LTC facilities triaged as non-IJ medium are investigated when the next on-site survey occurs.</li> </ul> <p>Complaint investigations of LTC facilities triaged as medium</p>	<ul style="list-style-type: none"> <li>• Complaint investigations of LTC facilities triaged as low</li> <li>• Complaints of non-deemed non-LTC facilities triaged as non-IJ low are not separately investigated but tracked/trended for potential focus areas during the next on-site survey.</li> </ul>
<b>18. Core Infrastructure</b>	<ul style="list-style-type: none"> <li>• Timely ASPEN data entry of survey workload</li> <li>• Attendance at mandatory federal surveyor training</li> <li>• MDS, OASIS, QIES and IRF-PAI systems activities</li> <li>• Maintenance of the nurse aide registry and assessments of nurse aide training and competency evaluation programs</li> <li>• Review of the nurse aide registry to assure that it is being operated in compliance with the requirements.</li> <li>• Maintenance of a home health hotline</li> <li>• Performance Measurement Activities</li> <li>• Implement &amp; promote fulfillment of CMS GPRA goals and Quality Initiative, including collaboration with QIOs on the GPRA goals (pressure ulcer reduction, restraint use reduction).</li> </ul>			

	<ul style="list-style-type: none"> <li>• Training of survey &amp; certification staff, including transcript &amp; qualifications maintenance. (See separate Training Mission Letter)</li> <li>• Emergency preparedness essential functions (see download)</li> </ul>			
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*Statistical Convention:* Whenever standards are expressed in months, 0.9 of the succeeding month is included in order to permit completion of any survey in progress. Hence a 12 month average is tracked as 12.9 months. Similarly, a 3.0 year interval is tracked as 36.9 months and a 6.0 year interval is tracked at 72.9 months.

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