



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

Ref: QSO-19-17-AO/CLIA

DATE: August 20, 2019

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: FY 2018 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program

Memorandum Summary

Annual Report to Congress: The 2018 annual RTC details the review, validation, and oversight of the FY 2017 activities of the approved AOs Medicare accreditation programs as well as the CLIA Validation Program.

- Section 1875(b) of the Social Security Act (the Act) requires the Centers for Medicare & Medicaid Services (CMS) to submit an annual report to Congress on its oversight of national AOs and their CMS-approved accreditation programs.
- Section 353(e)(3) of the Public Health Service Act (PHSA) requires CMS to submit an annual report of the CLIA validation program results.

Background

The Social Security Act, Section 1875(b) requires a performance evaluation of each CMS-approved Accreditation Organization (AO) to verify that accredited provider entities demonstrate compliance with the Medicare Conditions of Participation (CoPs). The Clinical Laboratory Improvement Amendments of 1988 (CLIA), under Section 353 of the Public Health Service Act, requires that any laboratory performing certain testing on human specimens for health purposes, must meet the requirements established by HHS and have in effect an applicable certificate. The CMS annual Report to Congress (RTC) details the review, validation, and oversight of the AOs Medicare accreditation programs as well as those under CLIA.

State Agency surveyors conduct the validation surveys that are the basis for the analysis in the RTC. We appreciate the tremendous work of the State surveyors that has made it possible for CMS to fulfill its AO oversight responsibilities and complete the annual report to Congress. Currently, CMS has approved accreditation programs for the following Medicare facility types: hospitals, psychiatric hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgery centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).

There are currently ten CMS approved Medicare accreditation organizations (AO) identified in the report:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Osteopathic Association / Healthcare Facilities Accreditation Program (AOA/HFAP)
- Community Health Accreditation Program (CHAP)
- Center for Improvement in healthcare (CIHQ)
- DNV GL – Healthcare (DNV GL)
- The Compliance Team (TCT)
- The Joint Commission (TJC)
- Institute of Medical Quality (IMQ)

There are currently another seven AOs approved under CLIA, which are:

- AABB
- American Association for Laboratory Accreditation (A2LA)
- American Osteopathic Association / Healthcare Facilities Accreditation Program (AOA/HFAP)
- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (CAP)
- The Joint Commission (TJC)

Additional Oversight Initiatives

Posting AO Performance Data:

To increase transparency for consumers, CMS will post new information on the CMS.Gov website, including the latest quality of care deficiency findings following complaint surveys at facilities accredited by AOs, a list of providers determined by CMS to be currently out of compliance that also references the provider's AO, and overall performance data for the AOs themselves. The list will include only hospitals at this time, however CMS hopes to be able to have the same publically available information for other providers and suppliers at a future time.

<https://qcor.cms.gov/main.jsp>

The Validation Program:

CMS is piloting a more streamlined, effective way to assess AOs' ability to ensure that facilities and suppliers comply with CMS requirements.

CMS evaluates the ability of AOs to accurately assess providers' and suppliers' compliance with health and safety standards through a validation survey process. Historically, CMS has measured the effectiveness of AOs by choosing a sample of facilities and suppliers, performing a state-conducted assessment survey within 60 days following an AO survey, and comparing results. In a pilot test, CMS is eliminating the second state-conducted validation survey and instead using direct observation during the original AO-run survey to evaluate the AO surveyors' ability to assess compliance with CMS Conditions of Participation.

Direct observation will enable CMS not only to evaluate AO performance more effectively, but also to suggest improvements and address concerns with AOs immediately. This approach will relieve providers from having to undergo the burden of a state's follow up assessment. The approach is another example of the wide-ranging effort at CMS to eliminate duplication and relieve burden, reducing the amount of time that healthcare facilities must spend on compliance activities.

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

/s/
David Wright

Attachment: FY2018 Report to Congress

cc: Survey and Certification Regional Office Management

**REVIEW OF MEDICARE'S
PROGRAM FOR OVERSIGHT OF
ACCREDITING
ORGANIZATIONS AND THE
CLINICAL LABORATORY
IMPROVEMENT VALIDATION
PROGRAM**

FISCAL YEAR 2018



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Review of Medicare’s Program for Oversight of Accrediting Organizations

Introduction

Health care facilities must demonstrate compliance with the Medicare conditions of participation (CoPs), conditions for coverage (CfCs), or conditions for certification (depending on the type of facility) to be eligible to receive Medicare reimbursement. Section 1865 of the Social Security Act (the Act) allows health care facilities that are “provider entities”¹ to demonstrate this compliance through accreditation by a Centers for Medicare & Medicaid Services (CMS)-approved accreditation program of a private, national Accrediting Organization (AO).² AOs may voluntarily submit provider- and supplier-specific accreditation programs intended to demonstrate compliance with the applicable Medicare standards for CMS review and approval. AOs charge fees to facilities that seek their accreditation. Generally, AOs offer facilities at least two accreditation options: accreditation alone, or accreditation under a CMS-approved program for the purpose of participating in Medicare. CMS reviews and provides oversight only for those accreditation programs submitted by an AO requesting to have the program recognized as a Medicare accreditation program. Accordingly, this report addresses AO activity only as it relates to CMS-approved Medicare accreditation programs.

CMS has responsibility for oversight and approval of AO accreditation programs used for Medicare certification purposes, and for ensuring that providers or suppliers that are accredited under an approved AO accreditation program meet the quality and patient safety standards required by the Medicare conditions.^{3, 4} A thorough review of each Medicare accreditation program voluntarily submitted by an AO is conducted by CMS, including a review of the equivalency to the Medicare standards of its accreditation requirements, survey processes and procedures, training, oversight of provider entities, and enforcement.

Also reviewed are the qualifications of the surveyors, staff, and the AO’s financial status. Upon approval, any provider or supplier accredited by the AO’s approved program could be “deemed” by CMS to have met the applicable Medicare conditions and are referred to as having deemed status.⁵

Pursuant to Section 1875(b) of the Act, the Secretary of Health and Human Services (HHS) shall make a continuing study of the national accreditation bodies under Section 1865(a), and transmit to the Congress

¹ Section 1865(a)(4) of the Act defines “provider entity” to include a provider of services, supplier, facility, clinic, agency, or laboratory. Section 1861(d) defines a “supplier” to mean a physician or other practitioner, a facility, or other entity other than a provider. Section 1861(u) defines a “provider” to mean a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program. Note that “provider entities” do not include advanced diagnostic imaging (ADI) or durable medical equipment (DME) suppliers, which are required to be accredited under Section 1834 of the Act. Oversight of ADI and DME accreditation programs are administered separately by CMS and not subject to the Section 1875 reporting requirements.

² Accreditation for provider entities in accordance with Section 1865 is voluntary and not required for Medicare participation. Generally, accreditation by a CMS-approved national AO’s Medicare accreditation program is an alternative to being subject to assessment of compliance by the applicable State Survey Agency.

³ CoPs apply to providers; CfCs apply to suppliers; and Conditions for Certification apply to rural health clinics. In this report, the term “facility” is used to cover all types of institutional health care providers which require certification in order to participate in Medicare and “Medicare conditions” and is used to cover CoPs, CfCs, and Conditions for Certification.

⁴ The Act mandates the establishment of minimum health and safety standards that must be met by most providers and suppliers participating in the Medicare and Medicaid programs. These standards are found in Title 42 of the Code of Federal Regulations for each applicable provider/supplier type. The intention of the health and safety CoPs is to stipulate that each patient receives safe care. This often includes providing protection to the patient’s emotional health and safety as well as physical safety.

⁵ In accordance with Section 1865 of the Act, 42 CFR §§ 488.5(a)(4)(i) states that AOs may award accreditation under a CMS-approved Medicare accreditation program for 3 years. The AOs will re-survey every accredited provider through unannounced surveys, no later than 36 months after the prior accreditation effective date.

annually a report concerning the operation and oversight of all CMS-approved AO Medicare accreditation programs. CMS has implemented a comprehensive approach to the review and approval of an AO's Medicare accreditation program and its ongoing oversight of AO activities. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare conditions for each program type and that the organization has the capacity to adequately administer the program and provide ongoing oversight of facilities it accredits.

Currently, CMS has approved accreditation programs under 42 CFR Part 488 for the following facility types: hospitals, psychiatric hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgery centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).⁶ CMS maintains a comprehensive AO Medicare accreditation oversight program and continually strives to strengthen and enhance its ongoing oversight. The program includes:

Deeming application review – CMS rigorously reviews each Medicare accreditation program submitted by an AO initially and then periodically thereafter to determine whether the AO can adequately ensure that facilities comply with Medicare requirements;

Ongoing review – CMS evaluates the performance of each CMS-approved accreditation program on an ongoing basis through performance, comparability, and accreditation program reviews;

Electronic reporting systems – CMS builds, implements, and updates electronic systems for AO reporting on activities related to deemed facilities;

Performance measurement – CMS develops and implements performance measures which reflect each AO's compliance with administrative reporting requirements;

Validation survey program – CMS has expanded efforts across a growing number of AO programs and types of facilities to measure the effectiveness of the AO survey process in identifying areas of serious non-compliance with Medicare conditions. In the validation program, CMS conducts a survey of a facility within 60 days of an AO survey and compares the findings of the two surveys to evaluate the adequacy of the AO survey process⁷; and

Education – CMS conducts ongoing education for AO staff that includes, but is not limited to, quarterly conference calls, monthly liaison calls with each AO, an annual on-site training for all AOs with approved programs at CMS, provision of an AO resource manual, as well as availability of CMS surveyor training opportunities.

Overview

This report reviews AO activities in fiscal year (FY) 2017 (October 1, 2016 – September 30, 2017), compares this activity to past years, and outlines the current CMS oversight of approved Medicare accreditation programs organized in the following sections:

⁶ Note that other types of facilities may also participate in Medicare via an approved accreditation program, but to date, no AO has sought and received approval for any of these additional non-listed facility types. CMS also accredits suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and the technical component of ADI under other accreditation statutes.

⁷ State standard survey frequencies for all provider types is addressed in CMS' Mission and Priority Document (MPD) tier system. The State standard survey frequencies are resource driven and depend on CMS' annual funding level and specific criteria. Typically, State survey frequency is between 3–5 years (no more than 6 years) based on the provider type, tier priority, the number of specific providers in the state, and the budget.

Section 1 – Centers for Medicare & Medicaid Services’ Approval of Medicare Accreditation Programs

The process used for CMS approval and renewal of AO Medicare accreditation programs; the types of CMS reviews and decisions; the number of reviews that were performed and decisions made since FY 2010; the current AOs with approved Medicare accreditation programs; and the most recent CMS approval or review status for each AO Medicare accreditation program.

Section 2 – Scope of Accrediting Organization Medicare Accreditation Programs

The current number of deemed status and non-deemed Medicare-certified facilities by program type; the growth in deemed status facilities within the Medicare program since FY 2008; and the overall Medicare accreditation survey activities of each AO in FY 2017, including the number of initial and renewal accreditation surveys performed, the number of facilities denied and the number of facilities that voluntarily withdrew from an accreditation program.

Section 3 – Accrediting Organization Performance Measures

The AO reporting requirements and CMS methods for collecting AO quarterly data on Medicare accreditation program activities and deemed facilities; the FY 2017 AO performance measures and the results for each AO; and comparison of FYs 2016 and 2017 performance measure results.

Section 4 – Validation of Accrediting Organization Surveys

The AO Validation Program, the disparity rate for each program type nationally and by AO, and the number of representative sample validation surveys that have been performed for hospital and non-hospital facilities since FY 2007. The section also describes the comparative analysis process conducted for the 60-day validation surveys completed to assess the ability of each AO Program to evaluate and ensure compliance with the applicable Medicare conditions. The validation performance results for FYs 2015–2017 are presented by facility type for each AO. The FY 2017 AO and State Agency (SA) condition-level citations for each facility type are presented and compared. For hospital accreditation programs, validation performance results provide separate comparisons for short-term acute care and long-term care hospitals (LTCHs).

Section 5 – Life Safety Code, Health & Safety Disparity Rates Analysis and Complaint Survey Citations

The most frequently disparate 60-day validation survey condition-level deficiencies, Life Safety Code (LSC) and health and safety disparity rates, and an overall depiction of the disparity rates for individual AOs by program type; the top five complaint survey condition-level deficiencies by program type; the limitations surrounding the disparity rates; and conclusions and recommendations for decreasing the disparity rates.

Section 6 – Centers for Medicare & Medicaid Services Improvements

CMS executed and improved program management and oversight activities for FY 2017.

Section 7 – Clinical Laboratory Improvement Amendments Validation Program

Clinical Laboratory Improvement Amendments of 1988 (CLIA) includes statutory requirements for deeming by AOs, and for conducting AO validation reviews.

Appendix A – Performance Measures

Table 1 compares the performance measure results by AO for comparable FYs 2016–2017 performance measures discussed in Section 3.

Appendix B – Fiscal Year 2017 Life Safety Code and Health & Safety Disparity Rates

Detailed FY 2017 LSC and health and safety statistics for each program type and AO as discussed in Section 5.

Appendix C – Life Safety Code Category Definitions

LSC terminology and definitions.

SECTION 1: Centers for Medicare & Medicaid Services' Approval of Medicare Accreditation Programs

Application and Renewal Process

Approval of a National Accrediting Organization's Medicare Accreditation Program

The process for CMS approval of a national AO's Medicare accreditation program is voluntary and, therefore, applicant-driven. In order to gain approval of an accreditation program for Medicare deemed status purposes, an AO must demonstrate the ability to effectively evaluate a facility using accreditation standards which meet or exceed the applicable Medicare conditions, as well as survey processes that are comparable to those outlined in the State Operations Manual (SOM). Among other things, the SOM contains CMS' policy, interpretation of regulations, and instructions to SAs for conducting survey activities on behalf of CMS. Section 1865(a)(2) of the Act requires that CMS base its decision to approve or deny an AO's Medicare accreditation program application after considering the following factors:

- Program requirements for the accreditation program to meet or exceed Medicare requirements;
- Survey procedures are comparable to those of Medicare as outlined in the SOM;
- Ability to provide adequate resources for conducting surveys;
- Capacity to furnish information for use by CMS in enforcement activities;
- Monitoring procedures for providers or suppliers identified as being out of compliance with conditions or requirements; and
- Ability to provide the necessary data for validation surveys to CMS.

Section 1865(a)(3)(A) of the Act further requires that CMS publish a proposed notice in the *Federal Register*. This notice must be published within 60 days of receipt of an AO's complete application requesting approval of a Medicare accreditation program. The notice identifies the national AO making the request, describes the nature of the request, and provides at least a 30-day public comment period. CMS has 210 days from receipt of a complete application to publish a *Federal Register* notice of approval or denial of the request.

The regulations at 42 CFR § 488.5 set forth the detailed requirements that an AO must satisfy to receive and maintain CMS recognition and approval of a Medicare accreditation program. This section also details the procedures CMS follows in reviewing AO applications.

Renewal applications are subject to the same criteria and scrutiny as initial applications for approval of an AO's Medicare accreditation program. Approval of an AO's Medicare accreditation program is for a specified time period, with a 6-year maximum. Initial applications are generally provided a 4-year term of approval. This allows CMS to conduct a comprehensive review and evaluation of the renewal application within a shorter period of time to ensure that the accreditation program continues to meet CMS requirements. Some AOs are given approval on a conditional basis, while CMS reviews and monitors the accreditation program during a probationary period to determine if the program continues to meet or exceed Medicare requirements.

The application and renewal process provide the opportunity for a comprehensive evaluation of an AO's Medicare accreditation program performance. This process includes the AO's ability to ensure compliance with Medicare conditions for deemed status facilities, and the ability to comply with CMS' administrative requirements that facilitate ongoing oversight of the AO's CMS-approved accreditation program(s). CMS' evaluation process includes, but is not limited to, the following components:

- On-site observations are conducted to ensure that the accreditation program is fully implemented and operational as described in the written application:
 - Corporate on-site review; and
 - Survey observation.
- Comprehensive review of AO accreditation standards to ensure that the AO standards meet or exceed those of Medicare.
- Comprehensive review of the AO's:
 - Policies and procedures to ensure comparability with those of CMS;
 - Adequacy of resources to perform required surveys to ensure comparability with those of CMS;
 - Survey processes and enforcement to ensure comparability with those of CMS;
 - Surveyor evaluation and training to ensure comparability with those of CMS;
 - Electronic databases to ensure the AO has the capacity to provide CMS with the necessary facility demographic, survey-related, deficiency, adverse action, and accreditation decision data, etc.; and
 - Financial status to ensure organizational solvency and ability to support operations.

Focused Reviews of Accrediting Organization Medicare Accreditation Programs

CMS performs focused reviews in the following areas:

- *Standards and Survey Process Reviews*: Once approved, any subsequent changes in the AO's Medicare accreditation program standards or survey process must also be reviewed and approved by CMS prior to implementation by the AO. The purpose is to ensure that the program continues to meet or exceed Medicare requirements or remains comparable to Medicare survey processes and policies. Such reviews are conducted in accordance with 42 CFR § 488.5(a)(18) and 42 CFR § 488.5(a)(19).
- *Issue Review and Resolution*: AOs must demonstrate that their standards and review processes meet or exceed all applicable conditions of Section 1865 of the Act. CMS works with AOs to resolve issues when they are identified during the approval period.
- *Performance Review*: CMS reviews AO performance on an ongoing basis in accordance with Section 1875(b) of the Act. This includes, but is not limited to, review of the AO's survey activity, analysis of validation surveys, and review of the AO's continued fulfillment of the requirements at 42 CFR § 488.5.

Table 1 below summarizes the initial, renewal, and other reviews conducted by CMS.

Table 1
CMS Review of AO Medicare Accreditation Programs
FYs 2010–2017

Type of Review and CMS Decision	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Initial Applications								
• Decision: Full approval	1	3	1	1	1	0	1	0
• Decision: Denied	0	0	0	0	0	0	0	0
• Incomplete application	0	0	2	0	0	1	1	0
• Application withdrawn	2	1	1	1	0	0	0	0
Renewal Applications								
• Decision: Full approval	1	0	3	6	4	6	1	5
• Decision: Denied	0	0	0	0	0	0	0	0
• Decision: Conditional approval	2	0	0	0	0	0	0	0
• Decision: Final approval removing conditional status	2	0	0	0	0	0	0	0
Total Reviews of Initial and Renewal Applications	8	4	7	8	5	7	3	5
Focused Reviews								
• Standards review	15	18	20	3	25	12	23	78
• Survey process review	12	10	5	0	1	5	5	18
• Issue review and resolution	*	44	22	41	11	3	16	9
• Performance review	2	3	3	0	4	3	1	2
Total Focused Reviews	29	75	50	44	41	23	45	107

*Data was not collected for these issues during this timeframe.

From FY 2010 through FY 2017, CMS completed 47 reviews of renewal and initial applications (which included approvals published in the *Federal Register* as well as initial applications withdrawn by the AO prior to publication). In this same timeframe, CMS completed 414 focused reviews. In total, 461 comprehensive reviews were completed.

Approved Accrediting Organization Medicare Accreditation Programs

CMS reviews and approves separately, each provider or supplier Medicare accreditation program for which an AO seeks CMS approval. AOs currently have CMS approval for eight provider or supplier program types: hospital, psychiatric hospital, CAH, HHA, hospice, ASC, OPT, and RHC. As of September 30, 2017, there were 10 national AOs with 22 approved Medicare accreditation programs. (See Tables 2 and 3.)

Table 2
AOs with Approved Medicare Accreditation Programs
FY 2017

AO Acronym	Description
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
ACHC	Accreditation Commission for Health Care
AOA/HFAP	American Osteopathic Association/Healthcare Facilities Accreditation Program
CHAP	Community Health Accreditation Partner
CIHQ	Center for Improvement in Healthcare Quality
DNV GL	DNV GL-Healthcare
IMQ	Institute for Medical Quality
TCT	The Compliance Team
TJC	The Joint Commission

Table 3
Approved Medicare Accreditation Programs by AO
FY 2017

AO	Hospital	Psych Hospital	CAH	HHA	Hospice	ASC	OPT	RHC	Total
AAAASF						X	X	X	3
AAAHC						X			1
ACHC				X	X				2
AOA/HFAP	X		X			X			3
CHAP				X	X				2
CIHQ	X								1
DNV GL	X		X						2
IMQ						X			1
TCT								X	1
TJC	X	X	X	X	X	X			6
Total	4	1	3	3	3	5	1	2	22

The number of CMS-approved Medicare accreditation programs has grown steadily over the past several years resulting in 22 approved programs in FY 2017.

Approval of Medicare Accreditation Programs

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

Ambulatory Surgery Center

AAAASF's ASC Medicare accreditation program was initially approved December 2, 1998. AAAASF's current term of approval is effective November 27, 2012 through November 27, 2018. The final notice announcing this decision was published in the *Federal Register* (77 FR 70446) (November 26, 2012), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28640.pdf>.

Outpatient Physical Therapy and Speech-Language Pathology Services

AAAASF's OPT Medicare accreditation program was initially approved April 22, 2011. AAAASF's current term of approval is effective April 22, 2015 through April 22, 2019. The final notice announcing this decision was published in the *Federal Register* (80 FR 21244) (April 17, 2015), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2015-04-17/pdf/2015-08917.pdf>.

Rural Health Clinic

AAAASF's RHC Medicare accreditation program was initially approved March 23, 2012. AAAASF's RHC Medicare accreditation program was granted a 4-year term of approval effective March 23, 2016 through March 23, 2022. The final notice was published in the *Federal Register* (81 FR 9481) (February 25, 2016), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2016-02-25/pdf/2016-04092.pdf>.

Accreditation Association for Ambulatory Health Care, Inc.

Ambulatory Surgery Center

AAAHC's ASC Medicare accreditation program was initially approved December 19, 1996. AAAHC's current term of approval is effective December 20, 2012 through December 20, 2018. The final notice announcing this decision was published in the *Federal Register* (77 FR 70783) (November 27, 2012), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2012-11-27/pdf/2012-28728.pdf>.

Accreditation Commission for Health Care

Home Health Agency

ACHC's HHA Medicare accreditation program was initially approved February 24, 2006. ACHC's current term of approval is effective February 24, 2015 through February 24, 2021. The final notice announcing this decision was published in the *Federal Register* (80 FR 2708) (January 20, 2015), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2015-01-20/pdf/2015-00699.pdf>.

Hospice

ACHC's hospice Medicare accreditation program was initially approved November 27, 2009. ACHC's current term of approval is effective November 27, 2013 through November 27, 2019. The final notice announcing this decision was published in the *Federal Register* (78 FR 66364) (November 5, 2013), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2013-11-05/pdf/2013-26374.pdf>.

American Osteopathic Association/Healthcare Facilities Accreditation Program

Hospital

AOA/HFAP has had an approved hospital Medicare accreditation program since 1965. Although its hospital program is mentioned by name in the Act, it is also explicitly subject to the Secretary's review and approval. AOA/HFAP's current term of approval is effective September 25, 2013 through September 25, 2019. The final notice announcing this decision was published in the *Federal Register* (78 FR 53149) (August 28, 2013), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-28/pdf/2013-21008.pdf>.

Critical Access Hospital

AOA/HFAP's CAH Medicare accreditation program was initially approved December 27, 2001. AOA/HFAP's current term of approval is effective December 27, 2013 through December 27, 2019. The final notice announcing this decision was published in the *Federal Register* (78 FR 71619) (November 29, 2013), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28521.pdf>.

Ambulatory Surgery Center

AOA/HFAP's ASC Medicare accreditation program was initially approved January 30, 2003. AOA/HFAP's current term of approval is effective September 22, 2017 through September 22, 2023. The final notice announcing this approval was published in the *Federal Register* (82 FR 44414) (September 22, 2017), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2017-09-22/pdf/2017-20281.pdf>.

Community Health Accreditation Partner

Home Health Agency

CHAP's HHA Medicare accreditation program was initially approved August 27, 1992. CHAP's current term of approval is effective March 31, 2018 through March 31, 2024. The final notice announcing this decision was published in the *Federal Register* (83 FR 12769) (March 23, 2018), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2018-03-23/pdf/2018-05891.pdf>.

Hospice

CHAP's hospice Medicare accreditation program was initially approved April 20, 1999. CHAP's current term of approval is effective November 20, 2012 through November 20, 2018. The final notice announcing this decision was published in the *Federal Register* (77 FR 64344) (October 19, 2012), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2012-10-19/pdf/2012-25467.pdf>.

Center for Improvement in Healthcare Quality

Hospital

CIHQ's hospital Medicare accreditation program was initially approved July 26, 2013 for a 4-year term. CIHQ's current term of approval is effective July 26, 2017 through July 26, 2023. The final notice announcing this approval was published in the *Federal Register* (82 FR 28853) (June 26, 2017), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2017-06-26/pdf/2017-13207.pdf>.

DNV GL-Healthcare

Hospital

DNV GL's hospital Medicare accreditation program was initially approved September 29, 2008. DNV GL's current term of approval is effective August 17, 2018 through September 25, 2022. The final notice announcing this decision was published in the *Federal Register* (83 FR 41073) (August 17, 2018), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-17815.pdf>.

Critical Access Hospital

DNV GL's CAH Medicare accreditation program was initially approved December 23, 2010. DNV GL's current term of approval is effective December 23, 2014 through December 23, 2020. The final notice announcing this decision was published in the *Federal Register* (79 FR 69482) (November 21, 2014), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2014-11-21/pdf/2014-27576.pdf>.

Institute for Medical Quality

Ambulatory Surgery Center

IMQ's ASC Medicare accreditation program was initially approved for a 4-year term effective April 29, 2016 through April 29, 2020. The final notice announcing this approval was published in the *Federal Register* (81 FR 25675) (April 29, 2016), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2016-04-29/pdf/2016-10165.pdf>.

Performance Review:

Since being awarded CMS-approval of its ASC accreditation program, IMQ hasn't conducted a Medicare survey under this program for the purpose of deemed status. As a result, CMS has significant concerns that IMQ no longer meets the definition of a national accrediting organization according to § 488.1.

Due to lack of implementation, a 180-day accreditation program performance review was opened for IMQ's CMS-approved ASC accreditation program on February 28, 2017. The AO was required to provide CMS with evidence that they continued to meet the requirements for national accrediting organizations in accordance with CMS regulation at § 488.1 and § 488.5(a). At a minimum, this plan had to address: strategies for fully implementing and maintaining implementation of the ASC accreditation program on a national level; quarterly targets for numbers of Medicare surveys to be completed for the purposes of deemed status; ongoing marketing plans; and monthly progress toward meeting the agreed-upon evaluation criteria.

The corrective action plan was reviewed by CMS for acceptability, and CMS provided written feedback regarding IMQ's corrective action plan.

The 180-day accreditation program performance review ended September 29, 2017. CMS found that IMQ had made progress during the 180-day period, had satisfactorily implemented its CMS-approved ASC accreditation program, and therefore met the regulatory definition of a national AO. However, once IMQ began conducting Medicare surveys for the purposes of awarding deemed status, CMS identified significant issues with IMQ's survey process and required IMQ to provide additional documentation. While IMQ has begun to initiate revisions to these processes, full implementation has not yet been achieved.

On October 19, 2017, CMS placed IMQ's ASC accreditation program on probation for 180 calendar days to implement corrective actions. On June 8, 2018, CMS determined that IMQ implemented a program that has demonstrated significant improvement towards meeting CMS standards and use of a survey process comparable to that of CMS during its 180-day probationary period. In accordance with the provision at 42 CFR 488.8(c)(3)(i), the IMQ ASC accreditation program was removed from probationary status.

The Compliance Team

Rural Health Clinics

TCT's RHC Medicare accreditation program was initially approved July 18, 2014. TCT's current term of approval is effective July 18, 2018 through July 18, 2024. The final notice announcing this approval was published in the *Federal Register* (83 FR 29118) (June 22, 2018), and can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2018-06-22/pdf/2018-13436.pdf>.

The Joint Commission

Hospital

TJC's hospital Medicare accreditation program was initially approved July 15, 2010. Prior to July 15, 2010, TJC's hospital accreditation program had statutory status and did not require CMS review and approval. TJC's current term of approval is effective July 15, 2014 through July 15, 2020. The final notice announcing this decision was published in the *Federal Register* (79 FR 36524) (June 27, 2014), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15103.pdf>.

Psychiatric Hospital

TJC's psychiatric hospital Medicare accreditation program was initially approved for a 4-year period effective February 25, 2011 through February 25, 2015. TJC's current term of approval is effective February 25, 2015 through February 25, 2019. The final notice announcing this decision was published in the *Federal Register* (80 FR 9466) (February 23, 2015), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2015-02-23/pdf/2015-03559.pdf>.

Performance Review:

In accordance with CMS regulation at § 488.8(c)(3), CMS placed TJC's psychiatric hospital accreditation program on probation for 6 months. TJC had an opportunity to implement the approved corrective actions during the probationary period which ended December 17, 2016. CMS had 60 calendar days from the end of the probationary period to conduct a corporate on-site visit and issue written determination, including supportive findings, as to whether TJC's CMS-approved psychiatric hospital accreditation program continued to meet the Medicare requirements.

On January 24–26, 2017, CMS conducted a survey observation to determine whether programmatic changes identified in TJC's plan of correction (POC) had been fully implemented; and whether these changes resulted in compliance and survey process comparability to that of Medicare. Overall, the survey team performed well. On January 31, 2017 through February 2, 2017, CMS also conducted a corporate on-site visit to determine whether programmatic changes identified in the POC had been fully implemented; and whether the changes resulted in compliance and survey process comparability to that of CMS. As a result, on February 15, 2017, CMS recommended approval of TJC's psychiatric hospital accreditation program, with the option to exercise Immediate Jeopardy in accordance with 42 CFR § 488.8(d). CMS continues to work closely with TJC and monitor their psychiatric hospital accreditation

program activity.

Critical Access Hospital

TJC's CAH Medicare accreditation program was initially approved November 21, 2002. TJC's current term of approval is effective November 21, 2017 through November 21, 2023. The final notice announcing this decision was published in the *Federal Register* (82 FR 49817) (October 27, 2017), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2017-10-27/pdf/2017-23449.pdf>.

Home Health Agency

TJC's HHA Medicare accreditation program was initially approved September 28, 1993. TJC's current term of approval is effective March 31, 2014 through March 31, 2020. The final notice announcing this decision was published in the *Federal Register* (79 FR 14049) (March 12, 2014), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05328.pdf>.

Hospice

TJC's hospice Medicare accreditation program was initially approved June 18, 1999. TJC's current term of approval is effective June 18, 2015 through June 18, 2021. The final notice announcing this decision was published in the *Federal Register* (80 FR 29714) (May 22, 2015), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2015-05-22/pdf/2015-12524.pdf>.

Ambulatory Surgery Center

TJC's ASC Medicare accreditation program was initially approved December 19, 1996. TJC's current term of approval is effective December 20, 2014 through December 20, 2020. The final notice announcing this decision was published in the *Federal Register* (79 FR 69486) (November 21, 2014), and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2014-11-21/pdf/2014-27577.pdf>.

SECTION 2: Scope of Accrediting Organization Medicare Accreditation Programs

Medicare-Participating Facilities by Program Type:

In FY 2017, AOs were responsible for assuring compliance with Medicare conditions for 38 percent (13,013) of all Medicare-participating facilities in the eight program types for which there was a CMS-approved AO Medicare accreditation program. (See Table 4 and Graph 1.)

Table 4
Deemed & Non-Deemed Medicare-Participating Facilities
Program Types with a Medicare Accreditation Program Option
FY 2017

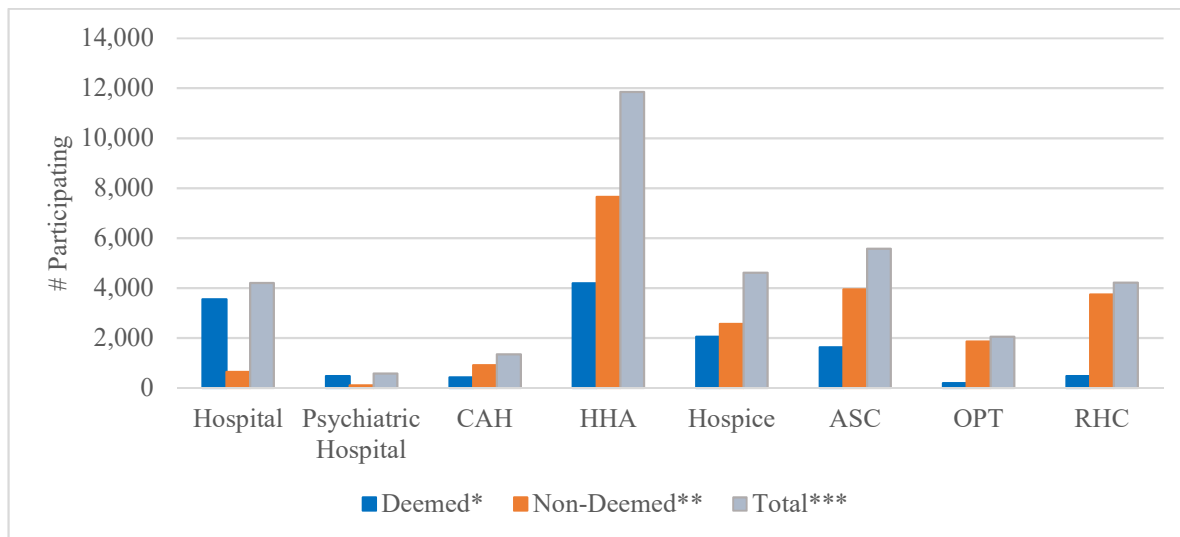
Program Type	Deemed* (percentage)	Non-Deemed** (percentage)	Total***
Hospital	3,557 (85)	652 (15)	4,209
Psychiatric Hospital	474 (81)	111 (19)	585
CAH	432 (32)	917 (68)	1,349
HHA	4,191 (35)	7,658 (65)	11,849
Hospice	2,058 (45)	2,563 (55)	4,621
ASC	1,631 (29)	3,949 (71)	5,580
OPT	197 (10)	1,860 (90)	2,057
RHC	473 (11)	3,749 (89)	4,222
Total	13,013 (38)	21,459 (62)	34,472

*As reported by AOs in Accrediting Organization System for Storing User Recorded Experiences (ASSURE).

**Surveyed by an SA for compliance with Medicare conditions.

***As reported by CMS Data Team 3/19/2018.

Graph 1
Deemed & Non-Deemed Medicare-Participating Facilities
Program Types with a Medicare Accreditation Program Option
FY 2017



*As reported by AOs in ASSURE.

**Surveyed by an SA for compliance with Medicare conditions.

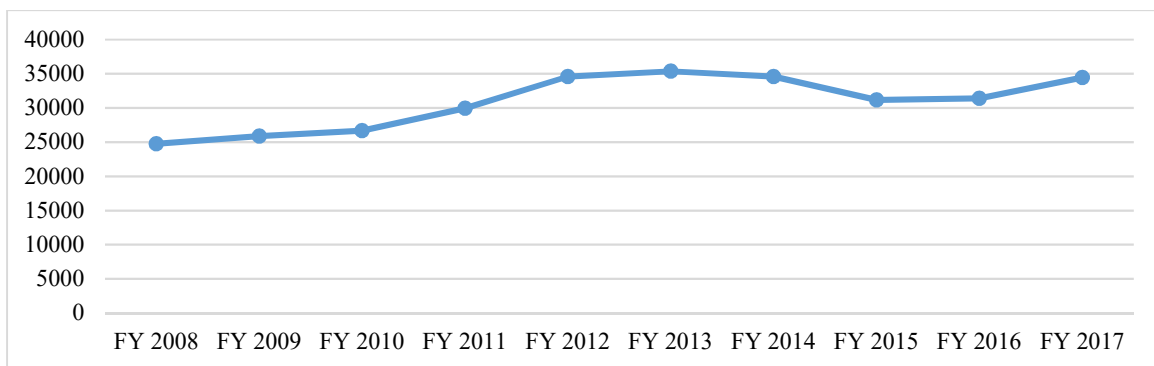
***As reported by CMS Data Team 3/19/2018.

In FY 2017, the AOs with CMS-approved Medicare accreditation programs were responsible for monitoring compliance with health and safety standards for varying percentages of the total number of Medicare-participating facilities for each program type. This percentage ranges from a high of 85 percent for hospitals to a low of 10 percent for OPTs. Hospitals have historically had the largest percentage of facilities participating in Medicare via accreditation and deemed status with one exception. In FY 2015, both hospitals and psychiatric hospitals had a high of 89 percent.

Growth in Medicare Deemed Facilities

The total number of Medicare-participating health care facilities across all program types has increased 39 percent from 24,752 in FY 2008 to 34,472 in FY 2017. Since FY 2008, the majority of those newly participating facilities with an accreditation option, enrolled and became certified in the Medicare program via accreditation from a CMS-approved Medicare accreditation program and deemed status. (See Graph 2.)

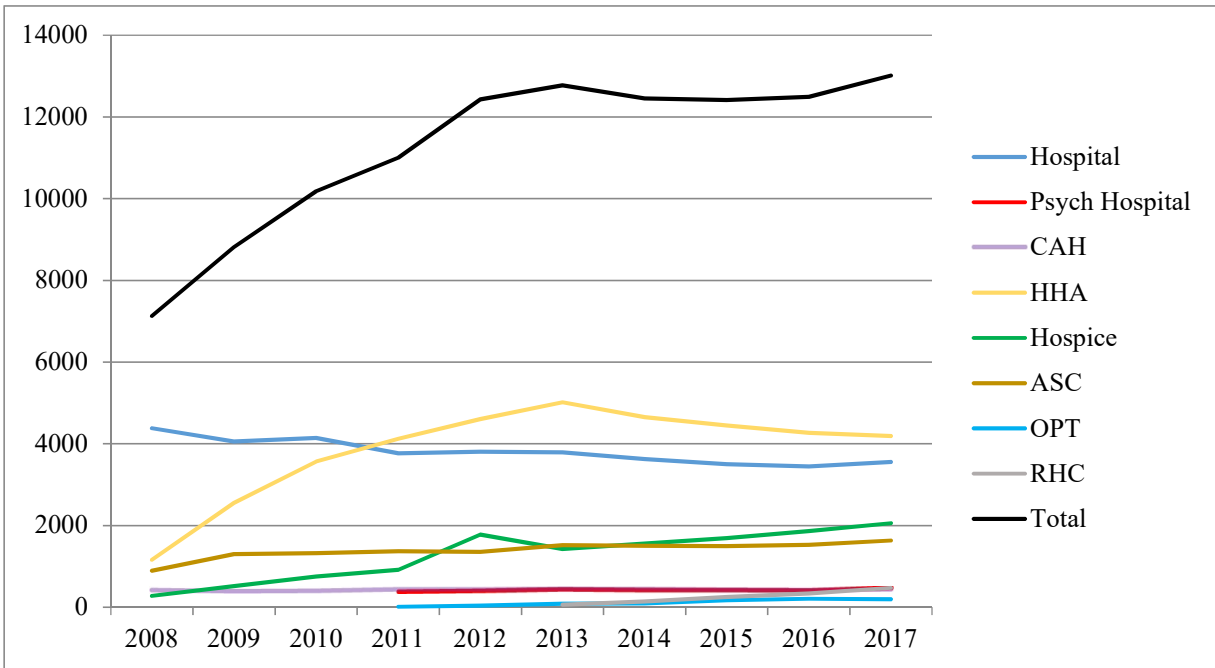
Graph 2
Medicare-Participating Health Care Facilities
FYs 2008–2017



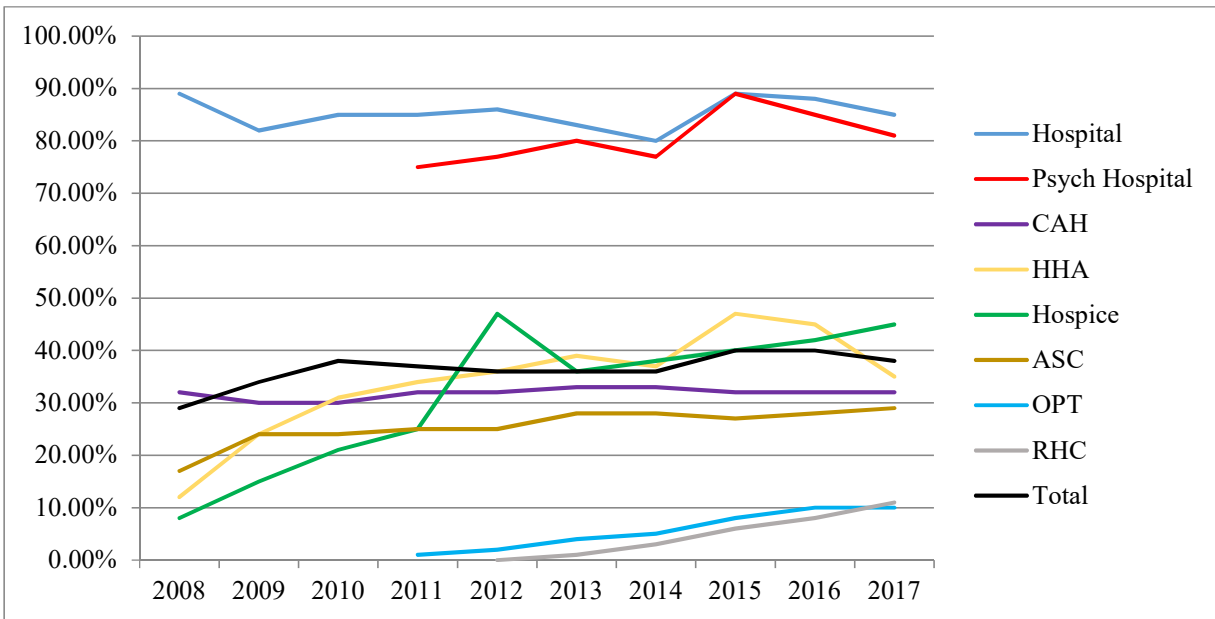
The growth in the number of deemed facilities is likely attributable, in part, to CMS’ workload priorities for SAs. The long-standing CMS policy for SAs has been that initial surveys for newly enrolling facilities with an approved accreditation option have a lower priority as compared to statutorily mandated recertification surveys of participating nursing homes, HHAs, and hospices; validation surveys; complaint investigations; other recertification surveys; and initial surveys of new applicants for which no accreditation option exists. As a result, an increasing number of facilities seeking initial Medicare participation have used CMS-approved Medicare accreditation programs to demonstrate their compliance with Medicare requirements to facilitate a faster enrollment and certification process.

Graphs 3 and 4 below show the number of facilities certified each year by CMS by virtue of a CMS-recognized Medicare accreditation program, and the percentage of all Medicare-certified facilities that these deemed facilities represent. These graphs represent the eight program types for which there is currently more than 1 year of data.

**Graph 3
Number of Deemed Facilities by Program Type
FYs 2008–2017**



**Graph 4
Deemed Facilities as Percentage of Medicare-Participating Facilities by Program Type
FYs 2008–2017**



- **Total:** Since the introduction of the original AO Medicare accreditation programs (hospitals, CAHs, HHAs, hospices, and ASCs), three more types of accreditation programs have been approved since FY 2008. The first OPT and psychiatric hospital Medicare accreditation programs were approved in FY 2011.⁸ The first RHC Medicare accreditation program was approved in FY 2012. Although the number of Medicare-participating facilities increased 39 percent, the growth in deemed facilities during that same period was much larger.
 - The number of facilities participating in Medicare via deemed status increased from 7,128 in FY 2008 to 12,495 in FY 2016, a 75-percent increase.
 - The number of facilities participating in Medicare via deemed status increased from 12,495 in FY 2016 to 13,013 in FY 2017, a 4-percent increase.
 - The SAs continue to survey and monitor the majority of Medicare-participating facilities. However, the proportion of facilities participating in Medicare via their accreditation from a CMS-approved Medicare accreditation program and deemed status has grown from 29 percent to 38 percent.
- **Hospital:** The number of Medicare-participating hospitals was largely unchanged between FYs 2008 and 2017. The hospital and psychiatric hospital programs are the only categories in which the majority of facilities participate in Medicare by virtue of accreditation under an approved Medicare accreditation program.
 - The number of deemed hospitals decreased from 4,381 in FY 2008 to 3,448 in FY 2016, a reduction of 21 percent. (Please note: this decrease in percentage is adjusted based on the separate reporting of 419 deemed psychiatric hospitals.)
 - The number of deemed hospitals increased slightly from 3,448 in FY 2016 to 3,557 in FY 2017, a 3-percent increase.
 - The proportion of all Medicare-participating hospitals that were deemed decreased by 3 percent from FY 2016 to FY 2017.
- **Psychiatric Hospital:** The number of Medicare-certified psychiatric hospitals increased from 516 in FY 2011 to 585 in FY 2017, a 13-percent increase.
 - The number of deemed psychiatric hospitals increased from 388 in FY 2011 to 419 in FY 2016, an 8-percent increase.
 - The number of deemed psychiatric hospitals increased from 419 in FY 2016 to 474 in FY 2017, a 13-percent increase.
 - The proportion of all Medicare-participating psychiatric hospitals which were deemed increased from 75 percent in FY 2011 to 81 percent in FY 2017.
- **CAH:** The number of Medicare-certified CAHs was increased slightly from 1,310 in FY 2008 to 1,349 in FY 2017, a three percent increase.
 - The number of deemed CAHs increased slightly from 415 in FY 2008 to 418 in FY 2016, a 1-percent increase.
 - The number of deemed CAHs increased from 418 in FY 2016 to 432 in FY 2017, a 3-percent increase.
 - The proportion of all Medicare-certified deemed CAHs remained at 32 percent in FY 2017.
- **HHA:** The number of Medicare-certified HHAs increased from 9,893 in FY 2008 to 11,849 in FY 2017, a 20-percent increase.
 - The number of deemed HHAs increased from 1,161 in FY 2008 to 4,271 in FY 2016, a 268-percent increase.

⁸ Prior to FY 2011, the number of psychiatric hospitals participating in Medicare through a CMS-approved accreditation program were included in the total number of hospitals.

- The number of deemed HHAs decreased from 4,271 in FY 2016 to 4,191 in FY 2017, a 2-percent decrease.
- The proportion of all Medicare-certified HHAs which were deemed nearly tripled from 12 percent in FY 2008 to 35 percent in FY 2017.
- **Hospice:** There has been significant growth in the Medicare hospice program as well. The number of Medicare-certified hospices increased from 3,388 in FY 2008 to 4,621 in FY 2017, a 36-percent increase. There has also been corresponding significant growth in the number and proportion of deemed hospices.
 - The number of deemed hospices increased from 278 in FY 2008 to 1,867 in FY 2016, a 572-percent increase.
 - The number of deemed hospices increased from 1,867 in FY 2016 to 2,058 in FY 2017, a 10-percent increase.
 - The proportion of all Medicare-certified hospices which were deemed increased five-fold from 8 percent in FY 2008 to 45 percent in FY 2017.
- **ASC:** The number of Medicare-certified ASCs increased from 5,217 in FY 2008 to 5,580 in FY 2017, a 7-percent increase.
 - The number of deemed ASCs increased significantly from 893 in FY 2008 to 1,527 in FY 2016, a 74-percent increase.
 - The number of deemed ASCs increased from 1,527 in FY 2016 to 1,631 in FY 2017, a 7-percent increase.
 - The proportion of all Medicare-certified ASCs which were deemed increased from 17 percent in FY 2008 to 29 percent in FY 2017.
- **OPT:** The number of Medicare-certified OPTs decreased from 2,471 in FY 2011 to 2,057 in FY 2017, a 17-percent decrease.
 - The number of deemed OPTs increased from 13 in FY 2011 to 206 in FY 2016, a 1,485-percent increase. This large percentage increase is due to the relatively recent availability of an accreditation option for OPTs. CMS approved the first Medicare OPT accreditation program in April 2011; therefore, there was a small number of deemed OPTs in FY 2011.
 - The number of deemed OPTs decreased slightly from 206 in FY 2016 to 197 in FY 2017, a 4-percent decrease.
 - The proportion of all Medicare-certified OPTs which were deemed increased from 1 percent in FY 2011 to 10 percent in FY 2017.
- **RHC:** The number of Medicare-certified RHCs increased from 4,108 in FY 2012 to 4,222 in FY 2017, a 3-percent increase.
 - The number of deemed RHCs increased from 3 in FY 2012 to 339 in FY 2016, an 11,200-percent increase. This large percentage increase is due to the relatively recent availability of an accreditation option for RHCs. CMS approved the first Medicare RHC accreditation program in May 2012; therefore, there was an extremely low number of deemed RHCs in FY 2012.
 - The number of deemed RHCs increased from 339 in FY 2016 to 473 in FY 2017, a 40-percent increase.
 - The proportion of all Medicare-certified RHCs which were deemed increased from less than 1 percent in FY 2012 to 11 percent in FY 2017.

Medicare Accreditation Program Survey Activity

An AO with a CMS-recognized Medicare accreditation program is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the health care quality and patient safety standards required by the Medicare conditions. The evaluation performed by the AO includes, but is not limited to, observation and review of the following: care and treatment of patients; care processes in the facility; the physical environment (PE) including compliance with the LSC when applicable; administrative and patient medical records; and staff qualifications. The AO performs an initial survey for a facility that is being reviewed by the AO for the first time. Initial surveys include surveys of facilities that are seeking initial Medicare certification as well as those facilities currently participating in Medicare and previously overseen by an SA or another AO. The AO may award accreditation under a CMS-approved Medicare accreditation program for up to 3 years. A renewal survey must be completed prior to the expiration date of the facility's Medicare accreditation to ensure that the facility remains in compliance with CMS requirements.

In addition, facilities seeking initial deemed status with an AO must be found to be in compliance with *all* conditions through the on-site survey activity. "Condition-level" deficiencies are the most serious type of deficiency cited, indicating a provider or supplier is not in compliance with an entire CoP. A "standard-level" deficiency means that the provider may be out of compliance with one aspect of the regulations but is considered less serious than a condition-level finding. If a facility is found to have condition-level non-compliance on an initial survey, the facility must be denied accreditation. A second deemed status survey must be conducted once the facility has submitted an acceptable POC and corrected all deficiencies. Through the process of reviewing survey reports and findings made by the AOs, CMS has identified that in some cases, an AO may not have cited certain findings at the appropriate level (e.g., deficiencies were cited inappropriately at the "standard" or "condition" level, instead of at the "condition" or "immediate jeopardy" level based on the surveyor documentation contained in the survey report). This issue may also create a "false low" in the reporting of denials. In identifying these issues, CMS is actively involved in reinforcing the decision-making process related to identification of the appropriate level of citation with the AOs. CMS Regional Offices (ROs) review all initial AO Medicare survey reports. Based on surveyor observations and evidence of non-compliance documented in the survey report, and follow-up with the AO, the RO has the authority to question the level of citation of a deficiency, raise it to the condition level as appropriate, and deny certification and the facility's application for participation in the Medicare program. Citing deficiencies at the appropriate level is an essential component to assuring the health and safety of patients receiving care in Medicare facilities.

Facilities have the right to voluntarily withdraw from their accreditation program(s). The various reasons for which a facility may choose to withdraw include but are not limited to the following: (1) facility mergers and/or acquisitions, (2) closures, (3) facility was unable to meet the applicable Medicare requirements, and (4) withdrawal to SA authority. In FY 2017, withdrawal to SA authority was the number one reason facilities withdrew from their accreditation program(s).

In FY 2017, the AOs reported having performed 1,185 initial surveys and 3,706 renewal surveys. The total number of deemed status facilities in FY 2017 was 13,040. The total number of facilities denied was 299. The number of voluntary withdrawals was 860. (See Table 5.)

Table 5
Total Number of Deemed Facilities, Initial Surveys and Renewal Surveys,
Denials and Withdrawals by AO Accreditation Program
FY 2017

Program Type/ AOs	Total Deemed Facilities	Initial Surveys	Renewal Surveys	Denials	Withdrawals
Hospital					
AOA/HFAP	113	0	50	2	12
CIHQ	42	2	9	2	1
DNV GL	308	7	90	2	13
TJC	3,104	18	1,119	9	72
Hospital Total	3,567	27	1,268	15	98
Psychiatric Hospital					
TJC	474	25	169	6	9
Psychiatric Hospital Total	474	25	169	6	9
CAH					
AOA/HFAP	24	0	10	0	3
DNV GL	73	3	33	0	3
TJC	336	4	117	2	2
CAH Total	433	7	160	2	8
HHA					
ACHC	769	97	193	46	68
CHAP	1,844	104	427	30	202
TJC	1,583	69	565	49	116
HHA Total	4,196	270	1,185	125	386
Hospice					
ACHC	277	63	44	18	11
CHAP	778	105	163	30	82
TJC	1,011	171	224	33	53
Hospice Total	2,066	339	431	81	146
ASC					
AAAASF	191	32	46	3	14
AAAHC	808	159	198	18	89
AOA/HFAP	28	0	7	0	2
IMQ	8	15	0	2	0
TJC	599	82	157	28	32
ASC Total	1,634	288	408	51	137
OPT					
AAAASF	197	55	34	4	41
OPT Total	197	55	34	4	41
RHC					
AAAASF	229	47	50	6	19
TCT	244	127	1	9	16
RHC Total	473	174	51	15	35
Total	13,040	1,185	3,706	299	860

Source: As reported by the AOs in ASSURE.

Note: The total number of deemed facilities in this table includes 27 facilities that are dually accredited; therefore, the total number of deemed facilities listed in Table 4 is less than this total.

SECTION 3: Accrediting Organization Performance Measures

Accrediting Organization Reporting Requirements

A major focus of CMS' ongoing work with each AO is monitoring and improving the AO's ability to provide CMS with complete, timely, and accurate information regarding deemed status facilities, as required at 42 CFR § 488.5(a)(4)(viii). It is important that AOs and CMS be able to accurately determine a facility's Medicare accreditation status on an ongoing basis. This information is vital for CMS to be able to identify which facilities participate in Medicare via their deemed status and are, therefore, subject to AO versus SA oversight. Additionally, when an AO makes an adverse Medicare accreditation program decision based on a facility's failure to satisfy the AO's health and safety standards or LSC requirements, it is imperative that CMS be notified promptly in order to take appropriate follow-up enforcement action. It is also essential for CMS to have information concerning upcoming AO survey schedules to effectively implement the validation program. To this end, AOs must submit the following to CMS:

- Monthly survey schedules which document the surveys that were completed for the previous month, and those scheduled for the current and following months;
- A report of all data pertaining to all Medicare accreditation and enforcement activity for each month;
- Facility notification letters for all Medicare accreditation program actions and any follow-up communication associated with those facility notification letters; and
- Responses to any formal correspondence from CMS.

In 2008, CMS directed the development of an electronic data collection tool that would enable the AOs to provide CMS with demographic and survey activity information for deemed facilities. The database, ASSURE, provides a method to collect, analyze, and manage data regarding deemed facilities. In 2013, the system moved to a web-based version. ASSURE centralizes data capture and reporting; supports the integration of AO data into the existing Quality Improvement Evaluation System (QIES) infrastructure for network access; ensures that data conforms to the national data structures framework; and allows for Certification and Survey Provider Enhanced Reports (CASPER) authentication and reporting.

CMS employs several methods to facilitate obtaining this information. In addition to providing AOs access to and implementing ongoing improvements to ASSURE, CMS provides the AOs with:

- Information on the essential elements that should be included in an AO facility notification letter regarding a facility's Medicare accreditation status, which facilitates AO communication with CMS;
- Dedicated Central Office (CO) and RO electronic mailboxes for AO submission of copies of facility notification letters concerning their Medicare accreditation program status; and
- Comparative analysis and feedback on the deemed facility data contained in ASSURE. This includes whether the facilities in ASSURE could be matched to certified facilities in CMS' national Medicare certification database.

Accrediting Organization Performance Measures and Scoring

In FY 2009, CMS instituted performance measures for AOs. These measures are reviewed and updated annually. These measures provide CMS with a method of assessing each AO's ability to provide CMS with timely, accurate, and complete information regarding the various aspects of facility survey and monitoring activities. They also enable CMS to determine the current Medicare accreditation status of certified health care facilities.

Each performance measure is scored on a quarterly basis. For survey schedule measures, the quarterly score is calculated based on monthly scores. Annual scores are the average of all four quarterly scores. Measures are scored as a percentage of correct submissions for a specific month/quarter.

Fiscal Year 2017 Accrediting Organization Performance Measures

In FY 2017, AOs were scored on their performance on 7 measures in 3 key performance focus areas: ASSURE Database, Facility Notification Letters, and Survey Schedule. (See Table 6.)

Table 6
AO Performance Measures
FY 2017

ASSURE Database:

AOs use the ASSURE electronic database to record all AO Medicare accreditation program activity, including enforcement activity, and to submit a quarterly export file of this ASSURE data to CMS.

Performance in this area was based on:

- The facilities with condition-level findings denied on initial surveys*
- The timeliness of notifying facilities of survey results
- The timeliness of notifying CMS of withdrawals
- The number of surveys with final survey decisions > 5 months

Facility Notification Letters:

AOs should electronically submit facility notification letters to CMS for all Medicare accreditation program actions in CMS-approved programs. Performance in this area was based on:

- The notification letters contain all required information.
- The data in ASSURE is being updated consistent with the letters.

Survey Schedule:

AOs should submit a monthly schedule which documents surveys completed in the past month as well as scheduled surveys for the current and next 2 months. Performance in this area is based on:

- The accuracy of the data in ASSURE regarding the number of surveys reported as completed for the quarter and the number of surveys actually completed each quarter

*Initial surveys that result in condition-level findings must be denied accreditation. Before being awarded accreditation for the purpose of Medicare deemed status, a facility must demonstrate substantial compliance with the Medicare requirements. Therefore, these facilities are required to correct identified deficiencies and undergo another survey to demonstrate full compliance with all Medicare conditions and an acceptable POC for any less serious, standard-level deficiencies before an AO may grant full accreditation and make a recommendation to CMS that the facility be granted deemed status.

Significant Changes for Fiscal Year 2017 Accrediting Organization Performance Measures

Retired Fiscal Year 2017 Performance Measures

In FY 2017, CMS retired five of the FY 2016 performance measures in four key performance focus areas.

ASSURE Database:

- The no-match lists as measured by:
 - The timeliness of electronic submission of no-match data follow-up activity
 - The evidence of no-match reconciliation

Facility Notification Letters:

- The accuracy and completeness of the letters submitted as measured by:
 - All required attachments are included.

Survey Schedule:

- The accuracy of monthly survey schedules (specifically, no instances of arrival of the SA to conduct a validation survey and being informed that the accreditation survey had not been conducted as indicated on the survey schedule)

Formal Correspondence:

- The timely responses to formal correspondence (on or before the specified due date)

New Fiscal Year 2017 Performance Measures

CMS added two new performance measures in one key performance focus area in FY 2017.

ASSURE Database:

- The timeliness of notifying CMS of withdrawals
- No pending final survey decisions > 5 months

Performance Measure Results

The FY 2016 and FY 2017 performance data for all AOs is presented below in two tables. The first table, Table 7, presents results for performance measures that were monitored in FYs 2016 and 2017. A comparison is presented by FY for these measures. The second table, Table 8, presents results for performance measures specific to FY 2017, including the addition of two new measures. Therefore, the data in Table 8 cannot be directly compared to the FY 2016 performance measure results and are presented independently. Both tables present the performance measures according to the key focus areas. All results include quarterly averages utilizing standard rounding rules. The data represent the percent frequency with which the task required by the measure was performed in an accurate, timely, complete manner. A discussion of the performance measure scoring, and results follows the tables.

**Table 7
Performance Measure Results (Percentage) for All AOs
Comparable Measures for FYs 2016–2017**

Performance Measure Results (Percentage) for All Accrediting Organizations Comparable Measures for FYs 2016–2017	FY 2016	FY 2017
Denied initial survey with condition-level findings	93	98
Timeliness of facility notification of survey results	96	97
Notification letters contain all required information	98	97
ASSURE is updated consistent with the letters	91	89
Number of surveys performed matches number reported in ASSURE	96	98

Note: IMQ’s Medicare accreditation program was initially approved April 29, 2016, and IMQ didn’t have data to calculate in FY 2017.

**Table 8
Performance Measure Results (Percentage) for All AOs
FY 2017
(Not Comparable to FY 2016 Measures)**

Performance Measure Results (Percentage) for All Accrediting Organizations FY 2017 Not Comparable to FY 2016 Measures	FY 2017
CMS notified timely of withdrawals	91
No pending final survey decisions > 5 months	100

Note: IMQ’s Medicare accreditation program was initially approved April 29, 2016, and IMQ didn’t have data to calculate in FY 2017.

Scoring Definitions:

- “Excelled” means a 100 percent score.
- “Performed well” means a 95–99 percent score.
- “Opportunity for improvement” means any score below 95 percent.

Highlights

1. ASSURE Database

- In FY 2016, five of the AOs excelled on the measure “Timeliness of facility notification of survey results.” Two of the AOs performed well scoring 99 percent and 98 percent respectively. Two of the AOs showed opportunity for improvement, scoring 74 percent and 93 percent respectively. In FY 2017, four of the AOs scored 100 percent on the same measure. Two of the AOs performed well scoring 97 percent and 99 percent respectively. Three of the AOs demonstrated opportunity for improvement with two of the AOs scoring 93 percent and the third AO scoring 92 percent. In both FYs 2016 and 2017, one of the AOs didn’t have any data to calculate.
- In FY 2016, five AOs scored 100 percent for the measure “Denied initial survey with conditions.” However, two of the AOs demonstrated opportunity for improvement scoring 83 percent and 68 percent respectively. Two of the AOs had sample sizes less than five; therefore, couldn’t calculate a score. In FY 2017, three of the AOs excelled, scoring 100 percent for the same measure. Two of the AOs performed well scoring 95 percent and 99 percent respectively. One of the AOs showed opportunity for improvement with a score of 91 percent. Three of the AOs had sample sizes less than five; therefore, couldn’t calculate a score for this measure. One of the AOs didn’t have any data to calculate this measure in both FYs 2016 and 2017. The overall AO performance has improved 5 percentage points since the last reported year.
- In FY 2017, two new performance measures were introduced: “CMS notified timely of withdrawals,” and “no pending survey > 5 months.” For the first measure, one of the AOs excelled, scoring 100 percent. Two of the AOs performed well, scoring 96 percent and 97 percent respectively. Four of the AOs demonstrated opportunity for improvement with scores ranging from 81 percent to 93 percent. Two of the AOs did not have sufficient samples sizes to calculate this measure. One of the AOs did not have data available to complete the calculation. For the second measure, “no pending survey > 5 months,” nine of the AOs excelled, scoring 100 percent. One of the AOs did not have data available to complete the calculation.
- At the end of FY 2017, no measures were retired due to inconsistent scoring and methodology revisions. CMS reviews the performance measure scores annually to determine which measures, if any, can be retired prior to the next FY.

2. Facility Notification Letters

- In FY 2016, four of the AOs excelled, scoring 100 percent for the measure “Letters contain all required information.” Three of the AOs performed well, with two AOs scoring 99 percent and the third AO scoring 98 percent. Two of the AOs showed opportunity for improvement with scores of 91 percent and 94 percent respectively. In FY 2017, three of the AOs excelled, scoring 100 percent for the same measure. Four of the AOs performed well with two AOs scoring 98 percent and one of the AOs scoring 96 percent and 99 percent respectively. Two of the AOs showed opportunity for improvement with scores of 91 percent and 94 percent respectively. Two of the AOs excelled in both FYs 2016 and 2017 for the same measure. One AO didn’t have any data to calculate this measure in both FYs 2016 and 2017.
- In FY 2016, one of the AOs excelled, scoring 100 percent for the measure “ASSURE is updated consistent with letters.” Three of the AOs performed well, with two of the AOs scoring 96 percent and the third AO scoring 99 percent. Five of the AOs showed opportunity for improvement with

scores ranging from 78 percent to 92 percent. In FY 2017, three of the AOs performed well with scores ranging from 95 percent to 98 percent for the same measure. Six of the AOs showed opportunity for improvement with scores ranging from 63 percent to 94 percent. In both FYs 2016 and 2017, one AO didn't have any data to calculate this same measure.

- At the end of FY 2017, no measures were retired due to inconsistent scoring. CMS reviews the performance measure scores annually to determine which measures, if any, can be retired prior to the next FY.

3. Survey Schedule

- In FY 2016, three AOs excelled, scoring 100 percent for the measure, "Number of surveys performed matches the number reported in ASSURE." Three of the AOs performed well with two of the AOs scoring 99 percent and the third AO scoring 98 percent. Three of the AOs showed opportunity for improvement, with scores ranging from 86 percent to 94 percent. In FY 2017, two of the AOs excelled, scoring 100 percent for the same measure. Six of the AOs performed well with scores ranging from 95 percent to 99 percent. One of the AOs showed opportunity for improvement with a score of 94 percent. For both FYs 2016 and 2017, two of the AOs excelled for the same measure and one of the AOs didn't have any data to calculate.
- The Survey Schedule measure wasn't retired at the end of FY 2017 due to inconsistent scoring. CMS reviews the performance measure scores annually to determine which measures, if any, can be retired prior to the next FY.

Accrediting Organization Specific Discussion (See Appendix A)

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)

For the performance measures that can be compared to FY 2016 scores, AAAASF continued to perform well on one of the two Facility Notification Letters performance measures, and the Survey Schedule performance measure. AAAASF continued to show opportunity for improvement for the measure, "ASSURE is updated consistent with letters." AAAASF performed well on the measure "denied initial survey with condition-level findings in FY 2017," a measure on which they excelled in FY 2016. For the new FY 2017 measures, AAAASF performed well on, "CMS notified timely of withdrawals," and excelled on the measure "no pending survey > 5 months." For all measures where AAAASF demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, AAAASF excelled on 2 of 7 measures in FY 2017.

Accreditation Association for Ambulatory Health Care, Inc. (AAAHHC)

For the performance measures that can be compared to FY 2016 scores, AAAHC continued to excel on one of two ASSURE Database performance measures. AAAHC continues to demonstrate opportunity for improvement for the performance measures "timeliness of facility notification of survey results," "notification letters contain all required information," and "ASSURE is updated consistent with letters." AAAHC performed well on the measure "number of surveys performed matches number reported in ASSURE," a measure on which they demonstrated opportunity for improvement in FY 2016. For the new FY 2017 measures, AAAHC showed opportunity for improvement for the measure "CMS notified timely of withdrawals," and excelled on the measure "no pending survey > 5 months." For all measures where AAAHC demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, AAAHC excelled on 2 of 7 measures in FY 2017.

Accreditation Commission for Health Care (ACHC)

For the performance measures that can be compared to FY 2016 scores, ACHC continued to excel on both ASSURE Database performance measures, and one of two Facility Notification Letters performance measures. ACHC continued to perform well on the measure “ASSURE is updated consistent with letters.” ACHC performed well on the measure, “number of surveys performed matches number reported in ASSURE,” a measure on which they excelled in FY 2016. For the new FY 2017 measures, ACHC performed well on the measure “CMS notified timely of withdrawals,” and excelled on the measure “no pending survey > 5 months.” For all measures where ACHC demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, ACHC excelled on 4 of 7 performance measures in FY 2017.

American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP)

For the performance measures that can be compared to FY 2016 scores, AOA/HFAP continued to excel in one of two ASSURE Database performance measures, one of two Facility Notification Letters performance measures, and the Survey Schedule performance measure. For the ASSURE Database performance measure “denied initial survey with condition-level findings,” AOA/HFAP did not have a sufficient sample size in FYs 2016 and 2017 to calculate this measure. AOA/HFAP performed well on the measure “ASSURE is updated consistent with letters,” a measure on which they excelled in FY 2016. For the new FY 2017 measures “CMS notified timely of withdrawals,” and “no pending survey > 5 months,” AOA/HFAP excelled. Overall, AOA/HFAP excelled on each of the FY 2017 performance measures, for which their sample size was at least 5, except for “ASSURE is updated consistent with letters.” CMS worked with AOA/HFAP and provided guidance on improving future scores. In summary, AOA/HFAP excelled on 5 of 7 performance measures in FY 2017.

Community Health Accreditation Partner (CHAP)

For the performance measures that can be compared to FY 2016 scores, CHAP continued to perform well on the Survey Schedule performance measure. CHAP continued to show opportunity for improvement on the measure “ASSURE is updated consistent with letters.” CHAP performed well on the measure “timeliness of facility notification of survey results,” a measure on which they showed opportunity for improvement in FY 2016. CHAP showed opportunity for improvement on the measure “denied initial survey with condition-level findings,” a measure on which they excelled in FY 2016. For the new FY 2017 performance measures, CHAP showed opportunity for improvement on the measure “CMS notified timely of withdrawals,” and excelled on the measure “no pending survey > 5 months.” For all measures where CHAP demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, CHAP excelled on 2 of 7 applicable measures in FY 2017.

Center for Improvement in Healthcare Quality (CIHQ)

For the performance measures that can be compared to FY 2016 scores, CIHQ continued to show opportunity for improvement on the Survey Schedule measure. CIHQ showed opportunity for improvement on the measures “timeliness of facility notification of survey results,” and “notification letters contain all required information,” measures on which they excelled in FY 2016. CIHQ also showed opportunity for improvement on the measure “ASSURE is updated consistent with letters,” a measure on which they performed well in FY 2016. For the comparable measure “denied initial survey with condition-level findings,” CIHQ’s sample size was too small to calculate. For the new FY 2017 measures, CIHQ excelled on the measure “no pending survey > 5 months,” but did not have a sufficient sample size to calculate the measure “CMS notified timely of withdrawals.” For all measures where

CIHQ demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, CIHQ excelled on 1 of 7 performance measures in FY 2017.

DNV GL-Healthcare (DNV GL)

For the performance measures that can be compared to FY 2016 scores, DNV GL continued to excel on the Survey Schedule performance measure. For the ASSURE Database performance measure “Denied initial survey with condition-level findings,” DNV GL did not have a sufficient sample size in FY 2017 to calculate this measure, therefore, a comparison cannot be made. DNV GL showed opportunity for improvement for the measures “timeliness of facility notification of survey results,” and “ASSURE is updated consistent with letters,” measures for which they excelled and performed well respectively in FY 2016. DNV GL performed well on the measure “notification letters contain all required information,” a measure on which they excelled in FY 2016. For the new FY 2017 measures, DNV GL excelled on the measure “no pending survey > 5 months,” and showed opportunity for improvement on the measure “CMS notified timely of withdrawals.” For all measures where DNV GL demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, DNV GL excelled on 2 of 7 measures in FY 2017.

Institute for Medical Quality (IMQ)

IMQ’s Medicare accreditation program was initially approved April 29, 2016. In FY 2017, IMQ didn’t have any information available for calculation.

The Compliance Team (TCT)

For the performance measures that can be compared to FY 2016 scores, TCT continued to excel on one of two ASSURE Database performance measures. TCT continued to perform well on the measure “timeliness of facility notification of survey results.” TCT performed well on the measures “notification letters contain all required information,” “ASSURE is updated consistent with letters,” and “number of surveys performed matches number reported in ASSURE,” measures for which TCT showed opportunity for improvement in FY 2016. For the new FY 2017 performance measure “CMS notified timely of withdrawals,” TCT didn’t have a sufficient sample size to calculate the measure. TCT excelled on the new FY 2017 performance measure “no pending survey > 5 months.” For all measures where TCT demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. In summary, TCT excelled on 2 of 7 performance measures in FY 2017.

The Joint Commission (TJC)

For the performance measures that can be compared to FY 2016 scores, TJC continued to excel on one of two ASSURE Database performance measures. TJC continued to perform well on the measures “notification letters contain all required information,” and “number of surveys performed matches number reported in ASSURE.” TJC continued to show opportunity for improvement for the measure “ASSURE is updated consistent with letters.” TJC performed well on the measure “denied initial survey with condition-level findings,” a measure for which TJC demonstrated opportunity for improvement in FY 2016. For the new FY 2017 measures, TJC showed opportunity for improvement on the measure “CMS notified timely of withdrawals,” and excelled on the measure “no pending survey > 5 months.” For all measures where TJC demonstrated an opportunity for improvement, CMS worked with the AO to determine possible causes and provided guidance on improving future scores. Overall, TJC excelled on 2 of 7 measures in FY 2017.

SECTION 4: Validation of Accrediting Organization Surveys

Accreditation Validation Program

Section 1864(c) of the Act permits SA validation surveys of provider and supplier types deemed for Medicare participation under Section 1865(a) of the Act as a means of validating the AOs' accreditation processes. A facility certified on the basis of being "deemed" to meet the Medicare conditions based on accreditation by a CMS-approved Medicare accreditation program and recommendation for deemed status by the AO, is not subject to routine surveys by SAs to determine compliance with all applicable Medicare conditions. However, these deemed status facilities may be subject to validation surveys authorized by CMS and generally conducted by an SA.

The Accreditation Validation Program is one component of CMS oversight of AOs with approved Medicare accreditation programs, and consists of two types of validation surveys:

- Substantial allegation surveys (also called "complaint surveys") – focused surveys based on complaints which, if substantiated, could indicate serious non-compliance with one or more Medicare conditions (see Section 5); and
- Representative sample validation surveys – full surveys which are routinely performed for a representative sample of deemed facilities as part of the annual CMS-AO representative sample validation survey program. These surveys must be completed by the SA within 60 days of an AO full accreditation survey for the same facility. In some cases, representative sample "mid-cycle validation surveys" may be conducted independent of a preceding AO survey.

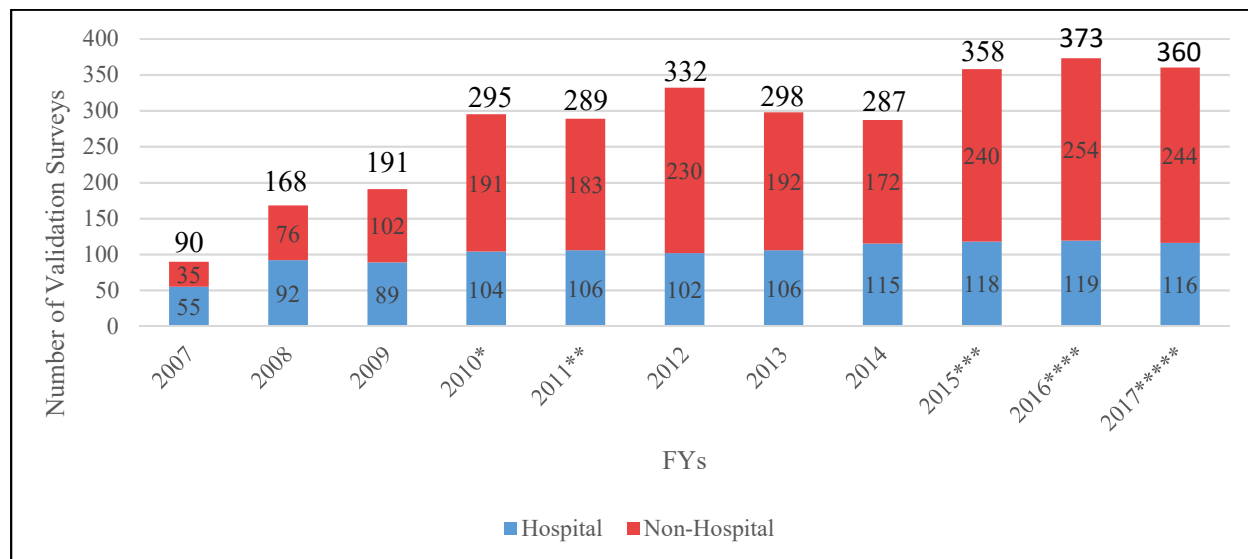
Note: The remaining portion of this section discusses the methodology for and results of CMS validation of the AOs' Medicare accreditation programs which is based only upon analysis of the 60-day representative sample validation surveys.

Prior to 2009, Section 1875 of the Act required CMS to report to Congress annually only on TJC's hospital program.⁹ Nevertheless, in FY 2007, CMS began conducting 60-day representative sample validation surveys for selected non-hospital facility types (CAHs, HHAs, and ASCs), in addition to those already being performed for deemed status hospitals. In FY 2010, hospice 60-day validation surveys were added, and in FY 2011, psychiatric hospital 60-day validation surveys were added. In FY 2017, CMS conducted a total of 360 representative sample 60-day validation surveys for 6 facility types across AOs.¹⁰ This total comprised 116 hospital surveys (including 21 psychiatric hospitals) and 244 non-hospital validation surveys. (See Graph 5.)

⁹ Section 125(b)(4) of P.L. 110-275 (2008) revised this provision to apply to all AOs.

¹⁰ In FY 2016, OPT, which includes the newly accredited TCT, and RHC providers were not part of the validation sample.

**Graph 5
Number of Representative Sample Validation Surveys for
Both Hospital and Non-Hospital Facilities
FYs 2007-2017**



*In FY 2010: The non-hospital total of 191 includes 72 mid-cycle ASC validation surveys.

**In FY 2011: The hospital total of 106 includes 33 mid-cycle LTCH validation surveys.

***In FY 2015: The hospital total of 118 includes 16 psychiatric hospital validation surveys.

****In FY 2016: The hospital total of 119 includes 21 psychiatric hospital validation surveys.

*****In FY 2017: The hospital total of 116 includes 21 psychiatric hospital validation surveys.

Since 2007, CMS has worked to strengthen its oversight of AOs. FYs 2014–2015 showed an increase in the amount of surveys conducted. These increases were due to the availability of additional mid-year AO validation program budget funds. FYs 2016–2017 showed a slight decrease in the number of surveys conducted. The recent history of validation survey samples is as follows:

- 2014: 115 hospital and 172 non-hospital surveys totaling 287 surveys
- 2015: 118 hospital and 240 non-hospital surveys totaling 358 surveys
- 2016: 119 hospital and 254 non-hospital surveys totaling 373 surveys
- 2017: 116 hospital and 244 non-hospital surveys totaling 360 surveys.

These numbers represent a 300-percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 360 in FY 2017. During the same time period, the number of non-hospital validation surveys conducted increased by 597 percent, from 35 surveys in FY 2007 to 244 surveys in FY 2017. The number of hospital validation surveys conducted increased by 111 percent, from 55 surveys in FY 2007 to 116 surveys in FY 2017.

60-Day Validation Surveys

The purpose of 60-day validation surveys is to assess the AO’s ability to ensure compliance with Medicare conditions. These validation surveys are on-site full surveys completed by SA surveyors no later than 60 days after the end date of an AO’s Medicare accreditation program full survey. The SA performs these surveys without any knowledge of the findings of the AO’s accreditation survey.

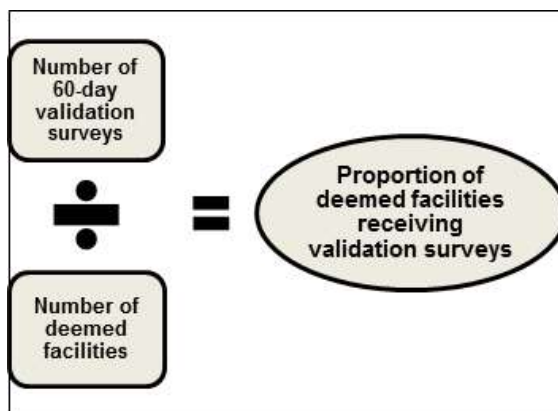
The composition of the validation sample is driven by a number of factors, including the total number of Medicare accreditation surveys scheduled by the AO and reported on monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual State validation survey volume targets based on

the number of deemed providers or suppliers located in the State. CMS determines the number of validation surveys to perform for each AO based on its total number of facilities, as well as the overall budgeted validation survey targets, by State and facility type. In this way, CMS builds a representative national sample for individual accreditation programs.

Proportion of Deemed Facilities Receiving Validation Surveys

The proportion of 60-day validation surveys completed for deemed facilities is calculated by dividing the number of 60-day validation surveys conducted by the total number of deemed facilities. (See Figure 1.)

Figure 1
Proportion of Deemed Facilities Receiving Validation Surveys

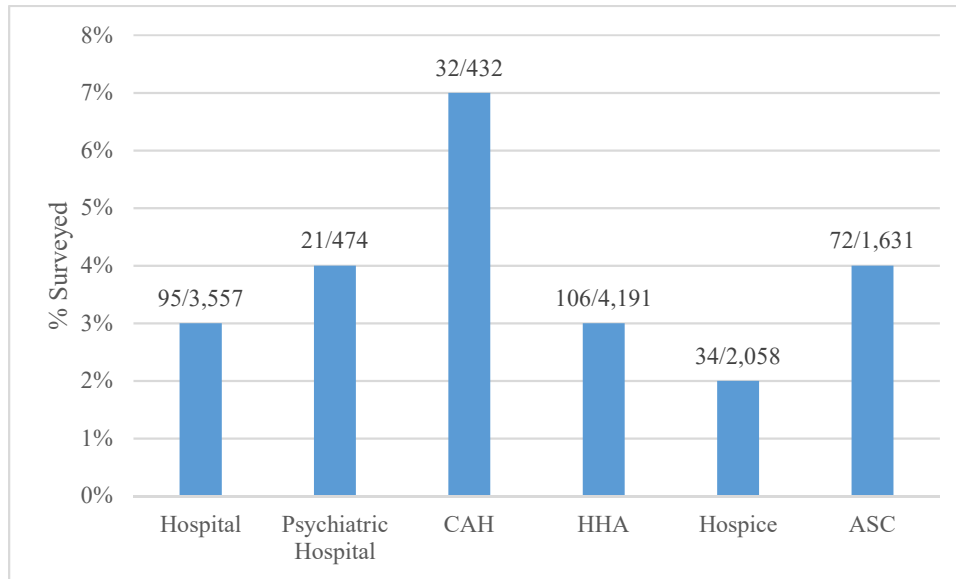


The proportion of deemed facilities that received a 60-day validation survey in FY 2017 is as follows:

- **Hospitals:** Three percent of deemed hospitals received a validation survey in FY 2017 (95 validation surveys conducted out of 3,557 deemed facilities).
- **Psychiatric Hospitals:** Four percent of deemed psychiatric hospitals received a validation survey in FY 2017 (21 validation surveys conducted out of 474 deemed facilities).
- **CAHs:** Seven percent of deemed CAHs received a validation survey in FY 2017 (32 validation surveys conducted out of 432 deemed facilities).
- **HHAs:** Three percent of deemed HHAs received a validation survey in FY 2017 (106 validation surveys conducted out of 4,191 deemed facilities).
- **Hospices:** Two percent of deemed hospices received a validation survey in FY 2017 (34 validation surveys conducted out of 2,058 deemed facilities).
- **ASCs:** Four percent of deemed ASCs received a validation survey in FY 2017 (72 validation surveys conducted out of 1,631 deemed facilities).

The percentage of 60-day validation surveys performed by provider type is depicted below in Graph 6.

**Graph 5
60-Day Validation Surveys Performed by Provider Type
FY 2017**



Validation Analysis

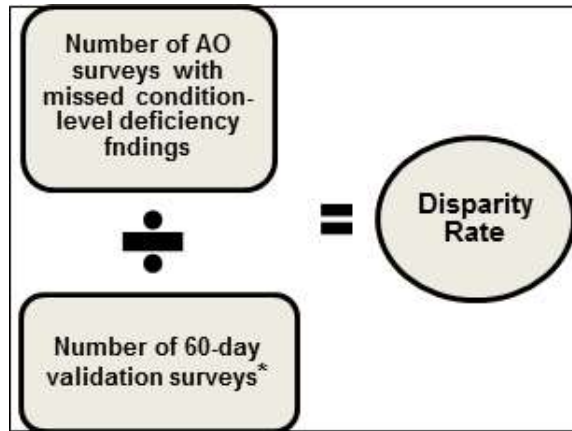
Condition-Level Deficiencies and Disparity Rate

After the 60-day validation surveys are completed, CMS performs a validation analysis and compares the condition-level deficiencies (i.e., serious deficiencies) cited by the SA with all deficiencies cited by the AO on its Medicare accreditation survey. The goal of this validation analysis is to determine whether the AOs are able to accurately identify serious deficiencies in a facility. The premise of the analysis is that condition-level deficiencies cited by the SA during the 60-day validation survey would also have been present 60 days prior, during the AO’s Medicare accreditation survey, and should also have been cited by the AO.

When the SA finds a condition-level deficiency in a deemed status facility, CMS removes its deemed status and places it under the jurisdiction of the SA until the facility comes into substantial compliance. If the facility is unable to demonstrate substantial compliance in a timely manner, the facility’s participation in Medicare is terminated. If compliance is demonstrated, CMS restores the facility’s deemed status and returns the facility to the AO’s jurisdiction.

When the SA cites a condition-level deficiency for which the AO has cited no comparable deficiency, the deficiency is considered by CMS to have been “missed” by the AO and is a factor in determining the AO’s “disparity rate” for each facility type. (See Figure 2.)

**Figure 2
Disparity Rate Calculation**



*The number of 60-day validation surveys includes the total number of 60-day validation surveys conducted regardless of whether the SA cited condition-level deficiencies.

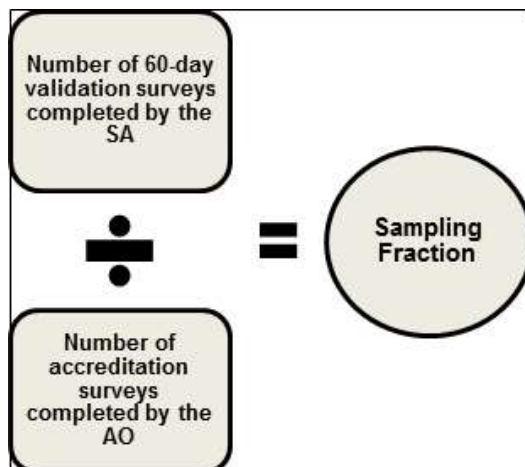
The methodology for the disparity rate is set by regulation at 42 CFR § 488.1. The numerator is the number of surveys where the AO did not cite a comparable serious (condition-level) deficiency as cited by the SA. The denominator is the total number of surveys in the 60-day representative validation sample. The result is the percentage of 60-day validation surveys where the AO did not cite a comparable serious deficiency as cited by the SA. For example, if there are 77 (60-day) validation surveys conducted, and the AO missed 12 condition-level deficiencies cited by the SA, the disparity rate would be 16 percent (12 divided by 77).

There are, however, limitations when discussing disparity rates. The disparity rate does not solely measure the AO’s performance. Additionally, a high AO disparity rate does not necessarily indicate unsatisfactory performance by the AO. (See Section 5.)

Sampling Fraction

The sampling fraction is the proportion of AO surveys conducted during the FY for which a representative sample 60-day validation survey was completed. (See Figure 3.)

**Figure 3
Sampling Fraction Calculation**



For example, if the number of 60-day validation surveys conducted by the SA is 33 and the overall number of accreditation surveys conducted by the AO over the same time period is 638, then the sampling fraction would be 33 divided by 638—which is 5 percent. CMS has worked to increase this sampling fraction for each AO and to include a minimum of five 60-day validation surveys per year for each AO program, no matter how small the program.

In summary, the *disparity rate* focuses on the number of 60-day validation surveys where the AO did not cite comparable condition-level deficiencies cited by SAs in relation to the total number of validation surveys completed by the SA. The *sampling fraction* is the proportion of 60-day validation surveys completed by the SA in relation to the number of Medicare accreditation surveys completed by the AO.

Validation Performance Results: Each Facility Type

The table below presents the results of the 60-day validation surveys for all AOs from FY 2015 through FY 2017 by facility type. (See Table 9.)

Table 9
60-Day Validation Survey Results for Each Facility Type
FYs 2015–2017

	FY 2015	FY 2016	FY 2017
HOSPITAL			
60-Day Validation Sample Surveys	102	98	95
SA Surveys with Condition-Level Deficiencies	42	50	47
AO Surveys with Missed Comparable Deficiencies	40	45	43
Disparity Rate	39%	46%	45%
Sampling Fraction	.08	.07	.07
PSYCHIATRIC HOSPITAL			
60-Day Validation Sample Surveys	16	21	21
SA Surveys with Condition-Level Deficiencies	12	12	14
AO Surveys with Missed Comparable Deficiencies	11	12	12
Disparity Rate	69%	57%	57%
Sampling Fraction	.10	.11	.11
CRITICAL ACCESS HOSPITAL			
60-Day Validation Sample Surveys	33	34	32
SA Surveys with Condition-Level Deficiencies	15	16	12
AO Surveys with Missed Comparable Deficiencies	15	15	11
Disparity Rate	45%	44%	34%
Sampling Fraction	.18	.24	.19

	FY 2015	FY 2016	FY 2017
HOME HEALTH AGENCY			
60-Day Validation Sample Surveys	104	110	106
SA Surveys with Condition-Level Deficiencies	23	23	16
AO Surveys with Missed Comparable Deficiencies	17	20	13
Disparity Rate	16%	18%	12%
Sampling Fraction	.05	.06	.07
HOSPICE			
60-Day Validation Sample Surveys	34	34	34
SA Surveys with Condition-Level Deficiencies	4	6	4
AO Surveys with Missed Comparable Deficiencies	3	6	4
Disparity Rate	9%	18%	12%
Sampling Fraction	.04	.04	.04
AMBULATORY SURGERY CENTER			
60-Day Validation Sample Surveys	69	75	72
SA Surveys with Condition-Level Deficiencies	31	28	33
AO Surveys with Missed Comparable Deficiencies	29	26	26
Disparity Rate	42%	35%	36%
Sampling Fraction	.09	.11	.10

The Hospice and HHA disparity rates are significantly different than the other facility types due to the lower percentage of surveys with condition-level deficiencies cited by SAs in the 60-day validation samples for both hospice and HHAs for FYs 2015–2017. This lower deficiency rate is primarily due to these facility types not having deficiencies related to PE conditions. There is no PE condition for HHAs since these services are provided in the patient’s home. Although hospices do have a PE condition, a number of hospice services are provided in the patient’s home as well.

From FY 2016 to FY 2017, CAHs had the largest decrease in the disparity rate of all the program types, with a 10-percent decrease. The disparity rates for hospitals decreased by 1 percent from FYs 2016 to 2017. The disparity rates for HHAs and hospices decreased by 6 percent from FY 2016 to FY 2017. In FY 2017, the disparity rate for psychiatric hospitals remained unchanged from FY 2016. The disparity rate for ASCs increased 1 percent from FY 2016 to FY 2017. This was the only program type to have an increase in disparity rate from FYs to 2017.

Validation Performance Results: Individual Accrediting Organizations

Each AO receives feedback on the results of CMS’ analysis of 60-day validation surveys for its deemed status facilities. The series of tables below present the results of the 60-day validation surveys by facility type for each of the AO Medicare accreditation programs from FYs 2015 to 2017. (See Tables 10-15.)

When the number of 60-day validation surveys completed by the SA is less than five surveys, the disparity rate is not presented. The small 60-day validation sample sizes limited the analysis of some AO

programs. Since 2008, CMS has tried to significantly increase the number of 60-day validation samples. With minimal exception, the sample size for every AO program was either maintained or increased from FYs 2011 to 2012. Due to decreased funding in FY 2013, the sample size decreased for each program type, except for psychiatric hospitals and CAHs. In FY 2014, the number of validation surveys for CAHs, HHAs, Hospices and ASCs decreased, also as a result of decreased funding. In FYs 2015 and 2016, the number of validation surveys for these same program types increased except for Hospices which remained the same. Only hospitals showed a decrease in the number of surveys performed from FY 2014 to FY 2017. In FY 2017, the sample size decreased for each program type except for psychiatric hospitals and hospices. The number of validation surveys for psychiatric hospitals and hospices remained the same from FY 2016 to FY 2017. CMS strives to maintain a larger sample size in the future based on the availability of Federal funds. The presentation of validation results over several time periods provides a more complete examination of the consistency of individual AO performance. Therefore, the results for the FYs 2015–2017 60-day validation surveys for individual AOs have been combined in the tables below to provide a more robust and reliable estimate of the disparity rates.

Hospital

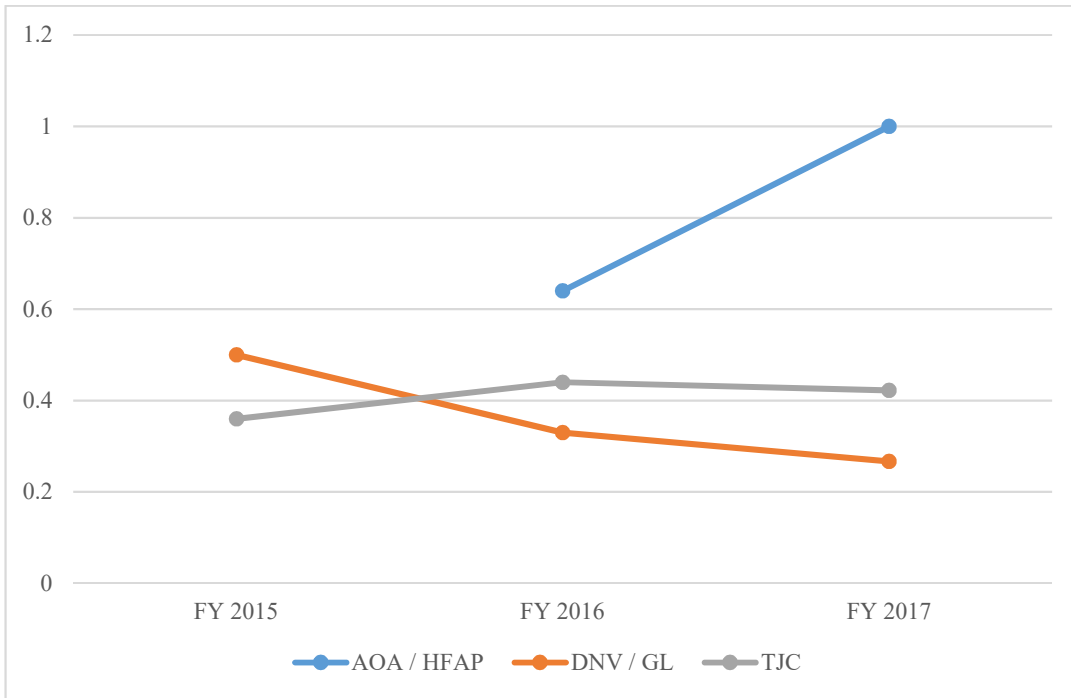
The AOs with hospital programs in FY 2017 were AOA/HFAP, CIHQ, DNV GL, and TJC. (See Table 10 and Graphs 7-10.)

Table 10
Hospital 60-Day Validation Survey Results by AO
FYs 2015–2017

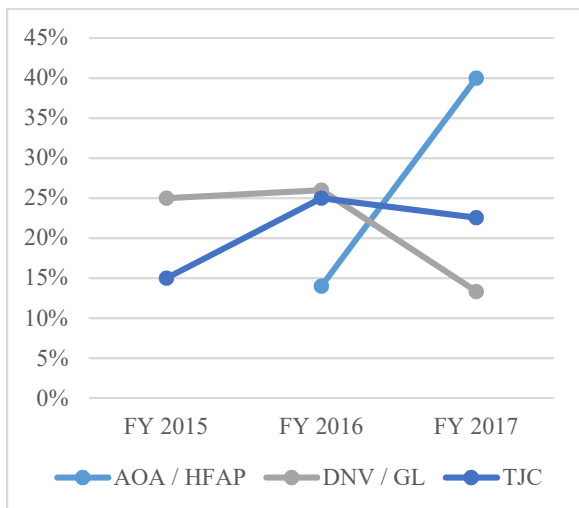
Emp	AOA/HFAP			CIHQ			DNV GL			TJC			Total
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015–2017
60-Day Validation Sample Surveys	4	14	5	1	1	4	8	15	15	89	68	71	295
SA Surveys with Condition-Level Deficiencies	*N/A	10	5	*N/A	*N/A	*N/A	5	5	4	33	34	34	130
AO Surveys with Missed Comparable Deficiencies	*N/A	9	5	*N/A	*N/A	*N/A	4	5	4	32	30	30	119
Overall Disparity Rate	*N/A	64%	100%	*N/A	*N/A	*N/A	50%	33%	27%	36%	44%	42%	40%
Health and Safety Disparity Rate	*N/A	14%	40%	*N/A	*N/A	*N/A	25%	26%	13%	15%	25%	23%	22%
Physical Environment Disparity Rate	*N/A	64%	100%	*N/A	*N/A	*N/A	25%	20%	13%	25%	25%	31%	29%
Sampling Fraction	*N/A	.34	.10	*N/A	*N/A	*N/A	.07	.16	.15	.08	.06	.06	.07

*N/A: When a minimum sample size of five is not achieved for an AO, no data is reported given the lack of statistical significance.

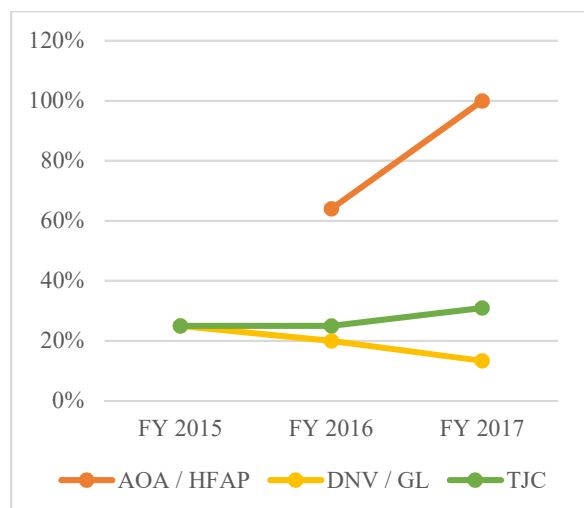
Graph 6
Hospital 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



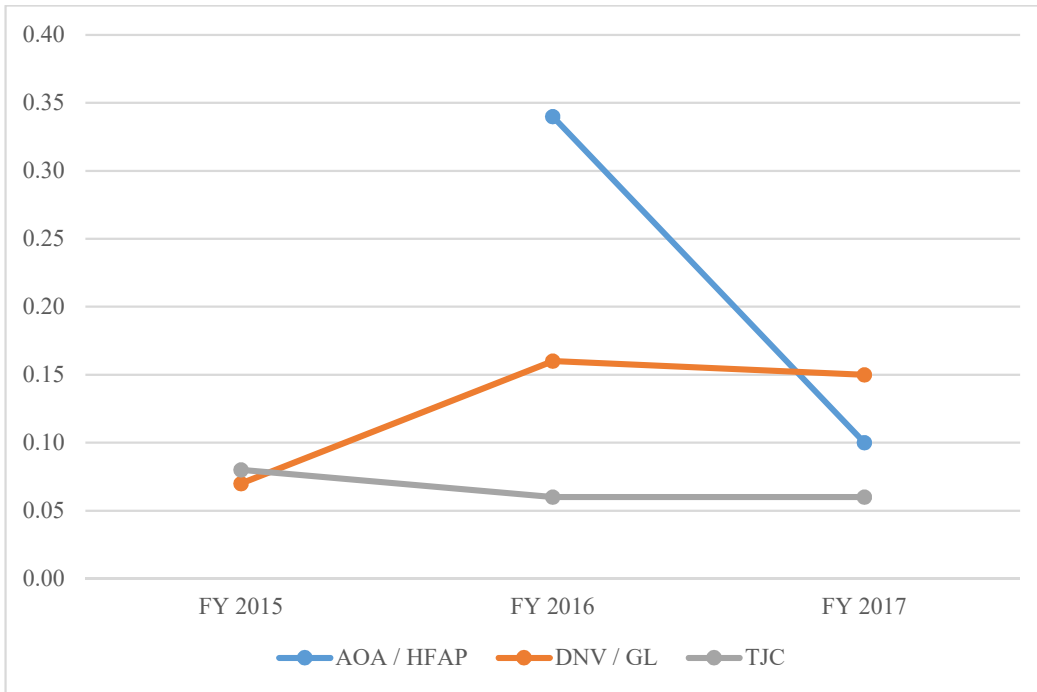
Graph 7
Hospital 60-Day Validation Survey
Health and Safety Disparity Rate Results
by AO
FYs 2015-2017



Graph 8
Hospital 60-Day Validation Survey PE
Disparity Rate Results
by AO
FYs 2015-2017



Graph 9
Hospital 60-Day Validation Survey Sampling Fraction Results by AO
FYs 2015–2017



- AOA/HFAP:** In FY 2017, the overall disparity rate was 100 percent based on the completion of five validation surveys. The number of validation surveys conducted represents a 10-percent sample of the surveys conducted by AOA/HFAP. The FY 2017 overall disparity rate is 36 percentage points higher than the overall disparity rate for FY 2016; however, the FY 2017 sample size was significantly smaller compared to FY 2016. The overall disparity rate for FY 2016 was based on a 34-percent sample of the surveys conducted during that period. In FY 2017, AOA/HFAP’s PE disparity rate was 60 percentage points higher than the health and safety disparity rate. In FY 2017, the SA cited PE at the condition level 10 times. AOA/HFAP missed five comparable deficiencies resulting in a disparity rate of 100 percent. The FY 2017 PE disparity rate is 36 percentage points higher than the FY 2016 PE disparity rate. The FY 2015 data wasn’t comparable due to the small sample size.
- CIHQ:** As a result of being a newly accredited AO, CIHQ completed only four validation surveys in FY 2017. Therefore, no additional data is reported.
- DNV GL:** In FY 2017, the overall disparity rate was 27 percent based on the completion of 15 validation surveys. The number of validation surveys conducted represents a 15-percent sample of the surveys conducted by DNV GL. The FY 2017 overall disparity rate is 23 percentage points lower than the overall disparity rate for FY 2015. The FY 2015 overall disparity rate was based on a 7-percent sample of the surveys conducted during that period. In FY 2017, DNV GL’s health and safety and PE disparity rates were 13 percent. The FY 2017 health and safety and PE disparity rates are 12 percentage points lower than the FY 2015 health and safety and PE disparity rates.
- TJC:** In FY 2017, the overall disparity rate was 42 percent based on the completion of 71 validation surveys. The number of validation surveys conducted represents a 6-percent sample of surveys conducted by TJC. The FY 2017 overall disparity rate is 6 percentage points higher than the disparity rate for FY 2015. The overall disparity rate in FY 2015 was based on an 8-percent sample of surveys conducted during that period. In FY 2017, TJC’s PE disparity rate was 8 percentage points higher

than the health and safety disparity rate. In FY 2017, the SA cited PE at the condition level 41 times. TJC missed 22 comparable deficiencies resulting in a disparity rate of 31 percent. The FY 2017 PE disparity rate is 6 percentage points higher than the FY 2015 PE disparity rate.

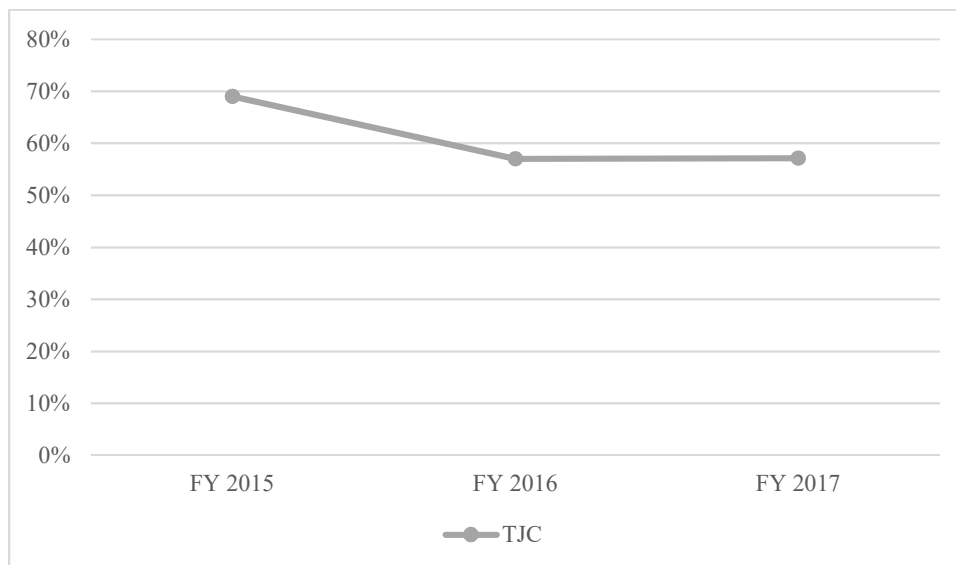
Psychiatric Hospital

TJC was the only AO with a CMS-approved psychiatric hospital Medicare accreditation program in FY 2017. The psychiatric hospital program was initially approved by CMS in FY 2011. (See Table 11 and Graphs 11-14.)

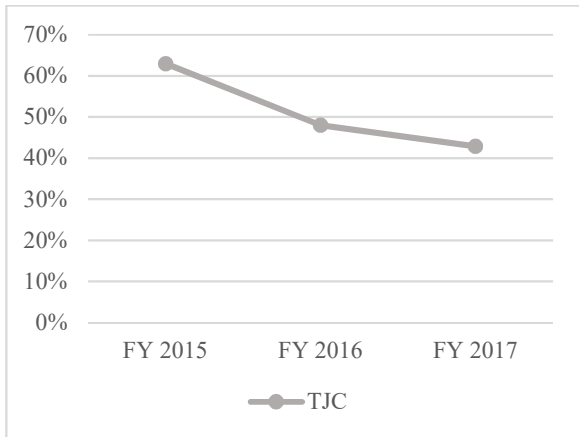
Table 11
Psychiatric Hospital 60-Day Validation Survey Results by AO
FYs 2015–2017

	TJC			Total
	FY 2015	FY 2016	FY 2017	FYs 2015–2017
60-Day Validation Sample Surveys	16	21	21	58
SA Surveys with Condition-Level Deficiencies	12	12	14	38
AO Surveys with Missed Comparable Deficiencies	11	12	12	35
Overall Disparity Rate	69%	57%	57%	60%
Health and Safety Disparity Rate	63%	48%	43%	50%
Physical Environment Disparity Rate	38%	19%	38%	31%
Sampling Fraction	.10	.11	.11	.11

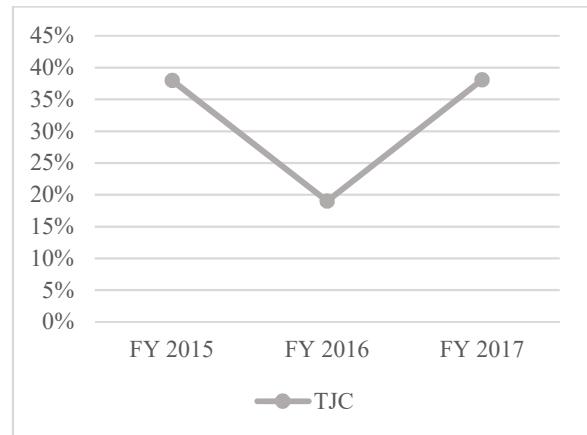
Graph 10
Psychiatric Hospital 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



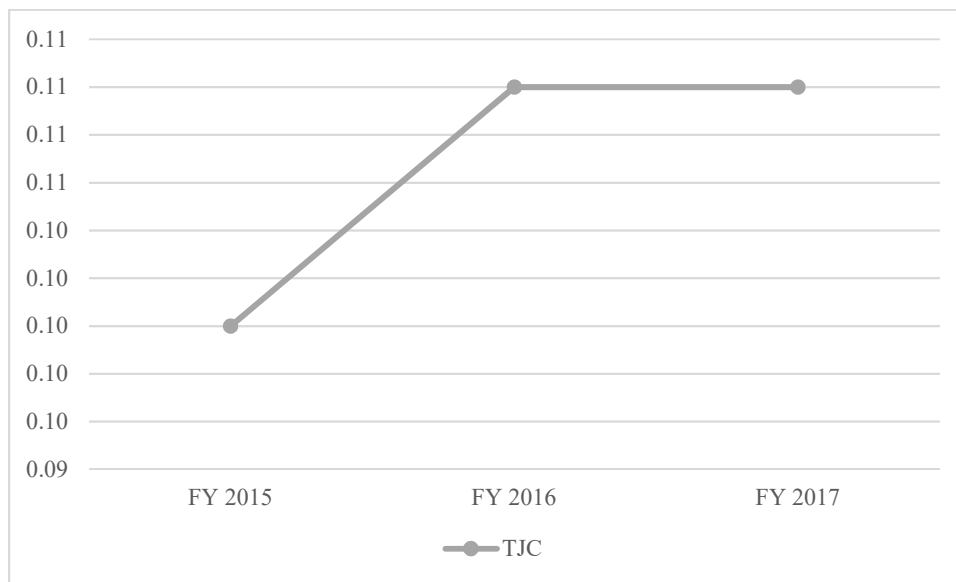
Graph 11
Psychiatric Hospital 60-Day Validation
Survey Health and Safety Disparity Rate
Results by AO
FYs 2015-2017



Graph 12
Psychiatric Hospital 60-Day Validation
Survey PE Disparity Rate
Results by AO
FYs 2015-2017



Graph 13
Psychiatric Hospital 60-Day Validation Survey Sampling Fraction Results
by AO
FYs 2015-2017



- TJC:** In FY 2017, the overall disparity rate was 57 percent based on the completion of 21 validation surveys. The number of validation surveys completed represents an 11-percent sample of the surveys conducted by the TJC. The FY 2017 overall disparity rate is 12 percentage points lower than the disparity rate for FY 2015. The FY 2015 disparity rate was based on a 10-percent sample of the surveys conducted during that period. In FY 2017, TJC’s health and safety disparity rate was 5 percentage points higher than the PE disparity rate. The primary driver of TJC’s health and safety disparity rate was the Governing Body condition. The SAs cited the Governing Body requirement at the condition level 11 times. TJC missed six comparable deficiencies resulting in a 29-percent

disparity rate. The FY 2017 health and safety disparity rate is 20 percentage points lower than the FY 2015 health and safety disparity rate.

CMS expected a decline in TJC psychiatric hospital program’s disparity rate from FY 2016 to FY 2017. However, the FY 2017 overall 57 percent disparity rate remains unchanged from the prior year.

Critical Access Hospital

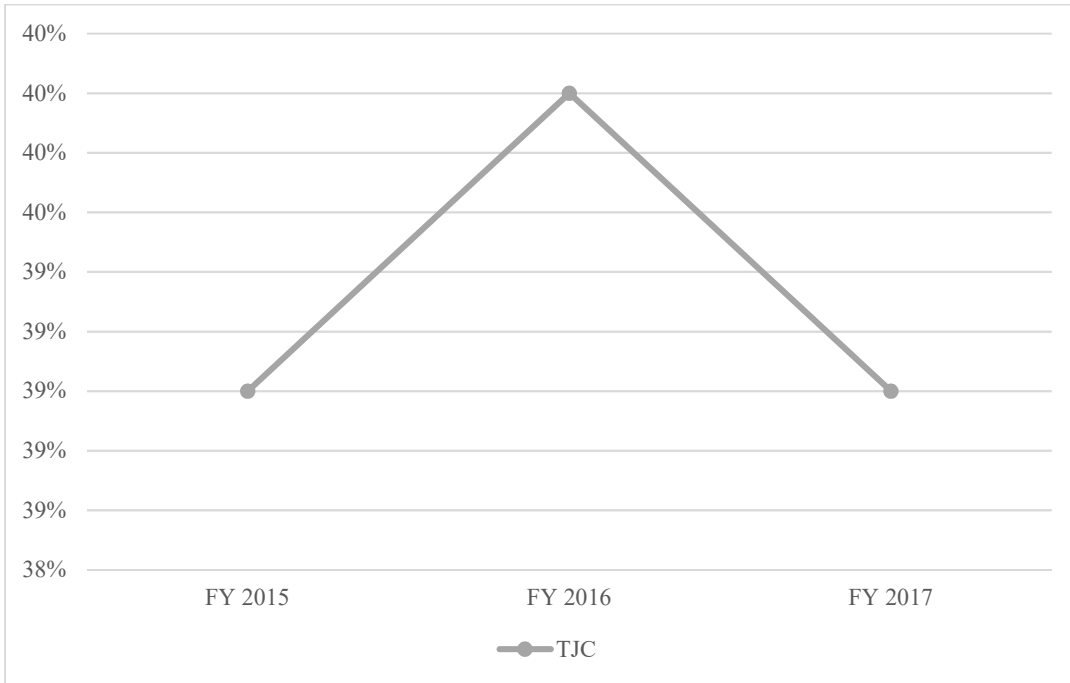
The AOs with CAH accreditation programs in FY 2017 were AOA/HFAP, DNV GL, and TJC. (See Table 12 and Graphs 15-18.)

Table 12
CAH 60-Day Validation Survey Results
by AO
FYs 2015–2017

	AOA/HFAP			DNV GL			TJC			Total
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015–2017
60-Day Validation Sample Surveys	3	2	3	2	2	6	28	30	23	99
SA Surveys with Condition-Level Deficiencies	*N/A	*N/A	*N/A	*N/A	*N/A	1	11	13	10	35
AO Surveys with Missed Comparable Deficiencies	*N/A	*N/A	*N/A	*N/A	*N/A	1	11	12	9	33
Overall Disparity Rate	*N/A	*N/A	*N/A	*N/A	*N/A	17%	39%	40%	39%	33%
Health and Safety Disparity Rate	*N/A	*N/A	*N/A	*N/A	*N/A	17%	25%	23%	9%	20%
Physical Environment Disparity Rate	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A	21%	33%	35%	30%
Sampling Fraction	*N/A	*N/A	*N/A	*N/A	*N/A	.17	.19	.25	.19	.20

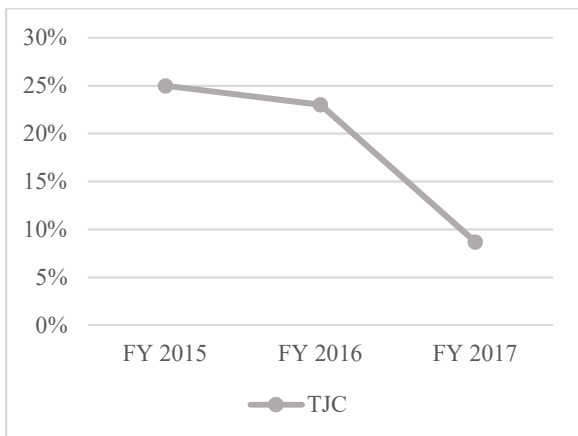
*N/A: When a minimum sample size of five is not achieved for an AO, no data is reported given the lack of statistical significance.

Graph 14
CAH 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017

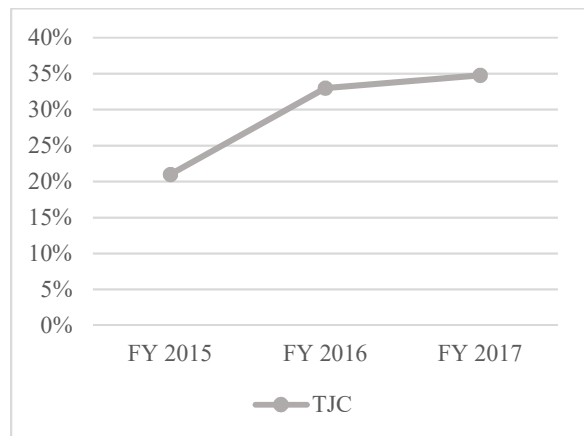


Note: Only AOs having a sample size of five or greater for two or more of the FYs in the look back period are represented in the graph. Therefore, the data for DNV-GL FY 2017 isn't included in the graph.

Graph 15
CAH 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



Graph 16
CAH 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



Graph 17
CAH 60-Day Validation Survey
Sampling Fraction Results by AO
FYs 2015–2017



Note: Only AOs having a sample size of five or greater for two or more of the FYs in the look back period are represented in the graph. Therefore, the data for DNV-GL FY 2017 isn't included in the graph.

- **AOA/HFAP:** In FY 2017, due to the low number of deemed CAHs due for resurvey, only three validation surveys were conducted. Therefore, no additional data is reported.
- **DNV GL:** In FY 2017, the overall disparity rate was 17 percent based on the completion of six validation surveys. The number of validation surveys conducted represents a 17-percent sample of the surveys conducted by DNV GL. In FY 2017, the health and safety disparity rate was 17 percent. In FY 2017, the primary drivers of DNV GL's health and safety disparity rate were as follows: Provision of Services; Organizational Structure; Surgical Services; and Periodic Evaluation and QA Review. The SA cited the Provision of Services requirement at the condition level two times. DNV GL missed one comparable deficiency. The remaining requirements were cited by the SAs at the condition level one time and DNV GL missed one comparable deficiency in each instance. Each condition yielded a 17-percent disparity rate. The PE condition wasn't cited by the SAs in FY 2017. FYs 2015 and 2016 data weren't comparable due to the small sample sizes.
- **TJC:** In FY 2017, the overall disparity rate was 39 percent based on the completion of 23 validation surveys. The number of validation surveys conducted represents a 19-percent sample of the surveys conducted by TJC. The FY 2015 overall disparity rate was also 39 percent based on a 19-percent sample of surveys conducted during that period. In FY 2017, the PE disparity rate was 26 percentage points higher than the health and safety disparity rate. The SA cited PE at the condition level 17 times. TJC missed eight comparable deficiencies resulting in a 35-percent disparity rate. The FY 2017 PE disparity rate is 14 percentage points higher than the FY 2015 PE disparity rate.

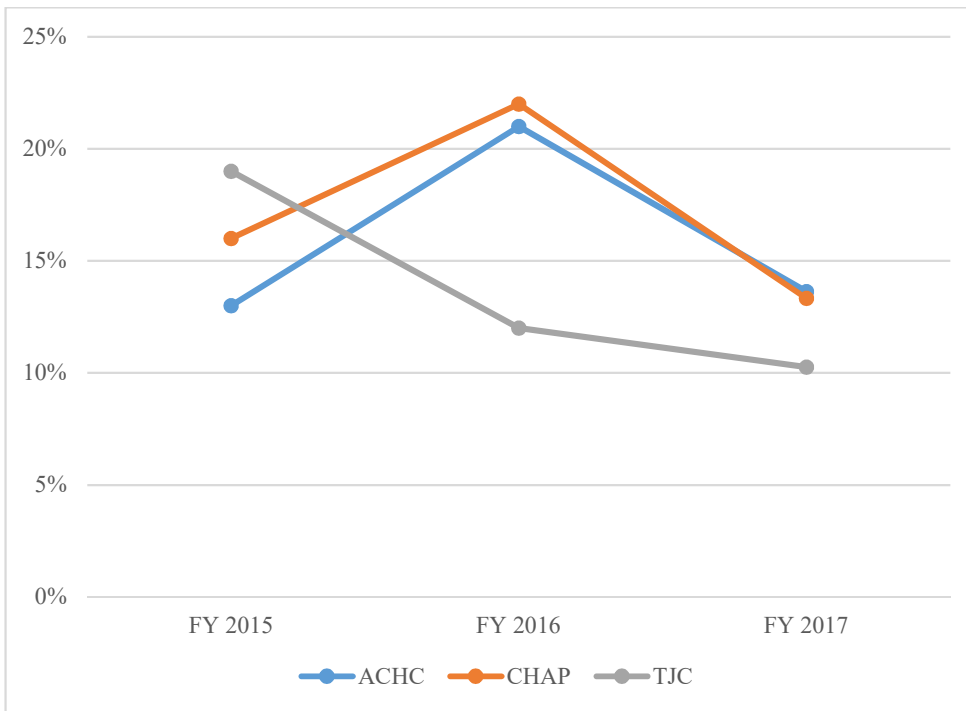
Home Health Agency

The AOs with HHA accreditation programs in FY 2017 were ACHC, CHAP, and TJC. (See Table 13 and Graphs 19-20.)

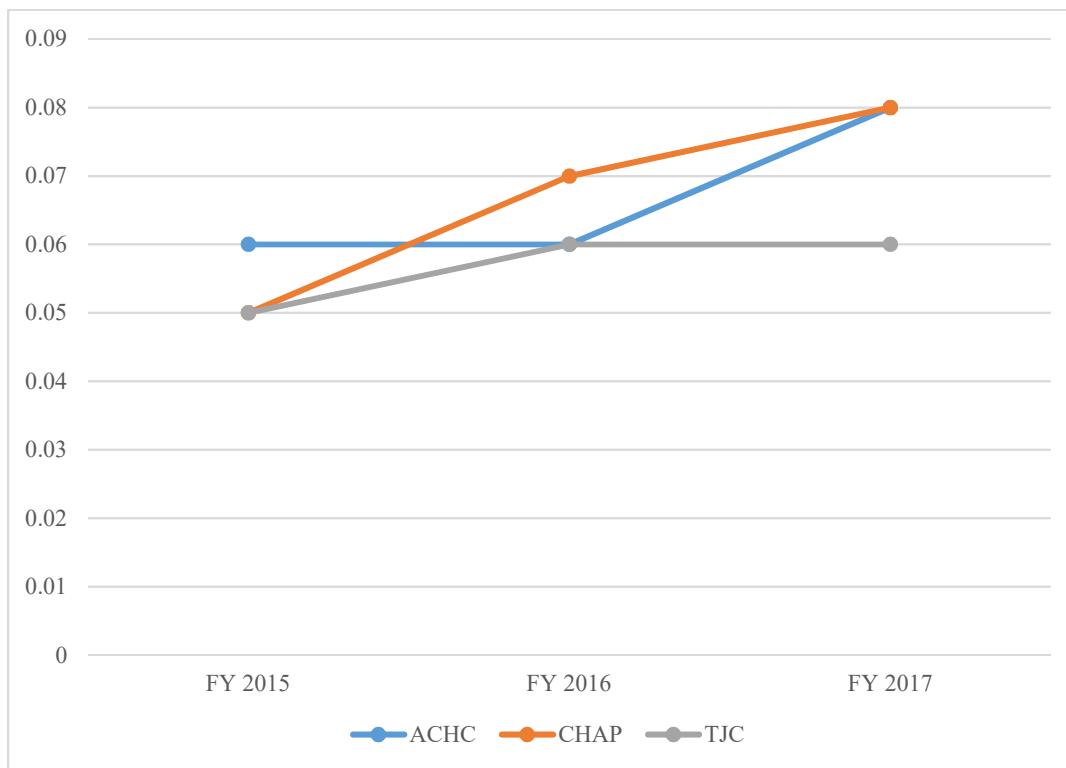
Table 13
HHA 60-Day Validation Survey Results by AO
FYs 2015–2017

	ACHC			CHAP			TJC			Total
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015–2017
60-Day Validation Sample Surveys	16	14	22	51	55	45	37	41	39	320
SA Surveys with Condition-Level Deficiencies	3	6	4	8	12	7	12	5	5	62
AO Surveys with Missed Comparable Deficiencies	2	3	3	8	12	6	7	5	4	50
Overall Disparity Rate	13%	21%	14%	16%	22%	13%	19%	12%	10%	16%
Sampling Fraction	.06	.06	.08	.05	.07	.08	.05	.06	.06	.06

Graph 18
HHA 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



Graph 19
HHA 60-Day Validation Survey
Sampling Fraction Results by AO
FYs 2015–2017



- ACHC:** In FY 2017, the overall disparity rate was 14 percent based on the completion of 22 validation surveys. The number of validation surveys completed represents an 8-percent sample of surveys conducted by ACHC. The FY 2017 overall disparity rate is 1 percentage point higher than the overall disparity rate of FY 2015. The FY 2015 overall disparity rate was based on a 6-percent sample of surveys conducted during that period. In FY 2017, the primary drivers of ACHC’s overall disparity rate were as follows: Acceptance of Patients, Plan of Care, Medical Supervision; Skilled Nursing Services; and Evaluation of the Agency’s Program. The Acceptance of Patients, Plan of Care, Medical Supervision and Skilled Nursing Services conditions were cited by the SAs at the condition level two times. ACHC missed one comparable deficiency. The Evaluation of the Agency’s Program condition was cited by the SAs at the condition level one time. ACHC missed the comparable deficiency. Each condition yielded a 5-percent disparity rate.
- CHAP:** In FY 2017, the overall disparity rate was 13 percent based on the completion of 45 validation surveys. The number of validation surveys completed represents an 8-percent sample of the surveys conducted by CHAP. The FY 2017 overall disparity rate is 3 percentage points lower than the disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on a 5-percent sample of surveys conducted during that period. In FY 2017, the primary driver of CHAP’s overall disparity rate was the Skilled Nursing Services condition. The SA cited this requirement at the condition level eight times. CHAP missed five comparable deficiencies resulting in a disparity rate of 11 percent.

- TJC:** In FY 2017, the overall disparity rate was 10 percent based on the completion of 39 validation surveys. The number of validation surveys completed represents a 6-percent sample of the surveys conducted by TJC. The FY 2017 overall disparity rate is 9 percentage points lower than the overall disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on a 5-percent sample of surveys conducted during that period. In FY 2017, the primary driver of TJC’s overall disparity rate was the Skilled Nursing Services condition. The SAs cited this requirement at the condition level four times. TJC missed three comparable deficiencies resulting in an 8-percent disparity rate.

Hospice

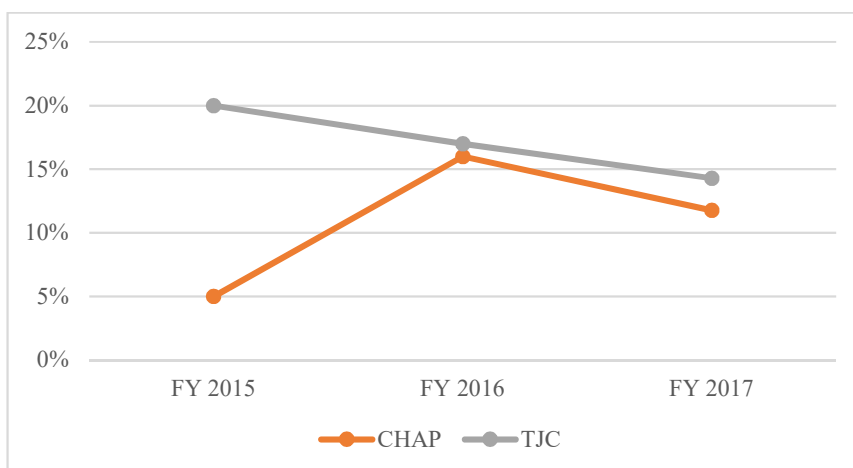
The AOs with hospice accreditation programs in FY 2017 were ACHC, CHAP and TJC. (See Table 14 and Graphs 21-22.)

Table 14
Hospice 60-Day Validation Survey Results by AO
FYs 2015–2017

	ACHC			CHAP			TJC			Total
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015-2017
60-Day Validation Sample Surveys	5	3	3	19	19	17	10	12	14	102
SA Surveys with Condition-Level Deficiencies	0	*N/A	*N/A	2	3	2	2	2	2	13
AO Surveys with Missed Comparable Deficiencies	0	*N/A	*N/A	1	3	2	2	2	2	12
Overall Disparity Rate	0%	*N/A	*N/A	5%	16%	12%	20%	17%	14%	12%
Sampling Fraction	.06	*N/A	*N/A	.05	.06	.06	.03	.03	.04	.04

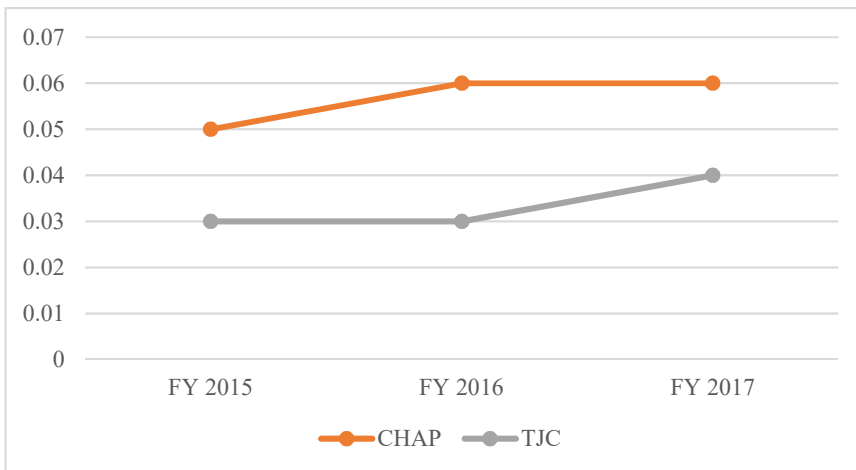
*N/A: When a minimum sample size of five is not achieved for an AO, no data is reported given the lack of statistical significance.

Graph 20
Hospice 60-Day Validation Survey Overall Disparity Rate Results by AO
FYs 2015–2017



Note: Only AOs having a sample size of five or greater for two or more of the FYs in the look back period are represented in the graph. Therefore, the data for ACHC FY 2015 isn't included in the graph.

Graph 21
Hospice 60-Day Validation Survey Sampling Fraction Results by AO
FYs 2015–2017



Note: Only AOs having a sample size of five or greater for two or more of the FYs in the look back period are represented in the graph. Therefore, the data for ACHC FY 2015 isn't included in the graph.

- **ACHC:** In FY 2017, due to the low number of deemed hospices due for resurvey, only three validation surveys were conducted. Therefore, no additional data is reported.
- **CHAP:** In FY 2017, the overall disparity rate was 12 percent based on the completion of 17 validation surveys. The number of validation surveys completed represents a 6-percent sample of the surveys conducted by CHAP. The FY 2017 overall disparity rate is 7 percentage points higher than the overall disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on a 5-percent sample of surveys conducted during that period. In FY 2017, the primary driver of CHAP's overall disparity rate was Quality Assessment & Performance. The SA cited the Quality Assessment & Performance requirement at the condition level two times. CHAP missed both comparable deficiencies resulting in a disparity rate of 12 percent.
- **TJC:** In FY 2017, the overall disparity rate was 14 percent based on the completion of 14 validation surveys. The number of validation surveys completed represents a 4-percent sample of the surveys performed by TJC. The FY 2017 overall disparity rate is 6 percentage points lower than the overall disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on a 3-percent sample of the surveys conducted during that period. In FY 2017, two conditions were cited by the SAs at the condition level. The Initial & Comprehensive Assessment of Patient requirement was cited by the SAs one time. TJC missed this comparable deficiency. The Interdisciplinary Group (IDG), Care Planning, Coordination of Services requirement was cited by the SAs twice. TJC missed one comparable deficiency. Both conditions yielded a 7-percent disparity rate, contributing to TJC's overall disparity rate.

Ambulatory Surgery Center

The AOs with ASC accreditation programs in FY 2017 were AAAASF, AAAHC, AOA/HFAP, IMQ and TJC. (See Table 15 and Graphs 23-26.)

Table 15
ASC 60-Day Validation Survey Results by AO
FYs 2015–2017

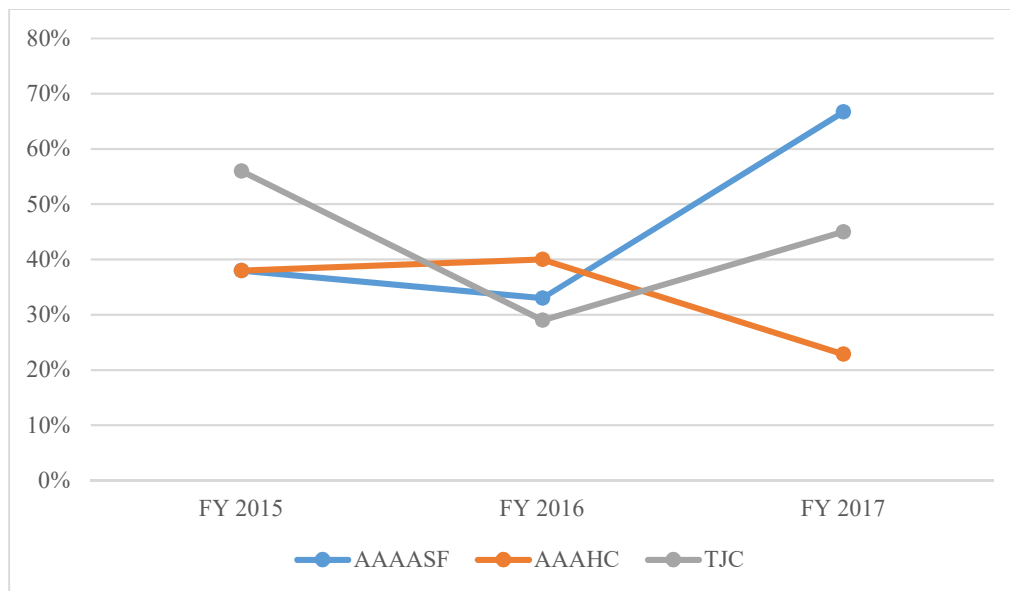
	AAAASF			AAAHC			AOA/HFAP**			TJC			Total
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015–2017
60-Day Validation Sample Surveys	8	6	6	42	35	35	1	0	0	18	34	31	216
SA Surveys with Condition-Level Deficiencies	3	2	4	17	15	12	*N/A	*N/A	*N/A	10	11	17	91
AO Surveys with Missed Comparable Deficiencies	3	2	4	16	14	8	*N/A	*N/A	*N/A	10	10	14	81
Overall Disparity Rate	38%	33%	67%	38%	40%	23%	*N/A	*N/A	*N/A	56%	29%	45%	38%
Health and Safety Disparity Rate	38%	17%	50%	29%	26%	11%	*N/A	*N/A	*N/A	44%	24%	35%	27%
Physical Environment Disparity Rate	13%	33%	33%	19%	17%	14%	*N/A	*N/A	*N/A	17%	18%	26%	19%
Sampling Fraction	.09	.06	.08	.11	.10	.10	*N/A	*N/A	*N/A	.08	.15	.13	.10

*N/A: When a minimum sample size of five is not achieved for an AO, no data is reported given the lack of statistical significance.

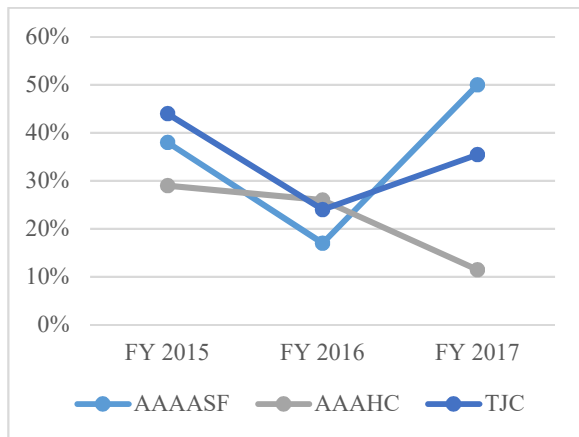
**Very few AOA/HFAP ASC validation survey selections have been made since FY 2012 due to the low numbers of deemed ASCs.

Note: IMQ ASC accreditation program received initial CMS approval April 2016. No IMQ selections in FY 2017.
 Graph 22

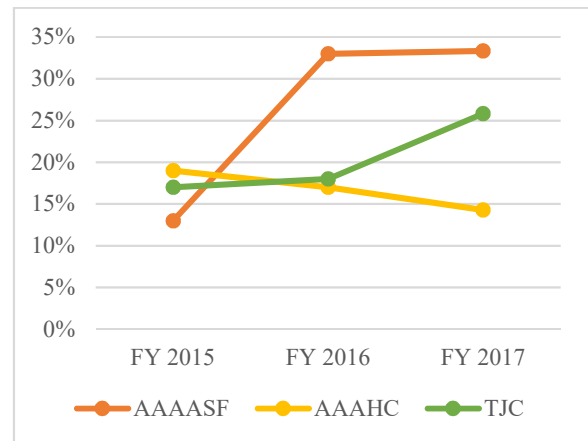
ASC 60-Day Validation Survey
Overall Disparity Rate Results by AO
FYs 2015–2017



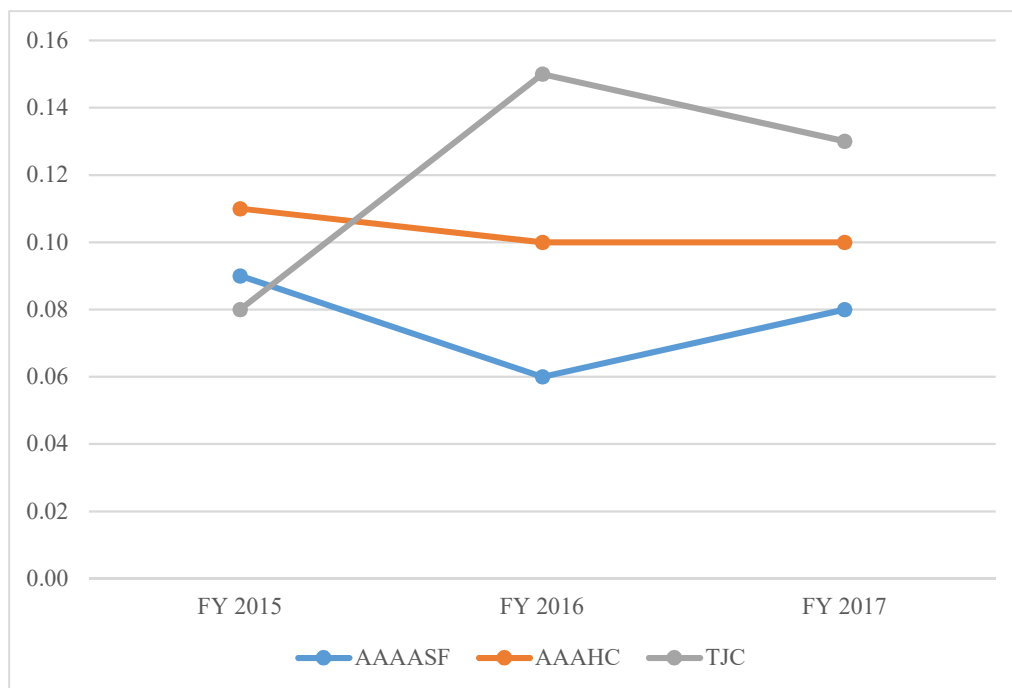
Graph 23
ASC 60-Day Validation Survey Health and Safety Disparity Rate Results by AO
FYs 2015-2017



Graph 24
ASC 60-Day Validation Survey PE Disparity Rate Results by AO
FYs 2015-2017



Graph 25
ASC 60-Day Validation Survey Sampling Fraction Results by AO
FYs 2015-2017



- AAAASF:** In FY 2017, the overall disparity rate was 67 percent based on the completion of six validation surveys. The number of validation surveys completed represents an 8-percent sample of the surveys performed by AAAASF. The FY 2017 overall disparity rate is 29 percentage points higher than the overall disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on a 9-percent sample of the surveys conducted during that period. In FY 2017, AAAASF’s health and safety disparity rate was 17 percentage points higher than the PE disparity rate. The primary driver for the health and safety disparity rate was Infection control. The SA cited the Infection

Control requirement at the condition level four times. AAAASF missed three comparable deficiencies resulting in a disparity rate of 50 percent. The FY 2017 health and safety disparity rate is 12 percentage points higher than the FY 2015 health and safety disparity rate.

- **AAAHC:** In FY 2017, the overall disparity rate was 23 percent based on the completion of 35 validation surveys. The number of validation surveys completed represents a 10-percent sample of the surveys performed by AAAHC. The FY 2017 overall disparity rate is 15 percentage points lower than the overall disparity rate for FY 2015. The overall disparity rate for FY 2015 was based on an 11-percent sample of the surveys conducted during that period. In FY 2017, AAAHC's PE disparity rate was 3 percentage points higher than the health and safety disparity rate. The SA cited the PE requirement at the condition level 11 times. AAAHC missed five comparable deficiencies resulting in a disparity rate of 14 percent. The FY 2017 PE disparity rate is 5 percentage points lower than the FY 2015 PE disparity rate.
- **AOA/HFAP:** Due to the consistently low number of deemed AOA/HFAP ASCs, no validation surveys were conducted in FY 2017. Therefore, no additional data is reported.
- **TJC:** In FY 2017, the overall disparity rate was 45 percent based on the completion of 31 validation surveys. The number of validation surveys completed represents a 13-percent sample of the surveys performed by TJC. The FY 2017 overall disparity rate is 11 percentage points lower than the overall disparity rate for FY 2015. The disparity rate for FY 2015 was based on an 8-percent sample of surveys conducted during that period. In FY 2017, TJC's health and safety disparity rate was 9 percentage points higher than the PE disparity rate. The primary driver of TJC's health and safety disparity rate was Governing Body and Management. The SA cited the Governing Body and Management requirement at the condition level 15 times. TJC missed eight comparable deficiencies resulting in a disparity rate of 26 percent. The FY 2017 health and safety disparity rate is 9 percentage points lower than the FY 2015 health and safety disparity rate.

Validation Performance Results: Physical Environment vs. Other Health Conditions Cited

Examining the specific condition-level deficiencies cited by the SAs across all 60-day validation surveys provides an indication of the types of quality problems that exist in these facility types as well as the relationship between SA and AO citations for specific conditions. CMS uses two approaches for this analysis: (1) a review of the types of condition-level citations identified by SAs and the comparable AO deficiency findings; and (2) a comparison of the number of surveys with PE condition-level deficiencies and the number of surveys with other types of condition-level deficiencies. Both approaches highlight the same conclusion: SAs identify more PE condition-level deficiencies than any other type of deficiency on validation surveys; and AOs miss a significant number of these PE deficiencies. These findings are consistent with validation analysis results until FY 2014. In FYs 2014–2016, the SAs identified more health and safety condition-level deficiencies than PE condition-level deficiencies in psychiatric hospitals. In FY 2015, the same is true for ASCs.

Comparison of State Agency and Accrediting Organization Condition-Level Citation Findings

The first analysis yields the number of facilities cited by SAs for specific condition-level deficiencies and the number of surveys where the AOs missed citing comparable deficiencies. These results are discussed below by each specific facility type. (See Tables 16-21 and Graphs 27-34.)

Table 16
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
Hospitals
FY 2017

Medicare Conditions* Sample Size - 95	Cited by SA	Missed by AO
Governing Body	24	13
Patient Rights	7	5
Quality Assurance Performance Improvement (QAPI)	12	9
Nursing Services	4	4
Medical Record Services	3	2
Pharmaceutical Services	4	3
Radiologic Services	1	1
Laboratory Services	1	1
Food and Dietetic Services	7	5
Physical Environment*	55	29
Infection Control	24	11
Organ, Tissue, and Eye Procurement	1	1
Surgical Services	5	3
Emergency Services	1	1
TOTAL	149	88

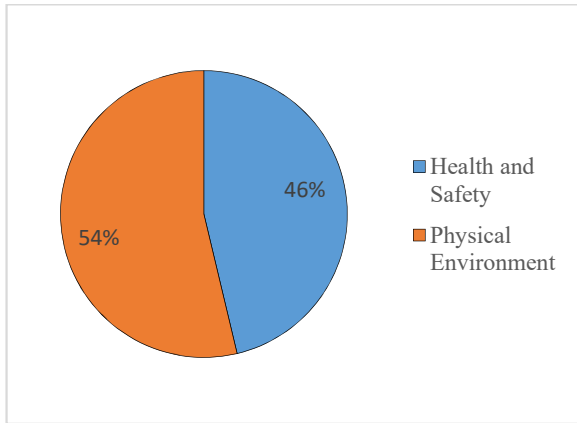
*Most frequently cited deficiency.

Note: The PE CoP includes the National Fire Protection Association (NFPA) 2012 edition of the LSC requirements that CMS has adopted as part of its health and safety standards.

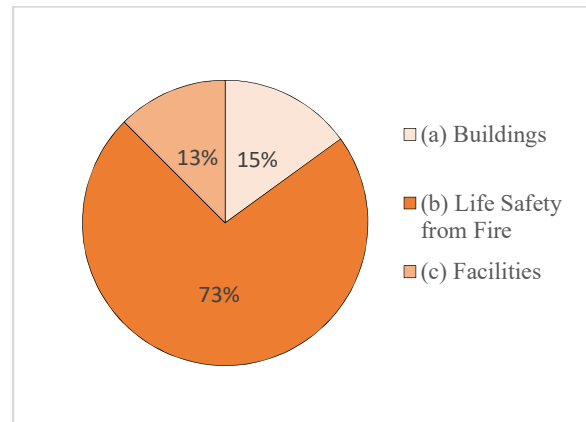
In FY 2017, the hospital sample consisted of 95 validation surveys. In this sample, the SAs cited condition-level deficiencies in 47 facilities. The PE CoP was the primary driver of the hospital disparity rate. The SAs cited PE at the condition level 55 times. The AOs missed 29 comparable deficiencies for PE. The findings were similar in FYs 2012–2016.

In FY 2017, the next most frequently SA-cited conditions were as follows: Infection Control and Governing Body were cited 24 times by the SAs at the condition level, and missed 11 and 13 times respectively by the AOs; and QAPI, cited at the condition level 12 times by the SAs, and missed nine times by the AOs.

Graph 26
Percentage of Health and Safety vs PE
Condition-Level Deficiencies Cited on 60-Day
Validation Surveys
Hospitals
FYs 2015–2017



Graph 27
Percentage of PE Standards Cited on 60-Day
Validation Surveys
Hospitals
FYs 2015–2017



From FY 2015 to FY 2017, there were 139 validation surveys cited with condition-level deficiencies for hospitals. Of the 139 surveys, 75 of the surveys had health and safety citations, 87 of the surveys had PE citations and 23 of the surveys were cited with both. For hospitals, the PE condition consists of three standards: (a) Buildings, (b) Life Safety from Fire, and (c) Facilities. There were 120 standards cited for the PE condition and 87 of these standards were related to Life Safety from Fire.

Table 17
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
Psychiatric Hospitals
FY 2017

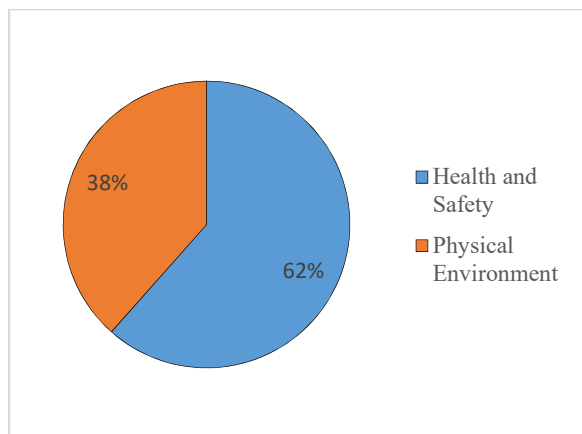
Medicare Conditions Sample Size – 21	Cited by SA	Missed by AO
Governing Body	11	6
Patient Rights	1	0
QAPI	4	4
Medical Staff	1	0
Nursing Services	5	3
Medical Record Services	1	0
Food and Dietetic Services	2	2
Utilization Review	1	1
Physical Environment*	18	9
Infection Control	4	4
Organ, Tissue, and Eye Procurement	1	1
Special Provisions Applying to Psychiatric Hospitals	1	1
Special Medical Record Requirements for Psychiatric Hospitals	7	2
Special Staff Requirements for Psychiatric Hospitals	4	3
TOTAL	61	36

*Most frequently cited deficiency

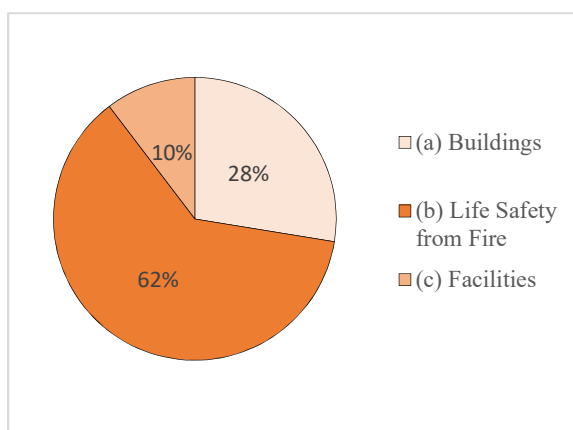
In FY 2017, the psychiatric hospital sample consisted of 21 validation surveys. In this sample, the SAs cited 14 facilities at the condition level. Physical Environment for psychiatric hospitals was the primary driver of the disparity rate. The SAs cited this requirement at the condition level 18 times. The AO missed nine comparable deficiencies. In FY 2016, Special Medical Record Requirements for psychiatric hospitals was the primary driver of the disparity rate.

In FY 2017, the next most frequently SA-cited conditions for psychiatric hospitals were as follows: Governing Body, cited 11 times by the SAs, and missed six times by the AOs; and Special Medical Record Requirements for psychiatric hospitals, cited seven times by the SAs, and missed two times by the AOs.

Graph 28
Percentage of Health and Safety vs PE
Condition-Level Deficiencies Cited on 60-
Day Validation Surveys
Psychiatric Hospitals
FYs 2015–2017



Graph 29
Percentage of PE Standards Cited on 60-
Day
Validation Surveys
Psychiatric Hospitals
FYs 2015–2017



From FY 2015 to FY 2017, there were 38 validation surveys cited with condition-level deficiencies for psychiatric hospitals. Of the 38 surveys, 32 of the surveys had health and safety citations, 20 of the surveys had PE citations, and 14 of the surveys were cited with both. For psychiatric hospitals, the PE condition consists of three standards: (a) Buildings, (b) Life Safety from Fire, and (c) Facilities. Twenty-nine standards were cited for the PE condition and 18 of these standards were related to Life Safety from Fire.

Table 18
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
CAHs
FY 2017

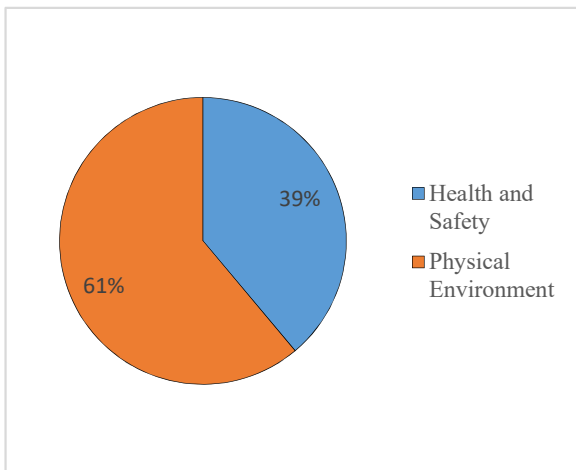
Medicare Conditions Sample Size – 32	Cited by SA	Missed by AO
Physical Plant and Environment*	19	9
Organizational Structure	1	1
Provision of Services	4	3
Surgical Services	1	1
Periodic Evaluation and Quality Assurance (QA) Review	1	1
TOTAL	26	15

*Most frequently cited deficiency

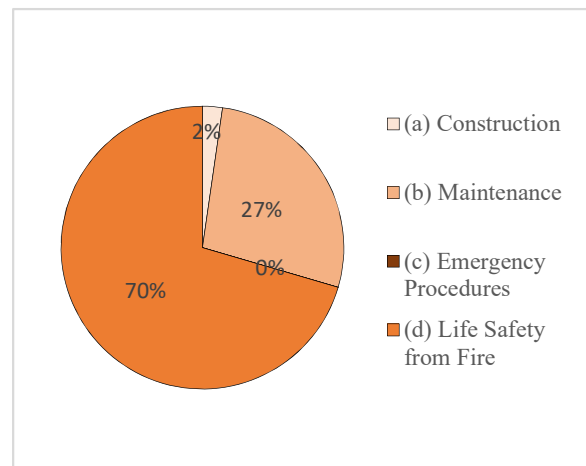
In FY 2017, the CAH sample consisted of 32 validation surveys. In this sample, 12 facilities were cited at the condition level by the SAs. Physical Plant and Environment was the primary driver of the disparity rate. The SAs cited this requirement at the condition level 19 times. The AOs missed nine comparable deficiencies for PE, which was also the most frequently cited condition in FYs 2012–2015.

In FY 2017, the next most frequently SA-cited condition for CAHs was Provision of Services, cited four times by the SAs, and missed three times by the AOs.

Graph 30
Percentage of Health and Safety vs PE
Condition-Level Deficiencies Cited on 60-Day
Validation Surveys
CAHs
FYs 2015–2017



Graph 31
Percentage of PE Standards Cited on
60-Day Validation Surveys
CAHs
FYs 2015–2017



From FY 2015 to FY 2017, there were 43 validation surveys cited with condition-level deficiencies for CAHs. Of the 43 surveys, 21 of the surveys had health and safety citations, 33 of the surveys had PE citations, and 11 of the surveys were cited with both. For CAHs, the PE condition consists of four standards: (a) Construction, (b) Maintenance, (c) Emergency Procedures, and (d) Life Safety from Fire. Forty-four standards were cited for the PE condition and 31 of these standards were related to Life Safety from Fire.

Table 19
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
HHAs
FY 2017

Medicare Conditions Sample Size – 106	Cited by SA	Missed by AO
Patient Rights	1	1
Compliance with Federal, State, Local Laws	1	1
Organization, Services, and Administration	1	0
Acceptance of Patients, Plan of Care & Medical Supervision	8	5
Skilled Nursing Services*	14	9
Therapy Services	1	1
Home Health Aide Services	5	2
Clinical Records	3	2
Evaluation of the Agency's Program	2	1
Comprehensive Assessment of Patients	1	1
TOTAL	37	23

*Most frequently cited deficiency

In FY 2017, the HHA sample consisted of 106 validation surveys. In this sample, the SAs cited condition-level deficiencies in 16 agencies. Skilled Nursing Services was the primary driver of the HHA disparity rate. The SAs cited the Skilled Nursing Services requirement at the condition level 14 times. The AOs missed nine comparable deficiencies. Acceptance of Patients, Plan of Care & Medical Supervision was the primary driver of the HHA disparity rate in FY 2016.

In FY 2017, the next most frequently SA-cited condition was Acceptance of Patients, Plan of Care & Medical Supervision, cited eight times by the SAs at the condition level, and missed five times by the AOs.

Table 20
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
Hospices
FY 2017

Medicare Conditions Sample Size – 34	Cited by SA	Missed by AO
Organizational Environment	1	1
Short-Term Inpatient Care	1	1
Residents of SNF/NF or ICF/MR	2	1
Federal, State, Local Laws & Regulations	1	1
Initial & Comprehensive Assessment of Patient	2	2
Interdisciplinary Group (IDG), Care Planning, Coordination of Services*	3	2
Quality Assessment & Performance Improvement	2	2
Infection Control	1	1
Hospice Aide and Homemaker Services	1	0
TOTAL	14	11

*Most frequently cited deficiency

In FY 2017, the Hospice sample consisted of 34 validation surveys. In this sample, the SAs cited condition-level deficiencies in four agencies. The primary driver of the hospice disparity rate was the IDG, Care Planning, Coordination of Services condition. The SAs cited IDG, Care Planning, Coordination of Services at the condition level three times. The AOs missed two comparable deficiencies. In FY 2016, the Quality Assessment & Performance Improvement condition was the primary driver of the hospice disparity rate.

In FY 2017, the next most frequently SA-cited conditions were as follows: Residents of SNF/NF or ICF/MR was cited two times by the SAs at the condition level, and missed one time by the AOs; and Initial & Comprehensive Assessment of Patient, and Quality Assessment & Performance Improvement were cited two times by the SAs at the condition level, and missed two times by the AOs.

Table 21
Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys
ASCs
FY 2017

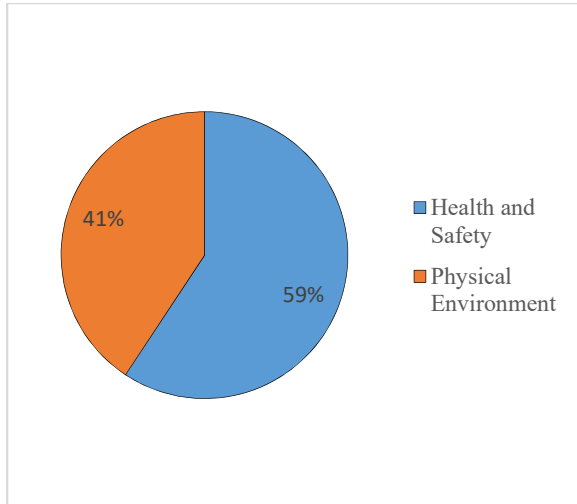
Medicare Conditions Sample Size – 72	Cited by SA	Missed by AO
Governing Body and Management	22	13
Surgical Services	6	5
Quality Assessment & Performance Improvement	11	7
Physical Environment*	31	15
Medical Staff	5	3
Nursing Services	4	4
Medical Records	1	1
Pharmaceutical Services	7	3
Laboratory and Radiologic Services	1	0
Infection Control	18	10
Patient Admission, Assessment and Discharge	1	0
TOTAL	107	61

*Most frequently cited deficiency

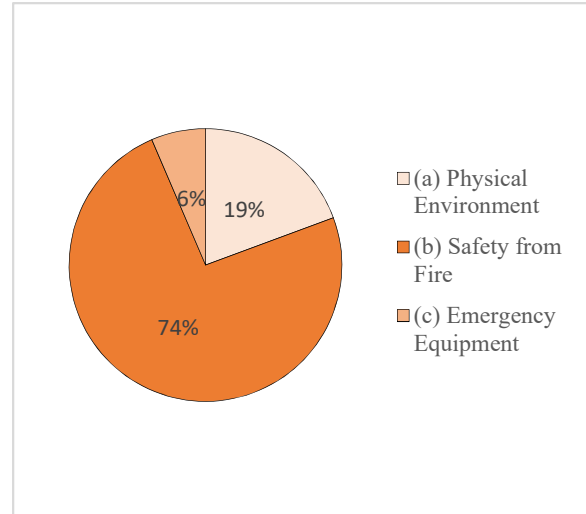
In FY 2017, the ASC sample consisted of 72 validation surveys. In this sample, the SAs cited condition-level deficiencies in 33 facilities. The primary driver of the disparity rate was the PE CoP. The SAs cited PE at the condition level 31 times. The AOs missed 15 comparable deficiencies for PE, which was also the most frequently cited condition in FY 2016.

In FY 2017, the next most frequently SA-cited conditions were as follows: Governing Body and Management was cited 22 times by the SAs at the condition level, and missed 13 times by the AOs; Infection Control, cited 18 times by the SAs at the condition level, and missed 10 times by the AOs; and Quality Assessment & Performance Improvement, cited 11 times by the SAs, and missed seven times by the AOs.

Graph 32
Percentage of Health and Safety vs PE
Condition-Level Deficiencies Cited on 60-
Day Validation Surveys
ASCs
FYs 2015–2017



Graph 33
Percentage of PE Standards Cited on
60-Day
Validation Surveys
ASCs
FYs 2015–2017



From FY 2015 to FY 2017, there were 92 validation surveys cited with condition-level deficiencies for ASCs. Of the 92 surveys, 67 of the surveys had health and safety citations, 46 of the surveys had PE citations, and 21 of the surveys were cited with both. For ASCs, the PE condition consists of three standards: (a) PE, (b) Safety from Fire, and (c) Emergency equipment. Sixty-two standards were cited for the PE condition and 46 of these standards were related to Safety from Fire.

Comparison of Deficiencies for Physical Environment and Other Health Conditions

The second analysis compares the validation results for condition-level deficiencies for PE conditions with the results for condition-level deficiencies for all other conditions. It also yields two disparity rates for each type of facility and AO. (See Tables 22-23 and Graph 35.)

Table 22
Number of 60-Day Validation Surveys for
Facility Types with LSC Requirements
FY 2017

Validation Survey Analysis	Hospital*	Psych Hospital	CAH	ASC
60-Day Validation Sample Surveys	95	21	32	72

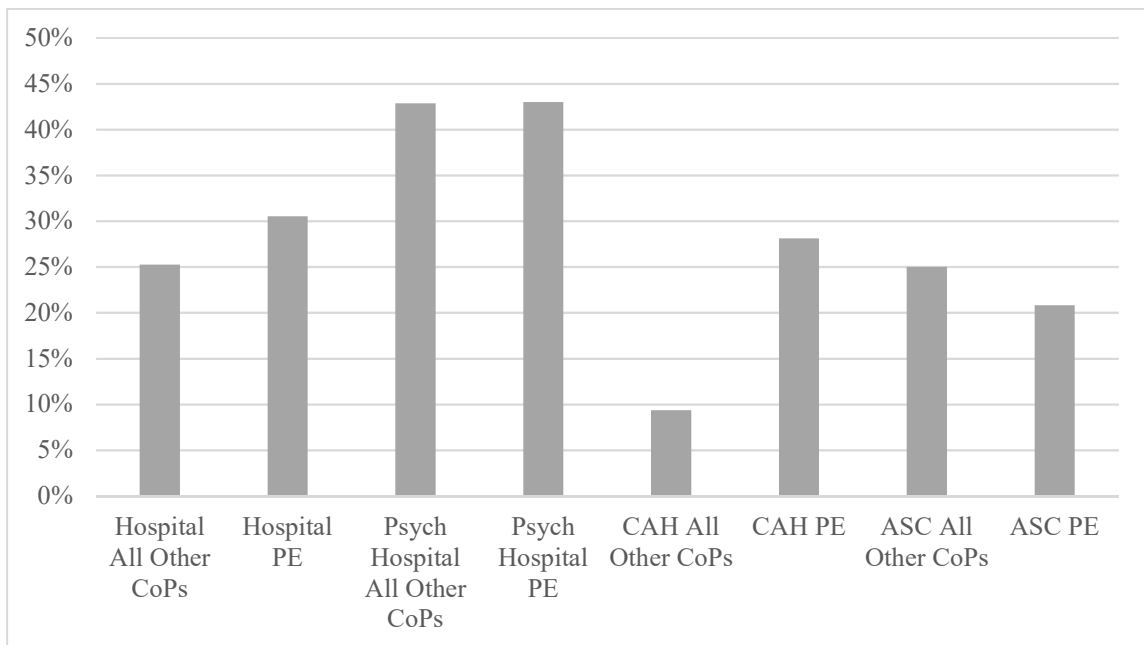
*Acute Care and LTCHs

Table 23
60-Day Validation Survey Results
Comparison between All Other CoPs Cited and PE for Facility Types with LSC Requirements
FY 2017

	Hospital All Other CoPs	Hospital PE	Psych Hospital All Other CoPs	Psych Hospital PE	CAH All Other CoPs	CAH PE	ASC All Other CoPs	ASC PE
SA Surveys with Condition-Level Deficiencies	28	29	10	10	3	10	24	17
AO Surveys with Missed Comparable Deficiencies	24	29	9	9	3	9	18	15
Disparity Rate	25%	31%	43%	43%	9%	28%	25%	21%

In FY 2017, the PE CoP had a significant impact on the overall disparity rate for both hospitals and psychiatric hospitals. The disparity rate based on the PE condition for hospitals is only 6 percentage points higher than the disparity rate based on other health and safety conditions. However, the FY 2017 results show that the PE condition, as well as the health and safety condition, significantly impacted the disparity rates for psychiatric hospitals. The PE disparity rate for ASCs was 4 percentage points lower than the disparity rate for other health and safety conditions compared to 5 percentage points in FY 2016. In FY 2017, the PE disparity rate for CAHs was 19 percentage points higher than the disparity rate for other health and safety conditions. In FY 2016, the PE disparity rate for CAHs was 14 percentage points higher than the disparity rate for other health and safety conditions. (See Graph 35.)

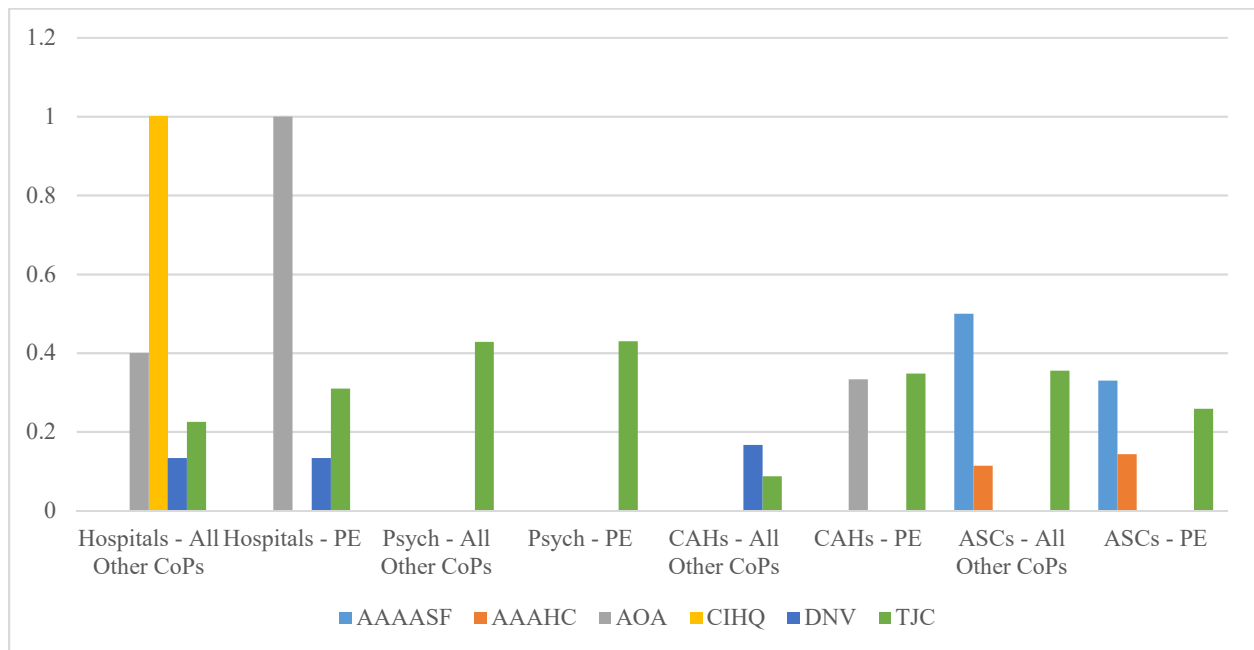
Graph 34
60-Day Validation Survey Disparity Rate Results
Comparison between All Other CoPs Cited and PE for Facility Types with LSC Requirements
FY 2017



The majority of the PE disparity rates consists of LSC deficiencies. CMS generates a report which identifies the top disparate LSC deficiencies as determined by the validation analysis. This report is provided annually to the AOs. These top LSC disparate deficiencies are consistent with deficiencies cited in FYs 2009 through 2017. This report is intended to provide the AOs with an understanding of the emphasis of CMS LSC surveys, which will allow the AOs to ensure their programs are appropriately surveying the same LSC provisions. An emphasis on the top disparate LSC deficiencies should assist the AOs in their efforts to reduce LSC disparities.

The AOs have had difficulty identifying deficiencies that SAs have cited related to the requirements in the 2000 edition of the LSC, which CMS adopted by regulation. CMS has been working with all AOs to provide guidance on the source of this problem, and possible ways to improve performance and reduce their PE disparity rate. CMS has continued to discuss with the AOs their concerns as well as their performance in the area of evaluating health care facility safety from fire. CMS has engaged in rulemaking to update the Federal regulations to the 2012 edition of the LSC. While CMS does not believe that the difference in LSC editions accounts for AOs' problems in identifying LSC deficiencies, this is an issue that AOs and the healthcare industry have raised and could affect the survey process. (See Graph 36.)

Graph 35
60-Day Validation Survey Results
Comparison between All Other CoPs Cited and PE for Facility Types with LSC Requirements
by AO
FY 2017



Comparison of Deficiencies and Disparity Rates for Long-Term Care Hospitals and All Other Hospital Subtypes¹¹

In 2010, CMS became concerned about the quality of care provided in LTCHs based on available SA survey findings. In the 2011 report to Congress, CMS reported on the analysis of mid-cycle validation surveys for 33 LTCHs. The Government Accountability Office (GAO) recommended in a September 2011 report that CMS strengthen oversight of LTCHs by, among other things, increasing the number of LTCH representative validation surveys and calculating a separate disparity rate for them.¹² (See Tables 24-26 and Graphs 37-41.) CMS attempted to increase the LTCH sample size for 60-day representative sample surveys. However, due to the scheduling of LTCH Medicare accreditation surveys by the AOs and the concentration of LTCHs in certain states, the ability of CMS to increase the sample size is limited. The need to mobilize a State survey team within 60 days of AO surveys that are not entirely predictable is the main limiting factor, as the fixed surveyor capacity of SAs makes it impractical for SAs in those states to conduct a larger number of validation surveys. In FY 2017, the total number of Medicare-participating LTCHs was 325 and the total number of Medicare-participating hospitals minus the LTCHs was 3,884.

Table 24
Number of 60-Day Validation Surveys and Overall Disparity Rate
LTCHs and All Other Hospital Subtypes
FYs 2015–2017

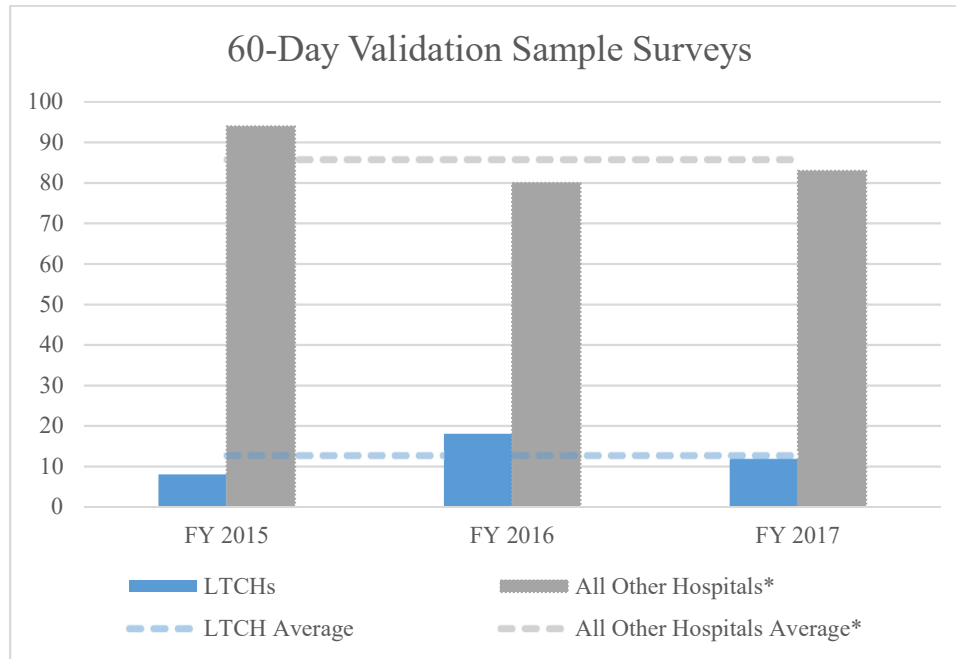
	LTCHs			All Other Hospitals*			Average LTCHs	Average All Other Hospitals*
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FYs 2015–2017	FYs 2015–2017
60-Day Validation Sample Surveys	8	18	12	94	80	83	12.67	85.67
Overall Disparity Rate	63%	39%	75%	37%	48%	41%	59%	42%

*All Other Hospital Subtypes are specific to acute care hospitals and do not include psychiatric hospitals.

¹¹ LTCHs differ from other acute care hospitals in that they furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, who need hospital-level care for relatively extended periods. Other hospital subtypes are specific to acute care hospitals and do not include psychiatric hospitals.

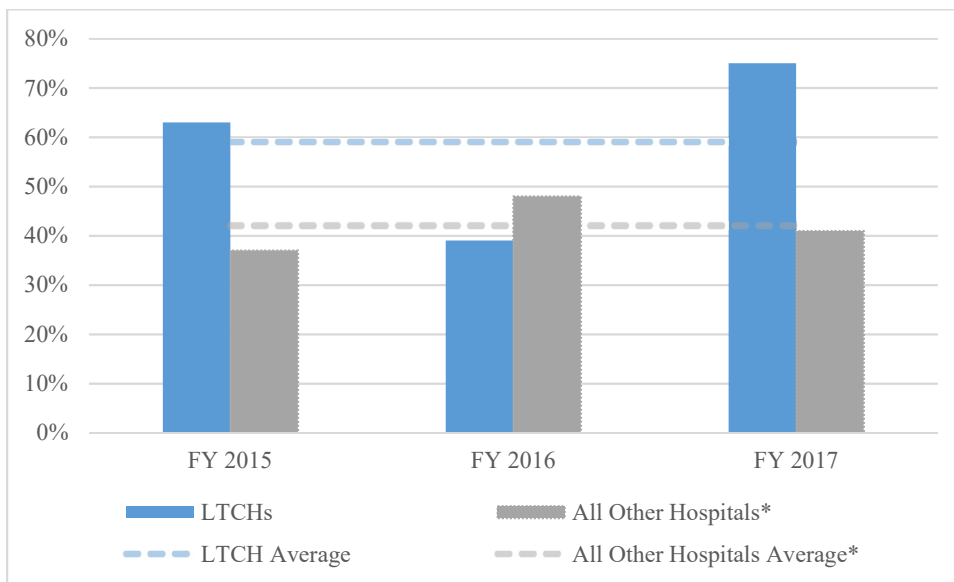
¹² “Long-Term Care Hospitals: CMS Oversight is Limited and Should be Strengthened,” GAO, GAO-11-810, September 2011.

Graph 36
Number of 60-Day Validation Surveys and Averages
LTCHs and All Other Hospital Subtypes
FYs 2015–2017



*All Other hospital subtypes are specific to acute care hospitals and do not include psychiatric hospitals. Total number of Medicare-participating LTCHs is 325 and the total number of Medicare-participating hospitals minus the LTCHs is 3,884.

Graph 37
Overall Disparity Rates and Averages
LTCHs and All Other Hospital Subtypes
FYs 2015–2017



*All Other hospital subtypes are specific to acute care hospitals and do not include psychiatric hospitals. Total number of Medicare-participating LTCHs is 325 and the total number of Medicare-participating hospitals minus the LTCHs is 3,884.

Table 25
Comparison of 60-Day Health and PE Validation Survey Results for LTCHs and
All Other Hospital Subtypes
FYs 2015–2017

Validation Survey Analysis	LTCHs - All Other Conditions			LTCHs PE			All Other Hospitals - All Other Conditions			All Other Hospitals PE		
	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017	FY 2015	FY 2016	FY 2017
SA Surveys with Condition-Level Deficiencies	3	6	8	3	1	3	22	22	20	24	30	26
AO Surveys with Missed Comparable Deficiencies	2	6	8	3	1	3	14	18	16	24	28	26
Disparity Rate	25%	33%	67%	38%	6%	25%	15%	23%	19%	26%	35%	31%

Graph 38
Comparison of 60-Day Health and PE Validation Survey Disparity Rate Results for LTCHs and All
Other Hospital Subtypes
FYs 2015–2017

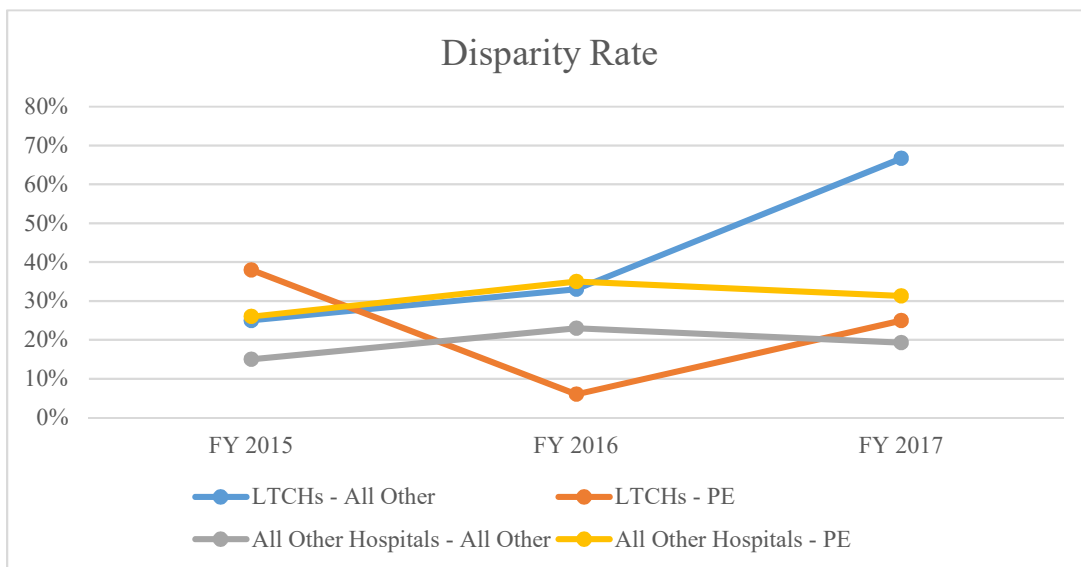
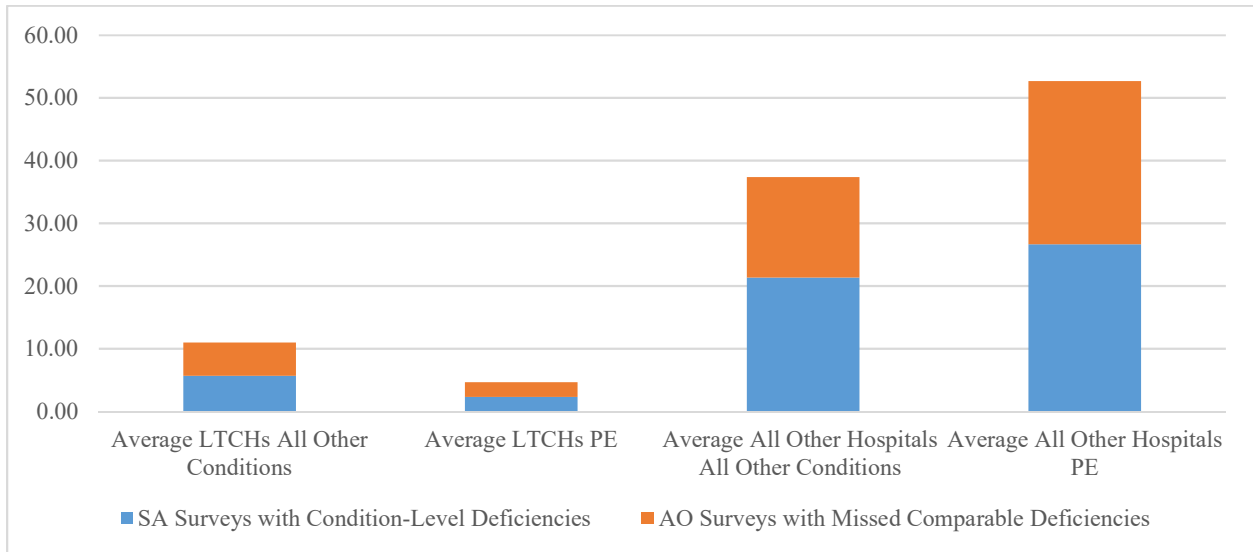


Table 26
Comparison of Averages
60-Day Health and PE Validation Survey Results for LTCHs and
All Other Hospital Subtypes
FYs 2015–2017

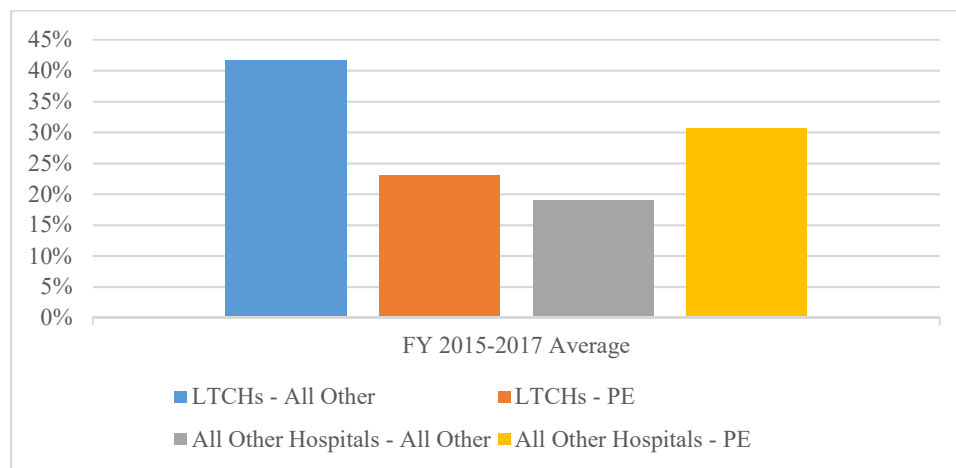
	FYs 2015–2017 Average LTCHs All Other Conditions	FYs 2015–2017 Average LTCHs PE	FYs 2015–2017 Average All Other Hospitals All Other Conditions	FYs 2015–2017 Average All Other Hospitals PE
SA Surveys with Condition-Level Deficiencies	5.67	2.33	21.33	26.67
AO Surveys with Missed Comparable Deficiencies	5.33	2.33	16.00	26.00
Disparity Rate	42%	23%	19%	31%

*All Other Hospital Subtypes are specific to acute care hospitals and do not include psychiatric hospitals.

Graph 39
Comparison of Averages
60-Day Health and PE Validation Survey Results for LTCHs and
All Other Hospital Subtypes
FYs 2015–2017



Graph 40
Comparison of Averages
60-Day Health and PE Validation Survey Disparity Rate Results for LTCHs and
All Other Hospital Subtypes
FYs 2015-2017



From FYs 2015–2017, there is a 19-percent difference between the overall average disparity rates in LTCHs’ PE and other condition-level deficiencies, and a 12-percent difference in all other hospitals’ PE and other condition-level deficiencies. When comparing the drivers of the average disparity rates, PE is the primary driver in all other hospital subtypes. In FY 2017, the PE disparate condition-level deficiencies comprised 25 percent of the disparity rate while Governing Body became the primary driver for the LTCHs disparity rate which was 33 percent. For all other hospital subtypes, PE is still the primary driver (31 percent) of the disparity rate in FY 2017 with Governing Body and Infection Control conditions comprising 11 percent and 10 percent of the disparity rate respectively.

In FY 2017, the most frequent disparate condition-level deficiencies for all other hospital subtypes and LTCHs were PE, Governing Body and Infection Control conditions.

Addressing Disparity Rates

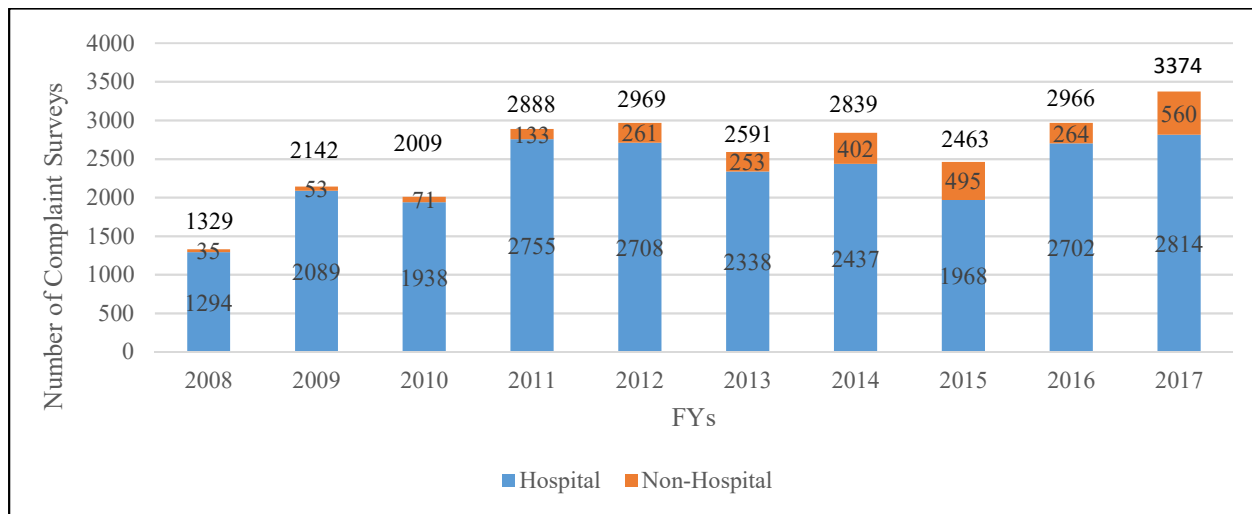
CMS has historically provided AOs with disparity rate analyses and opportunities for discussion on disparity rates across all CMS-approved accreditation programs. While CMS continues to utilize this strategy as an attempt to effect a positive change in disparity rates, CMS has determined that additional interventions are required. Due to the virtual stagnation of disparity rates over the past several years particularly related to PE and LSC, CMS has implemented a number of additional strategies to address this issue. In March 2017, CMS implemented monthly AO Liaison calls during which a number of topics are discussed, including disparity rate findings and possible solutions, as well as overall AO performance in other areas as described in Section 3. CMS has also participated in AO surveyor training sessions, delivering analysis findings directly to the AO’s survey cadre. And finally, CMS is embarking upon a Validation Program process improvement project, where the entire Validation Program will be evaluated for effectiveness and comparability.

SECTION 5: Life Safety Code, Health & Safety Disparity Rates Analysis and Complaint Survey Citations

Background and Objectives

As discussed in Section 4 of this report, allegation “complaint” surveys and representative sample validation surveys are the two validation survey types that comprise the Accreditation Validation Program. When a complaint is received based on allegations of noncompliance with the Medicare CoPs and CfCs, CMS performs a complaint survey to investigate the allegations. If the Regional Office determines it to be appropriate, a full survey of all the CoPs and CfCs will be conducted. In FY 2017, CMS conducted a total of 3,374 complaint surveys. This total comprised 2,814 hospital surveys, and 560 non-hospital complaint surveys. The non-hospital complaint surveys were specific to CAHs, HHAs, Hospices and ASCs. (See Graph 42.)

Graph 42
Number of Complaint Surveys for Both Hospital and Non-Hospital Facilities
FYs 2008-2017



The recent history of complaint surveys is as follows:

- 2008: 1,294 hospital and 35 non-hospital surveys totaling 1,329 surveys
- 2009: 2,089 hospital and 53 non-hospital surveys totaling 2,142 surveys
- 2010: 1,938 hospital and 71 non-hospital surveys totaling 2,009
- 2011: 2,755 hospital surveys and 133 non-hospital surveys totaling 2,888 surveys
- 2012: 2,708 hospital and 261 non-hospital surveys totaling 2,969 surveys
- 2013: 2,338 hospital and 253 non-hospital surveys totaling 2,591 surveys
- 2014: 2,437 hospital and 402 non-hospital surveys totaling 2,839 surveys
- 2015: 1,968 hospital and 495 non-hospital surveys totaling 2,463 surveys
- 2016: 2,702 hospital and 264 non-hospital surveys totaling 2,966 surveys
- 2017: 2,814 hospital and 560 non-hospital surveys totaling 3,374 surveys

The results of the complaint surveys are stored in the ASPEN Complaints Tracking System (ACTS). CMS has been reviewing and analyzing the data stored in ACTS to provide an additional data source to validate the overall performance of the AOs. Graphs 45, 49, 53, 57, 60 and 63 highlight the top five condition-level deficiencies that were cited during complaint surveys on AO accredited facilities from FYs 2015-2017.

Note: The methodology, limitation and conclusion discussions that follow are specific to the 60-day representative sample validation surveys.

A validation survey is a survey completed at a deemed facility by an SA within 60 days of the end date of an AO survey at the same facility. The results of the AO and SA surveys are compared, and a disparity rate is calculated. The disparity rate is the number of AO surveys where the AO did not cite deficiencies that were comparable to serious (condition-level) deficiencies identified during the SA surveys. This number is then divided by the total number of 60-day validation surveys conducted by the SA.

Since FY 2000, disparity rates have consistently been above an acceptable level for most of the program types. The PE condition, specifically LSC requirements, has consistently been the largest driver of the disparity rate for those program types with LSC requirements. This points to limitations in the AO's ability to identify non-compliance with the Medicare CoPs and CfCs LSC requirements.

The objective of this health and safety and LSC analysis is to identify the top categories that are most significantly influencing the disparity rate, identify potential root causes, and present recommendations for minimizing the overall disparity rate.

Methodology

CMS compares the SA validation survey condition-level deficiency citations to the AO survey findings. Separate validation summary reports are then generated for the health and safety CoPs, and the PE conditions cited by the SAs. The health and safety summary report identifies each SA CoP finding and identifies the comparable and non-comparable AO deficiency citations. If the AO has comparable findings to all the identified SA findings, then the survey is determined to be a comparable survey. However, if the AO does not identify a comparable deficiency for all the SA cited deficiencies, the survey is determined to be a disparate survey.

The PE summary report is similar to the health and safety summary report, but the PE summary report identifies and compares LSC categories and PE CoP requirements. If the AO has comparable findings to the identified PE deficiencies and LSC Categories, then the survey is considered to be a comparable survey. If the AO does not identify the SA-identified PE condition and LSC Category deficiencies, then the survey is considered to be a disparate survey.

The data from the summary reports is collected and stored in a database for analysis. The database contains a record for each facility that identifies the AO, each separate condition and LSC category identified by the SA, and if the AO cited a comparable deficiency. Reports are generated from the analysis of this data to develop individual summaries for each program type and for each AO and the program types in which they survey. These summaries include the following: (1) the number of validation surveys in the sample; (2) the number of conditions cited by the SAs in the validation surveys; (3) the number of surveys that were not comparable; (4) the overall disparity rate; (5) each condition that was cited by the SA; (6) the number of facilities with the condition cited; (7) the number of matching surveys for each condition; (8) the number of disparate surveys for each condition; and (9) the individual condition disparity rate.

As mentioned in Section 4 of this report, the overall disparity rate is determined by dividing the number of disparate surveys by the total number of validation surveys in the sample. Each individual condition disparity rate is determined by dividing the number of disparate surveys with that individual condition, by the total number of validation surveys in the sample. The LSC Category Disparity rate is determined by dividing the number of LSC Categories that were missed by the AO, by the total number of LSC Categories that were cited by the SA.

Limitations

There are some factors outside the control of CMS that may influence the data and disparity rates resulting from the report calculations. The AO disparity rates are based on the number of validation surveys that have been performed for each AO and program type. The disparity rate is only one way to measure AO performance. In some instances, the validation sample size is too small to provide statistically valid data. For example, if only one validation survey was performed for a particular AO and program type and that validation survey was found to be disparate, the disparity rate would be 100 percent. In order to provide a statistically valid sample size, additional validation surveys are required for each AO and program type. There are a number of factors that play into the number of representative validation surveys that can be performed. While scheduling validation surveys, CMS must consider the number of deemed facilities by state, program type and AO, the number and type of facilities on the AO schedule, the overall targeted sample size by state and program type and AO, the need to spread the survey workload over a year, and ensuring that any one state is not overloaded for any given month. Newly approved AOs also pose a challenge when it comes to increasing the sample size. Additionally, CMS resource and budget constraints, as well as state resources, both budget and human resources, may prohibit the ability to perform a greater number of validation surveys for a statistically valid sample.

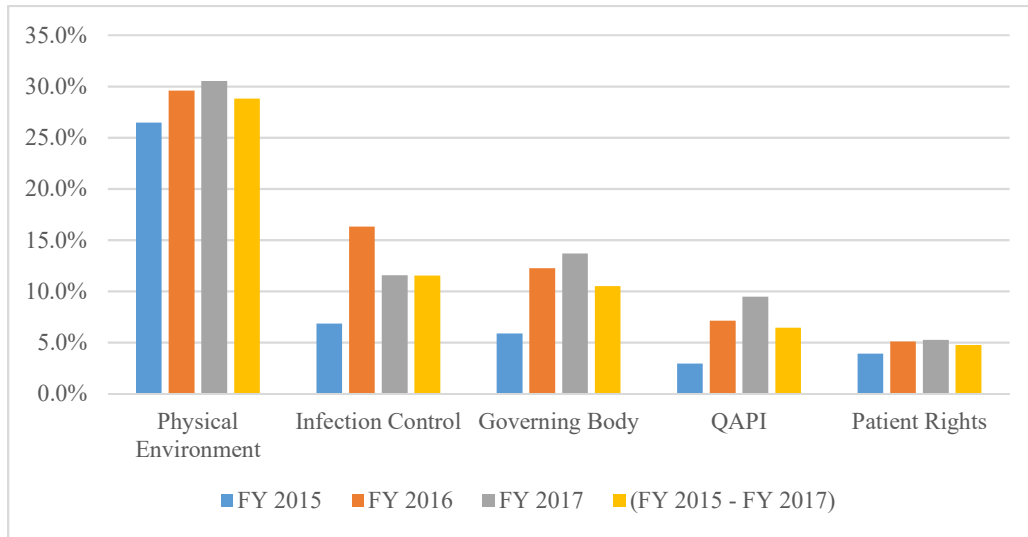
The SA performs their validation survey within 60 days of the AO survey which may have an effect on the disparate findings. During the 60-day gap between the AO and SA survey, some factors beyond CMS' control may have changed, making it difficult to provide an accurate comparison for the facility surveys.

Findings

The PE and Infection Control conditions are the top disparate citations for hospitals, psychiatric hospitals, ASCs, and CAHs. From FY 2015 through FY 2017, the PE condition was found to be in the top three disparate citations for all four of the program types and the Governing Body condition was one of the top five disparate citations for hospitals, psychiatric hospitals, and ASCs. The PE condition contains multiple standards; however, a large majority of the PE citations were comprised of the LSC standard within the condition. Within the LSC standard categories, Fire/Smoke Barrier, Hazardous Areas, Sprinklers, and Means of Egress were the top deficiency citations not cited by AOs, with the Fire/Smoke Barrier and Hazardous Areas noted in all four of the program's top five missed citations for FY 2015 through FY 2017. The other two LSC categories were found to be listed in the top five missed citations for at least three out of the four program types. The LSC category descriptions can be found in Appendix C. The graphs below discuss, by program type, the top disparate condition-level deficiencies, the top LSC disparity rates, and an overall depiction of the disparity rates for individual AOs. (See Graphs 43-64.)

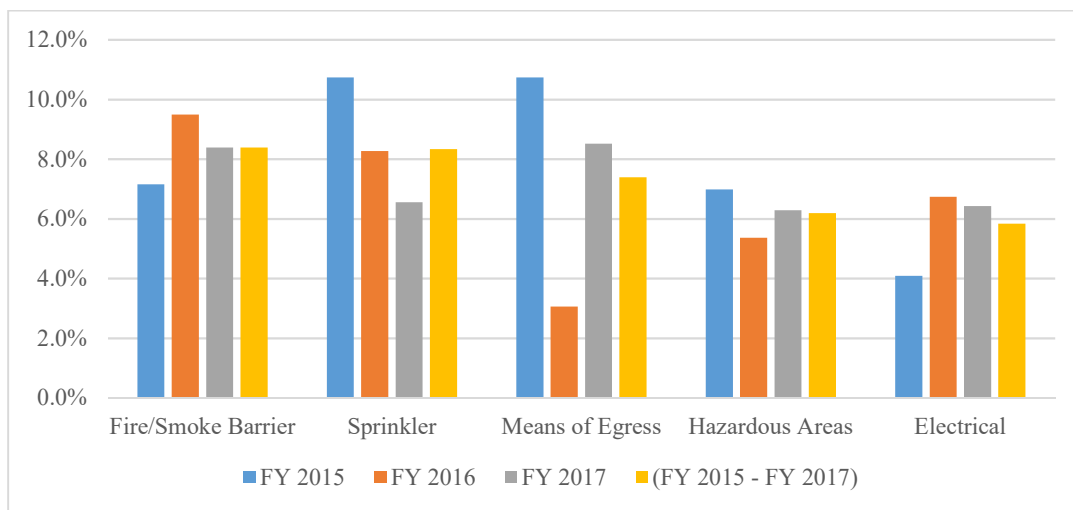
Hospital and Long-Term Care Hospital

Graph 43
Top Five Hospital and LTCH Disparity Rates
FYs 2015–2017



The hospital and LTCH samples consisted of 295 validation surveys in FY 2015 through FY 2017. PE was identified as the number one disparate CoP and primary driver of the disparity rate for all three years. There were 240 disparate findings from FY 2015 to FY 2017 and 85 of the disparate CoPs were related to Physical Environment which accounted for 35 percent of all the disparate findings. The top five disparate CoPs made up 76.3 percent of all hospital and LTCH disparate findings. The disparity rate for Infection Control decreased from 16.3 percent in FY 2016 to 11.6 percent in FY 2017, a reduction of 4.7 percent.

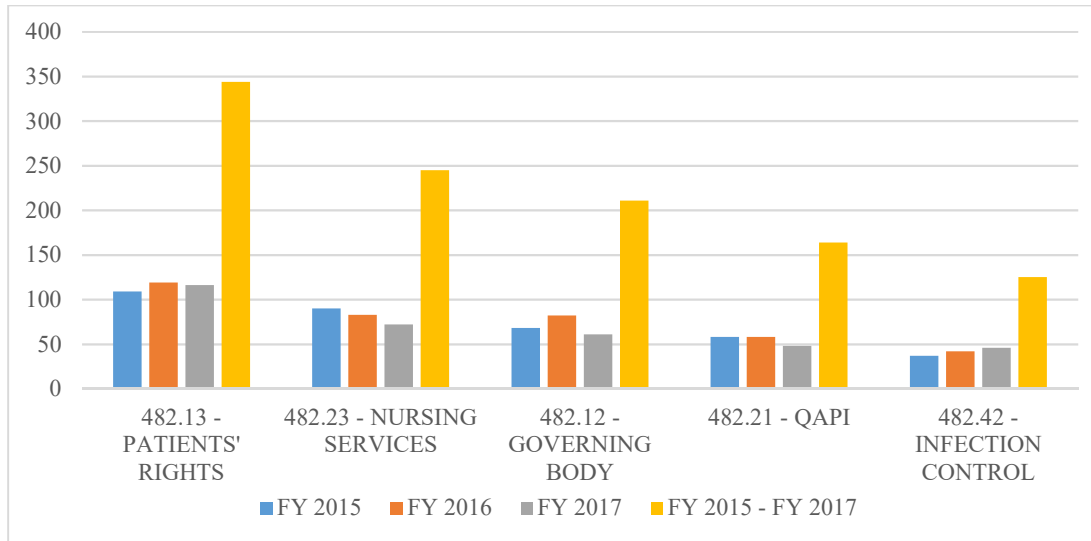
Graph 44
Top Five Hospital and LTCH
LSC Category Disparity Rates
FYs 2015–2017



Out of hospital and LTCH validation surveys, 2003 LSC category citations were cited by the SAs in FY 2015 through FY 2017. The Fire/Smoke Barrier citation disparity rate decreased from 9.5 percent in FY 2016 to 8.4 percent in FY 2017. The Sprinkler citation disparity rate decreased from 8.3 percent in FY 2016 to 6.6 percent in FY 2017.

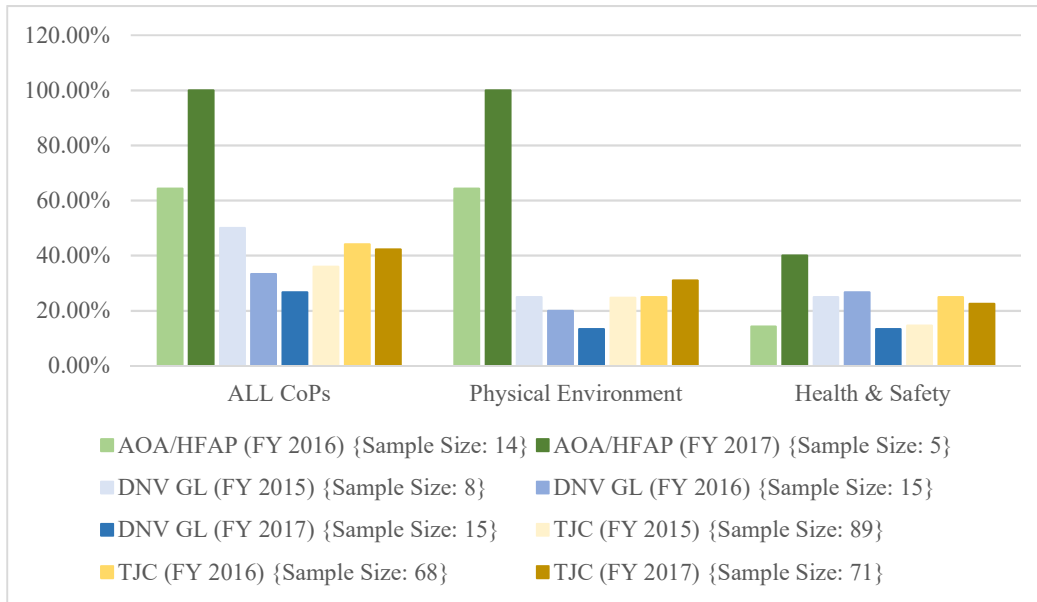
From FY 2015 to FY 2017, the top two most frequently cited LSC categories were Fire/Smoke Barrier, with 282 SA citations, and Sprinkler, with 298 SA citations. The AOs missed 168 comparable citations for Fire/Smoke Barrier (8.4-percent disparity rate) and 167 comparable citations for Sprinkler (8.3-percent disparity rate). From FY 2015 to FY 2017, a total of 724 missed LSC category citations comprised the top five disparate LSC categories, resulting in 65.9 percent missed LSC category citations for hospitals and LTCHs.

Graph 45
Top 5 Hospital and LTCH Condition-Level Deficiencies Cited
During Complaint Surveys
FYs 2015-2017



From FYs 2015 to 2017, there were a total of 1,470 condition-level deficiencies cited for AO accredited hospital and LTCH facilities during complaint surveys. During that time, the most frequently cited condition was Patient’s Rights, cited 344 times. The next most frequently cited condition was Nursing Services, cited 245 times. The number of Nursing Services citations steadily decreased from FY 2015 to FY 2017; however, the number of Infection Control citations slightly increased during that same time.

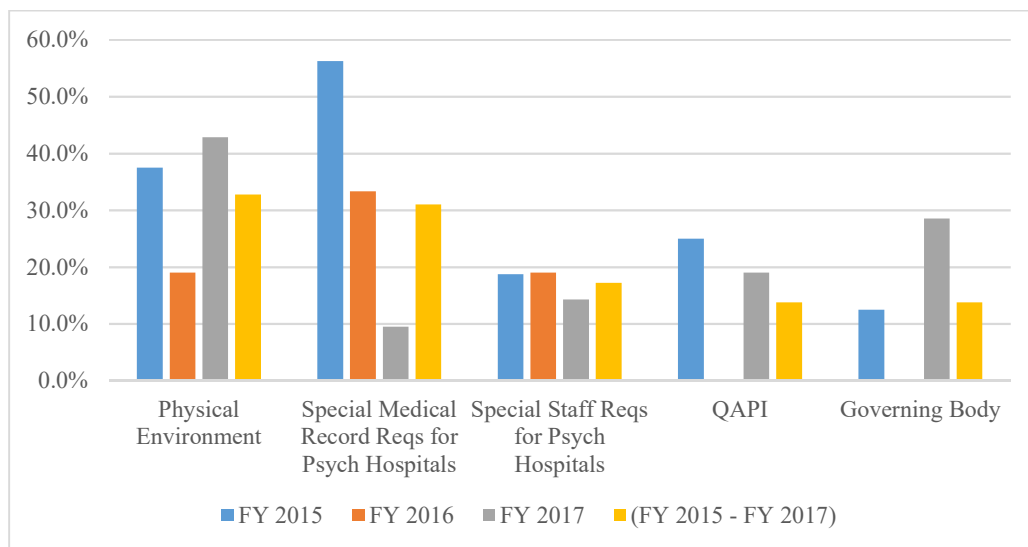
**Graph 46
Hospital and LTCH Disparity Rates by AO
FYs 2015–2017**



AOA/HFAP conducted 14 validation surveys in FY 2016 and 5 validation surveys in FY 2017. The overall disparity rate for AOA/HFAP increased from 64 percent in FY 2016 to 100 percent in FY 2017. In FY 2015, AOA/HFAP conducted 4 validation surveys. Due to the small sample size, the FY 2015 data isn't reflected in the graph. The overall disparity rate for DNV GL decreased from 50 percent in FY 2015 to 27 percent in FY 2017. The overall disparity rate for TJC increased from 36 percent in FY 2015 to 42 percent in FY 2017; however, the overall disparity rate for TJC decreased 2 percent from FY 2016 to FY 2017. CIHQ FYs 2015-2017 and AOA/HFAP FY 2015 aren't depicted in the graph due to the limited number of validation surveys performed by these AOs.

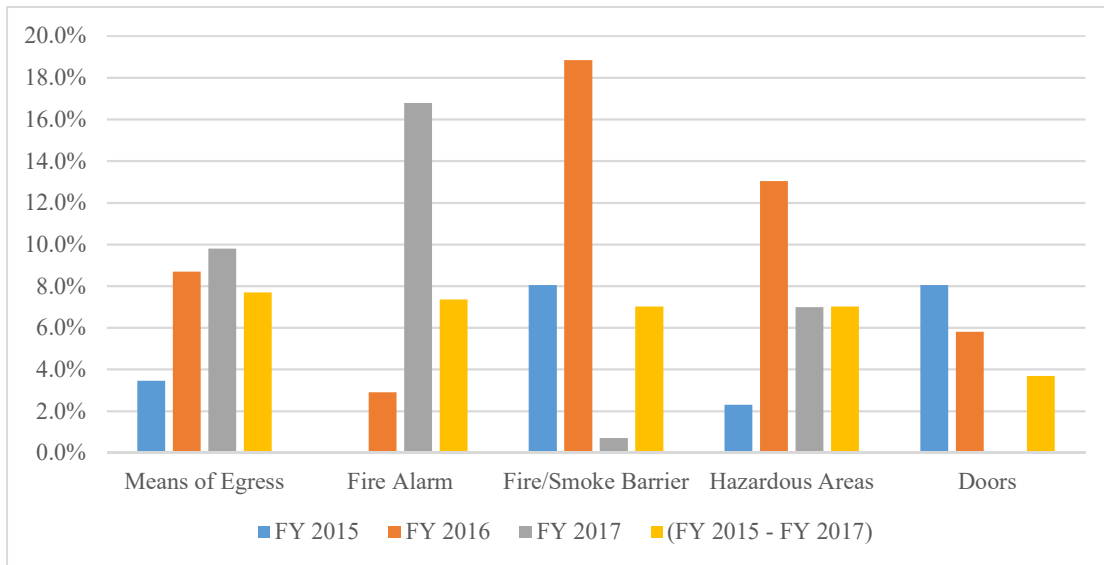
Psychiatric Hospital

**Graph 47
Top Five Psychiatric Hospital Disparity Rates
FYs 2015–2017**



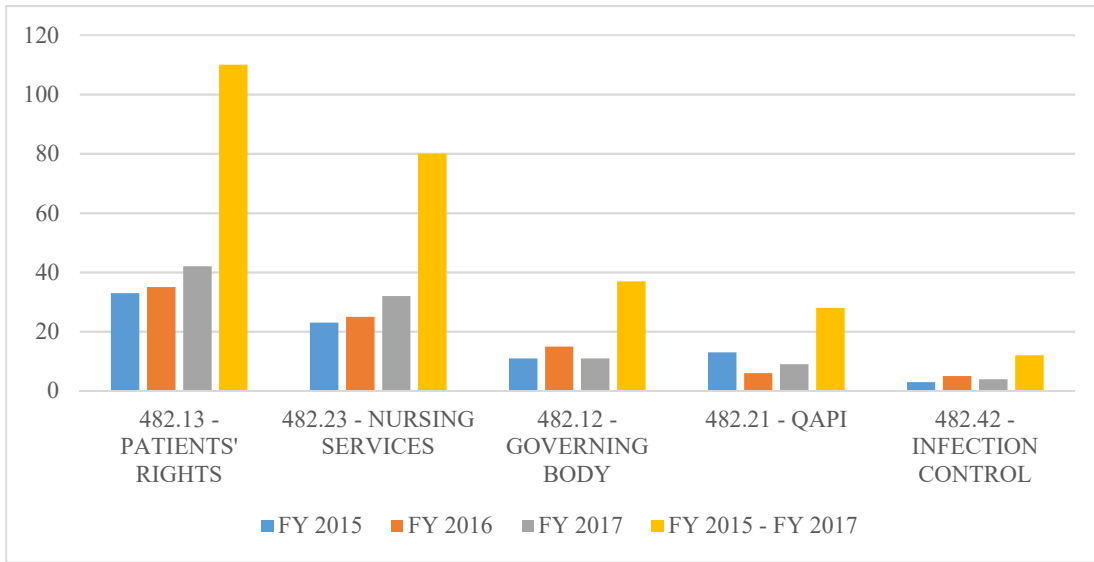
The psychiatric hospital sample consisted of 58 validation surveys from FY 2015 to FY 2017. TJC is the only AO with a CMS-approved psychiatric hospital Medicare accreditation program. Physical Environment was the number one disparate CoP for the three FYs. The SAs cited 32 condition-level citations from FY 2015 to FY 2017 and TJC missed 19 comparable deficiencies resulting in a 33-percent disparity rate. In FY 2015, Special Medical Record Requirements for Psychiatric Hospitals was the number one disparate citation with a 56-percent disparity rate which decreased to a 9.5-percent disparity rate in FY 2017. The overall disparity rate for psychiatric hospitals decreased from 69 percent in FY 2015 to 57 percent in FY 2017, resulting in a 12-percent decrease.

Graph 48
Top Five Psychiatric Hospital
LSC Category Disparity Rates
FYs 2015–2017



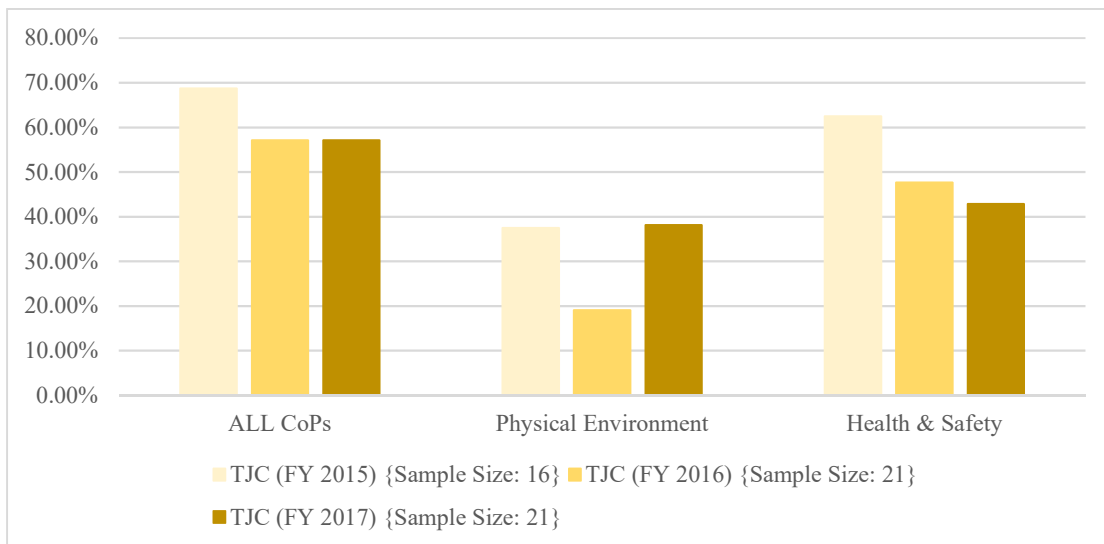
From FY 2015 to FY 2017, 58 psychiatric validation surveys were performed and 299 LSC category citations were cited by the SAs. The top two most frequently cited LSC categories for FY 2015 to FY 2017 were Means of Egress with 38 SA citations, and Fire Alarm with 39 SA citations. TJC missed 23 comparable citations for Means of Egress and 22 comparable citations for Fire Alarm, resulting in an 8-percent LSC category disparity rate and a 7-percent category disparity rate, respectively. Doors issues were the number one disparate LSC category in FY 2015 with a disparity rate of 8 percent which decreased to 0 percent in FY 2017. The top five disparate LSC category disparities make up 71 percent of all the LSC category disparities for FY 2015 to FY 2017.

Graph 49
Top 5 Psychiatric Hospital Condition-Level Deficiencies Cited During Complaint Surveys
FYs 2015–2017



From FY 2015 to FY 2017, there were a total of 325 condition-level deficiencies cited for AO accredited psychiatric hospitals during complaint surveys. During that time, the most frequently cited condition was Patient’s Rights, cited 110 times. The next most frequently cited condition was Nursing Services, cited 80 times. The number of Patient Rights and Nursing Services citations steadily increased from FY 2015 to FY 2017.

Graph 50
Psychiatric Hospital Disparity Rates by AO
FYs 2015–2017

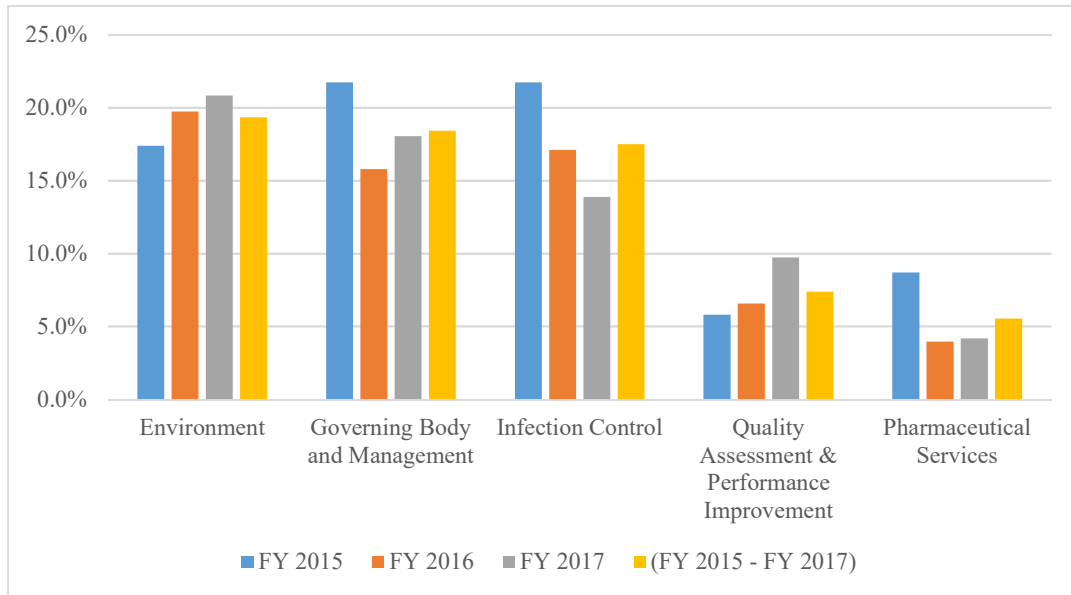


Fifty-eight psychiatric validation surveys were performed from FY 2015 to FY 2017. The overall disparity rate for TJC in FY 2017 was 57 percent, down from 69 percent in FY 2015; the PE disparity rate in FY 2017 and FY 2015 was 38 percent, which didn’t change; and the health and safety disparity rate for FY 2017 was 43 percent, down from 63 percent in FY 2015 for psychiatric hospitals. The Physical

Environment disparity rate jumped from 19 percent in FY 2016 to 43 percent in FY 2017 mainly attributed to the missed citation for the Fire Alarm Life Safety Code category. In FY 2017, Fire Alarm was missed 24 times out of a total of 56 missed Life Safety Code categories, contributing to 43 percent of the missed category citations.

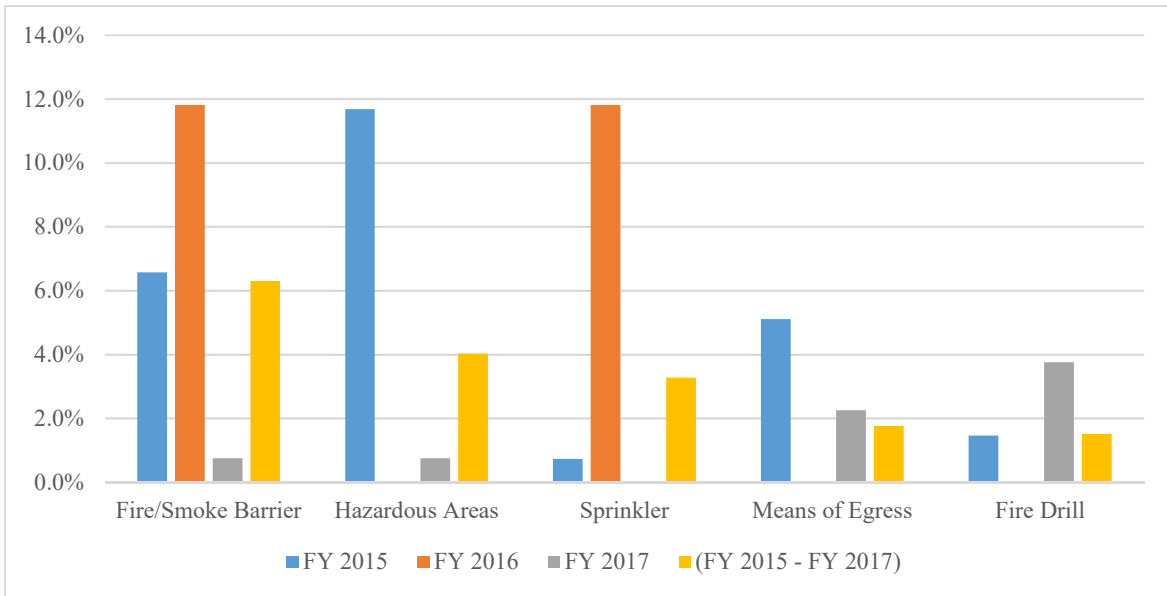
Ambulatory Surgery Center

**Graph 51
Top Five ASC Disparity Rates
FYs 2015–2017**



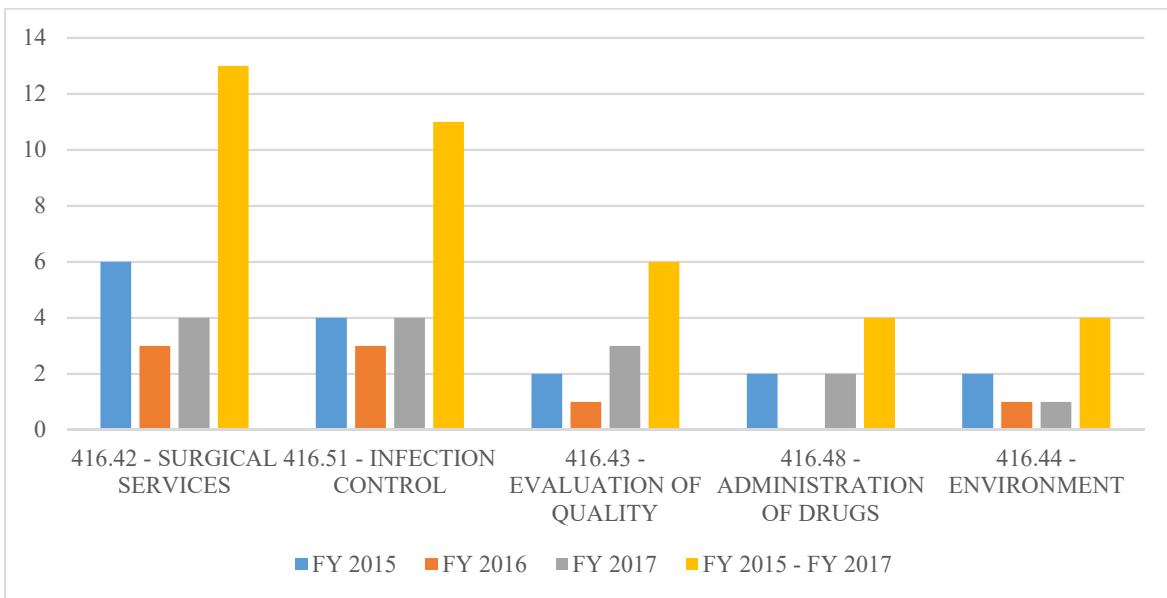
The ASC sample consisted of 217 validation surveys from FY 2015 to FY 2017. During that time, Environment, Governing Body and Management, and Infection Control were identified as the top three disparate conditions. However, the only disparity rate that increased yearly was the Environment condition. This disparity rate increased from 17 percent in FY 2015 to 21 percent in FY 2017. The overall disparity rate for ASCs dropped from 42 percent in FY 2015 to 36 percent in FY 2017. From FY 2015 to FY 2017, the top five disparate conditions made up 76 percent of all the disparate conditions.

Graph 52
Top Five ASC LSC Category Disparity Rates
FYs 2015–2017



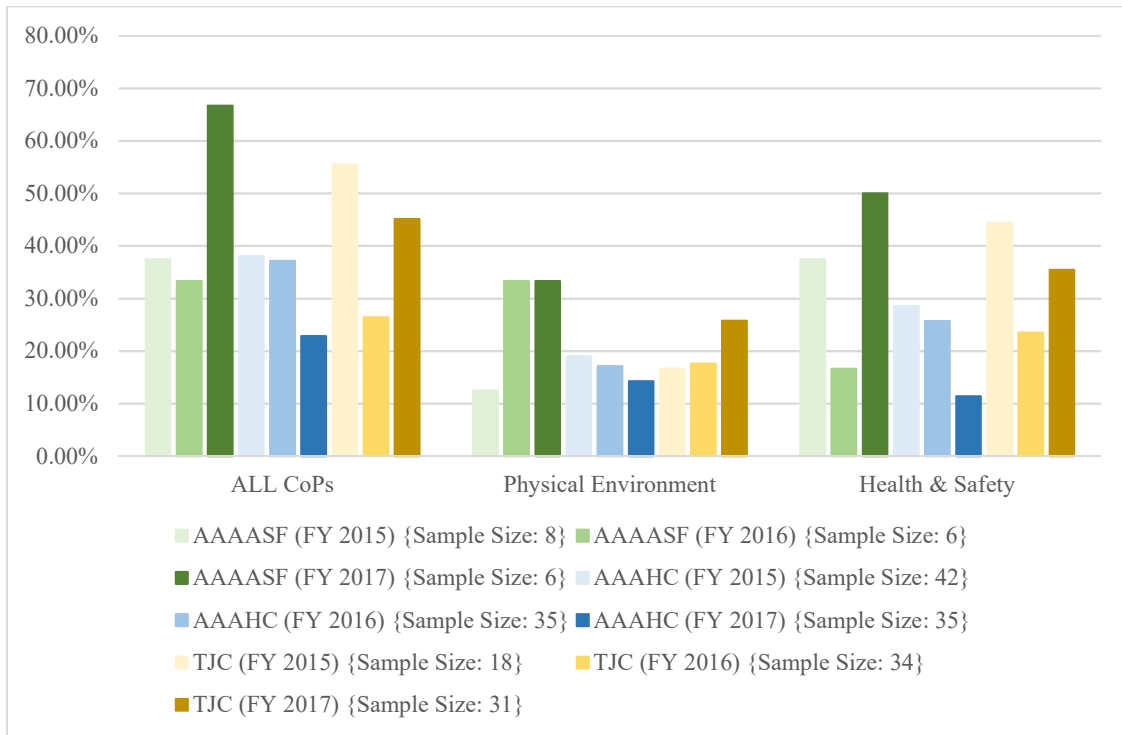
Out of 217 ASC validation surveys performed from FY 2015 to FY 2017, 397 LSC category citations were cited by the SAs. The most frequently cited LSC category for FY 2015 through FY 2017 was Fire/Smoke Barrier. During that time, the SAs cited this condition 69 times. Twenty-five of the citations were missed by the AOs resulting in a 6-percent LSC citation disparity rate; however, this disparity decreased from 7 percent in FY 2015 to 1 percent in FY 2017. A total of 67 missed LSC category citations comprised the top five disparate LSC categories, resulting in 88 percent of the missed LSC category citations for ASCs.

Graph 53
Top 5 ASC Condition-Level Deficiencies Cited During Complaint Surveys
FYs 2015-2017



From FY 2015 to FY 2017, there were a total of 51 condition-level deficiencies cited for AO accredited ASCs during complaint surveys. During that time, the most frequently cited condition was Surgical Services, cited 13 times. The next most frequently cited condition was Infection Control, cited 11 times. Environment is the only condition-level deficiency whose number of citations consistently decreased from FY 2015 to FY 2017. Although the graph depicts the total number of top five condition-level deficiencies cited from FY 2015 to FY 2017, Administration of Drugs was not cited in FY 2016.

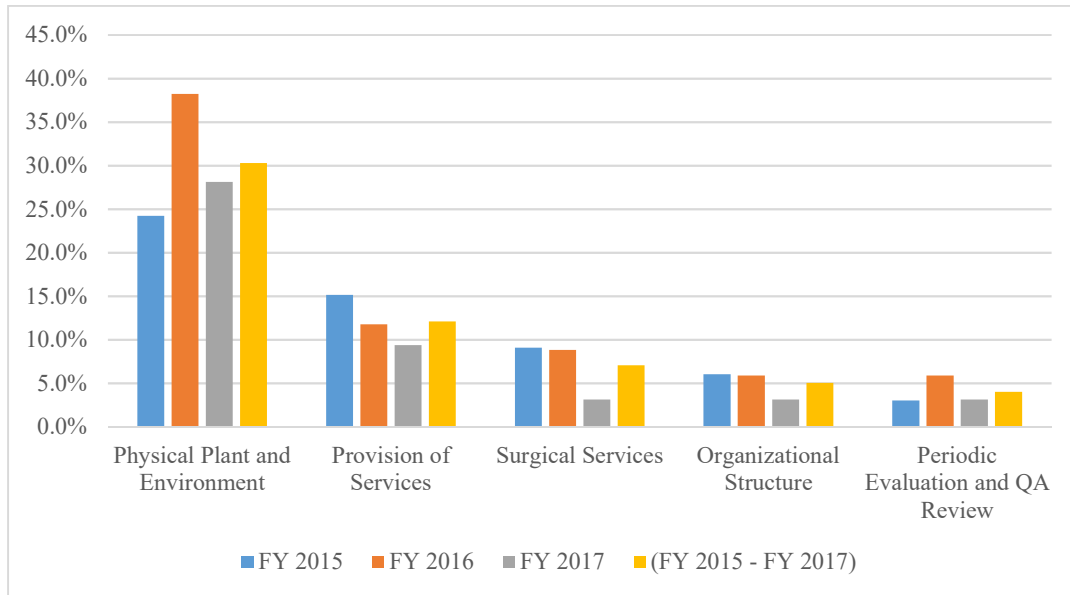
Graph 54
ASC Disparity Rates by AO
FYs 2015–2017



AAAASF, AAAHC, and TJC had validation surveys performed in FYs 2015-2017. AAAASF’s overall disparity rate increased by 29 percent from FY 2015 to FY 2017 while TJC’s and AAAHC’s overall disparity rates decreased 11 percent and 15 percent respectively from FY 2015 to FY 2017. AOA/HFAP isn’t depicted in the graph due to the limited number of validation surveys performed in FY 2015. In FYs 2016 and 2017, AOA/HFAP didn’t conduct any validation surveys.

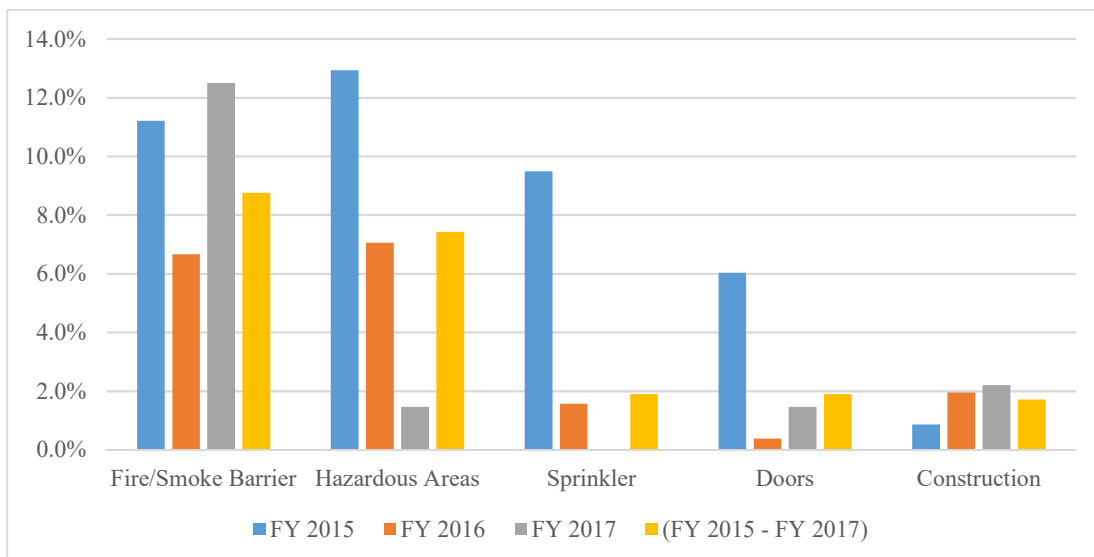
Critical Access Hospital

**Graph 55
Top Five CAH Disparity Rates
FYs 2015–2017**



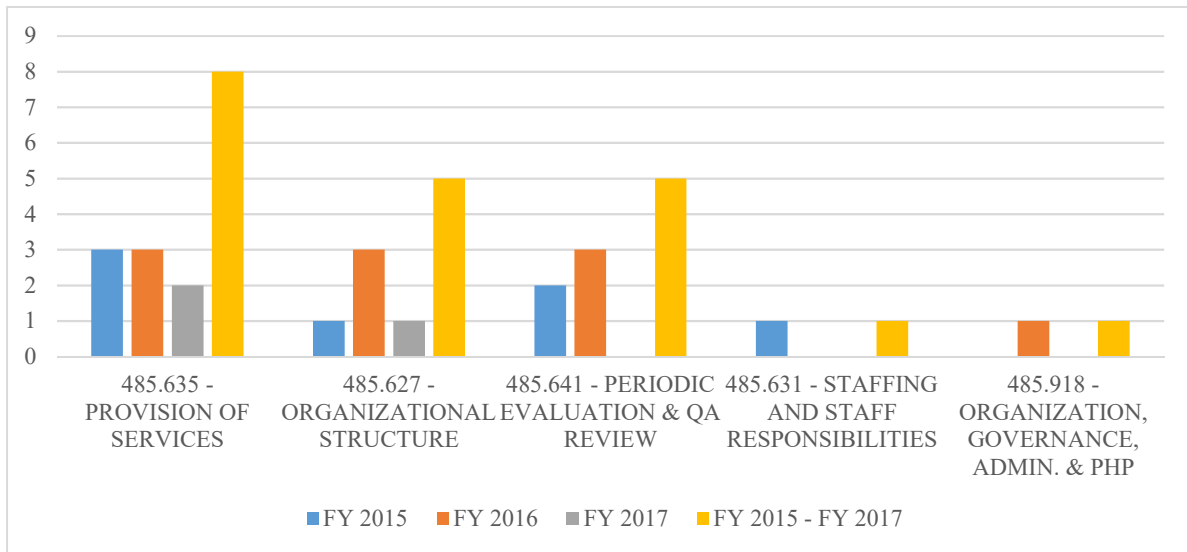
The CAH sample consisted of 99 validation surveys from FY 2015 to FY 2017. During this time, Physical Plant and Environment, Provision of Services, and Surgical Services were identified as the top three disparate conditions. However, the only disparity rate that increased was the Physical Plant and Environment condition which increased from 24 percent in FY 2015 to 38 percent in FY 2016. In FY 2017, the disparity rate decreased to 28 percent. The overall disparity rate for CAHs decreased from 45 percent in FY 2015 to 34 percent in FY 2017. From FY 2015 to FY 2017, the top five disparate conditions made up 87 percent of all the disparate conditions.

**Graph 56
Top Five CAH LSC Category Disparity Rates
FYs 2015–2017**



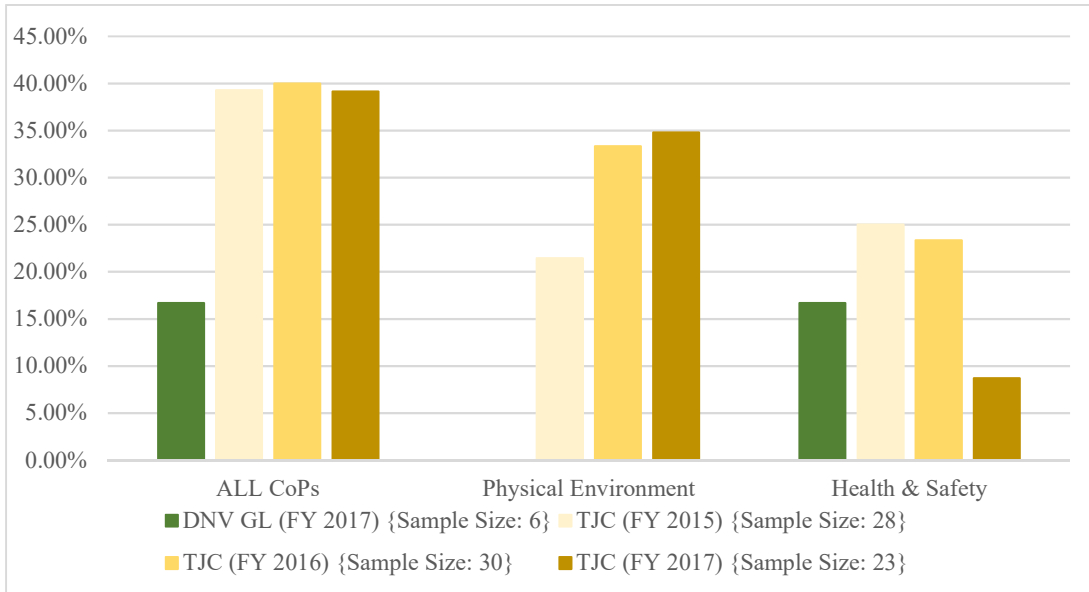
Out of 9 CAH validation surveys performed from FY 2015 to FY 2017, 525 LSC category citations were cited by the SAs. Fire/Smoke Barrier was the most frequently cited LSC category with 91 citations. The AOs missed 46 comparable LSC category citations over the three-year period. This resulted in a 9-percent LSC citation disparity rate. The second most frequently cited category was Hazardous Areas. However, the disparity rate for the Hazardous Areas category decreased from 13 percent in FY 2015 to less than 2 percent in FY 2017. There were a total of 114 missed LSC category citations in the top 5 disparate LSC categories out of a total of 162 missed citations. The top five disparate LSC category citations comprised 70 percent of all the missed LSC category citations for CAHs.

Graph 57
Top 5 CAH Condition-Level Deficiencies Cited
During Complaint Surveys
FYs 2015–2017



From FY 2015 to FY 2017, there were a total of 21 condition-level deficiencies cited for AO accredited ASCs during complaint surveys. During that time, the most frequently cited condition was Provision of Services, cited eight times. The next most frequently cited conditions were Organizational Structure and Periodic Evaluation & QA Review, both of which were cited five times. Although the graph depicts the total number of top five condition-level deficiencies cited from FY 2015 to FY 2017, only two of the five conditions had citations for all three years.

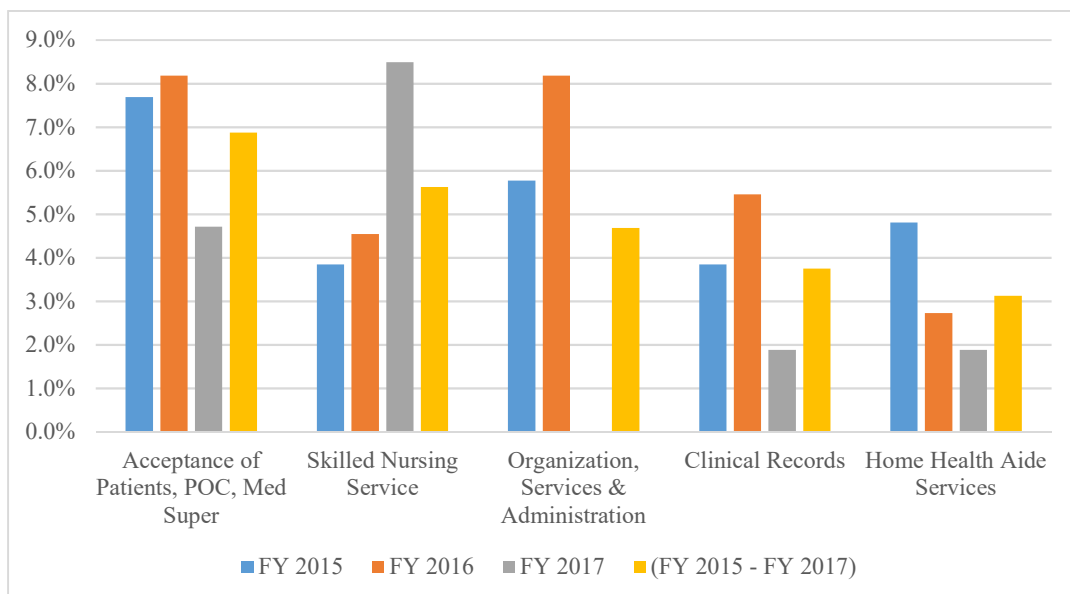
**Graph 58
CAH Disparity Rates by AO
FYs 2015–2017**



Validation surveys were performed for AOA/HFAP, DNV GL, and TJC in FYs 2015 to 2017; however, AOA/HFAP had three or less validation surveys completed during that time and DNV GL only had two validation surveys completed in FYs 2015 and 2016. Therefore, they are not included in this graph. DNV GL performed six validation surveys in FY 2017, but they didn't have any Physical Environment condition-level deficiencies cited by the SAs. TJC had a slight decrease in their overall disparity rate from 40 percent in FY 2016 to 39 percent in FY 2017.

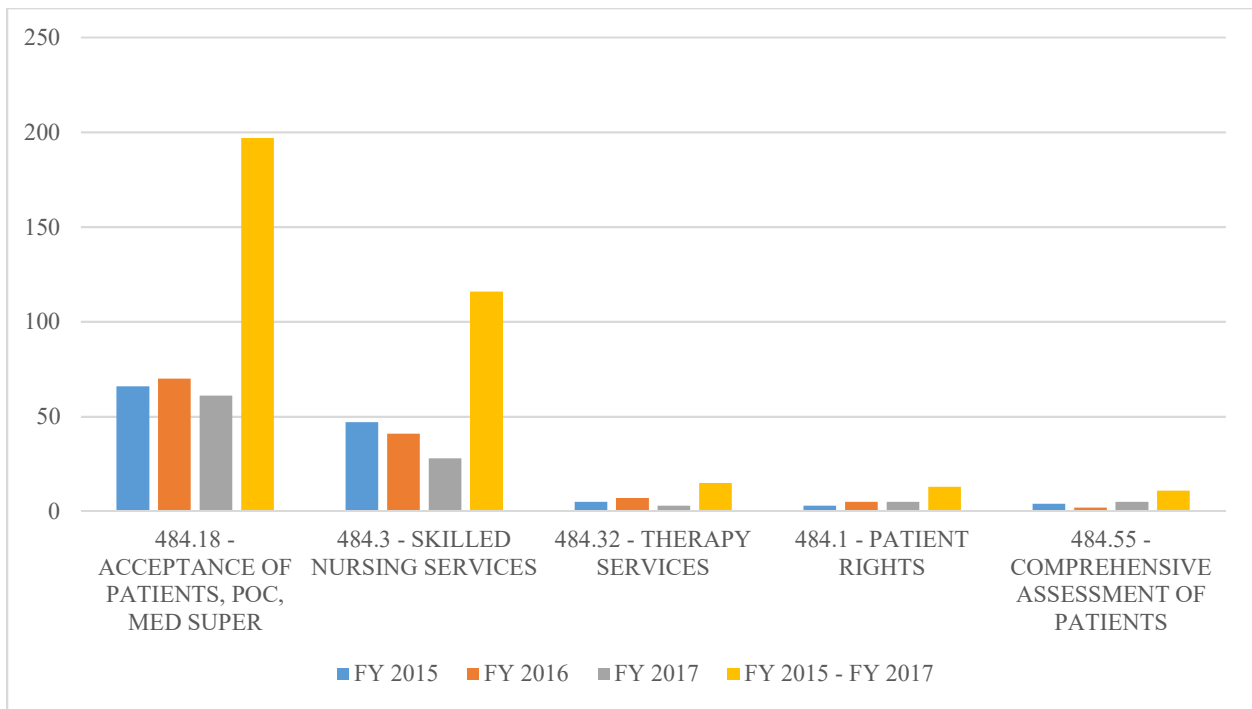
Home Health Agency

**Graph 59
Top Five HHA Disparity Rates
FYs 2015–2017**



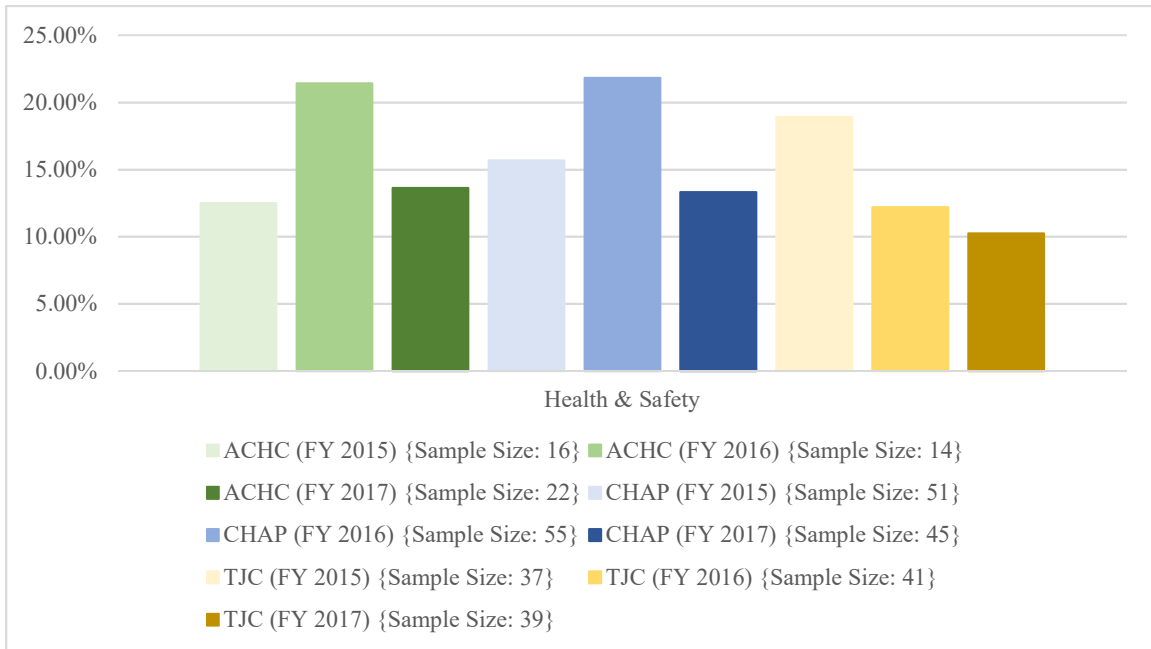
The HHA sample consisted of 320 validation surveys from FY 2015 to FY 2017. HHAs do not have any PE or LSC requirements. Acceptance of Patients, Plan of Care, Medical Supervision, Skilled Nursing Service, and Organization, Services & Administration were the top three disparate conditions identified for HHAs for FY 2015 to FY 2017. Acceptance of Patients, Plan of Care and Medical Supervision condition’s disparity rate increased slightly from 7.7 percent in FY 2015 to 8.2 percent in FY 2016. In FY 2017, the disparity rate decreased to 4.7 percent, a reduction of 3.5 percent. Organization, Services & Administration condition’s disparity rate increased from 5.8 percent in FY 2015 to 8.2 percent in FY 2016 while the disparity rate for the Skilled Nursing Service condition increased from 6 percent in FY 2015 to 9 percent in FY 2017. The overall disparity rate for HHAs decreased from 16 percent in FY 2015 to 12 percent in FY 2017. In FY 2016, the top five disparate conditions made up 70 percent of all the disparate conditions.

Graph 60
Top 5 HHA Condition-Level Deficiencies Cited
During Complaint Surveys
FYs 2015–2017



From FY 2015 to FY 2017, there were a total of 308 condition-level deficiencies cited for AO accredited HHAs during complaint surveys. During that time, the most frequently cited condition was Acceptance of Patients, POC, Med Super, cited 197 times. The next most frequently cited condition was Skilled Nursing Services, cited 116 times. The number of Skilled Nursing Services citations decreased by 19 citations from FY 2015 to FY 2017.

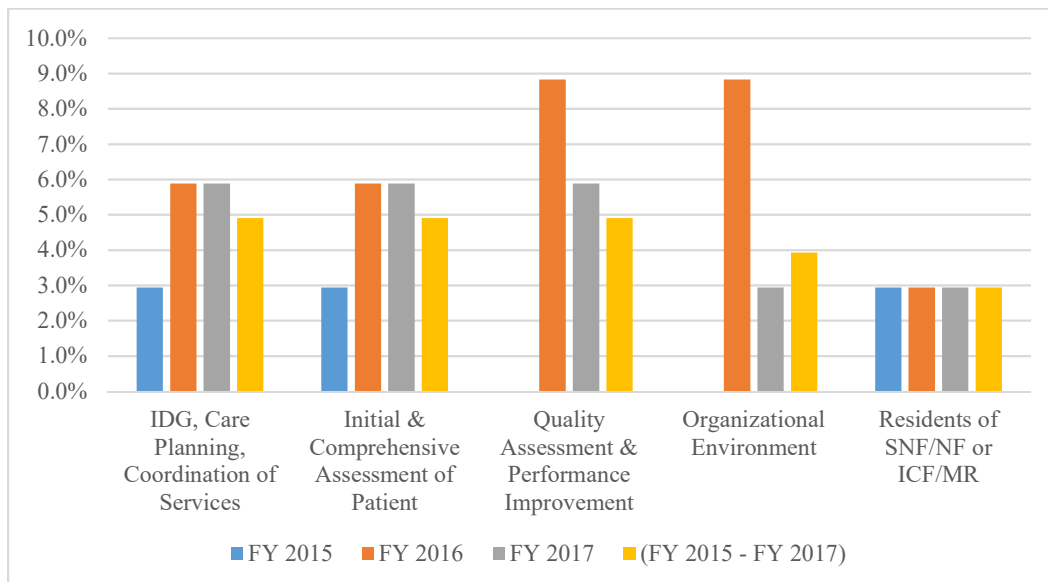
Graph 61
HHA Health and Safety Disparity Rates by AO
FYs 2015-2017



ACHC, CHAP, and TJC had HHA validation surveys performed from FY 2015 to FY 2017. The disparity rate for ACHC slightly increased from 12.5 percent in FY 2015 to 13.6 percent in FY 2017. The disparity rate for CHAP decreased from 15.7 percent in FY 2015 to 13.3 percent in FY 2017. The disparity rate for TJC steadily declined over the three-year period from 18.9 percent in FY 2015 to 10.3 percent in FY 2017.

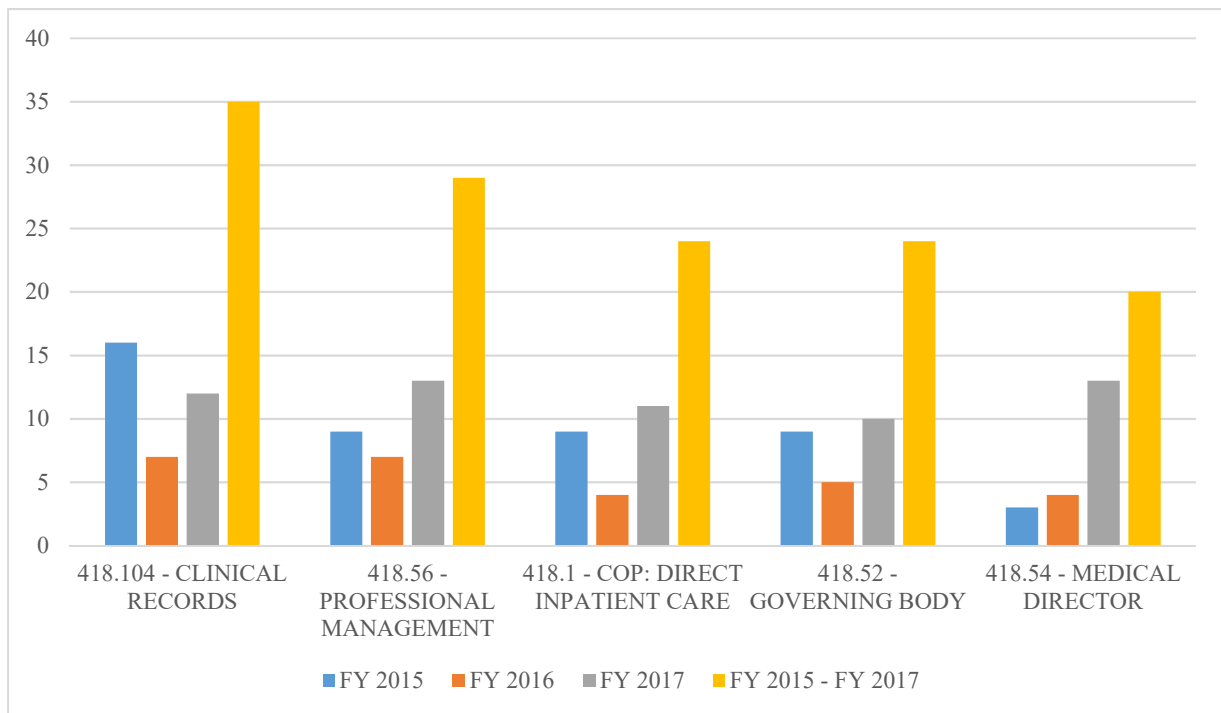
Hospice

Graph 62
Top Five Hospice Disparity Rates
FYs 2015-2017



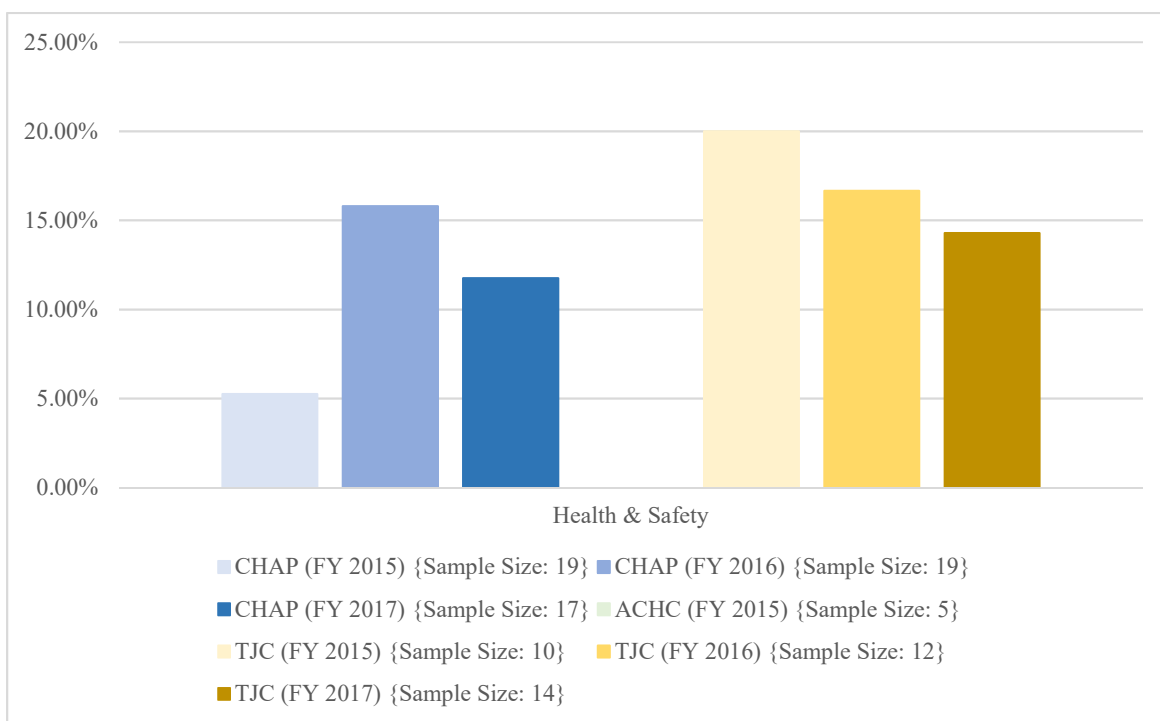
The hospice sample consisted of 102 validation surveys from FY 2015 to FY 2017. Hospice facilities do not have any PE or LSC requirements. In FY 2015, FY 2016, and FY 2017 only 4, 6, and 13 facilities were cited at the condition level by the SAs respectively. From FY 2015 to FY 2017, the SA cited a total of 44 condition-level deficiencies; 33 were missed by the AOs. The IDG, Care Planning, Coordination of Services and Initial & Comprehensive Assessment of Patient CoPs were the top two missed CoPs for the three-year period and the disparity rate for both increased from 3 percent in FY 2015 to 6 percent in FY 2017. The overall disparity rate for the Hospice program increased from 9 percent in FY 2015 to 12 percent in FY 2017.

Graph 63
Top 5 Hospice Condition-Level Deficiencies Cited During Complaint Surveys
FYs 2015–2017



From FY 2015 to FY 2017, there were a total of 211 condition-level deficiencies cited for AO accredited Hospice facilities during complaint surveys. During that time, the most frequently cited condition was Clinical Records, cited 35 times. The next most frequently cited condition was Professional Management, cited 29 times. The least cited condition was Medical Director, cited 20 times. However, the number of citations for this condition steadily increased from three citations in FY 2015 to 13 citations in FY 2017.

Graph 64
Hospice Health and Safety Disparity Rates by AO
FYs 2015–2017



CHAP and TJC had validation surveys conducted for FY 2015 to FY 2017. ACHC conducted 5 validation surveys in FY 2015, but there were no disparities resulting in a 0-percent disparity rate. Due to the limited number of validation surveys completed in FY 2016 and no validation surveys in FY 2017, ACHC isn't depicted in the graph for those years. CHAP's disparity rate increased from 5 percent in FY 2015 to 12 percent in FY 2017, while TJC's disparity rate steadily declined over the three-year period from 20 percent in FY 2015 to 14 percent in FY 2017.

Conclusion

CMS has identified the top conditions and LSC Categories driving the disparity rate. The PE/Environment is one of the leading disparate conditions, accounting for 20 to 45 percent of all disparate surveys from FY 2015 to FY 2017 throughout all the program types except for HHAs and hospices. The largest portion of the PE/Environment condition-level findings are LSC related. The SA and AO LSC survey validation findings are divided into various categories for analysis and comparison, yielding the top five disparate LSC categories. Fire/Smoke Barrier, the top disparate LSC category from FY 2015 to FY 2017 for each program type with the exception psychiatric hospitals where the Fire/Smoke Barrier category was the third highest disparate category. Means of Egress was the top disparate LSC category for psychiatric hospitals from FY 2015 to FY 2017 and was also one of the top five LSC categories for hospitals and ASCs. Hazardous Areas was the second highest disparate LSC category for ASCs and CAHs and it was also one of the top five disparate LSC categories for hospitals and psychiatric hospitals from FY 2015 to FY 2017. However, the Hazardous Areas disparate findings dropped significantly for all program types from FY 2016 to FY 2017 except for hospitals where it raised slightly from 5 percent to 6 percent. Among the AOs with a CMS-approved hospital accreditation program and LTCHs, DNV GL has the highest average health and safety disparity rate for FY 2015 to FY 2017 at 22 percent and TJC had the highest average PE disparity rate at 27 percent. AAAHC also had the lowest average health and safety (22 percent) and Physical Environment disparity rate (17 percent) for ASCs while AAASF had the

highest average health and safety (35 percent) and Physical Environment (26 percent) rate for FY 2015 to FY 2017. TJC was the only AO with a valid sample size for CAHs and their average health and safety and Physical Environment disparity rates for FY 2015 to FY 2017 were 19 percent and 30 percent respectively.

Recommendations

Accrediting Organizations Need to Focus Their Interventions on Their Top Disparate Conditions.

Each AO needs to develop interventions focusing on their high-volume disparate CoPs. If the AOs were to focus on the top disparate CoPs with the highest disparity rates, they would have an opportunity to positively impact their disparity rate. For example, for FY 2017, if the AOs would address the top five disparate CoPs for hospitals, they could potentially eliminate 71 percent of the disparate citations.

CMS will monitor the disparate findings on a quarterly basis concurrent with the FY in which the validation surveys are conducted. Trending of the CoPs involved as well as identification of the problem facilities will be discussed on the individual monthly AO liaison calls. Action plans to address identified trends and disparity rates will be required of each AO.

Detailed information for each program type and AO for Section 5 of this report can be found in Appendix B of this report.

SECTION 6: Centers for Medicare & Medicaid Services Improvements

The volume of facilities that participate in the Medicare programs through accreditation from a CMS-approved accreditation program continued to grow in FY 2017. Currently, 38 percent (13,013 facilities) of all Medicare-participating facilities that have an approved accreditation program option demonstrate compliance with the Medicare requirements and participate in the Medicare program via their deemed status. There are currently 10 CMS-recognized AOs and 22 approved accreditation programs.

CMS has worked to enhance systems and processes to ensure a robust and consistent approach to its monitoring and oversight of CMS-recognized AO performance and activities of their approved accreditation programs. In FY 2017, CMS focused on the following key areas in order to continue to refine and maintain an effective oversight infrastructure:

- CMS/AO Communication and Relationship Building
- AO Education
- Standards Update in Response to Changes in CMS Requirements
- Deemed Facility Data (See Section 2 for more information)
- AO Performance Measures (See Section 3 for more information)
- Validation Redesign Project (VRP)

CMS/Accrediting Organization Communication and Relationship Building

Communication

CMS embarked upon the implementation of a new model in FY 2017 for supporting the vital work that the national AO's provide. This model, which was began in March 2017, included a dedicated CMS central office AO liaison team that interacts with the Medicare AOs on a monthly basis addressing key issues as they arise. CMS believes this new model will support and strengthen the relationship between CMS and the AOs. CMS will continue its periodic meetings with the AOs, including quarterly teleconferences. These meetings serve to foster communication between the AOs and CMS and serve as a forum to: discuss any issues as they arise, communicate and discuss regulatory changes, assure ongoing deemed facility compliance with Medicare conditions, and provide information and education for AO staff. CMS CO, RO staff, and individual AOs communicate on a weekly, if not daily, basis either by email or telephone to address a wide variety of issues, including, but not limited to: specific deemed facility deficiencies, certification issues, program operations, surveys, requirements, interpretation of regulations, and data.

Consultation

CMS increased opportunities for AOs as well as other stakeholders to provide input into the development of sub-regulatory guidance concerning Medicare standards and survey processes. AOs and other key stakeholders are provided the opportunity to review and provide comment on guidance prior to release. CMS has committed to ongoing consultation with the AOs and the stakeholders in an effort to improve the resulting guidance.

Accrediting Organization Education

CMS affords AO staff many opportunities for education. CMS provides detailed written and verbal feedback to the AOs as part of the deeming application and data review processes. This feedback includes specific references to Medicare regulatory requirements as well as the SOM references and attachments. Formal education is provided periodically at the request of individual AOs. AOs are also

provided the opportunity to participate in face-to-face as well as online SA surveyor training. In FY 2017, CMS provided updates to the AO resource manual. This manual contains a wide variety of information on CMS requirements and expectations of AO performance.

Standards Update in Response to Changes in Centers for Medicare & Medicaid Services Requirements

Swing Beds requirements for Hospitals and CAHs

The final rule entitled, “Medicare and Medicaid Programs; Reform of Requirements for Long Term Care Facilities,” was published in the *Federal Register* on October 4, 2016, revising the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs, including provisions of the special requirements for hospitals and CAHs with swing beds. The effective date of the final rule was November 28, 2016. The final rule can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf>. On July 13, 2017, CMS published revisions to that final rule correcting technical and typographical errors identified in the October 4, 2016 final rule. The published revisions can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2017-07-13/pdf/2017-14646.pdf>.

Home Health Agency Regulations

CMS published a final rule on July 10, 2017 delaying the effective date for the final rule entitled "Medicare and Medicaid Programs: Conditions of Participation for Home Health Agencies" published in the *Federal Register* on January 13, 2017 (82 FR 4504). The published effective date for the final rule was July 13, 2017, and this rule delays the effective date for an additional 6 months until January 13, 2018. This final rule also includes two conforming changes to dates that are included in the regulations text. The CoPs include several major changes for home health care agencies, including Quality Assurance Performance Improvement (QAPI). Performance improvement projects will be phased in slower than other QAPI requirements, with a phase-in date of July 13, 2018. The published delay can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2017-07-10/pdf/2017-14347.pdf>.

Life Safety Code regulations

The final rule entitled, “Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities,” was published in the *Federal Register* on May 4, 2016, which provides updates to health care facilities’ fire protection guidelines to improve protections from fire for all Medicare beneficiaries in facilities. The effective date of the final rule was July 5, 2016. The final rule can be accessed at <https://www.gpo.gov/fdsys/pkg/FR-2016-05-04/pdf/2016-10043.pdf>. The final rule amended the fire safety standards for Medicare and Medicaid participating hospitals, CAHs, long-term care facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), ASCs, hospices which provide inpatient services, religious non-medical health care institutions (RNHCIs), and programs of all-inclusive care for the elderly (PACE) facilities. Further, this final rule adopted the 2012 edition of the LSC and eliminated references in regulations to all earlier editions of the LSC. It also adopted the 2012 edition of the Health Care Facilities Code (HCFC), with some exceptions.

CMS began surveying facilities for compliance with the 2012 edition of the LSC and HCFC on November 1, 2016. In addition, this allowed CMS the opportunity to train existing surveyors, revise fire safety survey forms, and update the ASPEN program.

CMS reviewed and approved 11 AO programs that have requirements containing LSC Standards to ensure consistency with CMS regulatory adoption of the 2012 edition of the LSC.

CMS developed a 2000 to 2012 edition LSC transition course. All AOs were provided access to this training course to ensure existing surveyors had the opportunity to receive training in support of CMS regulatory adoption of the 2012 edition of the LSC.

In reference to the LSC SharePoint site, improvements and system upgrades to the functionality of the site have been performed. These upgrades allow for more robust reporting, additional system notifications, and workflow notifications making the system more user friendly.

Meetings with ROs and AOs have been held to identify issues and opportunities for improvement. The LSC SharePoint site continues to be modified to increase functionality and usability.

Validation Redesign Project

In March 2018, CMS appointed a workgroup to redesign the validation survey process. The overall goal of the pilot is to redesign the validation program where the SAs evaluate the ability of the AO surveyors to survey for compliance to CMS CoPs versus conducting a second survey of the facility, as is the current practice. Facilities will be surveyed simultaneously by the appropriate SA and the AO, using the same Medicare certification full survey process (e.g., surveying for compliance with the Medicare CoPs or CfCs). Using the CMS/AO Observation Worksheet and Rating Guide developed by CMS, the SA surveyor team will evaluate the skill, knowledge, and performance of the AO's survey process and score the AO accordingly. There will be no separate SA validation survey conducted. SA surveyors/observers will complete an AO Observation worksheet and abbreviated 2567 upon completion of the AO survey. The AO will provide the survey report with the POCs going to the RO. The data from the CMS/AO Observation worksheet will be used for the disparity data report.

SECTION 7: Clinical Laboratory Improvement Amendments Validation Program

Introduction

CLIA of 1988 expanded survey and certification of clinical laboratories from interstate commerce laboratories to most facilities testing and reporting out human specimens, regardless of location. CMS regulates laboratory testing by these laboratories whether the testing is provided to beneficiaries of CMS programs or to others, including certain testing performed in physicians' offices, for a total of 255,170 CLIA certified facilities at the beginning of calendar year (CY) 2017. The CLIA standards are based on the complexity of testing; thus, the more complex the test is to perform, the more stringent the requirements. There are three categories of tests: waived, moderate, and high complexity. Laboratories that perform only waived tests are not subject to the quality standards under CLIA or routine oversight. Laboratories which perform moderate and high complexity testing are subject to routine on-site surveys. These laboratories have a choice of the agency they wish to survey their laboratory. They can select CMS via the SAs or a CMS-approved AO. CMS partners with the states to certify and inspect approximately 18,143 laboratories every 2 years. CMS-approved AOs conduct on-site surveys of an additional 15,552 laboratories every 2 years as well. Data from these inspections reflect significant improvements in the quality of testing over time. The CLIA program is 100-percent user-fee financed, and is jointly administered by three HHS components: (1) CMS manages the financial aspects, contracts and trains state surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation and policy development, approval of AOs, exempt states and proficiency testing providers, certificate generation, enforcement and data system design; (2) the Centers for Disease Control and Prevention (CDC) conducts research, provides scientific and technical support, jointly develops regulations with CMS, develops and disseminates educational materials, and coordinates the Secretary's Clinical Laboratory Improvement Advisory Committee (CLIAC); and (3) the Food and Drug Administration (FDA) performs test categorization, including waiver approvals.

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of FY 2017 performance by the seven AOs approved by CMS under CLIA. The seven organizations are:

- AABB
- American Association for Laboratory Accreditation (A2LA)
- AOA/HFAP
- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (CAP)
- TJC

CMS appreciates the cooperation of all the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved AO is required by law, this is an opportunity to present information about, and dialogue with, each organization as part of a mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act and the implementing regulations in 42 CFR part 493 require any laboratory that performs testing or assessment of human specimens for the diagnosis, prevention or treatment of a disease or impairment of, or the assessment of the health of, human beings to meet the requirements established by the CLIA statute and regulations including maintenance of an appropriate certificate. The CLIA certificate requirements include the option to meet the standards of an

approved AO, in which case they would be issued a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation provisions, the laboratory is not routinely subject to direct Federal oversight by CMS. Instead, the laboratory receives an inspection by the AO in the course of maintaining its accreditation, and by virtue of this accreditation, is “deemed” to meet the CLIA requirements. The CLIA requirements pertain to QA and quality control programs, records, equipment, personnel, proficiency testing, and other areas to assure accurate and reliable laboratory examinations and procedures, and the AO’s requirements must meet or exceed those CLIA requirements.

In Section 353(e)(2)(D), the Secretary is required to evaluate each approved AO by inspecting a sample of the laboratories they accredit and by “such other means as the Secretary determines appropriate.” In addition, Section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This section of this report is submitted to satisfy that requirement.

Regulations implementing Section 353 are contained in 42 CFR Part 493 “Laboratory Requirements.” Subpart E of Part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether an accredited laboratory is in compliance with the applicable CLIA requirements. Validation inspections for clinical laboratories are conducted no more than 90 days after the AO’s inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections provide:

- On a laboratory-specific basis, insight into the effectiveness of the AO’s standards and accreditation process; and
- In the aggregate, an indication of the organization’s capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, at 42 CFR § 493.575, provide that if the validation inspection results over a 1-year period indicate a rate of disparity¹³ of 20 percent or more between the findings in the AO’s results and the findings of the CLIA validation surveys, CMS will re-evaluate whether the AO continues to meet the criteria for an approved AO (also called “deeming authority”). Section 493.575 further provides that CMS has the discretion to conduct a review of an AO program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization’s accreditation process that the AO’s requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization’s accreditation program, which is described in its request for approval as an AO. Those standards are reviewed as a whole, and, if appropriate, are approved by CMS as being equivalent to or more stringent than the CLIA condition-level requirements.¹⁴ This equivalency is the basis for CMS granting the AO its deeming authority.

In evaluating an organization’s performance during a validation review, it is important to examine whether the organization’s inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization’s inspection process sufficiently identifies, brings

¹³ The methodology for the CLIA Rate of Disparity is calculated the same as in Figure 2 of this report. The only difference is that CLIA validation surveys are performed up to 90 days after an AO inspection instead of 60 days.

¹⁴ A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed and more specific. A condition-level deficiency is an inadequacy in the laboratory’s quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

about correction, and monitors for sustained correction, of laboratory practices and outcomes that do not meet their accreditation standards, so that those accredited by the programs continue to meet or exceed the CLIA program requirements.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all the cases in each sample have been reviewed, the rate of disparity for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by Section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, Section 353(e)(2)(D)(i), the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each AO. A representative sample of more than 15,000 accredited laboratories received a validation survey in 2017. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey for the AO it designates for CLIA compliance, irrespective of the number of accreditations it attains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, A2LA, AOA/HFAP, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, CAP, or TJC, thus the sample sizes for these organizations were larger. The sample sizes are roughly proportionate to each organization's representation in the universe of accredited laboratories; however, true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

Results of the Validation Reviews of Each Accrediting Organization

AABB

Rate of disparity: N/A

In FY 2017, approximately 206 laboratories used their AABB accreditation for CLIA program purposes. One validation survey was conducted, and no condition-level deficiencies were cited; therefore, no additional data is reported. (See Table 27.)

American Association for Laboratory Accreditation

Rate of disparity: N/A

On March 25, 2014, A2LA was the seventh AO to receive deeming authority by CMS. The organization has a total of three deemed facilities. No CLIA validation surveys were conducted during the FY17 survey cycle. (See Table 27.)

American Osteopathic Association/Healthcare Facilities Accreditation Program

Rate of disparity: 0%

For CLIA purposes, approximately 126 laboratories used their AOA/HFAP accreditation. Validation surveys were conducted in 10 AOA/HFAP-accredited laboratories. No condition-level deficiencies were cited in any of the validation surveys; therefore, the disparity rate is zero. (See Table 27.)

American Society for Histocompatibility and Immunogenetics

Rate of disparity: N/A

Approximately 111 laboratories used their ASHI accreditation for CLIA purposes. A total of four validation surveys were conducted in ASHI-accredited laboratories and no condition-level deficiencies were cited; therefore, no additional data is reported. (See Table 27.)

COLA

Rate of disparity: 11 percent

In FY 2017, 6,628 laboratories used their COLA accreditation for CLIA program purposes. A total of 184 validation surveys were conducted in COLA-accredited laboratories. Twenty-four laboratories were cited with condition-level deficiencies. In four of those laboratories, COLA findings were comparable to all the CLIA condition-level deficiencies cited. In the remaining 20 laboratories, however, COLA noted comparable findings for only some or none of the CLIA condition-level deficiencies cited; thus, there were 20 disparate cases yielding a disparity rate of 11 percent. (See Table 27.)

College of American Pathologists

Rate of disparity: 6 percent

In FY 2017, 6,323 laboratories used their CAP accreditation for CLIA program purposes. A total of 96 validation surveys were conducted in CAP-accredited laboratories. Six laboratories were cited with CLIA condition-level deficiencies. CAP findings weren't comparable to any of the CLIA condition-level deficiencies cited; thus, there were six disparate cases for a disparity rate of 6 percent. (See Table 27.)

The Joint Commission

Rate of disparity: 18 percent

In FY 2017, 2,155 laboratories used their TJC accreditation for CLIA program purposes. During this validation period, a total of 45 validation surveys were conducted in TJC-accredited laboratories. Nine laboratories were cited with CLIA condition-level deficiencies. In one of those laboratories, TJC findings were comparable to all the CLIA condition-level deficiencies cited. In eight laboratories, TJC noted comparable findings for only some or none of the CLIA condition-level deficiencies cited; thus, there were eight disparate cases yielding a disparity rate of 18 percent. (See Table 27.)

Table 27
Validation Survey Results for Clinical Laboratories
FY 2017

Number of—	AABB	A2LA	AOA	ASHI	CAP	COLA	TJC	Total
Accredited Labs	206	3	126	111	6,323	6,628	2,155	15,552
Validation Surveys	1	0	10	4	96	184	45	340
Surveys with Condition-Level Deficiencies	*N/A	*N/A	0	*N/A	6	24	9	39
Surveys with One or More Condition-Level Deficiencies Missed by AO	*N/A	*N/A	0	*N/A	6	20	8	34
Disparity Rate	*N/A	*N/A	0%	*N/A	6.3%	10.9%	17.8%	10%

*N/A: When a minimum sample size of five is not achieved for an AO, no data is reported given the lack of statistical significance.

Conclusion

CMS has performed this statutorily mandated validation review in order to evaluate and report to Congress on the performance of the seven laboratory AOs approved under CLIA. This endeavor is two-fold: to verify each organization’s capability to assure laboratory performance equal to, or more stringent than, that required by CLIA (“equivalency”); and to gain insight into the effectiveness of the AO’s standards and accreditation process on a laboratory-specific basis.

CMS recognizes that similarity of AO findings to CLIA validation survey findings is an important measure of the organization’s capability to ensure and sustain equivalency and effectiveness of oversight. When an accredited laboratory’s practices and outcomes fail to conform fully to the accreditation standards, it is important that the AO’s inspection protocol sufficiently identifies the deficiencies, brings about correction, and monitors for sustained compliance, so that the laboratory is again in full conformance with the accreditation standards and equivalency is sustained.

In the interest of furthering the mutual goal of promoting quality testing in clinical laboratories and furthering the goal of sustained equivalency, CMS hosts an annual meeting of all CMS-approved AOs for CLIA. The group meets to discuss and resolve issues of mutual interest and to share best practices. The group endeavors to improve their overall consistency in application of laboratory standards, coordination, collaboration, and communication in both routine and emergent situations. Through these efforts, CLIA hopes to further improve the level of laboratory oversight and ultimately, patient care.

APPENDIX A: Performance Measures

**Appendix A Table 1
Performance Measure Results (Percentage) by AO
Comparable Measures for FYs 2016-2017**

	AAAASF		AAAHC		ACHC		AOA/HFAP		CHAP		CIHQ		DNV GL		IMQ		TCT		TJC	
	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17	FY16	FY17
ASSURE Database																				
Timeliness of facility notification of survey results	99	100	74	92	100	100	100	100	93	97	100	93	100	93	*NA	*NA	98	99	100	100
Denied initial survey with condition-level findings	100	95	100	100	100	100	**NA	**NA	100	91	**NA	**NA	83	**NA	*NA	*NA	100	100	68	99
CMS notified timely of withdrawals	NA†	96	NA†	87	NA†	97	NA†	100	NA†	81	NA†	**NA	NA†	81	NA†	*NA	NA†	**NA	NA†	93
No pending survey > 5 months	NA†	100	NA†	100	NA†	100	NA†	100	NA†	100	NA†	100	NA†	100	NA†	*NA	NA†	100	NA†	100
Facility Notification Letters																				
Notification letters contain all required information	98	98	91	91	100	100	100	100	99	100	100	94	100	98	*NA	*NA	94	96	99	99
ASSURE is updated consistent with letters	92	86	86	83	99	97	100	98	78	94	96	63	96	94	*NA	*NA	88	95	81	88
Survey Schedule																				
Number of surveys performed matches number reported in ASSURE	99	99	86	95	100	99	100	100	98	98	91	94	100	100	*NA	*NA	94	97	99	98

NA†: New measure for FY 2017; not reported in FY 2016.

*NA: No information available for calculation.

**NA: Not applicable due to sample size less than five.

APPENDIX B: Fiscal Year 2017 Life Safety Code and Health & Safety Disparity Rates

Accrediting Organizations

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

Ambulatory Surgery Centers

AAAASF (FY 2017 ASC Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	6	6	6
Number of Surveys with Conditions Missed by AO	4	2	3
Disparity Rate	66.67%	33.33%	50.00%

Appendix B Table 1: AAAASF
ASC Disparity Rate
FY 2017

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Infection Control	4	1	3	50.00%
Nursing Services	2	0	2	33.33%
Medical Staff	3	1	2	33.33%
Environment	4	2	2	33.33%
Quality Assessment & Performance Improvement	3	1	2	33.33%

Appendix B Table 2: AAAASF
Top Five Disparate CoPs for ASCs
69 Percent of all Disparate Findings

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire Drill	2	2	20.00%
Hazardous Areas	2	1	10.00%
Construction	1	1	10.00%
Emergency Lighting	1	1	10.00%

Appendix B Table 3: AAAASF
Missed LSC Citations for ASCs
100 Percent of all Missed Citations

Accreditation Association for Ambulatory Health Care, Inc

Ambulatory Surgery Centers

AAAHHC (FY 2017 ASC Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	35	35	35
Number of Surveys with Conditions Missed by AO	8	5	4
Disparity Rate	22.86%	14.29%	11.43%

Appendix B Table 4: AAAHC
ASC Disparity Rate
FY 2017

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Environment	11	6	5	14.29%
Infection Control	8	4	4	11.43%
Governing Body and Management	5	2	3	8.57%
Surgical Services	1	0	1	2.86%

**Appendix B Table 5: AAAHC
Top Disparate CoPs for ASCs
100 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Electrical	7	5	15.15%
Hazardous Areas	3	3	9.09%
Means of Egress	2	2	6.06%
Medical Gas	2	1	3.03%
EES	1	1	3.03%
Sprinkler	1	1	3.03%

**Appendix B Table 6: AAAHC
Missed LSC Citations for ASCs
100 Percent of all Missed Citations**

Accreditation Commission for Health Care

Home Health Agency

ACHC (FY 2017 HHA Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	22	22
Number of Surveys with Conditions Missed by AO	3	3
Disparity Rate	13.64%	13.64%

**Appendix B Table 7: ACHC
HHA Disparity Rate
FY 2017**

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Acceptance of Patients, POC, Med Super	2	1	1	4.55%
Skilled Nursing Service	2	1	1	4.55%
Evaluation of the Agency's Program	1	0	1	4.55%

**Appendix B Table 8: ACHC
Top Disparate CoPs for HHAs
100 Percent of all Disparate Surveys**

American Osteopathic Association/Healthcare Facilities Accreditation Program

Hospitals

AOA/HFAP (FY 2017 Hospital Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	5	5	5
Number of Surveys with Conditions Missed by AO	5	5	2
Disparity Rate	100%	100%	40.00%

**Appendix B Table 9: AOA/HFAP
Hospital Disparity Rate
FY 2017**

CoP	Facilities with CoP	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	10	5	5	100.00%
Surgical Services	2	1	1	20.00%
Infection Control	2	1	1	20.00%
QAPI	1	0	1	20.00%

**Appendix B Table 10: AOA/HFAP
Top Disparate CoPs for Hospitals
100 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire/Smoke Barrier	34	22	14.10%
Hazardous Areas	22	22	14.10%
Doors	35	21	13.46%
Means of Egress	29	20	12.82%
Electrical	20	14	8.97%
Sprinkler	32	13	8.33%
Flammable & Combustible Storage	10	9	5.77%
Fire Extinguisher	9	6	3.85%
Fire Plan	7	6	3.85%
Medical Gas	6	5	3.21%

**Appendix B Table 11: AOA/HFAP
Top 10 Missed LSC Citations for Hospitals
88 Percent of all Missed Citations**

Critical Access Hospitals

AOA/HFAP (FY 2017 CAH Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	3	3	3
Number of Surveys with Conditions Missed by AO	1	1	0
Disparity Rate	33.33%	33.33%	100%

**Appendix B Table 92: AOA/HFAP
CAH Disparity Rate
FY 2017**

CoP	Facilities with CoP	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Plant and Environment	2	1	1	33.33%

**Appendix B Table 103: AOA/HFAP
Top Disparate CoP for CAHs
100 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire/Smoke Barrier	3	2	13.33%
Interior Finish	2	2	13.33%
Anesthetizing Location	1	1	6.67%
Construction	1	1	6.67%
Electrical	1	1	6.67%
Fire Plan	1	1	6.67%
Fire Drill	1	1	6.67%
Hazardous Areas	1	1	6.67%

**Appendix B Table 114: AOA/HFAP
Missed LSC Citations for CAHs
100 Percent of all Missed Citations**

Community Health Accreditation Partner

Home Health Agency

CHAP (FY 2017 HHA Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	45	45
Number of Surveys with Conditions Missed by AO	6	6
Disparity Rate	13.33%	13.33%

**Appendix B Table 125: CHAP
HHA Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Skilled Nursing Service	8	3	5	11.11%
Acceptance of Patients, POC, Med Super	4	1	3	6.67%
Home Health Aide Services	2	1	1	2.22%
Clinical Records	2	1	1	2.22%
Patient Rights	1	0	1	2.22%
Compliance w/Fed, State, Local Laws	1	0	1	2.22%

**Appendix B Table 136: CHAP
Top Six Disparate CoPs for HHAs
67 Percent of all Disparate Surveys**

Hospice

CHAP (FY 2017 Hospice Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	17	17
Number of Surveys with Conditions Missed by AO	2	2
Disparity Rate	11.76%	11.76%

**Appendix B Table 147: CHAP
Hospice Disparity Rate
FY 2017**

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Quality Assessment & Performance Improvement	2	0	2	11.76%
Residents of SNF/NF or ICF/MR	2	1	1	5.88%
Short-Term Inpatient Care	1	0	1	5.88%
IDG, Care Planning, Coordination of Services	1	0	1	5.88%
Federal, State, Local Laws & Regulations	1	0	1	5.88%
Initial & Comprehensive Assessment of Patient	1	0	1	5.88%
Organizational Environment	1	0	1	5.88%
Infection Control	1	0	1	5.88%

**Appendix B Table 18: CHAP
Top Disparate CoPs for Hospice
100 Percent of all Disparate Surveys**

Center for Improvement in Healthcare Quality

Hospitals

CIHQ (FY 2017 Hospital Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	4	4	4
Number of Surveys with Conditions Missed by AO	4	0	4
Disparity Rate	100%	0%	100%

Appendix B Table 19: CIHQ
Hospital and LTCH Disparity Rate
FY 2017

CoP	Facilities with CoP	Matching Surveys	Disparate Surveys	Disparity Rate
Infection Control	5	2	3	75.00%
Governing Body	3	2	1	25.00%
Patient Rights	2	1	1	25.00%
Food and Dietetic Services	2	1	1	25.00%
Pharmaceutical Services	1	0	1	25.00%

Appendix B Table 150: CIHQ
Top Five Disparate CoPs for Hospitals and LTCHs
100 Percent of all Disparate Surveys

DNV GL-Healthcare

Hospitals

DNV GL (FY 2017 Hospital Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	15	15	15
Number of Surveys with Conditions Missed by AO	4	2	2
Disparity Rate	26.67%	13.33%	13.33%

Appendix B Table 161: DNV GL-Healthcare
Hospital Disparity Rate
FY 2017

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	4	2	2	13.33%
Medical Record Services	1	0	1	6.67%
Organ, Tissue, and Eye Procurement	1	0	1	6.67%

Appendix B Table 172: DNV GL-Healthcare
Top Three Disparate CoPs for Hospitals
100 Percent of all Disparate Surveys

Category	Total Cited by SA	Missed by AO	Disparity Rate
Electrical	15	15	27.27%
Sprinkler	9	8	14.55%
Hazardous Areas	7	7	12.73%
Fire/Smoke Barrier	9	6	10.91%
Doors	4	4	7.27%
Means of Egress	4	3	5.45%
Construction	3	3	5.45%
Cooking Facility	3	3	5.45%
HVAC	3	3	5.45%
Flammable & Combustible Storage	2	2	3.64%

Appendix B Table 23: DNV GL-Healthcare
Top 10 Missed LSC Citations for Hospitals
98 Percent of all Missed Citations

Critical Access Hospitals

DNV GL (FY 2017 CAHs)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	6	6	6
Number of Surveys with Conditions Missed by AO	1	0	1
Disparity Rate	16.67%	0%	16.67%

**Appendix B Table 184: DNV GL-Healthcare
CAHs Disparity Rate
FY 2017**

CoP	Facilities with CoP	Matching Surveys	Disparate Surveys	Disparity Rate
Provision of Services	2	1	1	16.67%
Periodic Evaluation and QA Review	1	0	1	16.67%
Surgical Services	1	0	1	16.67%
Organizational Structure	1	0	1	16.67%

**Appendix B Table 195: DNV GL-Healthcare
Top Disparate CoPs for CAHs
100 Percent of all Disparate Surveys**

The Joint Commission

Hospitals

TJC (FY 2017 Hospital and LTCH Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	71	71	71
Number of Surveys with Conditions Missed by AO	30	22	17
Disparity Rate	42.25%	30.99%	23.94%

**Appendix B Table 206: TJC
Hospital and LTCH Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	41	19	22	30.99%
Governing Body	21	9	12	16.90%
QAPI	10	2	8	11.27%
Infection Control	17	10	7	9.86%
Food and Dietetic Services	5	1	4	5.63%
Nursing Services	4	0	4	5.63%
Patient Rights	5	1	4	5.63%

**Appendix B Table 27: TJC
Top Seven Disparate CoPs for Hospitals and LTCHs
77 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Means of Egress	60	42	9.29%
Fire/Smoke Barrier	63	36	7.96%
Sprinkler	71	29	6.42%
Doors	38	24	5.31%
Fire Alarm	37	24	5.31%
Electrical	45	20	4.42%
Hazardous Areas	34	19	4.20%
Flammable & Combustible Storage	11	9	1.99%
Construction	13	8	1.77%
Emergency Lighting	9	8	1.77%

**Appendix B Table 2821: TJC
Top 10 Missed LSC Citations for Hospital
92 Percent of all Missed Citations**

Psychiatric Hospitals

TJC (FY 2017 Psychiatric Hospital Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	21	21	21
Number of Surveys with Conditions Missed by AO	12	9	9
Disparity Rate	57.14%	42.86%	42.86%

**Appendix B Table 29: TJC
Psychiatric Hospital Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	18	9	9	42.86%
Governing Body	11	5	6	28.57%
Infection Control	4	0	4	19.05%
QAPI	4	0	4	19.05%
Special Staff Requirements for Psychiatric Hospitals	4	1	3	14.29%
Nursing Services	5	2	3	14.29%

**Appendix B Table 30: TJC
Top Six Disparate CoPs for Psychiatric Hospitals
83 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire Alarm	28	24	16.78%
Means of Egress	20	14	9.79%
Hazardous Areas	13	10	6.99%
Construction	4	3	2.10%
Fire Plan	1	1	0.70%
Fire Drill	9	1	0.70%
Fire/Smoke Barrier	18	1	0.70%
Smoking Regulations	1	1	0.70%
Sprinkler	15	1	0.70%

**Appendix B Table 31: TJC
Missed LSC Citations for Psychiatric Hospitals
100 Percent of all Missed Citations**

Ambulatory Surgery Center

TJC (FY 2017 ASC Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	31	31	31
Number of Surveys with Conditions Missed by AO	14	8	11
Disparity Rate	45.16%	25.81%	35.48%

**Appendix B Table 222: TJC
ASC Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Environment	16	8	8	25.81%
Governing Body and Management	15	7	8	25.81%
Quality Assessment & Performance Improvement	7	2	5	16.13%
Infection Control	6	3	3	9.68%
Surgical Services	2	0	2	6.45%
Nursing Services	2	0	2	6.45%
Pharmaceutical Services	5	3	2	6.45%

**Appendix B Table 233: TJC
Top Seven Disparate CoPs for ASCs
94 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Medical Gas	13	8	8.89%
Electrical	7	6	6.67%
EES	4	4	4.44%
Fire Drill	6	3	3.33%
Means of Egress	5	3	3.33%
Anesthetizing Location	4	3	3.33%
Fire/Smoke Barrier	10	2	2.22%
Emergency Lighting	4	2	2.22%
HVAC	4	2	2.22%
Doors	2	1	1.11%

**Appendix B Table 244: TJC
Top 10 Missed LSC Citations for ASCs
94 Percent of all Missed Citations**

Home Health Agency

TJC (FY 2017 HHA Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	39	39
Number of Surveys with Conditions Missed by AO	4	4
Disparity Rate	10.26%	10.26%

**Appendix B Table 255: TJC
HHA Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Skilled Nursing Service	4	1	3	7.69%
Comprehensive Assessment of Patients	1	0	1	2.56%
Clinical Records	1	0	1	2.56%
Home Health Aide Services	2	1	1	2.56%
Therapy Services	1	0	1	2.56%
Acceptance of Patients, POC, Med Super	2	1	1	2.56%

**Appendix B Table 266: TJC
Top Six Disparate CoPs for HHAs
100 Percent of all Disparate Surveys**

Hospice

TJC (FY 2017 Hospice Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	14	14
Number of Surveys with Conditions Missed by AO	2	2
Disparity Rate	14.29%	14.29%

**Appendix B Table 37: TJC
Hospice Disparity Rate
FY 2017**

CoPs	Facilities with CoP	Matching Surveys	Disparate Surveys	Disparity Rate
IDG, Care Planning, Coordination of Services	2	1	1	7.14%
Initial & Comprehensive Assessment of Patient	1	0	1	7.14%

**Appendix B Table 38: TJC
Disparate CoPs for Hospice
100 Percent of all Disparate Surveys**

Critical Access Hospital

TJC (FY 2017 CAH Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	23	23	23
Number of Surveys with Conditions Missed by AO	9	8	2
Disparity Rate	39.13%	34.78%	8.70%

**Appendix B Table 39: TJC
CAH Disparity Rate
FY 2017**

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Plant and Environment	17	9	8	34.78%
Provision of Services	2	0	2	8.70%

**Appendix B Table 270: TJC
Disparate CoPs for CAHs
100 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire/Smoke Barrier	28	15	12.40%
Means of Egress	18	13	10.74%
Flammable & Combustible Storage	6	6	4.96%
Fire Alarm	9	4	3.31%
Doors	8	4	3.31%
Construction	3	2	1.65%
Fire Plan	3	2	1.65%
EES	2	2	1.65%
Hazardous Areas	9	1	0.83%
HVAC	4	1	0.83%

**Appendix B Table 41: TJC
Top Ten Missed LSC Citations for CAHs
98 Percent of all Missed Citations**

Program Types

Hospital

ALL AOs (FY 2017 Hospital and LTCH Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	95	95	95
Number of Surveys with Conditions Missed by AO	43	29	25
Disparity Rate	45.26%	30.53%	26.32%

Appendix B Table 42: Hospital Disparities FY 2017

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	55	26	29	30.5%
Governing Body	24	11	13	13.7%
Infection Control	24	13	11	11.6%
QAPI	12	3	9	9.5%
Food and Dietetic Services	7	2	5	5.3%
Patient Rights	7	2	5	5.3%

Appendix B Table 283: Top Six Disparate CoPs for Hospitals
81 Percent of all Disparate Surveys

Category	Total Cited by SA	Missed by AO	Disparity Rate
Means of Egress	93	65	8.52%
Fire/Smoke Barrier	106	64	8.39%
Sprinkler	112	50	6.55%
Electrical	80	49	6.42%
Doors	77	49	6.42%
Hazardous Areas	63	48	6.29%
Flammable & Combustible Storage	23	20	2.62%
Fire Alarm	52	18	2.36%
Construction	25	15	1.97%
Fire Extinguisher	22	13	1.70%

Appendix B Table 294: Top 10 Missed LSC Citations for Hospitals
93 Percent of all Missed Citations

Psychiatric Hospital

ALL AOs (FY 2017 Psychiatric Hospital Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	21	21	21
Number of Surveys with Conditions Missed by AO	12	9	9
Disparity Rate	57.14%	42.86%	42.86%

Appendix B Table 305: Psychiatric Hospital Disparities FY 2017

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Environment	18	9	9	42.86%
Governing Body	11	5	6	28.57%
Infection Control	4	0	4	19.05%
QAPI	4	0	4	19.05%
Nursing Services	5	2	3	14.29%
Special Staff Requirements for Psychiatric Hospitals	4	1	3	14.29%

Appendix B Table 46: Top Six Disparate CoPs for Psychiatric Hospitals
72 Percent of all Disparate Surveys

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire Alarm	28	24	16.78%
Means of Egress	20	14	9.79%
Hazardous Areas	13	10	6.99%
Construction	4	3	2.10%
Fire/Smoke Barrier	18	1	0.70%
Sprinkler	15	1	0.70%
Fire Drill	9	1	0.70%
Fire Plan	1	1	0.70%
Smoking Regulations	1	1	0.70%

**Appendix B Table 47: Top Nine Missed LSC Citations for Psychiatric Hospitals
100 Percent of all Missed Citations**

Ambulatory Surgery Center

ALL AOs (FY 2017 ASC Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	72	72	72
Number of Surveys with Conditions Missed by AO	26	15	18
Disparity Rate	36.11%	20.83%	25.00%

Appendix B Table 48: ASC Disparities FY 2017

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Environment	31	16	15	20.83%
Governing Body and Management	22	9	13	18.06%
Infection Control	18	8	10	13.89%
Quality Assessment & Performance Improvement	11	4	7	9.72%
Surgical Services	6	1	5	6.94%

**Appendix B Table 49: Top Five Disparate CoPs for ASCs
82 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Electrical	15	5	3.76%
Fire Drill	10	5	3.76%
Medical Gas	15	3	2.26%
Means of Egress	8	3	2.26%
Anesthetizing Location	4	3	2.26%
EES	5	2	1.50%
Construction	2	2	1.50%
Fire/Smoke Barrier	16	1	0.75%
Hazardous Areas	8	1	0.75%

**Appendix B Table 50: Top Nine Missed LSC Citations for ASCs
100 Percent of all Missed Citations**

Critical Access Hospital

ALL AOs (FY 2017 CAH Surveys)	All CoPs	PE	Health & Safety
Number of 60-Day Validation Surveys	32	32	32
Number of Surveys with Conditions Missed by AO	11	9	3
Disparity Rate	34.38%	28.13%	9.38%

Appendix B Table 51: CAH Disparities FY 2017

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Physical Plant and Environment	19	10	9	28.13%
Provision of Services	4	1	3	9.38%
Periodic Evaluation and QA Review	1	0	1	3.13%
Surgical Services	1	0	1	3.13%
Organizational Structure	1	0	1	3.13%

**Appendix B Table 52: Top Five Disparate CoPs for CAHs
100 Percent of all Disparate Surveys**

Category	Total Cited by SA	Missed by AO	Disparity Rate
Fire/Smoke Barrier	31	17	12.50%
Means of Egress	19	13	9.56%
Flammable & Combustible Storage	6	5	3.68%
Fire Alarm	10	3	2.21%
Construction	4	3	2.21%
Fire Plan	4	3	2.21%
Hazardous Areas	10	2	1.47%
Doors	8	2	1.47%
EES	2	2	1.47%
Interior Finish	2	2	1.47%

**Appendix B Table 53: Top 10 Missed LSC Citations for CAHs
96 Percent of all Missed Citations**

Hospice

ALL AOs (FY 2017 Hospice Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	34	34
Number of Surveys with Conditions Missed by AO	4	4
Disparity Rate	11.76%	11.76%

Appendix B Table 54: Hospice Disparities FY 2017

CoPs	Facilities with CoP(s)	Matching Surveys	Disparate Surveys	Disparity Rate
Quality Assessment & Performance Improvement	2	0	2	5.88%
IDG, Care Planning, Coordination of Services	3	1	2	5.88%
Initial & Comprehensive Assessment of Patient	2	0	2	5.88%
Infection Control	1	0	1	2.94%
Federal, State, Local Laws & Regulations	1	0	1	2.94%
Residents of SNF/NF or ICF/MR	2	1	1	2.94%
Short-Term Inpatient Care	1	0	1	2.94%
Organizational Environment	1	0	1	2.94%

**Appendix B Table 55: Disparate CoPs for Hospice Facilities
100 Percent of all Disparate Surveys**

Home Health Agency

ALL AOs (FY 2017 HHA Surveys)	All CoPs	Health & Safety
Number of 60-Day Validation Surveys	106	106
Number of Surveys with Conditions Missed by AO	13	13
Disparity Rate	12.26%	12.26%

Appendix B Table 56: HHA Disparities FY 2017

CoPs	Facilities with CoPs	Matching Surveys	Disparate Surveys	Disparity Rate
Skilled Nursing Service	14	5	9	8.49%
Acceptance of Patients, POC, Med Super	8	3	5	4.72%
Home Health Aide Services	5	3	2	1.89%
Clinical Records	3	1	2	1.89%
Comprehensive Assessment of Patients	1	0	1	0.94%
Evaluation of the Agency's Program	2	1	1	0.94%
Therapy Services	1	0	1	0.94%
Compliance w/ Fed, State, Local Laws	1	0	1	0.94%
Patient Rights	1	0	1	0.94%

**Appendix B Table 57: Top Five Disparate CoPs for HHAs
100 Percent of all Disparate Surveys**

APPENDIX C: Life Safety Code Category Definitions

Anesthetizing Location: Location where inhalation agents are used to produce sedation, analgesia, or general anesthesia.

Construction: Buildings should be classified to their type of construction based on the five different construction types: Type I, Type II, Type III, Type IV, and Type V with fire-resistive ratings.

Cooking Facility: An area for food preparation and commercial cooking operations requiring protection for exhaust and automatic extinguishing system.

Doors: The door assembly including any combination of a door, frame, hardware, and other accessories that is placed in an opening in a wall that is intended primarily for access or for human entrance or exit.

Electrical: Electrically connected energized with a source of voltage and general term of equipment, including fitting, devices, appliances, luminaires, apparatus, machinery and the like used as part of electrical installation.

Elevator: A machine used for carrying people and things to different levels in a building and components, machinery, and shaft.

Fire Plan: A fire or emergency management program that is documented and shall include four phases: mitigation, preparedness, response, and recovery.

Emergency Lighting: Emergency illumination provided for means of egress in designated areas and the performance of the system in relation to length of operation and testing.

Essential Electrical System (EES): A system comprised of alternate sources of power and all connected distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a health care facility during interruption of normal power sources, and to minimize disruption within the internal wiring system.

Eye Wash: An apparatus for irrigating the eyes after exposure to dust or other debris or chemical contamination. The shower directs one or two streams of water so that they flush over the eyes and lids and must be inspected and maintained.

Fire Alarm: A system or portion of a combination system that consist of components and circuits arranged to monitor and annunciate the status of fire alarm or supervisory signal initiating device to initiate the proper response to those signals.

Fire Drill: Practice of the fire plan to evacuate or relocate persons in the event of a fire, to be conducted quarterly for each shift.

Fire Extinguisher: A portable device, carried or on wheels and operated by hand, containing an extinguishing agent that can be expelled under pressure for the purpose of suppressing or extinguishing a fire.

Fire/Smoke Barrier: Fire compartment or Smoke compartment within a building enclosed by either a fire or smoke barrier on all sides including the top and bottom.

Flammable & Combustible Storage: Storage area for combustible materials that have a flash point at or above a 100° F and flammable materials that have a flash point at or below 100° F.

Furnishings and Decorations: Draperies, curtains, and other loosely hanging fabrics and films servicing as furnishings or decorations in health care occupancies.

Generator: A complete emergency power system coupled to a system of conductors, disconnecting means and overcurrent protective devices, transfer switches, and all control, supervisory, and support devices up to and including the load terminals of the transfer equipment needed for the system to operate as a safe and reliable source of electrical power.

Hazardous Areas: An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure.

Heating Venting Air Conditioning (HVAC): System components and air distribution; integration of ventilation of air conditioning system with building construction, including air handling rooms, protection of openings, and fire, smoke, and ceiling dampers; and automatic controls and acceptance testing.

Interior Finish: The exposed surfaces of walls, ceilings, and floors in a building.

Means of Egress: A continuous and unobstructed way of travel from any point in a building or structure to a public way consisting of three separate and distinct parts: (1) the exit access, (2) the exit, and (3) the exit discharge.

Medical Gas: A patient medical gas or support gas. An assembly of equipment and piping for the distribution of nonflammable medical gases such as oxygen, nitrous oxide, compressed air, carbon dioxide, and helium.

Smoking Regulations: Regulations adopted pertaining to locations prohibited, signs, and containers permitted for disposal.

Sprinkler: A system that consists of an integrated network of piping designed in accordance with fire protection engineering standards that includes a water supply source, a water control valve, a water flow alarm, and a drain. The system is normally activated from a fire and discharges water over the fire area through sprinkler heads.