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

Admin Info: 25-05-All

DATE: January 13, 2025

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Fiscal Year (FY) 2025 Mission & Priorities document (MPD) – Action

Memorandum Summary

The Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG) remain dedicated to ensuring the health and safety of all Americans. The FY 2025 MPD reflects this dedication, along with our ongoing commitment to strengthen oversight, enhance enforcement, increase transparency, and improve quality of care.

The MPD structure includes three sections: (1) new program updates since the issuance of the previous FY MPD; (2) standing information that we do not anticipate changing throughout the year; and (3) listing of the priority tier structure for survey & certification activities by provider and supplier type.

FY 2025 MPD updates include:

- Information on the Hospice Special Focus Program criteria;
- Revisions to Surveyor Guidance for Home Health Agencies (HHAs);
- Revised Facility Assessment guidance;
- New guidance on the use of Enhanced Barrier Precautions in LTC;
- Updates to Appendix PP/LTC Surveyor Guidance;
- New Surveyor Skills Review assessments for FY 2025;
- Announcement regarding the testing of a risk-based survey process for LTC;
- Revised guidance for ESRD facilities;
- Updates to the Transplant programs and survey process;
- New requirements for CMHCs based on the release of the Hospital Outpatient Perspective Payment System final rule (CMS-17860FC);
- New attestation requirements for PRTFs;
- Revised guidance regarding REH enrollment and conversion and updated FAQs; and
- Updates to the certification transition process

Background:

The MPD is an annual document that directs the work of QSOG, SOG, and State Survey Agencies (SAs) based on regulatory changes, adjustments in budget allocations, new initiatives, and new requirements based on statute. The MPD covers survey, certification, enforcement, and the Medicare funding allocation process for states. Survey activities must be scheduled and conducted per the priority tier structure provided in the MPD. The four priority tiers reflect statutory mandates and program emphases, with tier 1 being the highest priority and tier 4 being the lower priority.

In addition, the MPD provides background information for each of the 18-certified provider and supplier types, accreditation and deeming surveys, and CMS priorities for initial surveys of prospective providers and suppliers enrolling in Medicare. It also outlines the priorities for surveying relocations of existing providers and suppliers, projected validation survey workload, system requirements, state performance standards, and the upcoming surveyor training schedule. The MPD is intended to be a living document, as priorities may change throughout the year, and therefore will be updated, as necessary. These updates will be communicated via an Admin Info memo. For ease of identification, updates to the MPD and/or download(s) will be made in red, italicized font and posted on the QSOG Mission & Priority Information website: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/qsog-mission-and-priority-information.

Survey and Certification (S&C) Medicare Funding Allocation Process

The S&C program may operate under the terms and conditions of a Continuing Resolution, with funding based on the previous FY base budget, as noted in Appendix 1, column A, until such time that Congress passes a final appropriation for S&C funding.

Contact:

For questions or concerns relating to this memorandum, please contact your CMS Location.

Effective Date:

Immediately. Please communicate to all appropriate staff within 30 days.

/s/

Karen L. Tritz Director, Survey & Operations Group	David R. Wright Director, Quality, Safety & Oversight Group

Attachment(s):
FY 25 MPD
Appendix 1: FY25 MPD Projected Allocations
Appendix 2: Priority tier structure for survey & certification activities

Resources to Improve Quality of Care:

Check out CMS's new Quality in Focus interactive video series. The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid. Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the Quality, Safety, & Education Portal Training Catalog, and select Quality in Focus.

Policy Memos

Get guidance memos issued by the Quality, Safety and Oversight Group by going to CMS.gov page *and entering your email to sign up. Check the box next to "CCSQ Policy, Administrative, and Safety Special Alert Memorandums" to be notified when we release a memo.*

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Quality Assurance for the Medicare & Medicaid Programs

FY 2025 Mission & Priorities Document (MPD)

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New Guidance for FY 2025

Hospice Program

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

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

CMS published memorandum QSO-25-02-Hospice on October 4, 2024, which outlines the hospice SFP criteria and the roles and responsibilities for CMS, the SAs, and the accrediting organizations (AOs). The first SFP cohort will be selected by the end of CY 2024 and surveys will begin in January, 2025, and conducted by contracted surveyors. The SAs will continue to conduct all complaint investigations for allegations triaged at an IJ or Non-IJ High, including hospice programs in the SFP. SAs will enter complaint intakes into the iQIES system and inform the CMS SOG hospice subject matter expert at CMS_HospiceSFP@cms.hhs.gov about all outstanding non-IJ medium and non-IJ low complaints (pending prior to selection in the SFP). Please include "complaint" in the subject line of the email. When the hospice program completes the SFP and elects SA oversight (as opposed to an AO), the state is required to conduct a survey within one-year post-SFP completion, which will start a new standard 36-month survey cycle.

Home Health Agencies (HHAs)

CMS revised the State Operations Manual (SOM) Appendix B – Guidance for Surveyors: HHAs to include updates based on several final rules that amended HHA Conditions of Participation (CoPs). We made conforming revisions to the regulatory tags and interpretive guidelines. We also combined the HHA survey protocol and interpretive guidelines into one document, updated Level 1 tags, and made clarifications and technical corrections to other guidance based on stakeholder feedback. Several previously released S&C, QSO, and Admin Info memos with revisions to Appendix B are now obsolete and have been expired (see QSO-24-07-HHA).

CMS revised SOM Chapter 10 to provide procedures regarding the informal dispute resolution (IDR) process for both HHAs and hospice programs. The revisions also include guidance for SAs and the CMS SOG Locations on recommending and imposing HHA alternative sanctions and hospice enforcement remedies (see QSO-24-11-HHA & Hospice).

Long Term Care (LTC)

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

CMS published memorandum QSO-24-13-NH on June 18, 2024 revising guidance for State Survey Agencies and long-term care facilities (LTC) to align with the revised requirements for Facility Assessment. The revised requirements specify what the facility assessment must include, how the assessment should drive staffing decisions and inform the facility about what skills and competencies staff must possess. The assessment of the resident population should also contribute to identifying additional needs for residents or other material resources that are needed to provide the required care and services to residents. For additional information, please review QSO-24-13-NH.

CMS issued guidance for SAs and LTC facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include the use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The new guidance related to EBP was incorporated into F880 Infection Prevention and Control (QSO-24-08-NH).

CMS released revised Long-Term Care (LTC) Surveyor Guidance. to enhance quality and oversight of the LTC survey process. Revisions cover various regulatory areas and include clarifications and technical corrections throughout Appendix PP of the SOM.

CMS is testing a risk-based survey (RBS) approach that allows consistently higher-quality facilities to receive a more focused survey that takes less time and resources than the traditional standard recertification survey, while ensuring compliance with health and safety standards. Following completion of testing, CMS will present the next phase.

CMS announced a national campaign to support staffing in nursing homes to make it easier for individuals to enter careers in nursing home workforce, investing over $75 million in financial incentives such as scholarships and tuition reimbursement. CMS will provide more information as it becomes available.

End-Stage Renal Disease (ESRD) Facilities

CMS continues to monitor quality of care for all nursing home patients that receive home dialysis in their nursing home, skilled nursing facility, or other long-term care facility settings. On March 22, 2023, CMS revised policy memorandum QSO-18-24-ESRD, *Guidance and Survey Process for Reviewing Home Dialysis Services in a Nursing Home*. Surveyors should continue to perform onsite visits at the patient's place of residence to evaluate dialysis services provided by the ESRD facility using the survey procedures that were included in the memorandum. Surveyors will determine the number of nursing homes to visit by reviewing the agreements between the dialysis facility and nursing homes. A sliding scale for this calculation is included in QSO-18-24.

CMS categorizes Tier 2 survey activities of the top five (5) percent of ESRD facilities with poor clinical outcomes across defined clinical measures. Each year, CMS releases the ESRD facility Outcomes List, which establishes the state's workload for this Tier 2 work. Tier 2 facilities that are deemed by a CMS-approved AO are not the responsibility of the SA. In FY2024, CMS-approved ESRD facility AOs began implementing its procedures for performing Tier 2 surveys. SAs should review its Tier 2 list for the current fiscal year and confirm the facility's deeming status. AOs will continue to survey deemed Tier 2 ESRD facilities.

Transplant Programs

On October 10, 2024, CMS released two policy memoranda:

QSO-25-03-Transplant, *Revisions to the State Operations Manual (SOM), Chapter 2- The Certification Process; SOM Appendix X, Guidance to Surveyors: Organ Transplant Programs; and SOM Chapter 9- Exhibits – Advance Copy.* The memorandum provides a consistent approach to the transplant survey process and certification activities since surveying transplant programs transitioned to state survey agencies in 2019. CMS' updates include but are not limited to, the areas of pre-survey preparation, medical record review, clinical observations, and Quality Assurance and Performance Improvement (QAPI). The policy memorandum serves as an advance copy of the State Operations Manual (SOM) updates. Please refer to the CMS SOM website for the official versions of the chapters.

QSO-25-04-Transplant, *Outcome Requirements for Initial Transplant Program Approval.* The policy memorandum reiterates outcome requirements 42 CFR §482.80 and reminds CMS surveyors and State Survey Agencies (SA) to confirm the availability of outcomes data before initiating an onsite survey. If the outcomes data is not available, an onsite survey cannot be initiated and the SA should notify the prospective provider that the initial survey will occur once the data becomes available.

Community Mental Health Centers

On March 3, 2024, CMS released memorandum QSO-24-06-CMHC, *Revisions to Chapter 2 and Appendix F of the State Operations Manual (SOM) –Community Mental Health Centers (CMHCs).* CMS has revised the SOM to reflect changes associated with the November 22, 2023, release of the Hospital Outpatient Perspective Payment System (OPPS) final rule (CMS-1786-FC). These regulations include new requirements for intensive outpatient (IOP) services, new definitions added to personnel qualifications, and adding additional practitioners who may lead interdisciplinary team meetings as necessary. Additionally, the survey process is revised, and other revisions are included for clarity.

Psychiatric Residential Treatment Facilities

On July 12, 2024, CMS released memorandum Admin Info: 24-17-PRTF, *Psychiatric Residential Treatment Facility (PRTF) Self-Attestation of Compliance with Restraint and Seclusion Standards and Provider Agreement Validation for Certification and Recertification.*

During recertification surveys of PRTFs, SAs have found that some facilities do not have evidence of an attestation submitted to the State Medicaid Agency (SMA) and/or an active provider agreement with the SMA. CMS wants to ensure SAs have access to these required documents as part of the presurvey process. CMS is now requiring SAs to validate and input a certified PRTF's active provider agreement with the SMA into the survey documentation system at the time of a recertification survey. The SA will need to follow its established process (e.g., contacting the SMA or PRTF) to receive the attestation and now, the provider agreement, for input into the survey documentation system.

Rural Health Clinics and Federally Qualified Health Centers

Appendix G is being revised in FY2025 to concentrate on whether an RHC or FQHC is primarily engaged in 'outpatient' services rather than the previous definition of primarily engaged as 'primary care.'

Training and Education

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

SSR competency assessments will be released by provider type and in a phased approach. The list below shows the FY 2025 SSRs available on QSEP:

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

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

Rural Emergency Hospitals (REH)

FY 24 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital final rule published on August 28, 2023 codified the requirements for additional information that an eligible facility would be required to submit when applying for enrollment as a Rural Emergency Hospital (REH) at 42 CFR 488.70 *Special Requirements for Rural Emergency Hospitals*, as specified in the Consolidated Appropriations Act (CAA), 2021.

On September 6, 2024, CMS released revisions to QSO 23-07-REH, *Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation.* CMS revised guidance regarding the REH enrollment and conversion process for eligible facilities and updated Frequently Asked Questions (FAQs). The final interpretive guidance for REHs is pending and will be provided in a future release.

Certification Transition Process

To improve the enrollment certification process for Medicare-participating certified providers and suppliers, CMS transitioned certain certification-enrollment functions performed by the CMS Locations to CMS' Center for Program Integrity/Provider Enrollment and Oversight Group (CPI/PEOG) and the MACs. The workload transition commenced on November 7, 2022. CMS recently updated the standard operating procedures (SOPs) in the Admin Info memo on August 23, 2024 (see Admin Info: 24-22-ALL) to clarify initial certification processes for providers/suppliers seeking deemed via a CMS-approved AO. For all transitioned providers/suppliers annotated within the SOPs, with the exception of HHAs and Hospices, an AO may proceed with an initial survey once it is in receipt of the MAC recommendation letter and a copy of the facility's State license or State approval under a certification of need (CON) program (if either requirement is applicable under State law). For HHAs and Hospices, the AO must not conduct an initial survey until the SA has provided approval to the AO.

Standing Guidance

Purpose & Overview

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

Regulations

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

Priority Tier Structure for Survey & Certification Activities Overview

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

States are not required to complete tier 1 or tier 2 work before beginning the lower tiers, if the multi-tier work has been included in the state's approved budget submission, which describes how the State will complete Survey and Certification program goals and objectives. States must not make the scheduling and completion of such surveys a higher priority than their tier 1 and 2 workload, nor of their other initial certification survey workload. For guidance on addressing the backlog of complaint and recertification surveys, please refer to QSO-22-02-All.

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

We note that timely and successful uploading of complete survey kits into the designated electronic system is an essential component of the states' workload. States must implement measures to assure that these uploads are completed.

To streamline the enrollment and certification process for Medicare-certified providers/suppliers, certain certification functions previously performed by SOG, have transitioned to CMS' Center for Program Integrity (CPI) Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MACs). The MACs will process changes on the enrollment application without an approval recommendation from SOG and will coordinate directly with the state and Accrediting Organizations (AOs), when necessary. CPI/PEOG will be responsible for signing applicable provider agreements on behalf of CMS. The transition of certification enrollment work includes voluntary terminations, changes of ownership (CHOWs), administrative changes, and initial certification enrollment work for the majority of providers and suppliers: Ambulatory Surgical Centers (ASCs), Community Mental Health Centers (CMHCs); Comprehensive Outpatient Rehabilitation Facilities (CORFs); Home Health Agencies (HHA), Outpatient Physical Therapy/Outpatient Speech Pathology (OPT/OSP) and, Portable X-

Ray (PXR) Providers, Hospitals (including psychatric hospitals and transplant programs), Hospices, and ESRD Facilities. SOG will still remain responsible for processing enforcement actions. For additional information on the transition, please see Admin Info 20-08-ALL, Admin Info 21-06-ALL and Admin Info 22-02-ALL.

Provider and Supplier Oversight

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

Deeming options

Due to ongoing survey and certification resource constraints, initial certifications of providers/suppliers with the option to achieve deemed Medicare status through accreditation by an Accrediting Organization (AO) with CMS-approved deeming authority are a tier 4 priority for the SAs.

Despite the option for accreditation, End-Stage Renal Dialysis Facilities (ESRD) initial surveys will be a tier 1 priority because of the statutory requirement that initial surveys begin within 90 days after the Medicare Administrative Contractor (MAC) approves the CMS-855.

Providers/Suppliers with an accreditation option include:

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

CMS-Approved Accrediting Organizations (AOs):

- Accreditation Association for Ambulatory Health Care (AAAHC) - ASCs
- Accreditation Commission for Healthcare, Inc. (ACHC)- ASCs, CAHs, HHAs, Hospices, ESRD facilities
- American Association for Accreditation of Ambulatory Surgery Facilities (QuadA)- ASCs, OPT/SLP, RHCs
- Center for Improvement in Healthcare Quality (CIHQ)- CAHs, Hospitals, Psychiatric Hospitals
- Community Health Accreditation Partner (CHAP)- HHAs, Hospices

- DNV Healthcare- CAHs, Hospitals, Psychiatric Hospitals
- National Dialysis Accreditation Commission (NDAC) – ESRD Facilities
- The Compliance Team (TCT) - RHCs
- The Joint Commission (TJC) – ASCs, CAHs, HHAs, Hospices, Hospitals, Psychiatric Hospitals

For additional information please visit: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf

All other newly applying providers/suppliers not listed in tier 3 will be classified as tier 4 priorities unless approved on an exception basis by the CMS Location due to serious healthcare access considerations or similar special circumstances.
These affected Medicare providers/suppliers include:

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

Ambulatory Surgical Centers (ASCs)

Overview:
An ASC is a distinct entity that operates exclusively to provide surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.

Medicare-certified ASCs must comply with Medicare health and safety standards found at 42 CFR Part 416, including the Conditions for Coverage (CfCs).

Additional survey information:
States must continue to use the Infection Control Surveyor Worksheet (Exhibit 351) for each full survey of an ASC and any complaint surveys with an infection control allegation, to ensure that all applicable areas listed on the worksheet are assessed.

Validation Surveys:
States will continue to be responsible for conducting substantial allegation complaint surveys for deemed ASCs. However, in FY 24, states will not be conducting representative sample validation surveys.

Beneficial training courses:
The following courses are available 24/7 online via the CMS Quality, Safety and Education Portal (QSEP) (https://qsep.cms.gov for ASC surveyors as well as Medicare-certified ASCs and may be useful:

- Ambulatory Surgical Center Basic Training

- Ambulatory Surgical Center Refresher Training
- Universal Infection Prevention and Control

Priority tier structure for survey & certification activities for ASCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint Investigations prioritized as IJ – deemed ASCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	**Targeted Surveys (25%):** The state performs surveys totaling 25% of all non-deemed ASCs in the state (or at least 1, whichever is greater) focusing on ASCs not surveyed in more than 4 years or based on state judgment for those ASCs more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 priority. States with seven or fewer non-deemed ASCs must survey at least one ASC unless all non-deemed ASCs were surveyed within the prior two years. **Complaint investigations prioritized as non-IJ high**: to be initiated within 45 days (for deemed ASCs, within 45 days of CMS Location authorization). **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a**	**6-Year Interval:** Additional surveys are done to ensure that no more than six years elapse between surveys for any one particular non-deemed ASC. **Initial certification**- All others not listed under Tier 1 or 2	

	deeming option- If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.		

Contact Information:

- For questions, please contact: QSOG_ASC@cms.hhs.gov.

Providers of Outpatient Physical Therapy (OPT) and Speech-Language Pathology (SLP) Services

Overview:
Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of OPT and SLP services are required to comply with the federal requirements outlined in the Medicare Conditions of Participation (CoP) to receive Medicare/Medicaid payment. Outpatient rehabilitation therapy services include physical therapy (PT), including aquatic therapy, occupational therapy (OT), and SLP services.

Many rehabilitation agencies provide services from extension sites (an additional approved practice location) or in other off-premise locations in addition to their primary site of certification. SAs should ensure extension locations are incorporated into the survey process by selecting a sample of extension locations to survey in addition to the primary site. Additionally, SAs should inquire about off-premises services to determine if these should be extension locations (see SOM Chapter 2, Section 2300).

Validation Surveys:

States will continue to be responsible for conducting substantial allegation complaint surveys for deemed OPTs. However, in FY 24, states will not be conducting representative sample validation surveys.

Priority tier structure for survey & certification activities for Providers of OPT & SLP services

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized as IJ	**5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, whichever is greater),	**7-Year Interval**: Additional surveys are done to ensure that no more than seven years elapse between surveys for	**6-Year Avg:** Additional surveys are done (beyond tiers 2-3) such that all non-deemed providers in the state

Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	based on state judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 and 4 priorities. States with fewer than seven providers of this type are exempt from this requirement. **Complaint investigations prioritized as non-IJ high**: to be initiated within 45 days (for deemed, within 45 daysof CMS Location authorization). **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option -** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	any one particular provider. **Initial certification**- All others not listed under Tier 1 or 2	are surveyed, on average, every six years. (i.e., total surveys divided by total providers is not less than 16.7% = six years). There is a deemed status option for OPTs.

Contact Information:

- For questions, please contact: QSOG_OPT@cms.hhs.gov.

Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Overview:
A CORF is a facility established and operated at a single fixed location exclusively to provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician, and meets all the requirements of Subpart B –Conditions of Participation (CoPs): Comprehensive Outpatient Rehabilitation Facilities.

Additional survey information:
CORFs are surveyed every six years at a minimum.

Priority tier structure for survey & certification activities for CORFs

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

Contact Information:

- For questions, please contact: QSOG_CORF@cms.hhs.gov.

Community Mental Health Centers (CMHCs)

Overview:
The CoPs for CMHCs can be found at 42 CFR Part 485, Subpart J. The survey interval for the CMHCs will be every five years and fall into a tier 3 workload.

For additional guidance, please see: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CommunityHealthCenters and https://www.cms.gov/files/document/som107apfcmhc.pdf

Additional survey information:
CMS enters into agreements with CMHCs according to the provision of Partial Hospitalization Services. CMHCs must provide at least 40% of their services to non-Medicare patients. This requirement is monitored by the MAC.

Priority tier structure for survey & certification activities for CMHCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations triaged as IJ **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option	**5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, whichever isgreater), based on CMS Location judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 priorities. Targeted sample requirements do not apply to states with fewer than seven CMHCs. **Complaint Investigations: non-IJ high**	**5-Year Interval** **Initial certification-** All others not listed under Tier 1.	

Tier 1	Tier 2	Tier 3	Tier 4
exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			

Contact Information:

- For questions, please contact: CMHC@cms.hhs.gov.

End-Stage Renal Disease (ESRD) Dialysis Facilities

Overview:
A dialysis facility provides outpatient maintenance dialysis services, and/or home dialysis training and support services. A dialysis facility may be an independent or hospital-based unit. Dialysis facilities must be certified for inclusion in the Medicare Program by validating that the care and services of each facility meet specified safety and quality standards set forth by the CfC at 42 CFR Part 494.

States are responsible for conducting initial, re-certification, complaint, and associated revisit surveys of ESRD facilities (whether independent or hospital-based).

Accreditation for ESRD Facilities:
Effective January 4, 2019, ESRD facilities were given the option to seek entry into the Medicare program through a CMS-approved AO.

ESRD suppliers may participate through deemed status for initial and re-certification surveys by a CMS-approved accrediting organization.

Validation Surveys:
States will continue to be responsible for conducting substantial allegation complaint surveys for deemed ESRD facilities. However, in FY 24, states will not be conducting representative sample validation surveys.

Notable aspects of the ESRD survey responsibilities include:

- **Outcomes List Surveys:** CMS produces an Outcomes List annually which establishes the Tier 2 survey priorities for state agencies. The Outcomes List is a confidential report and ranks Medicare-certified dialysis facilities using clinical performance measures (defined below). State agencies are expected to survey 100% of the facilities that are ranked in the bottom 5% for performance and outcomes. Effective October 1, 2023, CMS-approved accrediting organizations as responsible for deemed Tier 2 facilities. If a facility on the Outcomes List is identified as a deemed facility by a CMS-approved AO,

the facility may be removed from the state's tier 2 workload. No further action by the SA is needed.

Deferment Criteria:
Dialysis facilities that are ranked in the bottom 5th percentile for performance on multiple, consecutive Outcomes Lists are being (or have the potential to be) surveyed more frequently than expected. To reduce duplicative survey efforts, CMS is providing flexibility towards completion of its surveys from the [current fiscal year] Outcomes List by allowing deferral of certain tier 2 surveys if **all** of the following conditions are met:

1. The facility identified in the [current fiscal year] Outcomes List was identified and surveyed based on the [previous fiscal year] Outcomes List;
2. The prior survey was performed within the last 12 months;
3. The prior survey resulted in no citations or standard-only citations with an accepted plan of correction;
4. There are no recent complaints against the facility triaged as immediate jeopardy (IJ) or non-IJ high; and
5. There are no other quality of care concerns. Information about quality of care concerns should be obtained from the ESRD Network that is assigned to the facility location.

- **Relocations:** As updated in the State Operations Manual, Chapter 2 for ESRD, requests for relocations, expansion of services, and/or addition of stations no longer automatically require an onsite survey. CMS Locations are to use the information available to them to determine whether an onsite survey or a desk review is most appropriate to process the request. If a CMS Location or SA receives a request for the above actions and determines that an onsite survey is needed, this should be treated as a tier 3 priority and completed as such. See SOM, Chapter 2, Section 2280 for additional guidance.

- **Expanding Services**: When a dialysis facility submits a request to add a service with a CMS-3427 form, the state agency should review the service(s) being added to determine whether an onsite survey is required. Certain services require an onsite survey for determination of approval or denial, while others may be processed with a desk review. For example, an onsite survey is generally not required for a dialysis facility that is requesting to add a home peritoneal dialysis training and support program when the dialysis facility already has an approved home hemodialysis training and support program. CMS and state agencies should refer to the SOM, Chapter 2, Section 2280 for additional guidance on when surveys are required. If an onsite survey is required, this should be categorized as a Tier 3 survey. Surveys for adding a service should be prioritized in a higher tier category when an access to care issue has been identified.

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

QSOG Website for ESRD Data Reports:

The state agency and CMS locations are responsible for assigning a Master Account Holder (MAH) to access these reports on the CMS ESRD data website at www.dialysisdata.org. The MAH may grant permission for report access to other designated users in the state or CMS location. For issues accessing the website or the reports contained in the website, please email ESRDQuestions@cms.hhs.gov.

The states and CMS locations are expected to use the available data reports on this site as a resource during the survey process and to assist in identifying annual survey priorities. The CMS ESRD data website contains the following reports for review:

- Dialysis Facility Reports (DFR) – These reports are released each FY and provide information on patient characteristics, treatment patterns, hospitalizations, mortality, and transplantation patterns for each Medicare-certified facility. The DFR characterizes selected aspects of clinical experience for an individual facility relative to other dialysis facilities in the state, ESRD Network, and across the United States. Since these data reports are useful for quality improvement and assurance activities, each state's surveying agency uses the DFR report as a resource during the S&C process to identify data-driven focus areas for review during a survey.
- Quarterly DFR Reports (Pre-survey data extract) – The quarterly DFR report, also referred to as the pre-survey data extract, provides more recent data on select measures of the comprehensive DFR including infection, fluid management, anemia, adequacy, nutrition and mineral metabolism. These reports are released on a quarterly basis in December (Q1), March (Q2), June (Q3) and September (Q4 – annual DFR).
- Outcomes List – The Outcomes List is a confidential list for use by state agencies and CMS locations for determining annual survey priorities. The annual Outcomes List applies to tier 2 (targeted) survey priorities and identifies the top 5% of ESRD facilities with poor clinical outcomes across four defined clinical measures based on their potential to impact patient outcomes.

  For FY2025, the defined clinical measure remains unchanged and includes:
  - Mortality
  - Hospitalizations
  - Hospitalizations related to septicemia
  - Long-term catheter
  - Percent of Prevalent Patients Waitlisted (PPPW)

The annual process for releasing and reviewing the Outcomes List will remain the same, i.e. available on www.dialysisdata.org at or near the start of each fiscal year.

Requirements for ESRD Surveyors:

State specialization of ESRD surveyors: states are expected to maintain a sufficient number of qualified ESRD surveyors. States must be prepared to survey ESRD facilities for such

technically and clinically complex areas as water treatment safety, dialyzer reuse safety, specialized infection control and prevention precautions, equipment operation and maintenance, and assessing clinical outcomes. The emphasis of the ESRD Core Survey process focuses on those practice patterns that are known to affect mortality and to provide potential safety risks to patients. The specialized and complex nature of the equipment and processes required for dialysis and for the safe, effective care and clinical management of an ESRD patient's course of treatment demands an equally complex survey process. The ESRD Core survey process is not intuitive and, to be implemented effectively, requires the surveyor to possess significant knowledge in the technical aspects of water treatment, dialysate preparation, infection control, dialysis equipment usage and maintenance, as well as in the safe care and clinical management of the many complex medical, psychosocial, and economic effects that ESRD has on each patient.

Before inclusion on an ESRD survey team (except as an observer or trainee/orientee), the surveyor must complete the following requirements:

- Online basic training, available on-demand on QSEP: https://qsep.cms.gov
    - ESRD Basic Core Survey Training
    - Immediate Jeopardy (Update) Training
    - Emergency Preparedness Basic Training
    - Surveyor Field Experience
- On-the-job participation in at least two ESRD surveys with preceptor including return demonstration of tasks.
- After successful completion of one ESRD survey with a preceptor, the new surveyor must complete one additional supervised ESRD survey as lead surveyor

Priority tier structure for survey & certification activities for ESRD

Tier 1	Tier 2	Tier 3	Tier 4
Investigation of complaint allegationstriaged as IJ. **Initial surveys**: States must conduct initial certification surveys within 90 days of the MAC approval of the CMS-855, unless the supplier has elected a deeming option.	**Outcomes List**: 100% of the ESRD facilities in the state on the Outcome List **Investigations of complaint allegations triaged as High**	**3.5-Year Max Interval (42.9 months)**: Additional surveys are done to ensure that no more than 3.5 years elapse between surveys for any one particular ESRD facility. **Investigations of complaint allegations triaged as medium.** **Relocations, expansion of service(s), and/or**	**3-Year Average:** Additional surveys are done (beyond tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of three years or less.

Tier 1	Tier 2	Tier 3	Tier 4
		addition of station(s) requests, as needed	

Contact Information:

- For questions, please contact: ESRDQuestions@cms.hhs.gov.

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

Overview:
Medicare-certified RHCs are located in rural areas designated as a shortage area, are not a rehabilitation agency or a facility primarily for the care or treatment of mental diseases. FQHCs are located in both rural/urban areas designated as shortage areas.

RHCs operate for the main purpose of providing primary care services to Medicare patients located in rural and shortage areas. FQHCs provide primary care services and dental care services to rural/urban areas and shortage areas. Both RHCs and FQHCs must comply with the applicable Medicare health and safety standards found at 42 CFR Part 491.

Medicare-participating FQHCs are not subject to certification and re-certification surveys as they self-attest to compliance. However, for FQHCs, CMS investigates complaints of credible allegations of substantial violations of CMS regulatory standards as a tier 2 priority. States will use most of the same health and safety standards as they do for RHCs when investigating FQHC complaints as detailed in Appendix G of the SOM.

Beneficial training courses:

The following courses are available 24/7 online via QSEP for RHC and FQHC surveyors, as well as Medicare-participating RHCs and FQHCs and may be useful:

- RHC/FQHC Basic Training

RHC/FQHC Resource Information:

- RHC/FQHC Regulations – CfCs 42 CFR 491
- RHC Interpretive Guidelines SOM: Appendix G
- SOM Chapter 2 – RHCs, sec. 2240 and FQHCs, sec. 2825

S&C activities for FQHCs and RHCs:
States will survey a 5% targeted sample of RHCs, with at least one in those states where 5% is less than one RHC. This tier 2 sample is not required for any state that has fewer than seven RHCs. States will select the sample, focusing on RHCs that have not been surveyed in more than 6 years and/or RHCs that represent a greater risk of quality problems based on their recent compliance history or other factors known to the state. States should use their individual history of growth, in addition to any state and local events/initiatives, as a guide to project workloads.

Validation Surveys:
States will continue to be responsible for conducting substantial allegation complaint surveys for deemed RHCs. However, in FY 24, states will not be conducting representative sample validation surveys.

Priority tier structure for survey & certification activities for FQHCs and RHCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized IJ- deemed RHCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Complaint investigations prioritized as IJ-FQHCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	5% Targeted Surveys- RHCs: Each year, the state surveys 5% of non-deemed RHCs (or at least one, whichever is greater), based on state judgment prioritizing those RHCs most at risk of quality problems. Some of the targeted surveys may qualify to count toward the tiers 3 and 4 priorities. States with fewer than seven RHC s are exempt from this requirement. Complaint investigations prioritized as non- IJ high: to be initiated within 45 days of the prioritization (for deemed RHCs, within 45 days of CMS Location authorization). Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option- If	7-Year Interval: Additional surveys are done to ensure that no more than seven years elapse between surveys for any RHC. Initial certification- All others not listed under Tier 1 or 2	**6-Year Average**: Additional surveys are done (beyond tiers 2-3) such that all non-deemed RHCs in the state are surveyed, on average, every six years. (i.e., total surveys divided by total RHCs is not less than 16.7%). There is no certification or re-certification requirement for FQHCs.

Tier 1	Tier 2	Tier 3	Tier 4
	more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.		

Contact Information:

- For questions, please contact: QSOG_RHC-FQHC@cms.hhs.gov.

Home Health Agencies (HHAs)

Overview of HHAs:
Basic Expectations: Under Section 1891(b) of the Act, the Secretary is responsible for assuring that CoPs and the resulting enforcement are adequate to protect the health and safety of individuals under the care of an HHA and to promote the effective and efficient use of Medicare funds. Under Sections 1861(o), 1864, and 1891(c) of the Act, SAs conduct surveys of HHAs to determine whether they are complying with the CoPs. HHA surveys should include a sample of extension locations, as applicable.

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

Surveyor Qualifications: Before any state or federal surveyor may serve on a HHA survey team (except as a trainee), he/she must complete the HHA Basic Surveyor Training course located in QSEP. Additionally, prior to finalizing the survey team, SAs must ensure that no conflicts of interest are present between surveyors and the HHA being surveyed. Section 488.735(b) sets out the circumstances that would disqualify a surveyor from surveying a particular agency.

V*alidation Surveys:* States will continue to be responsible for conducting substantial allegation complaint surveys for deemed HHAs. However, in FY 24, states will not be conducting representative sample validation surveys.

Important Notes:

- At this time, QSOG will continue to fund OASIS Education Coordinators (OEC) and OASIS Automation Coordinators (OAC). The OECs will provide technical assistance to

the HHA providers in the administration of the OASIS data set. The OACs will provide technical assistance to the HHA providers on the transmission of OASIS data.

- CMS no longer provides in person trainings specifically for OASIS Coordinators in reference to their duties but all trainings old and new, webinars and reference materials involving the OASIS are announced and posted on the Home Health Quality Reporting (QRP) page at the following link: https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-training The Division of Quality Systems for Assessments and Surveys (DQSAS) continues to provide technical support to the OACs.
- Contact information for OECs and OACs in each state is located on the following CMS website: OASIS Education Automation Coordinators

Priority tier structure for survey activities for HHAs

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapse between completed surveys for any particular agency. **Complaint investigations triaged as IJ.** SA must initiate an onsite survey within 2 business days of receipt. **Substantial Allegation Validation (Complaint) Surveys – IJs for deemed and non-deemed HHAs**: Only when authorized by the CMS Locations, complaint surveys are to be initiated onsite by the SA within two business days of CMS Location authorization.	**Complaint investigations prioritized as: Non-IJ High: SA must initiate an onsite survey within 45 calendar days of prioritization.** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**Initial certification-** All others not listed under Tier 1 or 2	**24.9 Mo. Avg**: Additional surveys (beyond tiers 1-3) done based on state judgment regarding HHAs most at risk of providing poor care so all HHAs are surveyed on average every 24 mos. (average of all tier 4 surveys ≤ 24.9 mos. to optimize the unpredictability of surveys. **Surveys of HHAs de-activated (by the MAC)–**for failure to bill Medicare for 12 consecutive months.

Tier 1	Tier 2	Tier 3	Tier 4
Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)			

Contact Information:

- For questions, please contact: HHAsurveyprotocols@cms.hhs.gov.
- For OASIS technical questions, please contact: HomeHealthQualityQuestions@cms.hhs.gov.

Hospice Agencies

Overview:
The requirement to survey hospice programs every 36 months was initially established in the IMPACT ACT 2014 and has been extended recently under the CAA 2021.

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

Survey Frequency:
Standard Survey- Each hospice program is subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months.

Complaint Investigation Surveys- A complaint investigation must be conducted of a hospice program when complaints against the hospice program are reported to CMS, the State, or local agency.

Surveyor Qualifications: Before any state or federal surveyor participates on a hospice survey team (except as a trainee), they must complete the Basic Hospice training course, which was updated in 2021. Additionally, prior to finalizing the survey team, SAs must ensure that no conflicts of interest (COI) are present between surveyors and the hospice program being surveyed. Section 488.1115(b) sets out the circumstances that would disqualify a surveyor from surveying a particular hospice program. A means for attesting to COI is available in the Internet Quality Improvement and Evaluation System (iQIES).

Survey Transparency: CMS is currently posting hospice survey reports in a prominent, easily accessible, readily understandable, and searchable manner, on the CMS Quality, Certification and Oversight Reports (QCOR) site (https://qcor.cms.gov/hosp_surveys/Hospice_landing.html), with plans to transfer to Care Compare in the future.

Multi-disciplinary survey teams: The CAA 2021 requires that hospice surveys conducted by more than one individual shall be conducted with a multidisciplinary team of professionals (to include at least one RN) (see 42 CFR 488.1120). This was effective December 27, 2020. A means for tracking team composition is available in iQIES.

Hospice Hotline: The CAA 2021 requires the SA to establish a toll-free hospice complaint hotline (see 42 CFR 488.1110). In the face of limited life expectancy, hospice patients and families must have a meaningful and effective mechanism to report concerns and complaints in a timely manner. Therefore, we are asking that SAs conduct a review of their hospice complaint hotline information in the Hotline Directory on CMS.gov on a monthly basis. SAs should test links and phone numbers to ensure accuracy. If the hotline URL and/or phone number needs updating, the SA should email their CMS Location point of contact with the corrected information.

Enforcement Remedies: The development and implementation of enforcement remedies for noncompliant hospice programs (See 42 CFR 488.1200-1265). CMS developed guidance on the new hospice enforcement actions in Chapter 10 of the SOM.

Ensuring consistency of hospice survey results: CMS is developing processes to facilitate consistency across surveying entities (CMS, States, Accrediting Organizations).

Special Focus Program (SFP): The hospice SFP provision was finalized in the CY 24 Home Health Prospective Payment System Rate Update Final Rule (CMS-1780-F), published on November 13, 2023. The final rule is available on the federal register: https://www.federalregister.gov/public-inspection/2023-24455/medicare-program-calendar-year-2024-home-health-prospective-payment-system-rate-update-quality

CMS published memorandum QSO-25-02-Hospice on October 4, 2024, which outlines the hospice SFP criteria and the roles and responsibilities for CMS, the SAs, and the accrediting organizations (AOs). The first SFP cohort will be selected by the end of CY 2024 and surveys will begin in January, 2025, and conducted by contracted surveyors. The SAs will continue to conduct all complaint investigations for allegations triaged at an IJ or Non-IJ High, including hospice programs in the SFP. SAs will enter complaint intakes into the iQIES system and inform the CMS SOG hospice subject matter expert at CMS_HospiceSFP@cms.hhs.gov about all outstanding non-IJ medium and non-IJ low complaints (pending prior to selection in the SFP). Please include "complaint" in the subject line of the email. When the hospice program completes the SFP and elects SA oversight (as opposed to an AO), the state is required to

conduct a survey within one-year post-SFP completion, which will start a new standard 36-month survey cycle.

Validation Surveys:
States will continue to be responsible for conducting substantial allegation complaint surveys for deemed hospices. However, in FY 25, states will not be conducting representative sample validation surveys.

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

Priority tier structure for survey & certification activities for Hospice agencies

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapse between completed surveys for any particular agency. **Complaint investigations prioritized as IJ – deemed and non-deemed hospices**: only with CMS Location authorization; onsite survey to be initiated within two business days of CMS Location authorization. **Initial certification** - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for	**Complaint investigations prioritized as: Non-IJ High: SA must initiate an onsite survey within 45 calendar days of prioritization.** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**Initial certification**- All others not listed under Tier 1 or 2	

Tier 1	Tier 2	Tier 3	Tier 4
providing the information)			

Contact Information:

- For questions, please contact: QSOG_Hospice@cms.hhs.gov.

Hospitals and Psychiatric Hospitals

Hospitals:
Overview: The CoPs for Hospitals can be found at 42 CFR Part 482.

For Hospitals/CAHs with swing beds, the requirements will continue to be surveyed as part of a scheduled hospital or CAH survey and do not need to be targeted for a separate, stand-alone survey, unless:

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

Note - For non-deemed hospitals or CAHs that wish to add swing-beds as a new service, see the tier status for scheduling those surveys. States must include swing-bed re-certification during hospital and CAH re-certification surveys.

Appendix A (Hospital guidance) and Appendix W (CAH guidance) swing-bed sections of the SOM have been updated to align with the LTC rules and refer to Appendix PP (LTC guidance). Appendix A and Appendix W will be utilized for surveying hospitals and CAHs, respectively, that have swing-beds. See QSO-18-26-Hospitals, CAHs for additional details.

For deemed and non-deemed hospitals/CAHS, beginning November 1, 2024, QSOG will assess the CoP for Hospital/CAH Reporting for Respiratory Illness. See QSO-25-05-Hospitals/CAHS.

Informed Consent For Hospital Conditions of Participation (CoPs): the Patient's Rights CoP at 42 CFR 482.13(b)(2); the Medical Record Services CoP at 482.24(c)(4)(v); and the Surgical Services CoP at 482.51(b)(2), additional guidance has been developed to reinforce hospitals' informed consent obligations due to increasing concerns about the absence of informed patient consent before allowing practitioners or supervised medical, advanced practice provider, or other applicable students to perform training- and education-related examinations outside the medically necessary procedure (such as breast, pelvic, prostate, and rectal examinations), particularly on anesthetized patients. The new guidance describes how surveyors must ensure that a hospital's patient informed consent policy and process, as well as its informed consent forms, contain elements and information that allow for a patient, or his or her representative, to make fully informed decisions about their care. See QSO-24-10-Hospitals.

Texting of Patient Information and Patient Orders for Hospitals and CAHs: New guidance has been added to the hospital and CAH medical record CoPs at 42 CFR 482.24 and 485.638, respectively, allowing for the texting of patient information and patient orders. All of the orders either written or text, require inpatient and outpatient medical records be accurately written, promptly completed, properly filed and retained, and accessible. Also, the hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. These requirements do not specify a specific method or system that must be used for author identification and record maintenance. See QSO-24-05-Hospital/CAH.

Emergency Medical Treatment & Labor Act (EMTALA) Investigations:
Based on CMS Location review of the allegations, the complaint may be classified as IJ or non-IJ high. The timeline for investigations in hospitals and critical access hospitals (CAH) for immediate jeopardy complaints specific to EMTALA and deaths associated with restraint or seclusion must be initiated within two business days. Non-IJ high prioritization requires the survey to be initiated within 45 days.

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

Psychiatric Hospitals:
Most Medicare-certified psychiatric hospitals participate via deemed status, based on their accreditation by The Joint Commission (TJC), Center for Improvement in Healthcare Quality (CIHQ) or DNV Healthcare (DNV). However, a small number of psychiatric hospitals have grandfathered partially deemed status (i.e., they are deemed for the regular hospital CoPs only by the Accreditation Commission for Healthcare, Inc. (ACHC) or DNV, leaving states responsible for surveying them for the two special conditions). This practice stems from a time when no AO had an approved psychiatric hospital Medicare deeming program. Although CMS no longer permits ACHC or DNV to partially deem new psychiatric hospital clients, we have grandfathered their existing psychiatric hospital clients. There are less than ten hospitals that remain partially deemed and partially under state jurisdiction. In addition, roughly 11% of all psychiatric hospitals are completely non-deemed. TJC, CIHQ, and DNV are currently the only approved accreditation organizations for psychiatric hospitals. Please continue to check the CMS website for a current listing https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers.

The SAs are responsible for conducting the psychiatric surveys for the two special conditions while they conduct surveys for the regular hospital conditions in psychiatric hospitals.

Validation Surveys:
States will continue to be responsible for conducting substantial allegation complaint surveys for deemed hospitals, psychiatric hospitals, and CAHs. However, in FY 24, states will not be conducting representative sample validation surveys.

Critical Access Hospitals (CAHs) Overview
To receive Medicare/ Medicaid payment, CAHs must comply with the federal requirements set forth in the Medicare CoPs. The goal of a CAH survey is to determine if the CAH complies with the CoP set forth at 42 CFR Part 485 Subpart F. The most current CAH interpretive guidance, in the SOM Appendix W.

CAH Guidance for Time-share and Lease Arrangements: This guidance clarifies expectations related to space-sharing arrangements, including time-sharing and leased space between CAHs and other health care entities. When CAHs choose to participate in these space-sharing arrangements, regardless of the arrangement, they are expected to demonstrate their independent compliance with the statutory and regulatory requirements outlined in the CoPs at all times. For more details see QSO-25-08-CAH.

Certification of CAH compliance with the CoPs is accomplished through observations, interviews, and document/record reviews. The survey process focuses on a CAH's performance of organizational and patient-focused functions and processes. See SOM Chapter 2 - The Certification Process for additional information.

To initially become certified as a CAH, a conversion survey is required. Prospective CAHs must first be certified and enrolled as a hospital, and only after that may seek conversion to CAH status.

- Therefore, requests from a non-deemed hospital to be certified as a CAH are not treated as initial surveys but as conversions and maybe surveyed as a tier 2, 3, or 4 priority.
- AOs with a CMS-approved CAH program can conduct a CAH conversion survey.

Annually, the CAH Distance Analysis Committee, comprised of staff from QSOG and SOG, will assess compliance with the location and distance requirements for CAHs before the due date of their triannual (every three years) re-certification or reaccreditation survey. The CMS locations will be responsible for completing a comprehensive assessment of any CAH within its jurisdiction that seeks to add an off-campus location or any hospital seeking conversion to CAH status. All assessments will evaluate the distance and location requirements of the main location and all provider-based off-site locations per memos QSO-16-08-CAH and QSO-19-16-CAH.

The CAH checklist has been updated to assist with documenting the results of the assessment. When you have completed all the steps of this SOP, ensure all results are recorded on the CAH checklist.

When the review demonstrates compliance with the location and distance requirements, the CAH Committee will send the completed checklists to the CMS Location overseeing the CAH to file the completed checklist in the CAH's file.

For issues identified during re-certification reviews, send the CAH checklist and description of the issue to the larger CAH Committee to discuss before escalating the issue to Senior Leadership.

For issues identified during CAH conversions or adding provider-based location reviews send a copy of the CAH checklist and description of the issues to your manager and the CMS SOG Division Director to address with the SOG Group Director/Deputy.

CAHs Adding Provider-based Locations

The MAC reviews the CAH's provider-enrollment application (Form CMS-855) for the addition of a provider-based location. Once completed, the MAC forwards the form and any submitted documentation to their CMS Location for review of compliance with 42 CFR §485.610(e)(2). If the CAH does not submit documentation noting how it continues to comply with the CAH distance requirements in their application (Form CMS-855), the CMS Location will request that information from the CAH during their distance review.

The CMS Location reviews the Form CMS-855 and any corresponding documentation from the CAH, as well as any information received from the SA, for evidence that the CAH's off-campus provider-based location is more than a 35-mile drive (or 15 miles in the case of mountainous terrain or an area with only secondary roads) from another hospital or CAH.

If the CMS Location verifies the CAH meets the CAH distance requirements with the addition of the provider-based location, the CMS Location issues a tie-in notice and notifies the MAC, the CMS Location Division of Financial Management and Fee for Service Operations (DFMFFSO), and the SA of the tie-in.

However, if the CMS Location review verifies that the CAH's provider-based location does not meet the CAH distance requirements at §485.610(e)(2), the CMS Location notifies QSOG for further review before rendering a final determination. Upon reaching a final determination, the CMS Location notifies QSOG, the MAC, the CMS Location DFMFFSO, and the SA. Once notified of the CMS Location review:

- The MAC takes no further action on the submitted CAH Form CMS-855 to add the provider-based location (under Chapter 15 of the Medicare Program Integrity Manual) until the MAC is notified of the CAH's decision as outlined below.
- The CMS Location informs the CAH that its provider-based location causes the CAH to no longer meet the 42 CFR §485.610(e)(2) distance requirement and offers the CAH the following options (A, B, or C):
  A. *Termination of participation*: By adding the provider-based location, the CAH would be placed on a 90-day involuntary termination track (as outlined in Section 3012 of the SOM) or the CAH can voluntarily terminate its participation from the program altogether.
  B. *Continued CAH certification*: The CAH may retain its CAH status by terminating the off-campus provider-based location arrangement that led to the non-compliance with 42 CFR §485.610(e)(2) distance requirements within the 90-day termination period or by physically moving the provider-based location so that the distance requirements are met.
  C. *Conversion*: The CAH may continue to participate in Medicare by converting to a hospital. If the CAH chooses to convert to a hospital, the CAH would need to submit another Form CMS-855 to the MAC to terminate their CAH enrollment along with a

separate Form CMS-855 to enroll as a hospital. The effective date of the CAH's hospital certification would coincide with the effective date of termination of CAH status. See Section 2005 of the SOM for the Medicare enrollment process.

Once the CMS Location notifies the MAC of its review that the CAH complies with 42 CFR §485.610(e)(2) distance requirements or, if not in compliance, of the CAH's choice of option A, B, or C (as described above), the MAC then proceeds with sending the Form CMS-855 and its recommendation for approval on the provider-based location to its affiliated CMS DFMFFSO for a determination under 42 CFR §413.65.

- The CMS Location DFMFFSO reviews the Form CMS-855 and confers with QSOG and CMS Location on specific issues as needed.
- The CMS Location DFMFFSO sends the CAH/Hospital (Form CMS-855 applicant) a notice letter with the determination on its request for provider-based location designation, with copies sent to the MAC, CMS Location, and the SA.
- The CMS Location notifies the AO (for those accredited CAHs deemed as meeting Medicare and Medicaid certification requirements).

Please see updates to Publication 100-07 - SOM Chapter 2
The CMS Center for Program Integrity (CPI), Provider Enrollment Division Publication 100-08 Program Integrity Manual, Chapter 15.10.2(E) instructs the MACs and aligns with the SOM Chapter 2 guidance.

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

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

Priority tier structure for survey & certification activities for Hospitals, Psychiatric Hospitals, & CAHs (Deemed)

Tier 1	Tier 2	Tier 3	Tier 4
Substantial Allegation Validation (Complaint) Surveys: Only when authorized by the CMS Location. IJ complaints, including restraint/ seclusion death incidents, must be initiated or completed within the applicable SOM timeframe and are tier 1 priority. **EMTALA Complaint Surveys**: Only when authorized by the CMS Location. All EMTALA complaints surveys authorized are prioritized as IJs or non-IJ high and are to be completed within the applicable SOM timeframe and are a tier 1 priority. **Full Surveys Pursuant to Complaints:** Full surveys may be required by the CMS Location after each complaint investigation that finds condition level non-compliance for deemed hospitals and	**Substantial Allegation Validation (Complaint) Investigations that are prioritized as non-IJ** high must be initiated within 45 days of CMS Location authorization	**N/A**	**N/A**

Tier 1	Tier 2	Tier 3	Tier 4
CAHs. These are a tier 1 priority. **Initial certification** - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)			

Priority tier structure for survey & certification activities for Hospitals, Psychiatric Hospitals-& CAHs (Non-Deemed)

Tier 1	Tier 2	Tier 3	Tier 4
Complaint surveys: Complaint allegations prioritized as IJs and CMS Location authorized EMTALA and restraint/ seclusion death incident surveys, initiated or completed within the applicable SOM timeframes.	**5-Year Max. Interval**: No more than five years elapse between surveys for any particular non-deemed hospital, psychiatric hospital, or CAH. **5% Targeted Sample**: States survey at least one, but not less than 5% of the non-deemed hospitals,5% of the non-deemed psychiatric hospitals, and 5% of non-deemed CAHs in the state, selected by the state based on state judgment regarding those most at risk of providing poor care. Some targeted surveys may count toward	**Recerts: 4-Year Max. Interval:** No more than four years elapse between surveys for any particular non-deemed hospital or CAH. **Recerts of Psych Hospitals**: 3-year average recert surveys of non-accredited/non-deemed psychiatric hospitals only. **New IPPS Exclusions:** All new rehabilitation hospitals/units & new psychiatric units seeking exclusion from IPPS (2),as well as existing providers newly seeking such	**3-Year Avg**.: Additional surveys are done (beyond tiers 2 and 3), based on state judgment regarding the non-deemed hospitals and CAHs that are most at risk of providing poor care, such that all non- deemed hospitals/CAHs in the state are surveyed,on avg, every three years (i.e., total surveys divided by total non-deemed hospitals/CAHs is not more than three years; separate calculation for hospitals and CAHs). Targeted surveys may count toward the three-year average.

Tier 1	Tier 2	Tier 3	Tier 4
	the tier 3 and 4 priorities. Targeted sample requirements do not apply to States with fewer than seven non-deemedhospitals, psychiatric hospitals, or CAHs.	exclusion. The SA does not need to conduct an on-site survey for verification of the exclusion requirements but instead may process an attestation	

Contact Information

- For questions, please contact: QSOG_Hospital@cms.hhs.gov.

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

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

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

CMS implemented a focused survey process in FY 2018. The revised process is designed to reduce surveyor time on record and paperwork review and increase surveyor observations and interactions with the residents and staff.

Additional information can be found on the ICF/IID portion of the CMS website.

Priority tier structure for survey & certification activities for ICF/IID

Tier 1	Tier 2	Tier 3	Tier 4
15.9 Mo. Max. Interval:No more than 15.9 months elapse between completed surveys for any particular ICF/IID. **12.9-Mo. Avg**: All ICF/IIDs in the state	**Complaint investigations triaged as Non-IJ high**	**Initial certification**-Surveyed at state priority	

Tier 1	Tier 2	Tier 3	Tier 4
are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less. **Complaint surveys triaged as IJ.** SA must initiate an onsite survey within two business days of receipt.			

Contact Information

- For questions, please contact: QSOG_ICFIID@cms.hhs.gov.

Long Term Care (LTC)

Ongoing Efforts:

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

- Off-hours Surveys: States must continue to conduct 10% of nursing home inspections off-hours (to be started mornings, evenings, and/or weekends). These surveys must be completed on consecutive calendar days. Additionally, 50% of these surveys (or 5% of all surveys) must be conducted on weekends in facilities with potential staffing issues.

- Special Focus Facilities (SFFs): States are required to conduct surveys in SFFs at least once every six months. CMS released new information about the SFF program in CMS memorandum QSO-23-01-NH.

- Resident Assessment Instrument/Minimum Data Set (RAI/MDS): All certified nursing homes and swing bed hospitals are required to encode and transmit MDS records to CMS in accordance with CMS established specifications and time frames. CMS expects the states to continue to provide staff to serve as RAI/MDS educational and technical resources to nursing homes and SA staff. As such, states must continue to adequately fund and staff the positions of a RAI coordinator and a RAI/MDS automation

coordinator. The State RAI coordinator and the RAI/MDS automation coordinators will be responsible for:

  - Maintaining up-to-date working knowledge of the RAI manual and MDS 3.0 assessment;
  - Attending all mandatory training sessions and demonstrating competency and skills in the RAI process, including coding and transmitting the MDS 3.0;
  - Participating in CMS-sponsored workgroups, meetings, and conferences;
  - Conducting at least two structured provider training courses within the FY, and provide ongoing RAI/MDS education and technical support to SNF/NF and swing bed hospital providers, and SA staff (training courses shall be documented and reportable to CMS); and
  - Educating providers and SA staff on reports from the data system, MDS outcome, or other reports.

- State Medicaid funding: States must secure the necessary Medicaid state share to fund activities attributable to Medicaid facilities or dually-certified facilities.

- Maintenance of Nurse Aide Training Registry: States are required to maintain a registry of all individuals who have completed a nurse aide training course and have passed a competency evaluation test. States must also investigate allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide or other individuals. See 42 CFR Subpart D and Section 4132 and 4141 of the SOM for additional requirements.
- Review of Requests for Waiver of Nurse Aide Training Program two-year Prohibition: States are required to maintain a list of approved nurse aide training programs. If a program is disapproved due to survey findings, the state has specific authority under the statute to review requests for waiving the disapproval particularly for those facilities where access to other approved programs is an issue. Please see S&C-18-02-NH memo for additional clarification.

- Enforcement and Civil Money Penalty (CMP) tool: CMS will continue to work on enforcement policies to support compliance. States are required to transfer all cases that warrant enforcement to the CMS Location.

- State reinvestment of CMP funds: States are required to reinvest CMP funds to improve and protect the health and safety of nursing home residents. CMS has provided additional guidance via Admin Info memo (Admin-18-16-NH). Each annual plan must be submitted by October 31st unless otherwise approved by CMS. They are also required to maintain a plan of how the funds are intended to be reinvested and report certain metrics about projects funded. CMS will continue to work with states to monitor and ensure the appropriate use of CMP funds. CMS released revisions to the CMP Reinvestment Program (CMPRP) in September 2023 (See QSO-23-23-NH).

- Emergency preparedness surveys: Please refer to the Emergency Preparedness website for additional information for these requirements and surveys.

Standard Health Survey Process

- All states must use the long-term care survey process (LTCSP) to assess compliance with the Requirements for Participation (RfP). CMS will continue to make software and guidance updates to existing and new regulations and will update the LTCSP Procedures Guide and Training documents accordingly.

    - Resources for all of these changes can be found on QSEP at https://qsep.cms.gov/ and at: Guidance to Laws & Regulations: Nursing Homes

- CMS continues to work on implementing revisions to Chapter 5 of the State Operations Manual (SOM) related to the management of facility-reported incidents and complaints, including adherence to federal timeframes for investigation, the collection of mandated elements from the initial and investigation reports, and the collection of data to support the tracking of facility reported incidents. These revisions were released in FY 2022 Also, CMS' memorandum Admin Info:23-06-NH outlined the following dates for implementation:

    - No later than October 1, 2023- Implementation of the maximum investigation timeframes, including the development and implementation of policies and procedures for complaints and facility-reported incidents (SOM Sections 5075 and 5310.2).
    - No later than October 1, 2024- Implementation of data entry requirements into ACTS (SOM Section 5060).

      The CMS Locations will be working with states on their plans for this work.

- CMS continues to improve the survey process and is testing a risk-based survey (RBS) approach that allows consistently higher-quality facilities to receive a more focused survey that takes less time and resources than the traditional standard recertification survey, while ensuring compliance with health and safety standards. Following completion of testing, CMS will present the next phase.

- Other Areas of Importance

    - Reducing the usage of Inappropriate Antipsychotics: CMS is committed to finding new ways to implement practices that enhance the quality of life for nursing home residents with dementia through promoting goal-directed, person-centered care for every nursing home resident. CMS continues to focus on reducing the use of antipsychotics and enhancing the use of non-pharmacologic approaches and person-centered dementia care practices in all nursing homes when their use is not clinically indicated. Also, we continue to evaluate actions to

address concerns about facilities using an inappropriate process to diagnose residents with schizophrenia to improve their quality measures artificially. CMS continues to revise interpretive guidance instructing surveyors on situations where a nursing home resident has potentially been misdiagnosed with schizophrenia, or prescribed unnecessary psychotropic medication. CMS continues to conduct offsite audits of facilities' documentation for coding and diagnosing residents with schizophrenia. CMS provides state agencies with the results of these audits to be used to help inform surveyors' investigations on the facility's next survey. We will continue to monitor the outcomes of state's surveys related to these issues, policies, and initiatives.

- Preventing discharges that violate federal requirements (also known as "involuntary discharges"): CMS remains concerned when residents are discharged in a manner that violates federal requirements and places resident's health and safety at risk. CMS requires states to transfer any case that involves non-compliance related to involuntary discharge to their CMS Location. CMS Locations will evaluate the non-compliance and impose the appropriate enforcement remedy.

- Nurse staffing requirements: CMS affirmed its commitment to hold nursing homes accountable for providing safe and high-quality care for the nearly 1.2 million residents living in Medicare- and Medicaid-certified long-term care facilities via the release of the Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting and QSO-24-13-NH: Revised Guidance for Long-Term Care Facility Assessment Requirements. Additional guidance on staffing requirements is forthcoming.

- CMS continues to survey LTC providers' compliance with the requirement to submit staffing information through the Payroll-Based Journal (PBJ) program, the requirement to have a registered nurse onsite eight hours a day, the requirement to have licensed staff onsite 24 hours a day, and the requirement to provide sufficient levels of staff to meet each resident's needs. Surveyors are expected to run a new CASPER PBJ report that identifies if a nursing home may not be compliant with these requirements. Surveyors are expected to cite noncompliance based on the information in this report and their onsite investigations. CMS will continue to monitor the outcomes of surveys compared to each facility's staffing report. CMS finalized new staffing requirements for facilities in the Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting. We will communicate any updates to this requirement as needed.

Priority tier structure for survey & certification activities for LTC

Tier 1	Tier 2	Tier 3	Tier 4
15.9-Month Max. Interval: No more than 15.9 months elapse between completed surveys for any particular nursing home. **12.9-Mo. Avg:** All nursing homes in the state are surveyed, on average, once per year. The statewide average interval between consecutive standard surveys must be 12.9 months or less. **Complaint investigations triaged as IJ** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option	**"Off-Hours" Surveys:**States are required to conduct at least 10% of the standard health surveys on the weekend or before 8:00 a.m. or after 6:00 p.m. (i.e., "off-hours). States shall conduct at least 50% of their required off-hours surveys on weekends using the list of facilities with potential staffing issues provided by CMS. **Complaint investigations triaged as Non-IJ high**	**Initial Surveys of Nursing Homes that are seeking Medicaid-only funding**–funded only by Medicaid (not Medicare) and surveyed at state priority. **Initial certification-** All others not listed above or under Tier 1 **Complaint investigations triaged as Non-IJ medium**	**Complaint investigations triaged as Non-IJ low**

Tier 1	Tier 2	Tier 3	Tier 4
exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			

**Note:*

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

Contact Information

- For regulatory questions, please contact: DNH_TriageTeam@cms.hhs.gov.
- For survey process questions, please contact: NHSurveyDevelopment@cms.hhs.gov.
- For schizophrenia audit questions, please contact: DNH_BehavioralHealth@cms.hhs.gov.

Portable X-Ray (PXR) Suppliers

Statutory Authority

The statutory authority for coverage of suppliers of portable x-ray services is found in §1861(s)(3) of the Act. The regulations are found in 42 CFR 486, Subparts A-C. The SOM Appendix D contains surveyor and interpretive guidelines.

Diagnostic x-ray tests (including tests furnished in a place of residence used as the patient's home) must be under the supervision of a physician. The "residence used as the patient's home" can include a SNF or hospital that does not provide x-ray services for its patients and arranges for these services through a portable x-ray supplier, such as a mobile unit. However, to be certified as a portable x-ray supplier, the mobile unit can neither be fixed at any one location nor permanently located in a SNF or a hospital. (SOM section 2420).

Location of Portable (PXR) Services

Despite the mobility of the services, the base office address of the supplier must be identified as the supplier, and the supplier must be approved in each state in which its operation is based. A post office box number does not suffice.

Portable x-ray suppliers operating across state lines may or may not maintain separate offices in multiple states. Those that operate in states other than where they are based must meet each state's state and local laws in which they operate. In such instances, the certifying SA must check whether the other state permits such operation by reciprocal state agreements. Note on the survey report whether the other state has such a requirement, and if so, whether the specific supplier is permitted to operate in the other state. (SOM Section 2422).

Priority tier structure for survey & certification activities for PXR

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

Tier 1	Tier 2	Tier 3	Tier 4
certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			

Contact Information

- For questions, please contact: CMSQSOG_PXR@cms.hhs.gov.

Psychiatric Residential Treatment Facilities (PRTFs)

Overview:
The regulation defines a PRTF as "a facility other than a hospital, that provides psychiatric services as described in 42 CFR, Section 441, subpart D, to individuals under age 21, in an inpatient setting." The rule also establishes one CoP for the use of restraint and seclusion that PRTFs must meet to continue to provide Medicaid inpatient psychiatric services to patients under 21.

Survey activity information:
SAs are to assure that surveys are conducted in 20% of the PRTFs in the state annually to validate the accuracy of the attestations and investigate complaints. States should assume surveys will be conducted in 20% of the PRTFs annually as a tier 2 and ensure that PRTF re-certification surveys are conducted at least every five years for each certified PRTF. Note: State survey costs (federal funds) for this activity are provided through mandatory Medicaid funds. States should enter all PRTF attestations and provider agreements received from the State Medicaid Agency into the ASPEN system upon receipt. SAs should refer to the SOM, Chapter 2, section 2830 for more details on the certification process for PRTFs and state-to-state differences when accepting out-of-state admissions.

Also, see https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PRTFs and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf

Priority tier structure for survey & certification activities for PRTFs (Medicaid Psych < 21)

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

Contact Information

- For questions, please contact: QSOG_PRTF@cms.hhs.gov.

Religious Nonmedical Health Care Institutions (RNHCIs)

No new changes or efforts. If any changes arise, CMS will send updates as appropriate.

Contact Information

- For questions, please contact: Survey Operations Group- Northeast at CMSBOSTONLTC@cms.hhs.gov.

Transplant Program

The transplant program re-certification survey interval has been changed to a maximum of five years to be consistent with the hospital survey intervals.

Due to the removal of the data submission, clinical experience, and outcome requirements at § 482.82, the Transplant Program Quarterly Reports (TPQR) are no longer required or created to determine compliance during re-approval surveys.

Data submission, clinical experience, and outcome requirements continue to be required for programs requesting initial approval as organ transplant programs. Initial transplant reports are available for each transplant program type to determine compliance with these requirements. State agencies should email the transplant mailbox at QSOG_TransplantTeam@cms.hhs.gov and request the report to obtain this information. Note: Organ transplant programs that have a

clinical experience requirement must have performed the required number of transplants before the initial survey is conducted. Reference § 482.80(d) for exceptions to this requirement.

Surveyor Qualifications
Before any state or federal surveyor may serve on a survey team (except as a trainee) for a transplant program survey, they must complete the Transplant Basic Surveyor Training course located in QSEP.

Priority tier structure for survey & certification activities for Transplant Programs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint – IJ: Investigation of complaint allegations triaged as IJ. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	**Mandatory Re-approval Surveys:** 5-year survey interval.	**Initial certification-** All others not listed under Tier 1.	

Contact Information

- For questions, please contact: QSOG_TransplantTeam@cms.hhs.gov.

Core Infrastructure

Key Developments in training:

To facilitate SA planning, we have provided updates below on key developments that will affect planning for training activities:

Leadership Training:
SA Directors and Deputy Directors must attend and participate in the annual CMS Survey Executives Training Institute. This event typically requires 2.5 days of attendance and usually occurs in the Spring/Summer each year. Travel and lodging expenses are paid 100% from federal funds as an addition to the state's survey budget allocation.

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

It is essential that accurate (e.g., survey coding) and complete survey data is available as soon as possible for any urgent follow-up actions or analysis. States must continue to ensure accurate and timely input and upload of information, including completing the CMS-670 per system requirements and CMS SOM Chapter 2, Section 2705, and evaluating their surveyor times.

Quality Improvement Initiative

Quality Improvement Organizations (QIOs), ESRD Networks, and SA partnerships are critical to improving nursing home, ESRD, and home health quality. In 2013, networks and SA collaborated in two new areas, the Infection Control Initiative and the Involuntary Discharge Initiative. Networks and SA will continue to work together on the Fistula First Initiative.

Beginning in August of 2012, CMS launched a National Nursing Home Collaborative that focuses on preventable healthcare-acquired conditions (HACs). As part of that initiative, the QIOs and their nursing home partners will work to strengthen the building blocks of change to help nursing homes make meaningful gains in the residents' quality of life and clinical outcomes. These building blocks may include but are not limited to: staffing, operations, finance, and leadership. We fully support the QIOs in this endeavor and will continue to strengthen our partnership by aligning resources, encouraging collaborative participation, and ensuring that each SA is a collaborative partner.

The core infrastructure required for quality improvement initiatives, applicable to all SAs, is focused on the following:

- Restraints, pressure ulcers, infection prevention and control, and immunization rates in nursing homes – Our mutual goal is to reduce the prevalence of pressure ulcers, reduce the incidents of restraints, infections, and increase the immunization rates in nursing homes.
- The SA's role is to:
    - Assure that state surveyors are adequately trained on the regulatory requirements and pertinent SOM interpretive guidelines;

- Make sure that surveyors follow the survey protocols and processes;
- Provide suitable enforcement remedies when nursing homes are cited;
- Provide appropriate communications and education for providers regarding the importance of these three priority areas, CMS' goals, and resources available to nursing homes; and
- Coordinate S&C activities with those of the QIOs, make appropriate referrals to the QIOs, and encourage systemic quality improvement in nursing home plans of correction.

- Working with Nursing Homes with Systemic Problems
  a. Meet requirements of the SFF initiative:
     - Select facilities to be designated as an SFF from the candidate list released periodically by CMS;
     - Survey SFFs twice every 12 months beginning from the date it is selected as an SFF;
     - Monitor SFF to determine if they meet graduation criteria or require more robust enforcement strategies.
  b. Coordinate with QIOs to provide nursing homes, which have systemic problems, with possible tools to assist them.
- Staffing data and Quality Measures (QMs) - With the help of SAs we are striving toward improving the adequacy of reported data for nursing home staffing data and QMs. The SA's role is to:
  - Ensure that surveyors follow survey protocols and processes in comparing survey and MDS information during the survey; and
  - Ensure that the RAI coordinator provides support and technical assistance for nursing homes in the coding of the MDS.
  - Monitor the accuracy of MDS coding and ensure that onsite surveys include a review of such coding.
- National Partnership to Improve Dementia Care in Nursing Homes: Launched in March 2012, the Partnership set a national goal of reducing the use of antipsychotic medications in nursing home residents by 15 percent. After achieving this goal in December 2013, CMS established new goals for reducing the use of antipsychotic medications in long-stay nursing home residents by 25 percent by the end of CY2015, and a 30 percent reduction by the close of CY2016 (using the original baseline rate established in Quarter 4, 2011). CMS is continuing to focus on reducing the use of antipsychotic medications through this initiative, such as working with a subset of nursing homes, identified as late adopters, who have had little to no improvement in their long-stay antipsychotic medication utilization rates. This multidimensional initiative includes transparency through public reporting; consumer, provider, prescriber, and surveyor education; research, interpretative guidance revisions, as well as quality improvement efforts involving partnerships with QIOs, National Nursing Home Quality Improvement Campaign. State Dementia Care Coalitions play a major role in sharing information, resources, data, and tools, conducting outreach with individual nursing homes, and engaging in educational programs with other agencies.

Additional emphasis applies to working with nursing homes and QIOs on the implementation of culture change that improves quality of life, through the use of individualized, person-centered care approaches, without compromising quality of care.

Performance Management Activities

State budget submissions must include thorough and well-structured action plans for effecting S&C program goals and objectives. The plans should outline effective strategies for achieving performance targets and conforming to CMS' state performance standards and priorities.

States should also identify how national goals and standards are being translated into individual performance objectives. If CMS finds that the SA does not meet the performance standards, the SA will be expected to develop and implement a corrective action plan.

Nurse Aide Registry (NAR)/Nurse Aid Training and Competency Evaluation Program (NATCEP)

States are required to maintain a registry of all individuals who have completed a nurse aide training course and have passed a competency evaluation test. States must also investigate allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide or other individuals.

The state must assure that the nurse aide registry is operated in compliance with federal requirements. This includes assuring:

- The SA reports findings of resident abuse, neglect, and misappropriation of resident property to the registry, and these findings are included in the registry within ten working days of the findings;
- In the case of a singular finding of neglect, the state has established a procedure so that a nurse aide can petition to have his or her name removed from the registry (The employment and personal history of the nurse aide must not reflect a pattern of abusive behavior or neglect and the nurse aide must wait one year from the substantiation of the finding before petitioning to have his or her name removed from the registry).

The allowable costs that can be charged to the Medicare State Certification program are outlined in Sections 1819(e) (1) and (2) of the Social Security Act. These costs relate to the state requirements to specify and review nurse aide training and competency evaluation testing programs together with the establishment and maintenance of the nurse aide registry. States are required to conduct these activities as part of the 1864 Agreement as authorized by Section 1864(d) of the Social Security Act. The actual training and competency evaluation testing of nurse aides is not payable as part of this agreement.

See the General Budget Formulation Guidelines section of this letter for instructions on the reporting of NAR/NATCEP expenses and associated full-time equivalent amounts.

In September 2003, a final rule was published that creates a category of the nursing home employee who may assist residents in eating and hydration. The SA may be involved with implementation if the state decides to allow the use of eating and hydration assistants. There may be state costs associated with the implementation of this regulation.

Home Health & Hospice Toll-Free Hotline and Investigative Unit
States must maintain a toll-free hotline to receive complaints and to answer questions about HHAs and hospices. States must also maintain a unit to investigate complaints. CMS only pays for the maintenance of the hotline and complaint unit and necessary survey or survey-related activity to follow-up on complaints regarding federal HHA and hospice requirements.

States must ensure that complaints from the hotline are effectively captured in the appropriate national database system.

RAI/MDS

All certified nursing homes and swing bed hospitals are required to encode and transmit MDS records to CMS following CMS established record specifications and timeframes. As such, CMS expects the states to continue to provide staff to serve as RAI/MDS educational and technical resources to the nursing homes and SA in each state during the FY. States must continue to adequately fund and staff the positions of a RAI coordinator and a RAI/MDS automation coordinator. The state RAI coordinator and the RAI/MDS automation coordinators will be responsible for the following tasks:

- Attending all mandatory training sessions and demonstrating competency and skills in the RAI process, including coding and transmitting the MDS 3.0;
- Participating in CMS-sponsored workgroups and training including virtual conferences, and satellite training programs for RAI Coordinators on the RAI process and the MDS 3.0.
- Conducting ongoing RAI/MDS education and training and providing technical support to SNF/NF and swing bed hospital providers and SA staff that--\
    - Addresses the RAI process and proper coding of MDS elements to assist providers in meeting OBRA MDS and PPS requirements;
    - Incorporates the MDS 3.0, including any changes to the RAI, manual, and survey processes.
- Includes at least two provider training courses annually, which may focus on basic RAI training for new providers or on topics identified either by the state or CMS as important for existing providers; administrative, educational, and technical support to providers that will assist in the accuracy of the coding of resident assessments; and the transmission of MDS data;
- The collection and housing of MDS data so that states can develop and test a wide range of program improvement initiatives;
- Coordinating with CMS, SAs, FIs, A/B Medicare Administrative Contracts (MACs) and associations in their education of SNF/NF and swing bed hospital providers and surveyors regarding the MDS 3.0 and changes to the RAI, manual and survey processes;

- Conducting any follow-up training in conjunction with CMS national RAI/MDS educational offerings;
- Educating providers and SA staff on reports from the data system, MDS outcome reports, RAI Manual revisions, and any revisions to the RAI process;
- Assist in promoting state-wide consistency with national policies and procedures;
- Complete semi-annual reporting of the CMS MDS training worksheet in the appropriate system to report the educational offerings that were conducted in the state during the year.
- Providing comprehensive education to CMS Location, SA RAI, and nursing home field-surveyor preceptors (RAI coordinators' conference and MDS 3.0 educational offerings) so that these individuals can successfully manage provider and surveyor inquiries and issues related to the RAI and survey processes and the MDS 3.0. States should budget for the travel for this conference(s). See the MPD training addendum for greater detail on the intended audiences, timing and locations of the educational offerings; and
- Providing training and training aids for SA and CMS Location training coordinators, field-surveyor preceptors, and surveyors so that these individuals can successfully understand, interpret and implement the changes to the MDS and related survey processes.

States are responsible for assuring their SA staff are trained in the use of the RAI process, including the MDS 3.0 and changes to the SOM, survey reports, and processes as a result of those changes. Each SA will be responsible for its RAI and Automation Coordinators and a nursing home field-surveyor preceptor, participating in the RAI Coordinators' Conference and MDS 3.0 educational offerings in the FY, which may also include a series of webinars. States are also responsible for ensuring that their RAI Coordinator(s) and S&C staff members collaborate to ensure that their SA staff are adequately prepared to perform their roles as surveyors or RAI coordinators. This is particularly important as the MDS 3.0 significantly impacts both the RAI and survey processes.

States should note that MDS expenditures are reflected as long-term care Medicare and Medicaid costs on form CMS-435. For more reporting instructions, please refer to the General Budget Formulation Guidelines section.

HHA/Outcome and Assessment Information Set (OASIS)
Per CMS-established record specifications and time frames, all certified HHAs are required to encode and transmit OASIS records for Medicare and Medicaid beneficiaries to the national OASIS database system. CMS expects states to continue to play a key role in providing educational and technical resources to the HHAs in each state. States will continue to fund the positions of the OASIS Educational Coordinator (OEC) and the OASIS Automation Coordinator (OAC) and will continue with the responsibilities outlined below:

- Each State has a designated OASIS OEC with the responsibility to ensure that all home care providers in the State have access to:
    - Training on the OASIS data

    - Training and technical support in integrating the OASIS items in the agency's record keeping system
- Each State has a designated OASIS OAC with the responsibility to ensure that all home care providers in the State have access to:
    - Training on the electronic submission of OASIS data
    - Training on correction of errors to OASIS data
    - Support in answering questions on the technical aspects of OASIS

The Home Health Quality Help Desk provides guidance on OASIS coding and documentation of OASIS items. OACs & OECs may refer unresolved issues to the Home Health Quality Reporting Program mailbox: homehealthqualityquestions@cms.hhs.gov.

Quality Improvement and Evaluation System (QIES) Automation Related Activities

To assess how information about OASIS, MDS, and SB-MDS is disseminated across the nation, the states will report semi-annually on training and technical assistance they have provided.

Instructions for reporting training activity using the MDS and HHA Training Worksheets are found on the secure website: https://web.qiesnet.org/qiestosuccess/training.html. The worksheets are accessed via the QIES-To-Success website and are available to state personnel who have the right to see the MDS or HHA reports. The information entered on the worksheets is stored in the National Database. CMS Central and CMS Location personnel can retrieve this data via the CASPER reports: MDS Training Reports or HHA Training Reports.
With CMS technical support and guidance, states will be expected to continue to work closely with the provider community and their MDS, SB-MDS, and OASIS software vendors to provide information on specific requirements related to the submission of MDS, SB-MDS and OASIS assessments especially with the move toward national implementation of the MDS 3.0, to the appropriate State or CMS repository. CMS expects that a facility's private sector software vendor will provide primary support to the facility for MDS, SB-MDS, and OASIS encoding and transmission. However, state personnel will be required to work with facilities and software vendors to educate them about this process. CMS has converted SNF and HHA providers to a virtual private network (Verizon Services) to meet confidentiality and security requirements.

However, each state must have one line accessible by CMS systems maintainers to ensure their system can be updated.

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

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

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

Reimbursement for MDS and OASIS Costs

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

CMS will continue to fund the cost of upgrading state computers needed to access the MDS and OASIS servers (discussed under Information Systems Hardware). Provider costs for hardware and software to maintain and transmit MDS, SB-MDS, and OASIS data from their facility to the states will continue to be the provider's responsibility. States are expected to incur some costs associated with operating the MDS, SB-MDS, and OASIS systems, specifically for staff time, training, and supplies to support the automated QIES.

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

Costs related to the publication, dissemination, and validation of software vendors' ability to comply with state specifications for any added MDS, SB-MDS, or OASIS sections or data (i.e., that portion of the MDS or OASIS that may be added to the State's RAI or HHA instrument at the state's discretion) will not be funded through the S&C budget. To the extent that a state develops customized applications for information maintained in the OASIS database (e.g., to support Medicaid payment), the costs of developing and maintaining these additional software applications (and any related hardware components) will not be funded through the S&C budget. We do not anticipate that any state will allocate more than a minimal amount of its MDS and OASIS costs to the Medicaid Program as administrative costs. The federal match for costs apportioned as Medicaid administrative costs will be 50% and should be reported by the state on line 14 (Other Financial Participation) of the quarterly Form CMS-64. Also, where state licensure programs benefit from the automation of the MDS and OASIS, the state itself should share in the MDS and OASIS automation costs.

The Quality Improvement and Evaluation System (QIES)

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

- Extension of the MDS/OASIS/SB-MDS systems to include new provider types in future years;
- Continued maintenance of the ASPEN suite of products (ASPEN Survey Explorer-Quality, ASPEN Central Office, ASPEN Enforcement Manager, ASPEN Scheduling and Tracking, and ASPEN Complaints and Tracking) and their integration with the state standard systems and support the migration to the new Internet Quality Improvement and Evaluation System (iQIES) that will replace the ASPEN suite of products; and,
- Further integration of the learning management system that supports most day-to-day operations of the survey and certification training program; and
- CMS provides travel/training funds to assure that states can send two or three staff members to two, three-day train-the-trainer sessions for QIES/ASPEN systems releases and ASPEN each FY. These are mandatory training events and once trained, these trainers are expected to perform comparable, hands-on training for agency staff in each of these areas.

<u>Quality IQIES/SB-MDS/MDS/OASIS State Systems Support</u>
Each state must continue to provide adequate staff for technical systems support based on the staffing recommendations provided below.

FTE

Rank*	FTE	All Provider types/ State (Excluding CLIA)
1	4	<600
2	4.5	600-1500
3	5	>1500

*These ranks may be adjusted upward if the CMS Location believes the volume of a state's complaints warrants more staff.

These FTEs should be allocated approximately as follows:

- MDS/SB-MDS/OASIS Automation Coordinator - 1 FTE
- Systems Administrator - 0.5 to 1 FTE

- Technical operations/system management support - 0.5 FTEs
- Technical support/training for providers, vendors and SA staff - 1-3 FTEs distributed amongMDS/SB-MDS/OASIS.
- ASPEN/QIES Coordinator - 1 FTE

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

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

- High-Speed Internet Access (i.e., DSL, broadband, cable modem, T1)
    - To improve survey efficiency and time associated with accessing information, states should ensure their survey staff have access to high-speed internet.
- Information Systems Hardware
    - The QIES system and components ASPEN are comprised of technologies that have been selected to deliver the most powerful access to a broad range of information related to facility quality monitoring and to support SA operations within a user-friendly interface. While the core server components of the QIES system (i.e., hardware and software) are provided and installed by CMS within each state, additional computers for SA end- users will be required to access this core system. These end-user systems are referred to as clients and include computers for users who work onsite within the SA office as well as off-site users including facility survey staff.

As the state QIES server assumes a larger role in day-to-day state operations, states should ensure that it is integrated into their existing systems infrastructure such as state LANs.

If SAs need to move the CMS QIES state servers to an alternate location, the SA will need to work with their CMS Location to include a $27,600 line item in their budget plan at the time of the move request (i.e., not waiting until the time of the move). So if a move is to take place at the beginning of the following FY, the funds would have to be made available in the preceding FY. This fee covers the move of the circuits and network support. The SA must submit a written request to the QIES Technical Support Office at a minimum of 90 days before the scheduled move date.

SAs currently vary in the number of laptop/notebook systems available for field surveyors' use in accessing ASPEN. Internally, most agencies provide network-based computing support for in-house staff managers. Furthermore, many states have included extensive system upgrades as part of their budget requests over the past few FY.

CMS expects that states will use their existing systems to the fullest extent possible to provide client access to the standard system components. To provide users with access to the standard system, states should follow one (or a combination) of the following approaches:

a. Existing state machines that meet the minimum requirements, as described below, are used to provide user access to the standard system. This includes desktop systems connected to an internal network, as well as laptop/tablet systems used mainly for ASPEN Survey Explorer–Quality (ASE-Q).
b. To the extent that existing state systems do not meet the minimum requirements (e.g., insufficient RAM), the state submits a plan and budget request to support upgrading these systems to the recommended performance levels, which includes the type of equipment to be purchased and associated costs. Upgrading an existing computer can include adding more RAM and disk capacity and purchasing processor upgrades. States should also include in the budget those costs associated with upgrading current computer operating systems to the prescribed Windows operating systems. The costs associated with upgrading equipment should not exceed the cost for the actual replacement. Finally, it is also appropriate for states to include a budget for additional staff/contractor costs incurred to manage the computer and operating system upgrade process.
c. To the extent that a state does not possess sufficient systems that are currently capable or able to be upgraded to the minimum standard, the state should submit a plan and budget request to support the acquisition of the number of new systems that are necessary to provide appropriate access. The budget request must include the number of each type of machine to be purchased and associated costs.
d. Nursing home survey process – CMS has moved towards a nursing home survey process, which utilizes Tablet technology. This technology allows ready access to data and information onsite by the surveyors and allows documentation of non- compliance to be easily transferred to the CMS-2567 form. CMS highly recommends that states plan for future survey process implementations as part of their hardware procurement process recognizing the need for Tablet PC configurations as a future need. The hardware that is budgeted by the SA is in addition to the hardware provided as part of the startup process, with the understanding that equipment costs will be distributed in the usual manner against Medicare/Medicaid/Licensure.

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

   Equipment purchases for LTC surveyors should include: one Tablet laptop (described in the table below, Minimum and Recommended Client Requirements) for each surveyor and one portable printer for every three such surveyors. The portable printers should be lightweight, capable of printing 17 pages or more per minute and capable of running on battery power alone.

Guidelines for the recommended system configuration and state size-based estimates for the number of systems required are found below. For planning purposes, it is expected that at least ten client systems will be required for in-office access to the standard system and related components, based on State size (i.e., small, average, large). In other words, a large State should

have 30 client systems that meet the minimum standards for agency staff. For field systems, States should seek to maintain a ratio of at least one laptop/tablet system per two surveyors.

- Laptops: Recommended field system is any Windows computer designed for light-weight portability and provides both a keyboard option and an option to operate the device as a flat tablet. Any selected surveyor computer must also meet the required technical specification provided.
- Encryption Policy: CMS' encryption policy requires all agency data be protected from unauthorized access. There may be various levels of protection for agency data, but for personally identifiable information (PII), the policy states that dissemination of such data using any portable devices or recordable media, (e.g., CDs, DVDs, Cartridges, Diskettes, Laptops, External Hard Drives, USB Memory Sticks or thumb drives, etc.), requires encryption. Whole disk encryption of the hard-drive for Laptops or Tablet PCs must be employed, including for home-based systems. For additional information, please see CMS encryption policy.

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

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher Required for LTC SurveyProcess Implementation Recommended for Other**
Processor	Pentium Class (or equivalent) @ 1.2 GHz	Pentium Class (or equivalent) @ 2.0 GHz
Memory (RAM)	2 GB	4 GB
Available Disk Space	4 GB	10 GB on SATA 2 drive at 7200 RPM
Monitor	13" Color	Desktop 19": Color Flat Panel ≥1024x768 screen resolution Flat Panel for laptop or tablet

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher Required for LTC SurveyProcess Implementation Recommended for Other**
*Operating System**	Windows 7 – 32 bit Windows 7 – 64 bit	Windows 7 – 32 bit Windows 7 – 64 bit Windows 8.1 – 32 bit Windows 8.1 – 64 bit Windows 10 – 32 bit Windows 10 – 64 bit
Secure Access/Encryption (See Encryption Policy)	Required – See Encryption Policy	Required – See Encryption Policy
Anti-virus	Current License	Current License
Universal Serial BusPort	One	Three
Removable Media (see Encryption Policy)	USB Drive	USB Drive
Pointing Device	Mouse or equivalent (e.g. trackball or touchpad)	Mouse or equivalent (e.g. trackball or touchpad) and Pen/Stylus
Network InterfaceCard *(See CMS ARS security guidelines for acceptable wireless configurations)*	Wired for network connectivity;and Wireless network cards mustsupport WPA-2 level encryption	Wired for network connectivity; and Wireless network cards must support WPA-2 level encryption
Optical Drive	CD –ROM	CD/DVD-ROM (External for tablet)

Minimum and Recommended Client Requirements: EXISTING or NEW EQUIPMENT		
Component	**Minimum**	**Minimum or Higher Required for LTC SurveyProcess Implementation Recommended for Other**
Audio	Standard built-in speakers	Attachable microphone and standard built-in speakers
Battery (laptop or tablet)	6-cell lithium-ion	6-cell lithium-ion
*Browser***	Internet Explorer v 11.0	Internet Explorer v 11.0

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

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

**Internet Explorer v11 will need to operate in compatibility mode in order for the software to operate properly.

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

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

Emergency Preparedness

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

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

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

    - Essential S&C business functions, including:
        - Provision of prompt responses to complaints regarding patients/residents who are in immediate jeopardy.
        - Provision of monitoring and enforcement of healthcare providers. Even in widespread or significant disasters where reduced S&C activities may occur, key activities (such as complaint investigations, provider communications, communication with CMS regarding any advisable adjustment to previously-imposed enforcement actions that might impede evacuee placement, etc.) will still need to occur to ensure the health and safety of patients and residents.
        - Conducting timely surveys or re-surveys in the aftermath of a disaster.
    - Identification of strategies to ensure maintenance and protection of S&C critical data.
    - A program of COOP exercises, conducted at least annually by designated staff to ensure State, Regional, Tribal and Federal responsiveness, coordination, effectiveness and mutual support.

2. Effective Communication & Coordination with CMS

    - *Point of contact*: A state S&C emergency point of contact (and back-up) is available 24/7 to the CMS Location . The contact:
        - Coordinates state S&C activities with CMS;
        - Addresses questions and concerns regarding S&C essential functions;
        - Provide status reports; and
        - Ensures effective communication of federal S&C policy to local constituencies (see details below).

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

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

    - *Information and status reports:* The SA or the State ICS maintains capability and operational protocols to provide the CMS Location with (i) state policy actions (such as a Governor's emergency declarations or waiver of licensure requirements) and (ii) an electronic provider tracking report, upon request, regarding the current status of

healthcare providers affected by a disaster. The capability includes (but is not limited to):

Provider Contacts	Provider Status	Provider Plans
• Provider's name • CMS Certification Number (CCN) • Provider type • Address (Street, City, ZIP Code)	• Provider status (evacuated, closed, damaged, etc.) • Resident/patient/client status • Loss of power and/or provider unable to be reached • Etc.	• Estimated date for restored operations • Source of information • Date of the status information

Recovery Functions

The SA and the CMS Locations will determine recovery functions on a case-by-case basis between. In the context of S&C, recovery functions represent those activities that are required to ensure that a provider has reestablished the environment and systems of care necessary to comply with federal certification requirements.

Funding

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

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

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

States are still required to submit electronic affected provider status reports to the CMS Location during emergency events, which include (but not limited to) the data elements identified above.

Web-based Platform for Section 1135 Waivers during Emergencies

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the HHS Secretary declares a Public Health Emergency (PHE) under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his/her regular authorities. For example, under Section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements. During a PHE, such as the COVID-19 pandemic, CMS must be able to both answer PHE-related inquiries and respond to 1135 waiver requests. This must be done in a timely manner to respond quickly to unfolding events.

In 2021, CMS created an automated 1135 process with a publicly accessible web form. The form offers standardized, user-friendly submissions by requesters. All Section 1135 waiver requests and/or PHE-Related inquiries should be directed to the CMS 1135 Web Portal for processing. In addition, links to 1135 web portal trainings and quick start guides can be found at https://www.cms.gov/about-cms/agency-information/emergency/epro/resources/waivers-and-flexibilities.

Note: Submitters should not send 1135 waiver requests and PHE-related inquiries to areas outside of the CMS 1135 Web Portal (e.g., local CMS Location email addresses, COVID-19@cms.hhs.gov address, etc.).

Relationship to SPSS
If a significant emergency occurs in a state that disrupts normal S&C activity and that is well outside the level that can typically be expected in the state, CMS will take such circumstances into account to avoid penalizing the state for SA performance issues unavoidably caused by the emergency.

Energy Productivity

Consistent with the President's policies and executive direction, CMS seeks to improve the energy productivity of S&C operations. Insofar as transportation and fuel costs are significant items of S&C expense, we encourage states to lease or modernize their automobile fleets with highly efficient vehicles that meet or exceed 40 miles per gallon in combined city/highway EPA mileage ratings. We will continue CMS incentives to enlarge upon transportation and other energy productivity improvements. In the event that one-time funding becomes available later in the FY, we suggest states conduct some advance analysis of what would be feasible to take advantage of such funds and how the state would accomplish appropriate cost-accounting among affected funding sources if Medicare one-time funds were available.

Alignment with SPSS

States must maintain documentation and information systems to ensure accurate and timely provision of information on survey activities, findings, enforcement, and surveyor performance. Timely uploading is an important aspect of such a system. Concerning the performance of

surveys within the required frequencies, most non-LTC provider types continue to be part of the SPSS for frequency of surveys specified in tiers 1-3. The SPSS includes all of the following with regard to survey frequency.

Providers/Suppliers: Tier 1-3 performance is measured by SPSS	
Statutory Providers	Other Providers
• Nursing homes • HHAs • Hospices • Validations- of all deemed providers/suppliers • ICF/IIDs	• Hospitals (all types) • RHCs • ESRD facilities • ASCs • OPTs (Rehabilitation Agencies) • CORFS

States must track their tier workload on a quarterly and annual basis. During the year, states must report the quarterly results to the CMS Locations by the end of the month following the end of the quarter. As part of their oversight and trouble-shooting responsibilities, CMS Locations will be monitoring and working with the states on the performance of the tiered workload.

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

- Timely data entry of survey workload;
- Attendance at mandatory federal surveyor training MDS, OASIS, QIES, and IRF-PAI systems activities;
- Maintenance of the nurse aide registry and assessments of nurse aide training and competency evaluation programs;
- Review of the nurse aide registry to assure that it is being operated in compliance with the requirements;
- Maintenance of a home health and hospice hotline;
- Performance measurement activities;
- Implement & promote the fulfillment of CMS Government Performance and Results Act (GPRA) goals and quality initiatives as needed;
- Training of S&C staff, including transcript & qualifications maintenance; and
- Emergency preparedness essential functions.

Contact Information
For questions, please contact the appropriate program area:

- QSOG_ASC@cms.hhs.gov
- QSOG_CORF@cms.hhs.gov
- HHAsurveyprotocols@cms.hhs.gov
- HHAsurveyprotocols@cms.hhs.gov
- QSOG_OPT@cms.hhs.gov
- CMSQSOG_PXR@cms.hhs.gov
- QSOG_RHC-FQHC@cms.hhs.gov
- QSOG_Hospital@cms.hhs.gov

- QSOG_TransplantTeam@cms.hhs.gov
- QSOG_ESRDQuestions@cms.hhs.gov
- QSOG_PsychiatricHospital@cms.hhs.gov
- QSOG_PRTF@cms.hhs.gov
- QSOG_ICFIID@cms.hhs.gov
- CMHC@cms.hhs.gov
- QSOG_CAH@cms.hhs.gov

Additional priority tier structure for survey & certification activities

Priority tier structure for survey & certification activities for New Provider Initial Surveys

Tier 1	Tier 2	Tier 3	Tier 4
Initial certification of the ESRD Facilities: States conduct initial certification surveys within 90 days of the MAC approval of the CMS-855, unless the supplier has elected a deeming option. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be	**Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority. **Relocations of the parent or main location of existing non-deemed providers or suppliers.** **Relocations of any provider/supplier displaced during a public health emergency declared by HHS.**	**Initial certification-** All others not listed under Tier 1 or 2 **Relocations of non-deemed branches or off- site locations.** *Note*: Conversion of a non-deemed hospital to a CAH, or a non-deemed CAH back to a hospital is a conversion, not an initial certification and at state option may be done as tier 2, 3, or 4. However, the conversion of a deemed hospital or CAH or the addition of swing beds as a new service in an existing deemed or non-deemed hospital or CAH is a tier 4 priority.	While CAHs may also be deemed, these are conversions, not initial certifications; however, deemed CAHs are expected to be surveyed by their AOs for their conversion surveys. **The addition of home health branches** are administrative actions thus not a deeming option. (AOs deem compliance with CoPs/CfCs, not administrative actions). Though surveys may not be involved, these actions should remain in the tier structure as they are often resource intensive. **The addition of multiple hospice locations** may warrant a survey. These surveys should be scheduled

Tier 1	Tier 2	Tier 3	Tier 4
a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			consistent with the tier structure as they are often resource intensive. **Relocations of deemed providers or suppliers.**

Priority tier structure for survey & certification activities for Complaint Investigations

Tier 1	Tier 2	Tier 3	Tier 4
Complaint Investigations triaged as or, in the case of hospitals, psychiatric hospitals, or CAH DPUs,where the CMS Location authorizes investigation of a hospital or CAH DPU restraint/ seclusion death incident. **Full Surveys Pursuant to Complaints**: Full surveys may be required by the CMS Location after each complaint investigation that finds condition level non-compliance for deemed providers/suppliers. These are a tier 1 priority.	Complaint Investigations triaged as Non-IJ High.	Complaint investigations of non-deemed acute & continuing care providers/suppliers triaged as Non-IJ Medium are investigatedwhen the next on-site survey occurs. Complaint investigations of LTC facilities triaged as Non-IJ Medium.	Complaint investigations of LTC facilities triaged as Non-IJ Low. Complaints of non-deemed acute & continuing care providers/suppliers triaged as Non-IJ Low are not investigated separately but tracked/trended for potential focus areas during the next on-site survey.

Budget Formulation Guidelines

CMS is requiring the States to evaluate and justify planned Medicare survey workload and budgets, consistent with MPD requirements, at the provided funding level in attachment A. CMS recognizes that the FY2025 MPD has not been published, and adjustments may need to be made. As part of the narrative, please provide information detailing the budgeted workload to be accomplished in each of the four MPD tiers at the funding level provided by your State. Further guidance on final funding allocations will be provided once the final FY 2025 appropriations are enacted

Due Dates:

State materials due to CMS Locations:	10/15/2024
CMS Location recommendations to HQ:	10/30/2024
CMS report out to CCSQ Leadership:	11/10/2024

Budget Plan for FY25:

CMS requests that States carefully review their ongoing Medicare workload and submit an initial budget plan and limited justification materials for FY 2025 at the base funding level provided for each State in Attachment A. Within this detail, please provide information detailing the budgeted workload to be accomplished. To establish the State funding guidelines for FY25, CMS HQ worked with the Location Budget contacts to review the historical spending of the States from FY17-FY24 and the reasons for those, whether over, under, or on track. The proposed base funding amounts shown in Attachment A are preliminary and may be subject to increase depending on the final FY 2025 funding level approved by Congress. States shall briefly describe the funding level, critical workload, and tier-level completion in accordance with current MPD requirements at the provided funding level, as shown in the attachment, as well as their Hospice funding request. Each Location, in turn, will review and submit their recommendation to CMS HQ for final disposition. CMS will finalize State allocations and request routine budget materials (CMS-435's, 434's, 1465's, etc.) when final appropriations have been enacted. CMS requests that States carefully review their ongoing Medicare workload and submit an initial budget plan and limited justification materials for FY 2025 at a flat funding level. Within this detail, please provide information detailing the budgeted workload to be accomplished at the flat-lined funding level.

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

IMPACT Act

FY 2025 marks the last year of IMPACT Act funding. However, continuing in FY 2025, funds to cover the nationwide shortfall in IMPACT funds will come from the Consolidated Appropriations Act (CAA) fund source. In execution, each State will receive funds from only one fund source, either the IMPACT Act or CAA. The final IMPACT funding allocations will be made available once all the State requests have been received for the year (November/December timeframe). All IMPACT funds should be reported separately on the mini-CMS 435 Hospice-IMPACT form. IMPACT funding amounts should not be included on the main CMS 435. If a state sees any significant issues with its allocation, or has

questions about the allocations or cost accounting, please communicate those promptly to your CMS Location staff.

Consolidated Appropriations Act (CAA)

The FY 2021 appropriations bill provided additional funds for Hospice survey work, beginning in FY 2022. This funding will continue to be utilized and made available in conjunction with the IMPACT funding to fully fund all Hospice survey work in FY 2025. To ensure that there is no confusion among multiple funding sources, as stated above, each State will receive funds from only one of the two fund sources, the CAA funds or IMPACT Act, not both. States will be informed which type of funding is provided. All CAA funds should be reported separately on the mini-CMS 435 Hospice -CAA form. However, like IMPACT funds, CAA funding amounts should not be included on the main CMS 435. If a State sees any significant issues with its allocation, or has questions about the allocations or cost accounting, please communicate those promptly to your CMS Location staff. The CAA provides funds for additional Hospice-related work, including a Special Focus Facility program. Rough estimates for this activity should be included in your budget requests. Further details on this program will be provided by CMS QSOG/SOG program staff.

Continued guidelines from previous FYs

Title XVIII Budget Closeouts

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

- *Budget Closeout Requirements*: The main goal is to establish a common grants closeout process in line with current Departmental regulations, statutes, and audit recommendations. With respect to the states, this will primarily be a change to the timeframes involved in closeout, the possibility for unilateral closeouts, as well as an increase in emphasis on closing awards in a timely manner. The actual work required to affect a proper closeout will remain substantially the same.
    - The timelines for this process are as follows:
        - Final financial reports, consistent with terms of award, are due 90 calendar days from a grant's completion date;
        - Full closeout, meaning that all applicable administrative actions and all required work of the federal award have been completed and takes actions as described in 45 CFR 75.381, is due no later than 270 days from a grant's completion date;
        - If the closeout cannot be completed within the 270-day timeframe, CMS may elect to complete a unilateral closeout.

CMS HQ will provide states sufficient notification of upcoming due dates for both report and closeout due dates via written memorandum and email notification and will work with states to meet the due

dates noted. CMS HQ will work with states on a case-by-case basis if there are reasons that they are unable to meet the guidelines noted above.

MDS and HHA mini-CMS-435 forms

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

HHA Cost Allocation

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

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

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

State Licensure Shares

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

NAR/NATCEP Costs

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

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

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

Training Line on CMS-435

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

Final Budget Package

In summary, the final budget package should include:

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

   Please make a tier statement as a clearly identified paragraph toward the top of the budget narrative. It can be as simple as "tiers 1, 2 and 3 will be done, but not initial surveys in tier 3 and tier 4." Or the statement can be more detailed, especially if the state will complete part of a tier, and needs to specify what won't be done in the tier;
9. Most recent Indirect Cost Agreement.

CMS Budget Analysis and Adjustment

CMS' Headquarters will continue to partner with CMS Locations to review and agree upon a final budget amount for FY25 for each state once Congress has finalized a budget. The funding available to states will be allocated based on several factors that are considered such as:

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

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

Contact Information

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

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

Overview:

CLIA regulates the quality and safety of clinical laboratory testing performed on humans located in the U.S. The program ensures the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. CLIA has regulatory requirements for quality that all laboratories must meet.

Definition of a Laboratory

A clinical laboratory is defined by CLIA as a facility for the biological, microbiological, serological, chemical, immunehematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Said another way, a clinical laboratory is defined by CLIA as any facility which performs laboratory testing on specimens obtained from humans for the purpose of providing information for the diagnosis, prevention, or treatment of disease or for health assessment.

AOs with CMS-Approved Programs

Currently there are seven AOs with CMS-approved programs:

- American Association for Laboratory Accreditation (A2LA)
- American Association of Blood Banks (AABB)
- American Society for Histocompatibility & Immunogenetics (ASHI)
- College of American Pathologists (CAP)
- COLA, Inc. (COLA)
- Accreditation Commission for Health Care (ACHC)
- The Joint Commission (TJC)

CLIA Certificates

- *Certificate of Waiver (COW):* Issued to a laboratory that only performs waived tests.
- *Certificate for Provider Performed Microscopy Procedures (PPMP):* Issued to a laboratory in which a physician, midlevel practitioner, or dentist performs only specific microscopy

procedures during a patient's visit. See list of PPMP procedures, which are a subset of moderate complexity tests.

- *Certificate of Registration (COR):* A COR is temporary and permits the laboratory to conduct non- waived (moderate and/or high complexity) tests until the laboratory is inspected and found to be in compliance with CLIA regulations.

- Certificate of Compliance (COC): Issued to a laboratory after an inspection by a CLIA state survey agency that determines the laboratory to be in compliance with all applicable CLIA requirements.

- Certificate of Accreditation (COA): Issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS.

CLIA Resource Information

- CLIA Regulations – CLIA Regulations 42 CFR 493
- SOM Appendix C: Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services

Priority QSOG Activities for Laboratories

CLIA is a user-fee funded program that requires the following surveys to be prioritized throughout the year as needed (See SOM 6102.1):

When scheduling surveys use the following priorities:

- Complaints with possible IJ
- Other complaint investigations
- Initial surveys
- Recertifications
- Follow-up/Revisits
- Validations
- PPM/CoW/Special Surveys

Recertification surveys should be prioritized by the date of the last recertification survey (laboratories with the largest time gap since the last recertification survey should be surveyed first).
State Agencies should refer to the CLIA annual Fiscal Year Budget Call Letter for guidance on developing projected workloads.

Contact Information

- For questions, please contact: LabExcellence@cms.hhs.gov.

Quality, Safety & Education Division (QSED)

Mission

QSED's mission, in partnership with CMS Locations and SAs, is to make sure there's a knowledgeable and skilled survey workforce, as well as informed providers and suppliers, throughout the United States. QSED actively supports the mission of CMS and the Department of Health and Human Services (HHS) by leading and overseeing all surveyor training and testing design, development, and delivery.

Statutory Authority

The Social Security Act (the Act) obliges the HHS Secretary to "…provide for the comprehensive training of state and federal surveyors in the conduct of standard and extended surveys." It also requires that "No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary." It mandates the "Secretary of HHS, through the CMS Administrator, [will] assure that surveyors are trained to make determinations about the [CoPs] of providers", as well as the CfC for suppliers.

- Authority: Section 1819G of the Social Security Act. Related authority: US Code, Section 1396 – 1396v, Subchapter XIX, Chapter 7 and Title 42. And Chapter IV, Title 42, and Title 45, Code of Federal Regulations, and Section 1919(g), "Survey and Certification Process," subparagraph (iii).

Survey-specific Training

QSED's comprehensive training programs are designed to give SA and CMS location surveyors the knowledge, skills, and abilities they need to survey healthcare facilities to determine if they meet CMS conditions and standards. QSED plans, manages, and executes training for about 10,000 surveyors who survey different types of health care facility providers and suppliers.

QSED gives specialized surveyor training for these survey processes:

- ASCs
- CAHs
- CLIA
- CMHCs
- ESRDs
- HHAs
- Hospices
- Hospitals, including:
    - EMTALA
    - Psych Hospitals
    - Transplant
- ICF/IIDs
- LSC

- LTC
- OPT/OSP
- PRTFs
- RHCs and FQHCs
- OPOs

Surveyor Qualifications

Before any state or federal surveyor may serve on a survey team (except as a trainee) for a program survey, they must complete the requirements outlined in the surveyor training plan on the Quality, Safety and Education Portal (QSEP) at https://qsep.cms.gov.

Training Plans

QSED developed a specialized Training Plan for each of the survey processes listed above. The Training Plan outlines a comprehensive series of training activities that surveyors must successfully complete before they're allowed to independently conduct surveys. Its serves as a training roadmap to help surveyors learn the concepts and skills needed to conduct a survey.

The Training Plan lists training activities in order of completion. Surveyors complete prerequisite training first, then basic training, and later post-basic and advanced training.

State Training Coordinators (STCs), Training Managers, and Regional Training Administrators (RTAs) should use the Training Plans to schedule, coordinate, and guide new surveyors through the series of training activities and preceptor-led on-the-job observations and mentoring. Surveyors, STCs, and RTAs can access the Training Plans online by logging into the QSEP training portal at https://qsep.cms.gov and then, selecting the Training Plan link.

See the Terms and Definitions below for more information about Training Plans.

Training Plan Terms & Definitions

- Prerequisite Training (mandatory): The sum of all knowledge surveyors are required to have before taking any of the Basics Training. This knowledge may be acquired through mandatory courses, required readings, orientation, on-the-job mentoring, observations, or supervised field experiences, etc.

- Basics Training (mandatory): The sum of all fundamental trainings that give surveyors the essential principles and processes of surveying for a specific provider or supplier type. Basics Training gives learners a standard level of proficiency. Successful completion of all Prerequisite Training and Basics Training is required before learners can start independent surveys.

- Post-Basics Training (mandatory): The sum of all additional and advanced trainings that give surveyors essential information related to more complex or specific aspects of surveying for

a specific provider or supplier type. Mandatory Post-Basics Training gives learners a level of proficiency required to maintain success and confidence while surveying independently.

- Post-Basics Training (recommended): Comprised of learning opportunities designed to further enhance experienced surveyors' skills. These trainings are available to surveyors after successful completion of all Prerequisite Training and Basics Training requirements. Post-Basics Training including Advanced Training, Refresher Training, Competency Testing, and Continuing Education.

- Advanced Training: Higher-level training aimed towards equipping experienced surveyors who've completed Basics Training and are surveying independently, with more in-depth skills. The requirements (mandatory vs. recommended) for taking Advanced Training vary from program to program.

- Refresher Training: Directed towards surveyors who've already completed all Basics Training and are proficient with the survey process. Refresher Training revisits topics like compliance, safety, and quality procedures through simulated case studies and scenarios. Refresher Training further educates experienced surveyors and reinforces their existing knowledge and skills on topics like new regulations and enforcement.

- Competency Testing: Assesses the proficiency, knowledge, and skills of surveyors based on specified and established performance standards. Competency Testing gives surveyors the opportunity to demonstrate their skills through checklists and other readiness tools that are critical for superior job performance.

- Continuing Education: Gives resources and activities designed to further enhance experienced surveyors' skills. These trainings are intended to give more information about a specific provider or supplier type.

- Useful Resources (recommended): Give more information that can help surveyors in their work, including CMS Forms, State Operations Manual sections and appendices, CDC or CMS guides, or other documentation that may be helpful or necessary to surveyors.

Quality, Safety & Education Portal (QSEP)

The QSEP online training portal is a user-friendly, learner-centered system designed to empower surveyors to lead, manage, and master their training. On QSEP, Training Plans give learners access to the full curriculum of training activities and guidance on the CMS survey process and knowledge of health care facility regulations.

The QSEP Help Desk can be reached by phone at 1-855-791-8900 or email at HelpDesk@QSEP.org.

Please see the system requirements later in this section for the computer equipment and systems needed to access the federal online training available on the QSEP. The requirements must be reviewed with IT staff to make sure all surveyors have the proper equipment and software needed to access training.

For an introductory overview, please see the QSEP User Training — Surveyor25 video.

SA Roles & Responsibilities

QSED works with CMS Central Office, CMS Locations, and SA staff to make sure there's a knowledgeable and skilled survey workforce throughout the United States. SA survey and certification staff play an important role:

- Throughout surveyor orientation, training, and testing
- As participants in CMS workgroups

SA Orientation & Field Survey Observations & Experience

As the first part of their training experience, newly hired surveyor and certification staff attend a SA-led orientation and training program. During this time, new hires must successfully complete the CMS-required prerequisites and start on-the-job training and mentoring with their preceptors.

New surveyor candidates pair with experienced preceptors during their SA-led orientation to observe the survey process. Specifically, they observe the surveyor role as their preceptors mentor them.
New surveyor candidates continue to participate in field survey observations and experiences throughout their prerequisite and basic trainings. At first, new surveyors observe their preceptors demonstrating their skills on SA surveys and during role play. As they learn and progress, new surveyors start to demonstrate their survey skills and abilities under their preceptors' guidance. Preceptors guide and mentor new surveyors, giving feedback and reinforcement. Eventually, new surveyors can independently perform the surveyor.

The on-the-job training provided by the SA is essential for new surveyor candidates to be able to attain the skills needed to conduct surveys. The purpose of these activities is to train new surveyor candidates about how to apply the knowledge from and demonstrate their ability to perform the skills learned in their federal and SA training.

Preceptors observe surveyor candidates to be sure they've been adequately trained to conduct the CMS survey process and make determinations about the CoPs and/or CfCs of the surveyed health care facility provider or supplier.

Workgroup Participation

QSED keeps developing various surveyor and certification training courses. To create job-focused training, we use frontline expertise from SA staff to help with content review and input. Periodically, QSED may ask for help with training development projects.

QSED may ask the SA to nominate/select surveyors to participate in workgroups to test pilot training. QSED may also request participation in workgroups and committees as needed. We ask that $15,000 be placed in each SA budget for this purpose.

Training Schedules

Online Training

- The majority of QSED surveyor training is now available online at https://qsep.cms.gov/welcome.aspx.

In-Person Training

- All in-person events will be communicated as appropriate.

Questions about any training content, direction, availability, etc. may be directed to the QSED Mailbox.

QSEP System Requirements

The following computer configuration is needed to access QSEP training. If your computer doesn't have the proper hardware, training may run slowly or not at all. SAs and CMS Locations must have the proper equipment and software to access and run the online training. Be sure your computer system meets or exceeds these requirements.

Before running training on your computer, compare your current system configuration with the system requirements below.

Hardware Minimum Requirements

- 1.5 GHz CPU or greater with a minimum of 4 GB RAM (8 GB recommended)
- Network connection (work): Ethernet, Wi-Fi
- Network connection (offsite): Fios, DSL, Cable broadband Internet (dial-up isn't supported)
- Speakers may be required; refer to course requirements. (Speakers are required for most Online Training)
- Note that 3G and 4G connections aren't recommended when taking tests.

Operating Systems Requirements

- Windows 8 or (or later)
- Mac OS X 12 (or later)
- Google Android 13 (or later)
- Apple iOS 16.0 (or later)

QSEP Officially Tested & Supported Platforms

Wherever possible, both the QSEP website and its associated courses have been designed to run on any HTML5 compatible browser and on any platform, including mobile devices like Apple iOS and Google Android compatible phones and tablets.

There are exceptions, particularly with older course materials (created using now-defunct technologies like Adobe Flash or Windows Media Player). Where there are exceptions, QSEP shows the additional

software requirements needed to launch those courses. Future courses created using older technologies will eventually be replaced with modern HTML5 versions.

The tables below show the platform and browser configurations tested and supported by QSEP (noted by 'X').

QSEP Tested Platforms -Microsoft Windows

Microsoft	Microsoft Edge	Firefox	Google Chrome
Windows 8	X	X	X
Windows 10	X	X	X
Windows 11	X	X	X

QSEP Tested Platforms -Apple macOS

Apple Mac	Safari	Firefox	Google Chrome
macOS 15.x Sequoia	X	X	X
macOS 14.x Sonoma	X	X	X
macOS 13.x Ventura	X	X	X
macOS 12.x Monterey	X	X	X

Video Requirements

Videos in the online training modules are often used for scenario-based learning activities, with these computer requirements:

- Windows Media Player will need to be installed and the plugin enabled on the learner's browsers for access of videos within the QSEP.

- Operating Systems Requirements
  - Windows 8 or later
  - Mac OS X 12.0 or later Software Requirements
  - Windows Media Player 12+

Active computer speakers with volume control are also needed.

Headset Requirements & Recommendations

Headsets are helpful to lessen distractions. Here are the headset recommendations:

- Learners in a cubicle environment need separate headsets to prevent disturbance to others working close by

- To hear audio segments of online training, headsets should be able to be plugged into the computer

- For teleconference participation, headsets should be able to be plugged into a phone

General Headset Specifications

Headsets vary in style. Here are some recommendations:

- Headsets should fit your needs and be comfortable all day, whether they're over the head, over the ear, behind the neck, wired or wireless, or adjustable

- Wireless headphone devices should be rechargeable

- Headsets need to have volume control, audio performance, and a microphone to allow for conversation (not audio only)

- Noise-cancelling microphones are recommended

- Select a headset model and brand ideal for telephone intensive users, like call-center, help-desk, and customer service representatives

Operating System & Browser Support

QSEP is a browser-based application designed to work with today's most commonly used browsers. Any hardware or operating system capable of supporting these browsers should be able to run the QSEP website without a problem.

Here are specific minimum technical requirements for running QSEP:

Minimum System Requirements for running QSEP

	Windows	Mac OS X	Linux
Operating Systems	Windows 8.0 or later 32-bit / 64-bit	12.0 or later	Ubuntu 14.0 or later, Red Hat *.0 or later, Open SuSE 15.2 or later (all 32- bit)
Processor	Intel Core i3 CPU 2.XX GHz or AMD processor (8 GB of RAM recommended)	Apple MI	Intel or AMD x86
JavaScript	JavaScript and cookies enabled	JavaScript and cookies enabled	JavaScript and cookies enabled
Other	Active X enabled Java 6 or later		Java 6, GNOME/KDE windowing system

Supported browsers

QSEP was developed in .Net and Bootstrap Framework. Bootstrap supports the latest, stable releases of all major browsers and platforms. On Windows, we recommend Chrome but QSEP also supports other browsers listed below**.**

Mobile devices

Bootstrap supports the latest versions of each major platform's default browsers. Note that proxy browsers (such as Opera Mini, Opera Mobile's Turbo mode, UC Browser Mini, Amazon Silk) are not supported.

	Chrome	**Firefox**	**Safari**	**Android Browser & WebView**	**Microsoft Edge**
Android	Supported	Supported	N/A	Android v5.0+ supported	Supported
iOS	Supported	Supported	Supported	N/A	Supported
Windows 10 Mobile	N/A	N/A	N/A	N/A	Supported

Desktop browsers

Similarly, the latest versions of most desktop browsers are supported.

	Chrome	**Firefox**	**Internet Explorer**	**Microsoft Edge**	**Opera**	**Safari**
Mac	Supported	Supported	N/A	N/A	Supported	Supported
Windows	Supported	Supported	Supported, IE10+	Supported	Supported	Not supported

VPN

VPN isn't recommended for accessing QSEP since it can block the courseware from playing.

Contact Information

- For questions, please contact: the QSED Mailbox at QSOG_QSED@cms.hhs.gov.

Rural Emergency Hospitals (REH)

REHs are a new Medicare outpatient provider type established by the Consolidated Appropriations Act (CAA), 2021 (CAA,) signed into law on December 27, 2020. This legislation was passed in response to rural hospital closures and in an effort to address barriers in access to health care for rural communities. The REH CoPs, payment policies and enrollment policies were published in the CY 2023 OPPS final rule (78 FR 72159). To be eligible to be an REH, a facility must, as of December 27, 2020, have been:

- A Critical Access Hospital (CAH); or

- A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act) with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D) of the Act). (**Note:** This section of the statute uses Metropolitan Statistical Areas as defined by the Office of Management and Budget for defining "rural areas', and is different than other governmental designations such as health professional shortage area, etc.); or

- A subsection (d) hospital (as so defined) with not more than 50 beds that was treated as being located in a rural area pursuant to section 1886(d)(8)(E) of the Act (referred to as a "rural hospital"). **Note:** This section of the Act refers to the urban to rural reclassification process as defined in 42 CFR 412.103. To be eligible for REH designation, the reclassification from urban to rural status must have occurred as of December 27, 2020. Reclassifications which occurred after this date do not meet the REH eligibility requirements. Facilities must submit a copy or documentation of the reclassification to the State Agency (SA) along with the additional information required for enrollment.

Survey information: REHs are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to participate in Medicare and be eligible to receive Medicare/Medicaid payment. The initial guidance for REH provisions, conversion process and Conditions of Participation (CoPs), which also includes FAQs, can be found in the CMS memorandum QSO-23-07-REH. Revised guidance and updated FAQs were released via QSO 24-20. A newly developed State Operations Manual Appendix (Appendix O) with survey procedures and CoP regulatory text is also available. The interpretive guidance for REHs is pending and will be provided in a future release.

Beneficial training courses: REH Basic training modules are currently being developed and is projected to be released during FY 25. CMS will release REH Basic Surveyor Training via the Quality Safety Education Portal (QSEP) website when available.

Accreditation for REHs:
Currently there are no CMS-approved AOs approved for deeming of REHs, a deeming option for the REH program will be considered by CMS after we have had adequate time and opportunity

to effectively monitor and evaluate the introduction of REHs into the Medicare program but will be no earlier than three years from the date on which the first REH has been certified. Please see CMS memorandum QSO-24-01-REH for more information.

Emergency Medical Treatment & Labor Act (EMTALA) Investigations:
Based on CMS Location review of the allegations, the complaint may be classified as IJ or non-IJ high. The timeline for investigations in hospitals, critical access hospitals (CAH) and REHs for immediate jeopardy complaints specific to EMTALA and deaths associated with restraint or seclusion must be initiated within two business days. Non-IJ high prioritization requires the survey to be initiated within 45 days. Guidance regarding the responsibilities of Medicare participating hospitals in emergency cases may be found in Appendix V

Initial REH surveys:
Eligible facilities converting to an REH may self-attest to meeting the REH CoPs and will not require an automatic on-site initial survey as eligible facilities are expected to be in full compliance with the existing CAH and hospital requirements at the time of the request for conversion. Facilities that were eligible as of December 27, 2020, which subsequently closed and re-enrolled in Medicare **require** an initial on-site survey by the SA. While the SA will perform an initial on-site survey in accordance with the current FY Mission & Priority Document to evaluate compliance with the REH CoPs, these facilities must also submit an attestation for the applicable eligibility requirements, rural status, and rural reclassification criteria if applicable along with the other additional information required.

Priority tier structure for survey & certification activities for REHs (non-deemed)

Tier 1	Tier 2	Tier 3	Tier 4
Complaint surveys: Complaint allegations prioritized as IJs and CMS Location authorized EMTALA investigations initiated or completed within the applicable SOM timeframes. **Targeted Sample:** Because all REHs are a new non-deemed provider type, States should survey 100% of REHs within 12 months of the REH certification date.	**3-Year Max. Interval**: No more than three years elapse between surveys for any non-deemed REH.	**Recerts: 4-Year Max. Interval:** No more than four years elapse between surveys for any non-deemed REH. **Initial certification-** All others not listed under Tier 1.	**3-Year Avg**.: Additional surveys are done (beyond tiers 2 and 3), based on state judgment regarding the non-deemed REHs that are at most risk of providing poor care.

Tier 1	Tier 2	Tier 3	Tier 4
Initial certification - Provider/Supplier's application to Medicare exceeds 150 days - determined access to care issue (the provider is responsible for providing the information)- If more than 150 days has passed since the MAC has recommended approval of the application, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue. Initial certification of eligible facilities that subsequently closed and require an initial on-site survey.			

- Contact Information: For questions, please contact: QSOG_REH@cms.hhs.gov.

Appendix 1 - FY25 MPD Projected Allocations

	A	B1	B2	C	D
State	FY24 Base Budget	FY25 PM Funding Amount	FY25 Hospice/CAA Budget Amount+	Estimated Supplemental Validation Funding*	FY25 Final Allocations (All Funding Sources)
CT	$6,468,994	$6,468,994	$79,109	$0	$6,548,103
ME	$2,498,406	$2,586,600	$64,500	$0	$2,651,100
MA	$8,940,402	$9,255,998	$85,671	$0	$9,341,669
NH	$1,430,025	$1,430,025	$64,000	$0	$1,494,025
RI	$1,843,630	$1,908,710	$60,000	$0	$1,968,710
VT	$1,464,514	$1,516,211	$50,000	$0	$1,566,211
NJ	$8,428,871	$8,726,410	$199,236	$0	$8,925,646
NY	$16,884,616	$16,884,616	$412,056	$0	$17,296,672
PR	$476,536	$493,358	$77,637	$0	$570,995
DE	$1,168,301	$1,168,301	$0	$0	$1,168,301
DC	$1,207,585	$1,250,213	$75,000	$0	$1,325,213
MD	$3,997,045	$4,138,141	$29,084	$0	$4,167,225
PA	$10,602,398	$10,976,663	$199,156	$0	$11,175,819
VA	$5,205,297	$5,389,044	$231,607	$0	$5,620,651
WV	$2,614,588	$2,614,588	$158,765	$0	$2,773,353
Subtotal	**$73,231,208**	**$74,807,872**	**$1,785,821**	**$0**	**$76,593,693**
AL	$5,226,415	$5,226,415	$27,983	$0	$5,254,398
FL	$12,742,607	$12,742,607	$75,000	$0	$12,817,607
GA	$5,989,725	$6,201,162	$450,070	$0	$6,651,232
KY	$5,198,945	$5,382,468	$179,550	$0	$5,562,018
MS	$2,268,207	$2,348,275	$0	$0	$2,348,275
NC	$8,830,707	$9,142,431	$132,000	$0	$9,274,431
SC	$2,726,467	$2,726,467	$178,865	$0	$2,905,332
TN	$4,594,338	$4,756,518	$82,500	$0	$4,839,018
Subtotal	**$47,577,411**	**$48,526,343**	**$1,125,968**	**$0**	**$49,652,311**
IL	$16,981,201	$17,580,637	$178,953	$0	$17,759,590
IN	$7,313,057	$7,571,208	$212,436	$0	$7,783,644
MI	$12,451,690	$12,891,235	$128,025	$0	$13,019,260
MN	$9,233,175	$9,559,106	$135,000	$0	$9,694,106
OH	$15,997,267	$16,561,971	$69,000	$0	$16,630,971
WI	$6,953,440	$7,198,896	$180,372	$0	$7,379,268
Subtotal	**$68,929,830**	**$71,363,053**	**$903,786**	**$0**	**$72,266,839**
AR	$6,278,918	$6,278,918	$298,676	$0	$6,577,594
LA	$7,070,882	$7,320,484	$313,446	$0	$7,633,930
NM	$2,424,303	$2,509,881	$192,898	$0	$2,702,779
OK	$7,070,882	$7,070,882	$300,000	$0	$7,370,882

Appendix 1 - FY25 MPD Projected Allocations, continue

	A	B1	B2	C	D
State	FY24 Base Budget	FY25 PM Funding Amount	FY25 Hospice/CAA Budget Amount+	Estimated Supplemental Validation Funding*	FY25 Final Allocations (All Funding Sources)
TX	$33,636,191	$34,823,549	$753,687	$0	$35,577,236
Subtotal	**$56,481,176**	**$58,003,714**	**$1,858,707**	**$0**	**$59,862,421**
IA	$5,643,968	$5,643,968	$300,000	$0	$5,943,968
KS(AG)	$3,463,950	$3,586,227	$300,000	$0	$3,886,227
KS(H)	$1,497,208	$1,550,059	$0	$0	$1,550,059
MO	$11,713,269	$12,126,747	$525,000	$0	$12,651,747
NE	$3,038,268	$3,145,519	$74,551	$0	$3,220,070
CO	$5,552,868	$5,748,884	$56,567	$0	$5,805,451
MT	$1,818,841	$1,883,046	$70,000	$0	$1,953,046
ND	$1,723,644	$1,784,489	$59,760	$0	$1,844,249
SD	$1,520,393	$1,574,063	$21,589	$0	$1,595,652
UT	$2,420,362	$2,505,801	$325,000	$0	$2,830,801
WY	$1,234,750	$1,234,750	$33,066	$0	$1,267,816
Subtotal	**$39,627,521**	**$40,783,553**	**$1,765,533**	**$0**	**$42,549,086**
AZ	$3,646,528	$3,775,250	$285,500	$0	$4,060,750
CA	$45,601,595	$47,211,331	$2,034,814	$0	$49,246,145
HI	$1,737,687	$1,799,027	$50,852	$0	$1,849,879
NV	$1,794,936	$1,858,297	$531,300	$0	$2,389,597
AK	$1,101,362	$1,140,240	$101,910	$0	$1,242,150
ID	$1,764,941	$1,827,243	$73,160	$0	$1,900,403
OR (Health)	$1,257,302	$1,301,685	$132,560	$0	$1,434,245
OR (HR)	$3,285,275	$3,401,245	$0	$0	$3,401,245
WA(H)	$2,292,631	$2,373,561	$150,020	$0	$2,523,581
WA(SS)	$4,803,445	$4,973,007	$0	$0	$4,973,007
Subtotal	**$67,285,702**	**$69,660,886**	**$3,360,116**	**$0**	**$73,021,002**
Blank	**$353,132,848**	**$363,145,421**	**$10,799,931**	**$0**	**$373,945,352**

Additional Funding levels to be considered after Congress approves Fiscal Year 2025 Budget.

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

Provider and Supplier Oversight

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

Priority tier structure for survey & certification activities for ASCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint Investigations prioritized as IJ – deemed ASCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	**Targeted Surveys (25%):** The state performs surveys totaling 25% of all non-deemed ASCs in the state (or at least 1, whichever is greater) focusing on ASCs not surveyed in more than 4 years or based on state judgment for those ASCs more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 priority. States with seven or fewer non-deemed ASCs must survey at least one ASC unless all non-deemed ASCs were surveyed within the prior two years. **Complaint investigations prioritized as non-IJ high**: to be initiated within 45 days (for deemed ASCs, within 45 days	**6-Year Interval:** Additional surveys are done to ensure that no more than six years elapse between surveys for any one particular non-deemed ASC. **Initial certification**- All others not listed under Tier 1 or 2	

Tier 1	Tier 2	Tier 3	Tier 4
	of CMS Location authorization). **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.		

Contact Information:

- For questions, please contact: QSOG_ASC@cms.hhs.gov.

Priority tier structure for survey & certification activities for Providers of OPT & SLP services

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized as IJ **Initial certification** - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	**5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, whichever is greater), based on state judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 and 4 priorities. States with fewer than seven providers of this type are	**7-Year Interval**: Additional surveys are done to ensure that no more than seven years elapse between surveys for any one particular provider. **Initial certification**- All others not listed under Tier 1 or 2	**6-Year Avg:** Additional surveys are done (beyond tiers 2-3) such that all non-deemed providers in the state are surveyed, on average, every six years. (i.e., total surveys divided by total providers is not less than 16.7% = six years). There is a deemed status option for OPTs.

Tier 1	Tier 2	Tier 3	Tier 4
	exempt from this requirement. **Complaint investigations prioritized as non-IJ high**: to be initiated within 45 days (for deemed, within 45 daysof CMS Location authorization). **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option -** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.		

Contact Information:

- For questions, please contact: QSOG_OPT@cms.hhs.gov.

Priority tier structure for survey & certification activities for CORFs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized as IJ **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no**	**5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, whichever isgreater), based on state judgment for those providers more at risk	**7-Year Interval:** Additional surveys are done to ensure that no more than seven years elapse between surveys for any one particular provider.	**6-Year Avg:** Additionalsurveys are done (beyond tiers 2 and 3) such that all non-deemed providers in the state are surveyed, on average, every six years. (i.e., total

deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)- If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 and 4 priorities. States with fewer than seven providers of this type are exempt from this requirement.	**Initial certification-** All others not listed under Tier 1.	surveys divided by total providers is not less than 16.7% = six years).

Contact Information:

- For questions, please contact: QSOG_CORF@cms.hhs.gov.

Priority tier structure for survey & certification activities for CMHCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations triaged as IJ **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days	**5% Targeted Surveys**: Each year, the state surveys 5% of the providers in the state (or at least one, whichever isgreater), based on CMS Location judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the tier 3 priorities. Targeted sample requirements do not apply to states with	**5-Year Interval** **Initial certification-** All others not listed under Tier 1.	

Tier 1	Tier 2	Tier 3	Tier 4
has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	fewer than seven CMHCs. **Complaint Investigations: non-IJ high**		

Contact Information:

- For questions, please contact: CMHC@cms.hhs.gov.

Priority tier structure for survey & certification activities for ESRD

Tier 1	Tier 2	Tier 3	Tier 4
Investigation of complaint allegationstriaged as IJ. **Initial surveys**: States must conduct initial certification surveys within 90 days of the MAC approval of the CMS-855, unless the supplier has elected a deeming option.	**Outcomes List**: 100% of the ESRD facilities in the state on the Outcome List **Investigations of complaint allegations triaged as High**	**3.5-Year Max Interval (42.9 months)**: Additional surveys are done to ensure that no more than 3.5 years elapse between surveys for any one particular ESRD facility. **Investigations of complaint allegations triaged as medium.** **Relocations, expansion of service(s), and/or addition of station(s) requests**, as needed	**3-Year Average:** Additional surveys are done (beyond tiers 2-3) sufficient to ensure that ESRD facilities are surveyed with an average frequency of three years or less.

Contact Information:

- For questions, please contact: ESRDQuestions@cms.hhs.gov.

Priority tier structure for survey & certification activities for FQHCs and RHCs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint investigations prioritized IJ- deemed RHCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Complaint investigations prioritized as IJ-FQHCs: only with CMS Location authorization; survey to be initiated within two days of CMS Location authorization. Initial certification - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	5% Targeted Surveys- RHCs: Each year, the state surveys 5% of non-deemed RHCs (or at least one, whichever is greater), based on state judgment prioritizing those RHCs most at risk of quality problems. Some of the targeted surveys may qualify to count toward the tiers 3 and 4 priorities. States with fewer than seven RHC s are exempt from this requirement. Complaint investigations prioritized as non- IJ high: to be initiated within 45 days of the prioritization (for deemed RHCs, within 45 days of CMS Location authorization). Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option- If more than 150 days has passed since the MAC has recommended approval of the application and a	7-Year Interval: Additional surveys are done to ensure that no more than seven years elapse between surveys for any RHC. Initial certification- All others not listed under Tier 1 or 2	**6-Year Average**: Additional surveys are done (beyond tiers 2-3) such that all non-deemed RHCs in the state are surveyed, on average, every six years. (i.e., total surveys divided by total RHCs is not less than 16.7%). There is no certification or re-certification requirement for FQHCs.

Tier 1	Tier 2	Tier 3	Tier 4
	deeming option exists, then the initial certification would be a Tier 2 priority.		

Contact Information:

- For questions, please contact: QSOG_RHC-FQHC@cms.hhs.gov.

Priority tier structure for survey activities for HHAs

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapse between completed surveys for any particular agency. **Complaint investigations triaged as IJ.** SA must initiate an onsite survey within 2 business days of receipt. **Substantial Allegation Validation (Complaint) Surveys – IJs for deemed and non-deemed HHAs**: Only when authorized by the CMS Locations, complaint surveys are to be initiated onsite by the SA within two business days of CMS Location authorization. **Initial certification - Provider/Supplier with a CMS-determined access to**	**Complaint investigations prioritized as: Non-IJ High: SA must initiate an onsite survey within 45 calendar days of prioritization.** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**Initial certification-** All others not listed under Tier 1 or 2	**24.9 Mo. Avg**: Additional surveys (beyond tiers 1-3) done based on state judgment regarding HHAs most at risk of providing poor care so all HHAs are surveyed on average every 24 mos. (average of all tier 4 surveys ≤ 24.9 mos. to optimize the unpredictability of surveys. **Surveys of HHAs de-activated (by the MAC)–**for failure to bill Medicare for 12 consecutive months.

Tier 1	Tier 2	Tier 3	Tier 4
care issue (the provider is responsible for providing the information)			

Contact Information:

- For questions, please contact: HHAsurveyprotocols@cms.hhs.gov.
- For OASIS technical questions, please contact: HomeHealthQualityQuestions@cms.hhs.gov.

Priority tier structure for survey & certification activities for Hospice agencies

Tier 1	Tier 2	Tier 3	Tier 4
36.9-Mo. Max. Interval: No more than 36.9 months elapse between completed surveys for any particular agency. **Complaint investigations prioritized as IJ – deemed and non-deemed hospices**: only with CMS Location authorization; onsite survey to be initiated within two business days of CMS Location authorization. **Initial certification** - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)	**Complaint investigations prioritized as: Non-IJ High: SA must initiate an onsite survey within 45 calendar days of prioritization.** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority.	**Initial certification-** All others not listed under Tier 1 or 2	**N/A**

Contact Information:

- For questions, please contact: QSOG_Hospice@cms.hhs.gov.

Priority tier structure for survey & certification activities for Hospitals, Psychiatric Hospitals, & CAHs (Deemed)

Tier 1	Tier 2	Tier 3	Tier 4
Substantial Allegation Validation (Complaint) Surveys: Only when authorized by the CMS Location. IJ complaints, including restraint/ seclusion death incidents, must be initiated or completed within the applicable SOM timeframe and are tier 1 priority. **EMTALA Complaint Surveys**: Only when authorized by the CMS Location. All EMTALA complaints surveys authorized are prioritized as IJs or non-IJ high and are to be completed within the applicable SOM timeframe and are a tier 1 priority. **Full Surveys Pursuant to Complaints:** Full surveys may be required by the CMS Location after each complaint investigation that finds condition level non-compliance for	**Substantial Allegation Validation (Complaint) Investigations that are prioritized as non-IJ** high must be initiated within 45 days of CMS Location authorization	**N/A**	**N/A**

Tier 1	Tier 2	Tier 3	Tier 4
deemed hospitals and CAHs. These are a tier 1 priority. **Initial certification** - Provider/Supplier with a CMS-determined access to care issue (the provider is responsible for providing the information)			

Priority tier structure for survey & certification activities for Hospitals, Psychiatric Hospitals-& CAHs (Non-Deemed)

Tier 1	Tier 2	Tier 3	Tier 4
Complaint surveys: Complaint allegations prioritized as IJs and CMS Location authorized EMTALA and restraint/ seclusion death incident surveys, initiated or completed within the applicable SOM timeframes.	**5-Year Max. Interval**: No more than five years elapse between surveys for any particular non-deemed hospital, psychiatric hospital, or CAH. **5% Targeted Sample**: States survey at least one, but not less than 5% of the non-deemed hospitals,5% of the non-deemed psychiatric hospitals, and 5% of non-deemed CAHs in the state, selected by the state based on state judgment regarding those most at risk of providing poor care. Some targeted surveys may count toward the tier 3 and 4	**Recerts: 4-Year Max. Interval:** No more than four years elapse between surveys for any particular non-deemed hospital or CAH. **Recerts of Psych Hospitals**: 3-year average recert surveys of non-accredited/non-deemed psychiatric hospitals only. **New IPPS Exclusions:** All new rehabilitation hospitals/units & new psychiatric units seeking exclusion from IPPS (2),as well as existing providers newly seeking such exclusion. The SA	**3-Year Avg**.: Additional surveys are done (beyond tiers 2 and 3), based on state judgment regarding the non-deemed hospitals and CAHs that are most at risk of providing poor care, such that all non- deemed hospitals/CAHs in the state are surveyed,on avg, every three years (i.e., total surveys divided by total non-deemed hospitals/CAHs is not more than three years; separate calculation for hospitals and CAHs). Targeted surveys may count toward the three-year average.

Tier 1	Tier 2	Tier 3	Tier 4
	priorities. Targeted sample requirements do not apply to States with fewer than seven non-deemedhospitals, psychiatric hospitals, or CAHs.	does not need to conduct an on-site survey for verification of the exclusion requirements but instead may process an attestation	

Contact Information

- For questions, please contact: QSOG_Hospital@cms.hhs.gov.

Priority tier structure for survey & certification activities for ICF/IID

Tier 1	Tier 2	Tier 3	Tier 4
15.9 Mo. Max. Interval:No more than 15.9 months elapse between completed surveys for any particular ICF/IID. **12.9-Mo. Avg**: All ICF/IIDs in the state are surveyed, on average, once per year. The Statewide average interval between consecutive standard surveys must be 12.9 months or less. **Complaint surveys triaged as IJ.** SA must initiate an onsite survey within two business days of receipt.	**Complaint investigations triaged as Non-IJ high**	**Initial certification-** Surveyed at state priority	**N/A**

Contact Information

- For questions, please contact: QSOG_ICFIID@cms.hhs.gov.

Priority tier structure for survey & certification activities for LTC

Tier 1	Tier 2	Tier 3	Tier 4
15.9-Month Max. Interval: No more than 15.9 months elapse between completed surveys for any particular nursing home. **12.9-Mo. Avg:** All nursing homes in the state are surveyed, on average, once per year. The statewide average interval between consecutive standard surveys must be 12.9 months or less. **Complaint investigations triaged as IJ** **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial	**"Off-Hours" Surveys:**States are required to conduct at least 10% of the standard health surveys on the weekend or before 8:00 a.m. or after 6:00 p.m. (i.e., "off-hours). States shall conduct at least 50% of their required off-hours surveys on weekends using the list of facilities with potential staffing issues provided by CMS. **Complaint investigations triaged as Non-IJ high**	**Initial Surveys of Nursing Homes that are seeking Medicaid-only funding**–funded only by Medicaid (not Medicare) and surveyed at state priority. **Initial certification-** All others not listed above or under Tier 1. **Complaint investigations triaged as Non-IJ medium**	**Complaint investigations triaged as Non-IJ low**

Tier 1	Tier 2	Tier 3	Tier 4
certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			

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

Contact Information

- For regulatory questions, please contact: DNH_TriageTeam@cms.hhs.gov.
- For survey process questions, please contact: NHSurveyDevelopment@cms.hhs.gov.
- For schizophrenia audit questions, please contact: DNH_BehavioralHealth@cms.hhs.gov.

Priority tier structure for survey & certification activities for PXR

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

Tier 1	Tier 2	Tier 3	Tier 4
MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.			

Contact Information

- For questions, please contact: CMSQSOG_PXR@cms.hhs.gov.

Priority tier structure for survey & certification activities for PRTFs (Medicaid Psych < 21)

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

Contact Information

- For questions, please contact: QSOG_PRTF@cms.hhs.gov.

Priority tier structure for survey & certification activities for Transplant Programs

Tier 1	Tier 2	Tier 3	Tier 4
Complaint – IJ: Investigation of complaint allegations triaged as IJ. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	**Mandatory Re-approval Surveys:** 5-year survey interval.	**Initial certification-** All others not listed under Tier 1.	**N/A**

Contact Information

- For questions, please contact: QSOG_TransplantTeam@cms.hhs.gov.

Priority tier structure for survey & certification activities for New Provider Initial Surveys

Tier 1	Tier 2	Tier 3	Tier 4
Initial certification of the ESRD Facilities: States conduct initial certification surveys within 90 days of the	**Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with a deeming option-** If	**Initial certification-** All others not listed under Tier 1 or 2 **Relocations of non-deemed branches or off- site locations.**	While CAHs may also be deemed, these are conversions, not initial certifications; however, deemed CAHs are expected to

Tier 1	Tier 2	Tier 3	Tier 4
MAC approval of the CMS-855, unless the supplier has elected a deeming option. **Initial certification - Provider/Supplier's application to Medicare exceeds 150 days with no deeming option or with a CMS-determined access to care issue (the provider is responsible for providing the information)-** If more than 150 days has passed since the MAC has recommended approval of the application and no deeming option exists, then the initial certification would be a Tier 1 priority. This would also include cases where CMS has determined an access to care issue.	more than 150 days has passed since the MAC has recommended approval of the application and a deeming option exists, then the initial certification would be a Tier 2 priority. **Relocations of the parent or main location of existing non-deemed providers or suppliers.** **Relocations of any provider/supplier displaced during a public health emergency declared by HHS.**	*Note*: Conversion of a non-deemed hospital to a CAH, or a non-deemed CAH back to a hospital is a conversion, not an initial certification and at state option may be done as tier 2, 3, or 4. However, the conversion of a deemed hospital or CAH or the addition of swing beds as a new service in an existing deemed or non-deemed hospital or CAH is a tier 4 priority.	be surveyed by their AOs for their conversion surveys. **The addition of home health branches** are administrative actions thus not a deeming option. (AOs deem compliance with CoPs/CfCs, not administrative actions). Though surveys may not be involved, these actions should remain in the tier structure as they are often resource intensive. **The addition of multiple hospice locations** may warrant a survey. These surveys should be scheduled consistent with the tier structure as they are often resource intensive. **Relocations of deemed providers or suppliers.**

Priority tier structure for survey & certification activities for Complaint Investigations

Tier 1	Tier 2	Tier 3	Tier 4
Complaint Investigations triaged as or, in the case of hospitals, psychiatric hospitals, or CAH DPUs,where the CMS Location	Complaint Investigations triaged as Non-IJ High.	Complaint investigations of non-deemed acute & continuing care providers/suppliers triaged as Non-IJ Medium are investigatedwhen the	Complaint investigations of LTC facilities triaged as Non-IJ Low. Complaints of non-deemed acute &

Tier 1	Tier 2	Tier 3	Tier 4
authorizes investigation of a hospital or CAH DPU restraint/ seclusion death incident. **Full Surveys Pursuant to Complaints**: Full surveys may be required by the CMS Location after each complaint investigation that finds condition level non-compliance for deemed providers/suppliers. These are a tier 1 priority.		next on-site survey occurs. Complaint investigations of LTC facilities triaged as Non-IJ Medium.	continuing care providers/suppliers triaged as Non-IJ Low are not investigated separately but tracked/trended for potential focus areas during the next on-site survey.

For questions, please contact the appropriate program area:

- QSOG_ASC@cms.hhs.gov
- QSOG_CORF@cms.hhs.gov
- HHAsurveyprotocols@cms.hhs.gov
- QSOG_OPT@cms.hhs.gov
- CMSQSOG_PXR@cms.hhs.gov
- QSOG_RHC-FQHC@cms.hhs.gov
- QSOG_Hospital@cms.hhs.gov
- QSOG_TransplantTeam@cms.hhs.gov
- QSOG_ESRDQuestions@cms.hhs.gov
- QSOG_PsychiatricHospital@cms.hhs.gov
- QSOG_PRTF@cms.hhs.gov
- QSOG_ICFIID@cms.hhs.gov
- CMHC@cms.hhs.gov
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