



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

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**Admin Info: 20-02-ALL**

**DATE:** October 17, 2019

**TO:** State Survey Agency Directors

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

**SUBJECT:** Fiscal Year (FY) 2020 State Performance Standards System (SPSS) Guidance

**Memorandum Summary**

- CMS is releasing revisions to the process used to oversee state survey agency performance for ensuring Medicare/Medicaid certified providers and suppliers are compliant with federal requirements to improve and protect the health and safety of Americans.

**Background**

Every year, CMS conducts a formal assessment of each State Agencies' (SAs') performance relative to measures included in the SPSS program. CMS works with the SAs to strengthen oversight so that the care provided in nursing homes and/or by providers and suppliers is of the highest quality.

In April 2018, CMS launched an initiative to evaluate the SPSS process and identify ways to improve how we monitor and ultimately the SA performance. This effort supports our goal to protect and improve the health and safety of all individuals receiving services from Medicare/Medicaid providers throughout the country. We are pleased to begin implementing changes to the SPSS in FY 2020. These changes reflect the use of improved, current datasets with consistent and objective oversight. For example, since implementing the new long term care survey process in 2017, we now have more robust data that can be used to monitor and improve performance. The changes also reflect recommendations from CMS Regional Offices (ROs) and SAs, who regularly operate the program. The resulting updates to the SPSS aim to enable CMS and SAs to address areas of concern more effectively, and ultimately improve beneficiary safety and the quality of their care. Below are the three domains of the SPSS for the 2020 fiscal year:

- 1) Frequency: Conducting survey activities in accordance with required timelines;
- 2) Quality: Ensuring survey agencies are properly identifying and documenting noncompliance; and
- 3) Coordination of Provider Noncompliance: Ensuring survey agencies are taking action quickly to ensure remedies are imposed for provider noncompliance.

Within these domains, we have made several changes to improve the SPSS system. Below is a summary of these changes:

- Established State Performance Indicators that will help identify the underlying causes for inadequate performance in one or more of the scored performance measures.
- Included survey frequency run-rates, that are directly associated with Frequency domain measures and will be useful in the assessment of the mid-year progress made towards meeting Frequency measures goals during the fiscal year.
- Added the ability to include state specific measures, to tailor the program and address state-specific issues.
- Improved the process by which the program operates. For example, for some performance issues SAs will be given 18-24 months to make correction, given that SAs receive their final results several months into the next fiscal year. We will also be leveraging centralized data sources and hubs to access data and avoid redundant or duplicative data reporting.
- Included a new measure for cases where immediate jeopardy is cited that indicates if the survey agency delivered the IJ template at the exit conference, per Appendix Q of the State Operations Manual. Note: SAs and ROs are now required to attach the IJ template to the survey package when uploading to ASPEN Central Office/ASPEN Regional Office (ACO/ARO) for each instance of Immediate Jeopardy. For more information on the procedures for attaching documents, see the [ACO Procedures Guide \(https://qtso.cms.gov/system/files/qtso/ACO\\_PG\\_11.7.0.2\\_FINAL.pdf\)](https://qtso.cms.gov/system/files/qtso/ACO_PG_11.7.0.2_FINAL.pdf).

We also plan to significantly enhance our oversight of how SAs handle complaints and facility-reported incidents (FRIs). This includes how each state prioritizes reports of abuse or neglect, the timeliness of the investigation of reports, and the quality of these investigations. We note that these issues have also been the subject of reports by the Office of Inspector General<sup>1</sup> and the Government Accountability Office<sup>2</sup>. Abuse and neglect are never acceptable and CMS has included some updates in the SPSS guidance that will strengthen our oversight in this area. In addition, to ensure that SAs respond to allegations in a timely and thorough manner, CMS will be revising policies for SAs to investigate complaints and FRIs in Chapter 5 of the State Operations Manual. We will update the SPSS guidance once those revisions take place.

On behalf of CMS, we truly appreciate all the endless efforts to improve the health, safety and dignity of all Medicare and Medicaid enrollees.

**Contact:** Please contact the SPSS team at [SPSS\\_Team@cms.hhs.gov](mailto:SPSS_Team@cms.hhs.gov) with any questions or concerns.

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<sup>1</sup> HHS-OIG. *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect*. OIG-A-01-17-00513 (Washington, DC: June 2019) and HHS-OIG. *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated*. OIG-A-01-16-00509 (Washington, DC: June 2019).

<sup>2</sup> GAO. *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*. GAO-19-433 (Washington, DC: July 2019) and GAO. *CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years*. GAO-19-313R (Washington, DC: April 2019).

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

/s/

David R. Wright

cc: Survey and Certification Regional Office Management

**FY 2020**  
**State Performance Standards**  
**System Guidance**

**October 8, 2019**

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# Introduction

CMS is actively evaluating the State Performance Standards System (SPSS) and working to improve its efficiency, consistency, and relevance. The changes reflected in this year’s SPSS guidance document are informed by analysis of existing data and feedback from stakeholders at Regional Offices and State Survey Agencies. Some key challenges identified were: timeliness of data, subjectivity of measures, and burdensome or inefficient measures. Other data-related challenges were: difficulty differentiating performance across State Survey Agencies, no mechanism to rank State Survey Agency performance, and inability to pinpoint areas for State Survey Agency improvement over time. This redesign aims to align the SPSS with CMS’ expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve the health and safety of Americans (e.g., State Operations Manual [SOM], Chapter 8, Mission and Priority Document, survey procedure guides, etc.).

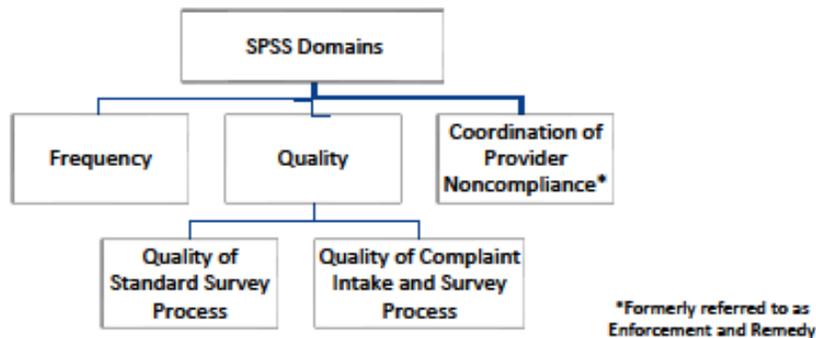
This introductory chapter orients users to the new SPSS design. Section A covers structural and domain-specific changes, section B provides information on ongoing activities, section C provides a crosswalk of the FY 2019 guidance to the FY 2020 guidance, and section D summarizes the domains and measures in this year’s guidance. Appendix 22 provides guidance on rounding issues.

## A. Primary changes to the SPSS

This section provides a high-level summary of changes to the SPSS guidance. Changes are categorized as structural (i.e., impacting all domains) or domain-specific.

### 1. Refinements to the SPSS structure

**Figure 1. Structure of the SPSS**



This year’s SPSS establishes a non-scored tier of measures that include Frequency run-rates and State Performance Indicators. To differentiate between these non-scored measures and the traditional scored SPSS measures (e.g., F1, Q1), scored measures will be referred to as “scoring measures.”

- Frequency run-rates are directly associated with Frequency domain measures and are useful in assessing progress made towards meeting Frequency measures during the fiscal year. CMS Central Office will produce these data.

- State Performance Indicators are associated with the Quality and Coordination of Provider Noncompliance domains and are useful for determining possible root causes for unmet scoring measures may not be met. State Performance Indicators are intended to identify potential areas of improvement without penalty through open collaboration and communication between State Survey Agencies and Regional Offices. CMS Central Office will produce these data.
  - More details on State Performance Indicators are provided in Appendix 16.
- Scoring measures are found in the Frequency, Quality, and Coordination of Provider Noncompliance domains.

## 2. Frequency Domain

This year's SPSS guidance includes a process for State Survey Agencies to request permission from CMS to exclude surveys from frequency measure calculations. CMS management will review and determine if an exclusion is approved, on a case by case basis. For example, providers affected by a natural disaster and covered under an 1135 Waiver may be excluded from the denominator of a frequency measure. The guidance is updated to include an evaluation of the timely completion of initial certification surveys for the End Stage Renal Disease (ESRD) program.

CMS will publish frequency measure run-rates, in the form of a quarterly data extract, to provide information on current State Survey Agency progress toward meeting annual Survey Frequency requirements. This data extract will be provided to the State Survey Agencies and Regional Offices. Data runs will identify the dates on which data are extracted. CMS plans to extract data at least 60 days after the end of a specified survey period. For example, data will be extracted on December 2, 2019 to identify frequency rates as of the end of fiscal year 2019.

## 3. Quality Domain

The revised SPSS guidance establishes sub-domains within the Quality domain that focus on the standard survey and complaint survey processes, separately.

- The guidance includes a revised method of evaluation and revised criteria associated with the Documentation of Deficiencies for Nursing Homes, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Non-Deemed ESRD Facilities, Home Health Agencies (HHAs), Hospice, and Hospitals scoring measure for standard and complaint surveys to reduce subjectivity and burden. The primary changes to this scoring measure include:
  - Reduce the number of criteria required for the Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD Facilities, HHAs, Hospice, and Hospitals scoring measure to four criteria for nursing homes and three criteria for non-nursing homes.
  - Emergency preparedness tags are also now included in this review. The guidance revises measures previously associated with the Federal Oversight Support Survey (FOSS) process to reflect the new Focused Concern survey process. For comparative nursing home surveys, the guidance also includes a revision to the SPSS scoring measure to now reflect the use of two years of comparative survey data.
  - Revise the requirements related to the quality of investigations of complaints and facility-reported incidents.
  - The ability to establish a state-specific scoring measure for a given year that leverages State Performance Indicators to identify potential areas of concern. State Survey Agencies and

Regional Offices will collaboratively identify this measure. The state-specific scoring measure is measure Q8.

- Add a new measure to assess State Agencies’ use of the Immediate Jeopardy (IJ) template in accordance with Appendix Q of the SOM.

#### **4. Coordination of Provider Noncompliance Domain**

The Enforcement domain has been renamed, “Coordination of Provider Noncompliance,” to more accurately reflect the role of State Survey Agencies.

In this guidance, the FY 2019 scoring measure previously referred to as E4 (Special Focus Facility Survey Frequency) has been moved to the Frequency domain as F5.

### **B. Ongoing Activities**

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Due to the number of changes to the SPSS, CMS will conduct ongoing monitoring and support activities. If you have questions or recommendations related to the SPSS, please contact [SPSS\\_Team@cms.hhs.gov](mailto:SPSS_Team@cms.hhs.gov).

Developmental measures and measures on hold will continue to be assessed and fine-tuned as needed. Developmental measures for this year include:

- Q7 – Complaint Surveys. Quality of Complaint/FRI Investigations for Nursing Homes, ICFs/IID and Non-Deemed ESRD Facilities, HHAs, Hospice, and Hospitals
- Q8 – Standard Surveys. State Specific Measure
- Q8 – Complaint Surveys. State Specific Measure
- Q9—Quality of Use of IJ Template

State performance on these measures will still be monitored and reported, but states will not be scored as passing or failing. However, CMS will continue to work with states to address any performance issues identified by these measures. Developmental measures will be evaluated and modified as needed throughout FY 2020 and are planned to become scored measures for FY 2021.

### **C. Crosswalk of FY 2019 SPSS with FY 2020 SPSS**

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This section provides a crosswalk of the FY 2019 SPSS guidance to the updated FY 2020 SPSS guidance (see tables 1-3). We have re-numbered based on elimination of old measures and creation of new measures. This section also summarizes changes to the format of this guidance document.

**Table 1. Crosswalk of FY 2019 SPSS Frequency Domain Measures to FY 2020 SPSS Frequency Domain Measures**

FY 2019 Frequency Measure	FY 2020 Frequency Measure
F1. Off-Hour Surveys for Nursing Homes	F1. Off-Hour Surveys for Nursing Homes
F2. Frequency of Nursing Home Surveys	F2. Frequency of Nursing Home Surveys
F3. Frequency of Non-Nursing Home Surveys – Tier 1 to Tier 3	F3. Frequency of Non-Nursing Home Surveys – Tier 1 to Tier 3
F4. Timeliness of Upload into CASPER of Standard Surveys for Non-Deemed Hospitals and Nursing Homes	F4. Timeliness of Upload into CASPER of Standard Surveys for Non-Deemed Hospitals and Nursing Homes
--	F5. Special Focus Facilities for Nursing Homes

CASPER = certification and survey provider enhanced reports

**Table 2. Crosswalk of FY 2019 SPSS Quality Domain Measures to FY 2020 SPSS Quality Domain Measures**

FY 2019 Quality Measure	FY 2020 Quality Measure
Q1. Documentation of Deficiencies for Nursing Homes, ESRD Facilities, ICFs/IID and Non-Deemed HHAs and Hospitals	Q1 – Standard Surveys. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD facilities, HHAs, Hospice, and Hospitals Q1 – Complaint Surveys. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD facilities, HHAs, Hospice, and Hospitals
Q2. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS	Q2 –Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS
Q3. Documentation of Noncompliance in Accordance with Federal Standards for Nursing Home Health FOSS Surveys	-
Q4. Identification of Health and LSC Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results	Q3 –Identification of Health LSC and EP Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results
Q6. Prioritizing Complaints and FRIs	Q4 – Prioritizing Complaints and FRIs <sup>†</sup>
Q7. Timeliness of Complaint and FRI Investigations	Q5 – Timeliness of Complaint and FRI Investigations <sup>†</sup>
Q8. Quality of EMTALA Investigations	Q6– Quality of EMTALA Investigations
-	Q7 –Quality of Complaint/FRI Investigations for Nursing Homes, ESRD Facilities, ICFs/IID and Non-Deemed HHAs, Hospice, and Hospitals *
-	Q8 – Standard. State-specific Measure* Q8 –Complaint. State-specific Measure*
-	Q9— Quality of Use of IJ Template

\* Indicates that the measure will be piloted or developmental in FY 2020

<sup>†</sup> Nursing home and non-nursing home providers

EP = Emergency Preparedness, ESRD = end-stage renal disease; ICFs/IID = Intermediate Care Facilities for Individuals with Intellectual Disabilities; HHA = home health agency; LSC = life safety code; FRI = facility-reported incident; FOSS = Federal Oversight Support Survey; FCS = focused concern survey; EMTALA = Emergency Medical Treatment & Labor Act; IJ = immediate jeopardy

**Table 3. Crosswalk of FY 2019 SPSS Enforcement and Remedy Domain Measures to FY 2020 SPSS Coordination of Provider Noncompliance (CPN) Domain Measures**

FY 2019 Enforcement and Remedy Measure	FY 2020 Coordination of Provider Noncompliance Measure
E1. Timeliness of Processing IJ Cases	CPN1. Nursing Homes. Timeliness of Processing IJ Cases CPN1. Non-Nursing Homes. Timeliness of Processing IJ Cases except for EMTALA
E2. Timeliness of Mandatory DPNA Notification for Nursing Homes	CPN2. Timeliness of Mandatory DPNA Notification for Nursing Homes
E3. Processing of Termination Cases for Non-Nursing Home Providers/Suppliers	CPN3. Processing of Termination Cases for Non-Nursing Home Providers/Suppliers
E4. Special Focus Facilities for Nursing Homes	Moved to Frequency domain

DPNA = denial of payment for new admissions; IJ = immediate jeopardy

The format of this year’s guidance document has also been updated. Each measure contains the following sections:

- Threshold criteria
- Scoring
- Evaluation (directs user to appendix)
- Reference(s)
- Each measure has an appendix that contains more detailed information on how to calculate the measure. The appendices contain the following sections:
  - Data Source(s)
  - Method (previously Method of Evaluation)

## D. Domain Summary

This section provides a summary of this year’s SPSS domains and the measures that fall into each domain (table 4). State Performance Indicators are described in Appendix 16.

**Table 4. Summary of SPSS Domains and Measures**

Type of Measure(s) Included	Frequency	Quality: Standard Surveys	Quality: Complaint Surveys	Coordination of Provider Noncompliance
Scoring Measures	<ul style="list-style-type: none"> <li>● F1. Off-Hour Surveys for Nursing Homes</li> <li>● F2. Frequency of Nursing Home Surveys</li> <li>● F3. Frequency of Non-Nursing Home Surveys – Tier 1 to Tier 3</li> <li>● F4. Timeliness of Upload into CASPER of Standard Surveys for Non-Deemed Hospitals and Nursing Homes</li> <li>● F5. Special Focus Facilities for Nursing Homes</li> </ul>	<ul style="list-style-type: none"> <li>● Q1 – Standard. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD facilities, HHAs, Hospice, and Hospitals</li> <li>● Q2 – Standard. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS</li> <li>● Q3 – Standard. Identification of Health LSC Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results</li> <li>● Q8 – Standard. State-specific Measure*</li> <li>● Q9—Implementation of IJ Template*</li> </ul>	<ul style="list-style-type: none"> <li>● Q1 – Complaint. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD facilities, HHAs, Hospice, and Hospitals</li> <li>● Q2 – Complaint. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS</li> <li>● Q4 – Complaint. Prioritizing Complaints and FRIs</li> <li>● Q5 – Complaint. Timeliness of Complaint and FRI Investigations</li> <li>● Q6– Complaint. Quality of EMTALA Investigations</li> <li>● Q7 – Complaint. Quality of Complaint/FRI Investigations for Nursing Homes, ESRD Facilities, ICFs/IID and Non-Deemed HHAs, Hospice, and Hospitals*</li> <li>● Q8 – Complaint. State-specific Measure*</li> <li>● Q9—Quality of Use of IJ Template*</li> </ul>	<ul style="list-style-type: none"> <li>● CPN1. Nursing Homes. Timeliness of Processing IJ Cases</li> <li>● CPN2. Non-Nursing Homes. Timeliness of Processing IJ Cases except for EMTALA</li> <li>● CPN3. Timeliness of Mandatory DPNA Notification for Nursing Homes</li> <li>● CPN4. Processing of Termination Cases for Non-Nursing Home Providers/ Suppliers</li> </ul>
State Performance Indicators		✓	✓	✓

\* Indicates that the measure is developmental in FY 2020

## General Instructions

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This year's SPSS Guidance provides instructions to Regional Offices on how to evaluate State Survey Agency performance across three Domains: Frequency, Quality, and Coordination of Provider Noncompliance. Each Domain is comprised of Scoring Measures.

In order to complete this year's State Performance Standard review in a timely manner, Regional Offices should conduct parts of the evaluation at least semi-annually, especially those measures that involve case documentation review including *Q1 – Standard. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD Facilities, HHAs, Hospice, and Hospitals, Q1 –Complaint. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-Deemed ESRD Facilities, HHAs, Hospice, and Hospitals, Q4 –Complaint. Prioritizing Complaints and FRIs, and Q6–Complaint. Quality of EMTALA Investigations*. Regional Offices will provide each State Survey Agency with a report of its mid-year findings so that State Survey Agencies can facilitate improvements throughout the remainder of the fiscal year. In addition, Central Office will provide further details on *Q8 – Standard. State-specific measure* and *Q8 –Complaint. State-specific measure* during the fiscal year.

Measures are calculated according to the specific instructions for each measure and its associated appendix. Measure scores are entered into the SPSS Database located within the CMS SharePoint site. In cases where a threshold criterion is not applicable to a State Survey Agency, the Regional Office will note this within the SPSS Database and the State Survey Agency will not receive a score for that threshold criterion. Regional Offices must enter all Scoring Measures, either through direct data entry of the measure's score or through measure-specific tools, primarily those that involve case documentation reviews for each State Survey Agency in their respective Regional Office. Once all scoring measures have been submitted into the SPSS Database, Regional Offices can then print a draft and final State Survey Agency Performance Review Summaries from the SPSS Database for the State Survey Agency to review.

There are no exceptions as to how each measure is scored unless CMS management has approved an exclusion. If a State Survey Agency does not meet a measure, it may provide information in a corrective action plan to address identified problems and/or to explain any extenuating circumstances that may have occurred during the fiscal year and prevented the State Survey Agency from meeting the measure.

If more information is needed, it should be transmitted in an electronic format by the State Survey Agency to the Regional Office that is usable by the Regional Office whenever possible. For example, the State Survey Agency should provide information to the RO as to where to locate files (e.g., attachments in ACO/ACTS, ACO/ACTS Notes section) in CMS systems that are necessary.

## Timeline

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The timeline for the FY 2020 SPSS is detailed in table 5 below. The period of evaluation is October 1, 2019 through September 30, 2020.

**Table 5. Period of Evaluation for FY 2020**

Evaluation Activity	Date
SharePoint input of Q1, Q4, and Q6 mid-year reviews	June 26, 2020
Submission of end-of-year reviews and scoring measures	January 25, 2021
CMS Regional Offices send draft reports to State Survey Agencies	February 15, 2021
State Survey Agencies send comments on the draft reports to CMS Regional Offices	March 1, 2021
CMS Regional Offices send final report to State Survey Agencies and enter data on SharePoint	March 15, 2021

## Corrective Action Plan

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For each Measure that is scored as “Not Met,” the State Survey Agency will develop and implement a corrective action plan that will address identified problems. The Regional Office will review and follow-up to ensure that the State Survey Agency is progressing toward making corrections. In some instances, a state may not be expected to fully improve their performance on a measure due to the timing of the final report for a given fiscal year. For example, if a state learns they failed a measure for fiscal year 2019 in April of 2020, there may not be enough time for a state to realistically fully correct all issues by the end of fiscal year 2020. In these cases, states will be expected to make corrections in 18 – 24 months.

A corrective action plan should also consider previous years’ corrective actions. For example, if a state failed a measure two years in a row, but still improved the second year as a result of the first year’s corrective action plan, CMS should recognize that the corrective actions from the first year had a positive impact on the state’s performance.

If performance was impacted by State law, regulation, or executive action during the fiscal year, the State Survey Agency should document this information in its corrective action plan. Any exclusions approved by CMS management may also be documented in the corrective action plan. This could include a declaration of a public health emergency where the Secretary of the Department of Health and Human Services invokes time-limited statutory authority to permit CMS to waive certain requirements. The RO will save the final approved corrective action plan on the SharePoint site.

## Reconsideration

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There is no formal appeal of findings relative to this Report of State Survey Agency Performance since the assessment is under the umbrella of the “Evaluation” Article (Article V) of the 1864 Agreement. However, where the SA and CMS cannot come to a final agreement on key findings, the SA may ask CMS for informal reconsideration. The request should be made in writing to the next higher level of line

authority above the CMS RO authority issuing the report. The request should be made within 14 calendar days of the date the SA received the draft SPSS results report.

## Contacts

For State Survey Agencies, please contact your CMS RO if you have questions about this guidance document.

For Regional Offices, contacts for each provider type are provided in table 6 below.

**Table 6. Central Office Contacts**

Inquiry Type	Contact	Email	Phone
General Inquiries	CMS SCG SPSS Team	<a href="mailto:SPSS_Team@cms.hhs.gov">SPSS_Team@cms.hhs.gov</a>	
Data Team	Francis Adanuty	<a href="mailto:Francis.Adanuty@cms.hhs.gov">Francis.Adanuty@cms.hhs.gov</a>	410-786-9867
Nursing Homes	Elaine Soong	<a href="mailto:Elaine.Soong@cms.hhs.gov">Elaine.Soong@cms.hhs.gov</a>	
Nursing Homes	Bonnie Reed	<a href="mailto:Bonnie.Reed@cms.hhs.gov">Bonnie.Reed@cms.hhs.gov</a>	410-786-2187
ICFs/IID, Non-Deemed ESRD Facilities, HHAs, and Hospice	Ekta Brahmhatt	<a href="mailto:Ekta.Brahmbhatt@cms.hhs.gov">Ekta.Brahmbhatt@cms.hhs.gov</a>	410-786-5475
DACS-EMTALA	Mary Ellen Palowitch	<a href="mailto:MaryEllen.Palowitch@cms.hhs.gov">MaryEllen.Palowitch@cms.hhs.gov</a>	410-786-4496
DACS-Hospital	Danielle Miller	<a href="mailto:Danielle.Miller@cms.hhs.gov">Danielle.Miller@cms.hhs.gov</a>	410-786-8818

# Frequency Domain

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## F1. Off-Hour Surveys for Nursing Homes

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### 1. Threshold Criterion

#### *Nursing home off-hour surveys*

At least 10 percent of standard surveys conducted in the fiscal year under review must begin either:

- on the weekend (Saturday or Sunday),
- in the early morning hours (before 8:00 am), or
- in the evening hours (after 6:00 pm), or
- on holidays.

At least 50 percent of all “off-hour” surveys must be completed on weekends and must be completed from a list of facilities with potential staffing issues provided by CMS. For a survey to count as beginning during off-hours, a health survey team of typical size and composition must enter the facility together. Also, the survey team must spend at least six hours onsite starting on a Saturday or Sunday. Life Safety Code (LSC) and Emergency Preparedness (EP) surveys are exempt (i.e., LSC and EP surveys are not required to be conducted during off-hours).

### 2. Scoring

If the percentage of nursing home surveys conducted during the off-hour timeframes is:

- greater than or equal to 10 percent and at least 50 percent of all “off-hour” surveys are completed on weekends and are completed from a list of facilities with potential staffing issues provided by CMS, this Measure is scored as “Met”
- otherwise, this Measure is scored as “Not Met”

### 3. Evaluation

See Appendix 1: F1 Off-Hour Surveys for Nursing Homes

### 4. Reference(s)

42 CFR § 488.307  
SOM, Chapter 7, section 7207B2  
Survey and Certification Group Letter: S&C-04-33  
QSO 19-02-NH

## **F2. Frequency of Nursing Home Surveys**

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### **1. Threshold Criteria**

#### ***Maximum survey frequency requirement***

For 100 percent of nursing homes, the State Survey Agency must conduct a standard health survey no later than 15.9 months after the last day of the previous standard health survey.

#### ***Statewide average interval requirement***

The statewide average time interval between consecutive standard health surveys must be 12.9 months or less.

### **2. Scoring**

If the maximum number of months between all standard surveys is:

- less than or equal to 15.9 months and the statewide average interval is less than or equal to 12.9 months, this Measure is scored as “Met”
- greater than 15.9 months or the statewide average interval is greater than 12.9 months, this Measure is scored as “Not Met”

#### ***Note***

If a survey was not conducted because of an unforeseen issue out of the State Survey Agency's control, the State Survey Agency may request that the specific survey be excluded from the denominator. In these uncommon circumstances, CMS will evaluate and determine if a survey can be excluded. Any facility in an area covered by an 1135 Waiver can be excluded from the denominator. In addition, CMS can determine an exclusion, on a case by case basis.

### **3. Evaluation**

See Appendix 2: F2 Frequency of Nursing Home Surveys

### **4. Reference(s)**

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

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

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### 1. Threshold Criterion

#### *Tier 1 Surveys*

The State Survey Agency conducts recertification, validation, and initial ESRD surveys according to Tier 1 requirements in the current Mission & Priority Document and the Final State Medicare Allocations Memorandum.

Recertification surveys for ICFs/IID, non-deemed HHAs and non-deemed hospices are performed within the maximum interval required. ICF/IID consecutive standard health surveys are performed at a statewide average time interval of 12.9 months or less. Validation surveys are conducted on a representative sample basis as required for the following deemed program types: hospitals, critical access hospitals (CAHs), psychiatric hospitals, ASCs and HHAs. Initial ESRD surveys are completed within 90 days of the Medicare Administrative Contractor's approval of the CMS-855.

### 2. Scoring

If Tier 1 recertification, validation and initial ESRD surveys within 90 days are all performed

- according to the Tier 1 Requirements, this Measure is scored as “Met”
- not according to the Tier 1 Requirements, this Measure is scored as “Not Met”

#### *Note – HHA/Hospice*

The State Survey Agency will neither be penalized nor will CMS send an associated non-delivery notice for specific surveys if the State Survey Agency can produce documentation that they received notification that:

- a HHA/Hospice has dropped their accrediting organization (AO) status 60 days or less from the maximum 36-month survey interval date for Hospice and 36.9-month interval date for HHAs, and
- the State Survey Agency was unable to schedule and complete the re-certification survey within the required timeframe as a result of that late notification.

If the State Survey Agency received notification that a HHA/Hospice has dropped their deemed status at 61-90 days from the maximum survey interval, and the State Agency provides documentation that they received such notification, these cases can be excluded from the sample, depending on the circumstances during the time of notification - as determined by the Regional Office. These will be determined by the RO on a case-by-case basis.

### 3. Evaluation

See Appendix 3: F3.1 Frequency of Non-Nursing Home Surveys – Tier 1

### 4. Reference(s)

HHAs – Section 1891(c)(2)(A) of the Act

ICFs/IID – 42 CFR §§ 442.15, 442.16, and 442.109

Hospices - Improving Medicare Post-Acute Care Transformation Act of 2014 - IMPACT Act (H.R. 4994).  
Admin Info: 15-09  
Validation Surveys - Sections 1864(c) and 1865 of the Act  
Initial ESRD Surveys - Bi-Partisan Budget Act of 2018  
42 CFR § 488.7  
FY 2020 Survey & Certification Mission and Priority Document  
FY 2020 Final State Medicare Allocations Memorandum

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

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### **1. Threshold Criterion**

#### ***Tier 2 Surveys***

The State Survey Agency conducts recertification surveys, targeted surveys and/or complaint surveys for the following facility types according to the Tier 2 Requirements in the current Mission & Priority Document and the Final State Medicare Allocations Memorandum:

- Non-deemed ASCs
- Non-deemed hospitals (including non-deemed CAHs and non-deemed psychiatric hospitals)
- Outpatient Physical Therapy providers (OPTs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Rural health clinics (RHCs)
- Non-deemed ESRD facilities
- Psychiatric Residential Treatment Facilities (PRTF)
- Community Mental Health Centers (CMHCs)

### **2. Scoring**

If recertification surveys, targeted surveys, and/or complaint surveys for the above facility types are conducted by the State Survey Agency:

- according to the Tier 2 Requirements, this Measure is scored as “Met”
- not according to the Tier 2 Requirements, this Measure is scored as “Not Met”

### **3. Evaluation**

See Appendix 4: F3.2 Frequency of Non-Nursing Home Surveys – Tier 2 & Tier 3

### **4. Reference(s)**

FY 2020 Survey & Certification Mission and Priority Document  
FY 2020 Final State Medicare Allocations Memorandum  
FY 2020 Targeted Sample List for ESRD Facilities  
FY 2020 Random Sample List for ASCs  
FY 2020 Targeted Sample List for Non-Deemed Hospitals

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

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### **1. Threshold Criterion**

#### ***Tier 3 Surveys***

The State Agency conducts recertification surveys for the following facility types according to the Tier 3 Requirements in the current Mission & Priority Document and the Final State Medicare Allocations Memorandum:

- Non-deemed ASCs
- Non-deemed hospitals (including non-deemed critical access hospitals and CAHs)
- Non-deemed psychiatric hospitals
- OPTs
- CORFs
- RHCs
- Non-deemed ESRD facilities

### **2. Scoring**

If recertification surveys for the above facility types are conducted by the State Survey Agency:

- according to the Tier 3 Requirements, this Measure is scored as “Met”
- not according to the Tier 3 Requirements, this Measure is scored as “Not Met”

### **3. Evaluation**

See Appendix 4: F3.2 Frequency of Non-Nursing Home Surveys – Tier 2 & Tier 3

### **4. Reference(s)**

FY 2020 Survey & Certification Mission and Priority Document  
FY 2020 Final State Medicare Allocations Memorandum

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

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### **1. Threshold Criterion**

#### ***Data entry for non-deemed hospitals (including non-deemed CAHs) and nursing homes***

The mean number of days from the latest date of the State Survey Agency survey completion to the date of successful data upload into CASPER (National Database) does not exceed 70 calendar days. For hospitals, if condition-level noncompliance is identified, the case should be excluded from the review.

### **2. Scoring**

If the average calendar days for data entry of both nursing home and non-deemed hospital (including non-deemed CAHs) surveys is:

- less than or equal to 70 calendar days, this Measure is scored as “Met”
- greater than 70 calendar days, this Measure is scored as “Not Met”

### **3. Evaluation**

See Appendix 5: F4 Timeliness of Upload into CASPER of Standard Surveys for Non-Deemed Hospitals and Nursing Homes

### **4. Reference(s)**

Article II (J) of the 1864 Agreement  
SOM, Chapter 7, section 7410C

## **F5. Special Focus Facilities for Nursing Homes (formerly E4)**

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### **1. Threshold Criterion**

#### ***Special Focus Facility Surveys***

Each State Survey Agency shall conduct one standard survey of each designated Special Focus Facility not less than once every six months.

When one SFF is removed either through termination or graduation, then another SFF is selected within 21 days as a replacement so all the SFFs slots are filled. For terminations, it would be 21 days from the effective date of termination. For graduations, it would be the date of the letter the State Survey Agency sent to the graduating SFF of its removal from the SFF program.

### **2. Scoring**

If both threshold criteria are met, this Measure is scored as “Met”  
If either threshold criteria is not met, this Measure is scored as “Not Met”

### **3. Evaluation**

See Appendix 6: Special Focus Facilities for Nursing Homes

### **4. Reference(s)**

Survey and Certification Group Letter: S&C 17-20  
Survey and Certification Group Letter: S&C-14-20  
Special Focus Facilities Procedures Guide

# Quality Domain

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## Q1. Standard Surveys. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-deemed ESRD Facilities, ASCs, HHAs, Hospice and Hospitals

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### 1. Threshold Criteria

#### *Nursing Homes*

The State Survey Agency achieves a score of 85 percent or above for each of the **four requirements** that evaluate whether the State Survey Agency documents all deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation and Appendices Q and PP of the SOM.

#### *Non-Nursing Homes*

The State Survey Agency achieves a score of 85 percent or above for each of the **three requirements** that evaluate whether the State Survey Agency documents all deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation, Appendix Q, Appendix Z, and other relevant SOM Appendices.

Non-nursing homes include:

- Non-deemed ESRD facilities
- ICFs/IID
- Non-deemed ASCs<sup>1</sup>
- Non-deemed HHAs
- Non-deemed hospice
- Non-deemed hospitals, including psychiatric hospitals and CAHs<sup>2</sup>

### 2. Scoring

There will be one combined score for all non-nursing home provider types and one score for nursing homes. CMS will also make available data for each individual non-nursing home provider. For the combined non-nursing home score and the nursing home score:

- If the score is greater than or equal to 85 percent among all tags examined, the Measure is scored as “Met.”
- If the score is less than 85 percent among all tags examined, the Measure is scored as “Not Met.”

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<sup>1</sup> In fiscal year 2019, State Agencies began conducting surveys for organ transplant programs. It is not required for Regional Offices to review States’ work in surveying these programs in fiscal year 2020.

<sup>2</sup> Excluding transplant hospitals and religious non-medical healthcare institutions.

### 3. Evaluation

See Appendix 7: Q1. Standard Survey. Documentation of Deficiencies for Nursing Homes, ASCs, ICFs/IID and Non-deemed ESRD Facilities, HHAs, Hospice, and Hospitals

See Appendix 9: Conduct of Reviews and Review Requirements

### 4. Reference(s)

42 CFR § 488.318

SOM, Principles of Documentation

Survey & Certification Memoranda related to the documentation of deficiencies

#### *Other notes on the nursing home sample to be reviewed by Regional Offices.*

- The RO can include any of the following surveys in the sample, as long as at least 50% of the surveys include deficiencies that are no higher than Severity Level 2:
  - Enforcement cases that are transferred to the RO,
  - Comparative surveys, and
  - Random sample of surveys.
- This review is conducted on standard surveys but does not include any resulting revisit surveys.

## **Q1. Complaint Surveys. Documentation of Deficiencies for Nursing Homes, ICFs/IID, ESRD facilities, ASCs, HHAs, Hospice, and Hospitals**

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### 1. Threshold Criteria

#### *Nursing Homes*

The State Survey Agency achieves a score of 85 percent or above for each of the **four requirements** that evaluate whether the State Survey Agency documents all complaint investigation deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation and Appendices Q and PP of the SOM.

#### *Non-nursing Homes*

The State Survey Agency achieves a score of 85 percent or above for each of the **three requirements** that evaluate whether the State Survey Agency documents all complaint investigation deficiencies on the CMS-2567, Statement of Deficiencies, in accordance with the Principles of Documentation, Appendix Q, Appendix Z, and other relevant SOM Appendices.

Non-nursing homes include:

- ESRD facilities
- ICFs/IID
- ASCs
- HHAs
- hospice
- hospitals, including psychiatric hospitals and CAHs<sup>3</sup>

## 2. Scoring

There will be one combined score for all non-nursing home provider types and one score for nursing homes. CMS will also make available data for each individual non-nursing home provider. For the combined non-nursing home score and the nursing home score:

If the score is greater than or equal to 85 percent among all tags examined, the Measure is scored as “Met.”

If the score is less than 85 percent among all tags examined, the Measure is scored as “Not Met.”

## 3. Evaluation

See Appendix 8: Q1. Complaint. Documentation of Deficiencies for Nursing Homes, ASCs, ESRD Facilities, ICFs/IID, HHAs, Hospice, and Hospitals

See Appendix 9: Conduct of Reviews and Review Requirements

## 4. Reference(s)

42 CFR § 488.318

SOM, Principles of Documentation

Survey & Certification Memoranda related to the documentation of deficiencies

### ***Other notes on the nursing home sample to be reviewed by Regional Offices.***

The RO can include any of the following surveys in the sample, as long as at least 50% of the surveys include deficiencies that are no higher than Severity Level 2:

- Enforcement cases that are transferred to the RO,
- Comparative surveys, and
- Random sample of surveys.

This review is conducted on complaint surveys but does not include any resulting revisit surveys.

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<sup>3</sup> Excluding transplant hospitals and religious non-medical healthcare institutions.

## Q2. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS (formerly Q2 and Q3)

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### 1. Threshold Criteria

Nursing Home health surveys evaluated by FOSS FCS are satisfactorily conducted, by effectively achieving the desired outcomes of the survey, using Federal standards, protocols, forms, methods, and procedures specified by CMS. A sample of facilities and concerns is chosen by each Region based on the guidance provided by CMS on FOSS focused concern surveys.

### 2. Scoring

A State Survey Agency will receive an overall FOSS FCS score and a score for each concern area investigated in this FY.

- The overall FOSS FCS score is a composite measure of all current FY concern areas. A State Survey Agency meets this measure if it achieves a score of 80 percent or more based on the scoring algorithm described below.
- The FOSS FCS score for each individual concern area is constructed separately by concern area. A State Survey Agency meets this measure if it achieves a score of 80 percent or more based on the scoring algorithm described below.

### 3. Evaluation

For each individual concern area investigated:

- A score of “Met” will be given when the state properly identifies non-compliance and the associated harm level or the non-compliance that was missed by the state was “No actual harm with a potential for minimal harm” (level one).
- A score of “Partially Met” will be given when the state fails to identify noncompliance or misidentifies the level of harm for noncompliance for “No actual harm with a potential for more than minimal harm, but not immediate jeopardy” (level two). A score of “Partially Met” will be given when the state agency identifies non-compliance but determines a level of harm that is not supported by the evidence available.
- A score of “Not Met” will be given when a state fails to identify “Actual harm that is not immediate jeopardy” (level three), “immediate jeopardy (level four) or Substandard Quality of Care.
- After receipt of the Focused Concern Survey report, the State will have 30 working days to appeal findings of “Not Met” or “Partially Met.” These appeals will be addressed by the Regional Office that conducted the survey.

#### 4. Scoring

For each survey, tally points for each concern area investigated as follows.

- The State receives 2 points per “Met” score
- The State receives 1 point per “Partially Met” score
- The State receives 0 points per “Not Met” score

For example, if a FOSS FCS includes the investigation of two concern areas and the first area is “Met” and the second area is “Partially Met,” the State receives 3 total points out of 4 for that FCS.

To calculate the State’s overall FOSS FCS score, create a numerator and denominator as follows.

- Numerator: Add all the points assigned to “Met,” “Not Met,” and “Partially Met” cases
- Denominator: Multiply the total number of cases examined by 2
- The overall score is the numerator divided by the denominator multiplied by 100.
- For example, if a State’s FOSS FCS includes the investigation of 10 concern areas, the total number of possible points that State could earn would be 20 (10 concern areas multiplied by a maximum of 2 points each). If the State met 6 of 10 areas, partially met 3 of 10 areas, and did not meet 1 of 10 areas, its total points earned would be 15 (the 6 “Met” areas multiplied by 2 plus the 3 “Partially Met” areas multiplied by 1). The State’s overall score would be 75 percent because 15 divided by 20 equals 0.75.

#### 5. Reference(s)

CMS Memo Number SCOPE QSOG-19-03-NH

CMS SCOPE memos located here:

<https://share.cms.gov/center/CCSQ/SCG/FO/SCOPEMemos/Forms/FiscalYear.aspx>

## **Q3. Identification of Health, LSC, and EP Deficiencies and Emergency Preparedness (EP) on Nursing Home Surveys as Measured by Federal Comparative Survey Results (formerly Q4)**

---

### **1. Threshold Criteria**

This threshold criterion evaluates the State Survey Agency's identification of onsite findings of noncompliance as measured by comparative survey results. For 90 percent or more of the deficiencies cited on the Regional Office comparative surveys *over the last two years* at immediate jeopardy or actual harm levels or that resulted in substandard quality of care (SQC), the State Survey Agency must cite the same findings on its survey at the same or higher severity level.

#### **Note**

For SQC at an F, the State Survey Agency had to cite the same findings at an F or higher.

### **2. Scoring**

If the percentage agreement rate is 90 percent or higher (without rounding up), this Measure is scored as "Met."

If the percentage agreement rate is less than 90 percent, this Measure is scored as "Not Met."

### **3. Evaluation**

See Appendix 11: Q3. Identification of Health, LSC and Emergency Preparedness (EP) Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results

### **4. Reference(s)**

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

## Q4. Prioritizing Complaints and Facility Reported Incidents (formerly Q6)

---

### 1. Threshold Criteria

#### *Nursing Homes*

In at least 90 percent of cases sampled, the State Survey Agency follows CMS guidelines for prioritizing Federal complaints and FRIs whether or not an onsite survey is conducted.

#### *Non-Nursing Homes*

In at least 90 percent of cases sampled, the State Survey Agency follows CMS guidelines for prioritizing Federal complaints and FRIs, whether or not an onsite survey is conducted. Non-nursing homes include:

- ESRD facilities
- ICFs/IID
- ASCs
- home health agencies
- hospice
- hospitals, including psychiatric hospitals and CAHs

### 2. Scoring

There will be separate scores for each provider type.

- If at least 90 percent of sampled intakes are prioritized appropriately, the measure is scored as “Met.”
- If less than 90 percent of sampled intakes are prioritized appropriately, the measure is scored as “Not Met.”

### 3. Evaluation

See Appendix 12: Q4. Prioritizing Complaints and Facility Reported Incidents

### 4. Reference(s)

SOM, Chapter 5, sections 5070-5075.

#### *Other notes on the sample to be reviewed by Regional Offices.*

- Up to 50 percent of the sample can include intakes that were a part of the enforcement cases that were referred to the Regional Office or cases where the intake was investigated during a comparative survey (LTC only).
- CMS may also request and review cases not entered into ACTS to determine if there are other intakes that were triaged appropriately. For example, based on low rates of intakes reported in the SPSS performance indicators, CMS may review intakes in state systems or documents to determine if there are other intakes that should have been entered in ACTS, and triaged and investigated appropriately.

- Samples used for Q4 review may also be used for Q7 only if there was an onsite survey.

## Q5. Timeliness of Complaint and Facility-Reported Incident Investigations (formerly Q7)

---

### 1. Threshold Criteria

#### *Nursing Homes*

- The SA initiates an investigation within two working days of the received end date for 95% of all complaints and incidents where the intake is prioritized as “IJ.”
- The SA initiates an investigation within 10 working days of the received end date for 95% of all complaints and incidents where the SA prioritizes the intake as “Non-IJ High.”

#### *Non-nursing Homes*

- The State Survey Agency initiates an investigation within 2 working days of the received end date for 95 percent of all complaints where the intake is prioritized as "IJ" for ESRD facilities, non-deemed HHAs, non-deemed ASCs, and non-deemed hospitals (including non-deemed psychiatric hospitals and CAHs).
- The State Survey Agency initiates an investigation within 2 working days of receipt of authorization from the Regional Office for 95 percent of all complaints where the intake is prioritized as "IJ" for deemed hospitals (including psychiatric hospitals and CAHs), deemed ASCs, deemed HHAs, and deemed hospices.
- The State Survey Agency initiates an investigation within 45 calendar days of receipt of authorization from the Regional Office for 95 percent of all non-IJ high complaints for deemed hospitals (including psychiatric hospitals and CAHs) and all hospices.

### 2. Scoring

If both nursing home threshold criteria are met, this Measure is scored as “Met,” otherwise this Measure is scored as “Not Met.”

If all three non-nursing home threshold criteria are met, this Measure is score as “Met,” otherwise this Measure is scored as “Not Met.”

Note: CMS may determine that a state has not met this measure based on its review of cases during normal, day-to-day operations. For example, this measure is calculated via an automated data pull from a database (ACTS). We note that, as part of normal operations, CMS staff review cases when imposing enforcement for certain types of noncompliance identified on a complaint or FRI survey. If, during their review, they identify issues with a state not investigating complaints or FRIs within the required timelines (e.g., due to incorrect data entry, incorrect triaging, or general delays in responding), CMS may deem a state as not having met this measure.

### 3. Evaluation

See Appendix 13: Q5. Timeliness of Complaint and Facility-Reported Incident Investigations

#### **4. Reference(s)**

SOM, Chapter 5, section 5075  
Memorandum QSO-19-14-Hospitals, CAHs

## **Q6. Quality of Emergency Medical Treatment & Labor Act Investigations (formerly Q8)**

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### **1. Threshold Criteria**

The State Survey Agency's Emergency Medical Treatment & Labor Act (EMTALA) complaint investigations meet CMS' guidance in Appendix V at an overall score of 90 percent or higher.

### **2. Scoring**

If the total overall score for all requirements combined is 90 percent or higher (without rounding up), this Measure is scored as "Met."

If the total overall score for all requirements combined is less than 90 percent, this Measure is scored as "Not Met."

For more details on scoring, see Appendix 14: Q6. Quality of EMTALA Investigations.

### **3. Evaluation**

See Appendix 14: Q6. Quality of EMTALA Investigations

### **4. Reference(s)**

Article II (A)(2) of the 1864 Agreement  
SOM, Chapter 5 and Appendix V  
SQS-19-14

## Q7. Quality of Complaint/Facility Reported Incident Investigations for Nursing Homes, Hospice, and Acute Care Hospitals – (formerly Q9) Developmental in FY 2020

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### 1. Threshold Criteria

*Nursing home investigations:* The SA achieves a score of 85 percent or above for each of three criteria that are used to review whether the SA investigates complaints and incidents according to CMS policy for complaint/incident handling.

*Non-Nursing home investigations:* The SA achieves a score of 85 percent or above for each of the six criteria that are used to review whether the SA investigates complaints and incidents according to CMS policy for complaint/incident handling. This measure is constructed for hospices and acute care hospitals only in this year.

### 2. Scoring

*Nursing homes.* If the State Survey Agency achieves a score of “Yes” 85 percent or above on each of the three threshold criteria, this Measure is scored as “Met.”

- Each individual threshold criteria is scored for each investigation examined and the percentage scored as “Yes” is the number scored as “Yes” divided by the total number of investigations examined.
- If any of the three threshold Criteria achieves a score of “Yes” less than 85 percent, this Measure is scored as “Not Met.”

*Non-nursing homes.* If the State Survey Agency achieves a score of “Yes” 85 percent or above on each of the six threshold criteria, this Measure is scored as “Met.”

- Each individual threshold criteria is scored for each investigation examined and the percentage scored as “Yes” is the number scored as “Yes” divided by the total number of investigations examined.
- If any of the three threshold Criteria achieves a score of “yes” less than 85 percent, this Measure is scored as “Not Met.”

### 3. Evaluation

See Appendix 15: Quality of Complaint/Facility Reported Incident Investigations for Nursing Homes, Hospice, and Acute Care Hospitals – (formerly Q9) Developmental in FY2020

### 4. References

Appendix PP and Chapter 5 of the State Operations Manual

Chapter 5, Appendix A (Hospital), Appendix M (Hospice) and Appendix X (Determining Immediate Jeopardy) of the State Operations Manual

## 5. Timeframe

Regional Offices will conduct a review mid-year and end-of-year.

### ***Other notes on the nursing home sample to be reviewed by Regional Offices.***

- Samples used for Q4 review may be used for Q7 only if there was an onsite survey.
- Up to 50 percent of the sample can include enforcement cases that are referred to the Regional Office or cases where the intake was investigated during a comparative survey (LTC only).<sup>4</sup>
- Only review intakes that resulted in an onsite survey. If the survey for the intake is conducted in FY 2021, the Regional Office will keep the intake in the sample for FY 2020. However, if the survey has not been conducted by the time the performance review occurs, the Regional Office should replace the intake.
- The review must be conducted by an individual in the Regional Office who is professionally qualified to evaluate the cases based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements.

### ***Other notes on the hospice and acute care hospital samples to be reviewed by Regional Offices.***

- In this year, the RO will use the same samples of complaint cases used to assess Q7 as it used to assess Q1.

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<sup>4</sup> Among enforcement cases conducted, the RO may randomly choose cases to count towards this measure.

## **Q8. Standard. State-specific Measures Guidance (Developmental)**

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The state-specific measure, which will be developmental this year, is based on SPSS state performance indicators or other information that the RO can report to the State Survey Agency and Central Office on a regular basis. This measure addresses states' unique performance improvement needs. To conduct the state-specific measure, Regional Offices will identify state concern areas and collaborate with State Survey Agencies to investigate root causes, develop plans, and monitor progress. It is possible for a state to not have a concern area in a given year, and therefore, the state would not require a state-specific measure that year.

Measure guidance can be found in Appendix 16. Further information on the state performance indicators that will inform the state-specific measure can be found in Appendix 16.

## **Q8. Complaint. State-specific Measures Guidance (Developmental)**

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The state-specific measure, which will be developmental this year, is based on SPSS state performance indicators or other information that the RO can report to the State Survey Agency and Central Office on a regular basis. This measure addresses states' unique performance improvement needs. To conduct the state-specific measure, Regional Offices will identify state concern areas and collaborate with State Survey Agencies to investigate root causes, develop plans, and monitor progress. It is possible for a state to not have a concern area in a given year, and therefore, the state would not require a state-specific measure that year.

Measure guidance can be found in Appendix 16. Further information on the state performance indicators that will inform the state-specific measure can be found in Appendix 16.

## Q9. Quality of Use of IJ Template (Developmental)

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### 1. Threshold Criteria

#### *Immediate Jeopardy Template Provided to Nursing Home and Non-Nursing Homes*

When an immediate jeopardy is determined during a survey, the State Survey Agency must provide a completed Immediate Jeopardy Template to the nursing home or non-nursing home at or before the exit interview except for EMTALA investigations.

#### *Immediate Jeopardy Template Completed Appropriately*

Immediate jeopardy templates provided to all providers must be accurately completed by the State Survey Agency.

### 2. Scoring

There will be separate scores for each provider type; however, this measure is currently developmental. Therefore, no scoring thresholds will be established in the current fiscal year.

### 3. Evaluation

See Appendix 17: Q9. Implementation of IJ Template

Note: SAs and ROs are now required to attach the IJ template to the survey package when uploading to ASPEN Central Office/ASPEN Regional Office (ACO/ARO) for each instance of Immediate Jeopardy. For more information on the procedures for attaching documents, see the ACO Procedures Guide ([https://qtso.cms.gov/system/files/qtso/ACO\\_PG\\_11.7.0.2\\_FINAL.pdf](https://qtso.cms.gov/system/files/qtso/ACO_PG_11.7.0.2_FINAL.pdf)).

### 4. Reference(s)

- SOM, Appendix Q
- QSO-19-09-ALL

# Coordination of Provider Noncompliance (CPN)

---

## CPN1. Nursing Homes. Timeliness of Processing Immediate Jeopardy (IJ) Cases (formerly E1)

---

### 1. Threshold Criteria

IJ processing: The State Survey Agency adheres to the 23-day termination process in at least 95 percent of the cases in which it determines there is an IJ that is not removed prior to the end of the survey. This excludes Medicaid-only cases.

### 2. Scoring

If the resulting percentage is  $\geq 95$  percent, this Measure is scored as "Met."

If the resulting percentage is  $< 95$  percent, this Measure is scored as "Not Met."

### 3. Evaluation

See Appendix 18: CPN1. Nursing Homes. Timeliness of Processing Immediate Jeopardy (IJ) Cases

### 4. References

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

## **CPN2. Non-Nursing Homes. Timeliness of Processing IJ Cases except for EMTALA (formerly E1)**

---

### **1. Threshold Criteria**

IJ processing: The State Survey Agency adheres to the 23-day termination process in at least 95 percent of the cases in which it determines there is an IJ that is not removed prior to the end of the survey. This excludes EMTALA and Medicaid-only cases.

### **2. Scoring**

If the resulting percentage is  $\geq 95$  percent, this Measure is scored as “Met.”

If the resulting percentage is  $< 95$  percent, this Measure is scored as “Not Met.”

### **3. Evaluation**

See Appendix 19: CPN2. Non-Nursing Homes. Timeliness of Processing Immediate Jeopardy (IJ) Cases except for EMTALA

### **4. References**

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

## **CPN3. Timeliness of Mandatory Denial of Payment for New Admissions (DPNA) Notification for Nursing Homes (formerly E2)**

---

### **1. Threshold Criteria**

Mandatory DPNA processing: The State Survey Agency adheres to the enforcement processing timeframes so that DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey.

In at least 80 percent of the cases, the State Survey Agency transfers the enforcement case to CMS by the 70<sup>th</sup> day or the imposition notice is sent by the State Survey Agency to the provider by the 70th day. This excludes cases involving Medicaid-only nursing homes.

### **2. Scoring**

If the resulting percentage is  $\geq 80$  percent, this Measure is scored as “Met.”

If the resulting percentage is  $< 80$  percent, this Measure is scored as “Not Met.”

### **3. Evaluation**

See Appendix 20: CPN3. Timeliness of Mandatory DPNA Notification for Nursing Homes

### **4. References**

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

## **CPN4. Processing of Termination Cases for Non-Nursing Home Providers/Suppliers (formerly E3)**

---

### **1. Threshold Criteria**

Termination processing: The State Survey Agency transfers the information required for the processing of termination cases to CMS by the 55<sup>th</sup> day in at least 80 percent of cases in which condition-level noncompliance is cited. This includes cases for all non-nursing home providers/suppliers, except for cases involving deemed providers/suppliers, EMTALA cases, transplant program termination, and Medicaid-only providers/suppliers.

### **2. Scoring**

If the resulting percentage is  $\geq$  80 percent, this Measure is scored as “Met.”

If the resulting percentage is  $<$  80 percent, this Measure is scored as “Not Met.”

### **3. Evaluation**

See Appendix 21: CPN4. Processing of Termination Cases for Non-Nursing Home Providers/Suppliers

### **4. Reference(s)**

Section 1866(b) of the Act

42 CFR § 489.53

SOM, Chapter 3 section 3012

# Appendix 1: F1 Off-Hour Surveys for Nursing Homes

## 1. Data Source(s)

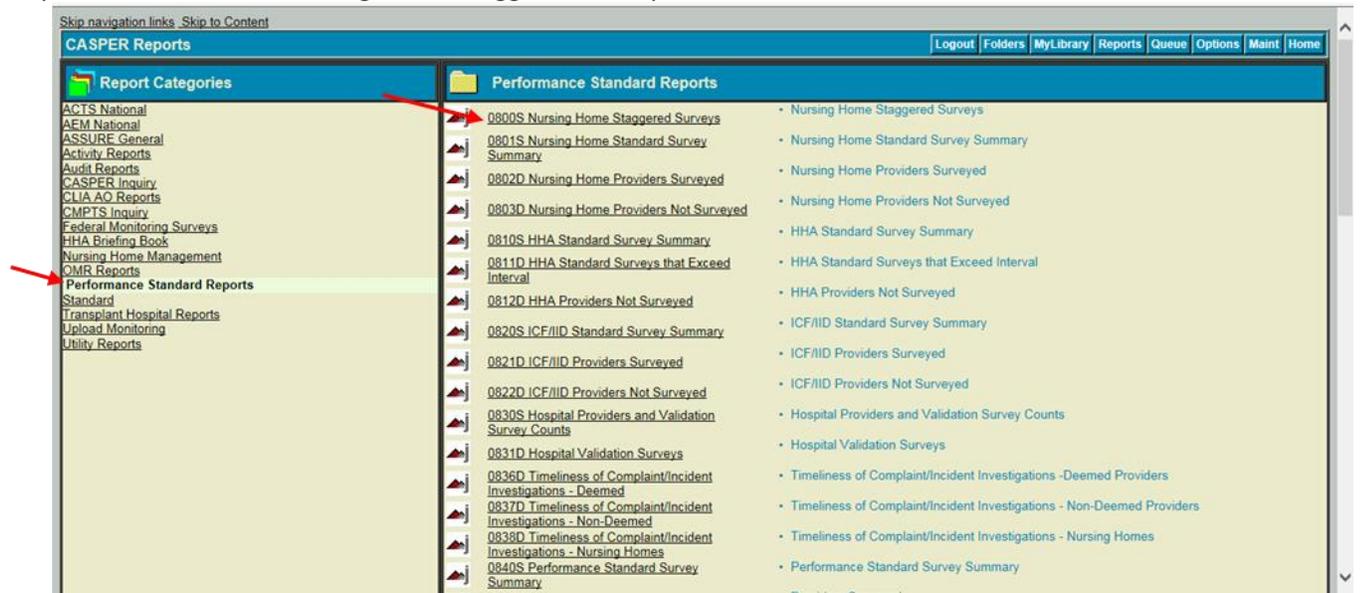
CASPER Report 0800S- Nursing Home Staggered Surveys  
SOAR Report-Off-Hours Tab

## 2. Method

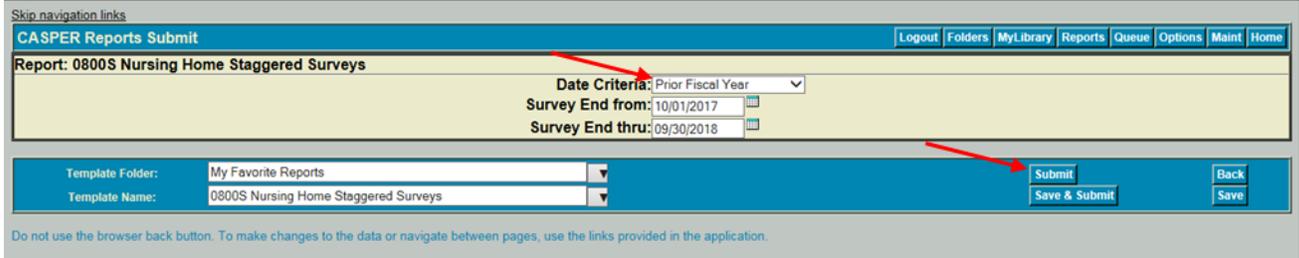
To calculate the F1 measures, the 0800S report must be generated.  
From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0800S- Nursing Home Staggered Surveys.



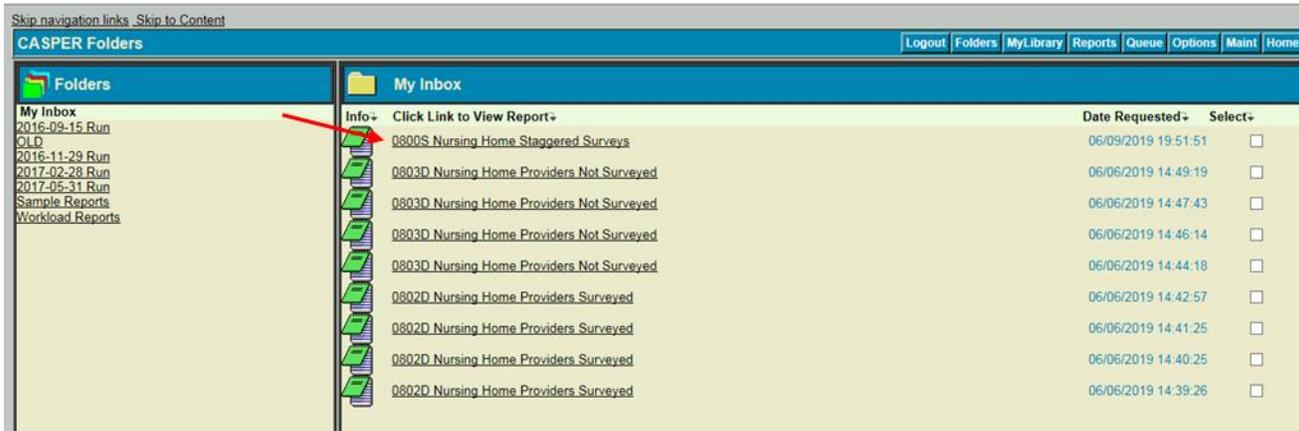
From the 0800S- Nursing Home Staggered Surveys page, use the drop-down menu to select the appropriate Fiscal Year. Then select Submit.



Once the report has been submitted, select the Folders Icon.



Once the report is complete it will appear on the Folders Page. Click on the Report to either Open or Save it.



Info	Click Link to View Report	Date Requested	Select
	0800S Nursing Home Staggered Surveys	06/09/2019 19:51:51	<input type="checkbox"/>
	0803D Nursing Home Providers Not Surveyed	06/06/2019 14:49:19	<input type="checkbox"/>
	0803D Nursing Home Providers Not Surveyed	06/06/2019 14:47:43	<input type="checkbox"/>
	0803D Nursing Home Providers Not Surveyed	06/06/2019 14:46:14	<input type="checkbox"/>
	0803D Nursing Home Providers Not Surveyed	06/06/2019 14:44:18	<input type="checkbox"/>
	0802D Nursing Home Providers Surveyed	06/06/2019 14:42:57	<input type="checkbox"/>
	0802D Nursing Home Providers Surveyed	06/06/2019 14:41:25	<input type="checkbox"/>
	0802D Nursing Home Providers Surveyed	06/06/2019 14:40:25	<input type="checkbox"/>
	0802D Nursing Home Providers Surveyed	06/06/2019 14:39:26	<input type="checkbox"/>

Identify the percent of staggered surveys for the specified State using the “% of Staggered Surveys” column in the CASPER Report 0800S Nursing Home Staggered Surveys.

To meet this Performance Measure, the percentage of Off-Hours Surveys must be greater than or equal to 10 percent

# Appendix 2: F2 Frequency of Nursing Home Surveys

## 1. Data Source(s)

CASPER Report 0801S- Nursing Home Standard Survey Summary

CASPER Report 0802D- Nursing Home Providers Surveyed

CASPER Report 0803D- Nursing Home Providers Not Surveyed

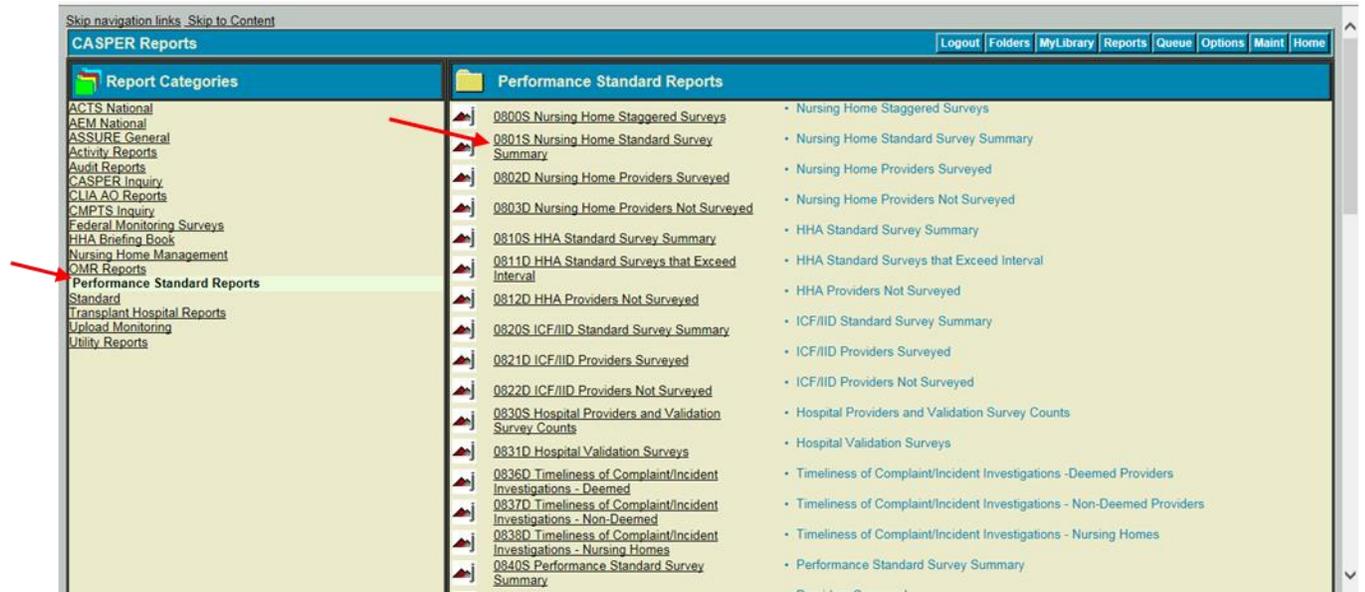
## 2. Method

To calculate F2 measures, both the 0801S and the 0802D reports must be generated.

From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0801S- Nursing Home Standard Survey Summary.



From the 0801S- Nursing Home Standard Survey Summary page, enter the appropriate Fiscal Year. Then select Submit.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0801S Nursing Home Standard Survey Summary

Date Criteria:  
Certification thru: 09/30/

Template Folder: My Favorite Reports  
Template Name: 0801S Nursing Home Standard Survey Summary

Submit Save & Submit Back Save

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0802D- Nursing Home Providers Surveyed Report.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Queuing Report QID:81710812 Name:0801S Nursing Home Standard Survey Summary for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

Back Folders Reports

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0802D- Nursing Home Providers Surveyed.

Skip navigation links Skip to Content

CASPER Reports Logout Folders MyLibrary Reports Queue Options Maint Home

Report Categories	Performance Standard Reports
ACTS National	0800S Nursing Home Staggered Surveys • Nursing Home Staggered Surveys
AEM National	0801S Nursing Home Standard Survey Summary • Nursing Home Standard Survey Summary
ASSURE General	0802D Nursing Home Providers Surveyed • Nursing Home Providers Surveyed
Activity Reports	0803D Nursing Home Providers Not Surveyed • Nursing Home Providers Not Surveyed
Audit Reports	0810S HHA Standard Survey Summary • HHA Standard Survey Summary
CASPER Inquiry	0811D HHA Standard Surveys that Exceed Interval • HHA Standard Surveys that Exceed Interval
CLIA/AQ Reports	0812D HHA Providers Not Surveyed • HHA Providers Not Surveyed
CMPTS Inquiry	0820S ICF//ID Standard Survey Summary • ICF//ID Standard Survey Summary
Federal Monitoring Surveys	0821D ICF//ID Providers Surveyed • ICF//ID Providers Surveyed
HHA Briefing Book	0822D ICF//ID Providers Not Surveyed • ICF//ID Providers Not Surveyed
Nursing Home Management	0830S Hospital Providers and Validation Survey Counts • Hospital Providers and Validation Survey Counts
OMR Reports	0831D Hospital Validation Surveys • Hospital Validation Surveys
Performance Standard Reports	0836D Timeliness of Complaint/Incident • Timeliness of Complaint/Incident Investigations -Deemed Providers
Standard	
Transplant Hospital Reports	
Upload Monitoring	
Utility Reports	

From the 0802D- Nursing Home Providers Surveyed page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Submit.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0802D Nursing Home Providers Surveyed

Geographical Breakdown:  
 Nation  
 Region  
 State

\* States: Alabama, Alaska, American Samoa, Arizona, Arkansas

Date Criteria:  
Certification thru: 09/30/2018

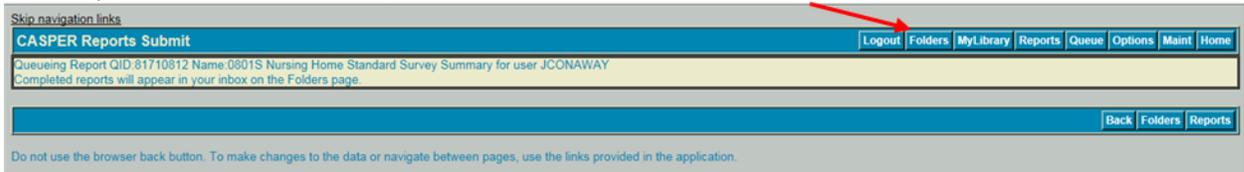
\* To select multiple items, hold down the Ctrl key and click the desired items

Template Folder: My Favorite Reports  
Template Name: 0802D Nursing Home Providers Surveyed

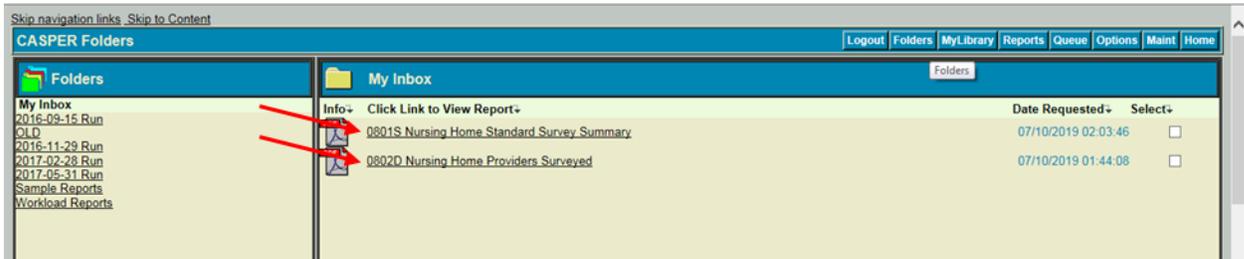
Submit Save & Submit Back Save

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Folders Icon.



Once both reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.



From the CASPER Report 0801S Nursing Home Standard Survey Summary, identify the number of active providers (call this [a]) and number of providers surveyed (call this [b]) for the specified State using the “# of Active Providers” and “# of Providers Surveyed” columns.

From the CASPER Report 0802D Nursing Home Providers Surveyed, count the number of providers that exceeded 15.9 months (call this [c]) using the "# of Months Between Surveys" column.

To calculate the maximum survey frequency requirement, subtract [c] from [b], divide by [a] and multiply by 100.

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

From the CASPER Report 0801S Nursing Home Standard Survey Summary, identify the statewide average interval requirement using the "Average Interval" column.

To meet this Performance Measure, the percentage Recertified must equal 100 percent and the Statewide Average must be less than or equal to 12.9 months.

### **Notes – Nursing Homes**

On Report 801S, the “Maximum Interval” column should be ignored, since it is calculated from the “Current Survey Date” (regardless of which year the survey actually occurred).

In the CASPER Reports, survey intervals are calculated using the Oracle function called

“MonthsBetween.” A full description of the function can be found at this site:

[http://download.oracle.com/docs/cd/B19306\\_01/server.102/b14200/functions089.htm](http://download.oracle.com/docs/cd/B19306_01/server.102/b14200/functions089.htm)

# Appendix 3: F3.1 Frequency of Non-Nursing Home Surveys – Tier 1

This measure evaluates a combination of Non-Nursing Providers/Suppliers included in Tier 1 work. Data is evaluated for recertification of non-deemed HHAs, ICFs/IID and non-deemed hospices, along with validation surveys of deemed hospitals, deemed ASCs, and initial ESRD surveys.

## Non-Deemed Home Health Agencies

### 1. Data Source(s)

- CASPER Report 0810S- HHA Standard Survey Summary
- CASPER Report 0811D- HHA Standard Surveys that Exceed Interval
- CASPER Report 0812D- HHA Providers Not Surveyed

### 2. Method

To calculate the F3.1 HHA measure, both the 0810S and the 0811D reports must be generated. From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0810S- HHA Standard Survey Summary.



From the 0810S- HHA Standard Survey Summary page, enter the appropriate Fiscal Year. Then select Submit.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0810S HHA Standard Survey Summary

Date Criteria:  
Certification thru: 09/30/

Template Folder: My Favorite Reports Submit Back

Template Name: 0810S HHA Standard Survey Summary Save & Submit Save

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0811D- HHA Standard Surveys that Exceed Interval Report.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Queueing Report QID:81710812 Name:0801S Nursing Home Standard Survey Summary for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

Back Folders Reports

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0811D- HHA Standard Surveys that Exceed Interval.

Skip navigation links Skip to Content

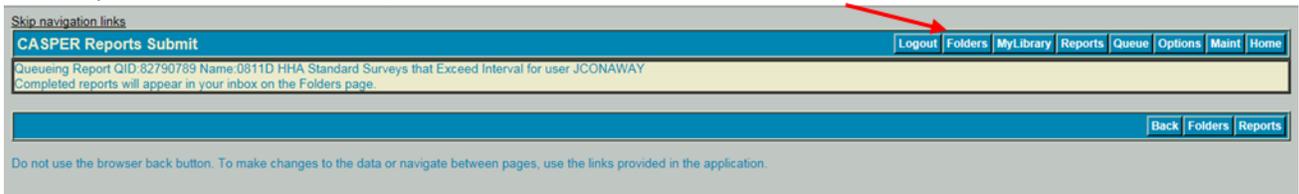
CASPER Reports Logout Folders MyLibrary Reports Queue Options Maint Home

Report Categories	Performance Standard Reports
ACTS National	0800S Nursing Home Staggered Surveys • Nursing Home Staggered Surveys
AEM National	0801S Nursing Home Standard Survey Summary • Nursing Home Standard Survey Summary
ASSURE General	0802D Nursing Home Providers Surveyed • Nursing Home Providers Surveyed
Activity Reports	0803D Nursing Home Providers Not Surveyed • Nursing Home Providers Not Surveyed
Audit Reports	0810S HHA Standard Survey Summary • HHA Standard Survey Summary
CASPER Inquiry	0811D HHA Standard Surveys that Exceed Interval • HHA Standard Surveys that Exceed Interval
CLIA AO Reports	0812D HHA Providers Not Surveyed • HHA Providers Not Surveyed
CMPIS Inquiry	0820S ICF/IID Standard Survey Summary • ICF/IID Standard Survey Summary
Federal Monitoring Surveys	0821D ICF/IID Providers Surveyed • ICF/IID Providers Surveyed
HHA Briefing Book	0822D ICF/IID Providers Not Surveyed • ICF/IID Providers Not Surveyed
Nursing Home Management	0830S Hospital Providers and Validation Survey Counts • Hospital Providers and Validation Survey Counts
OMR Reports	0831D Hospital Validation Surveys • Hospital Validation Surveys
Performance Standard Reports	0836D Timeliness of Complaint/Incident • Timeliness of Complaint/Incident Investigations -Deemed Providers
Standard	
Transplant Hospital Reports	
Upload Monitoring	
Utility Reports	

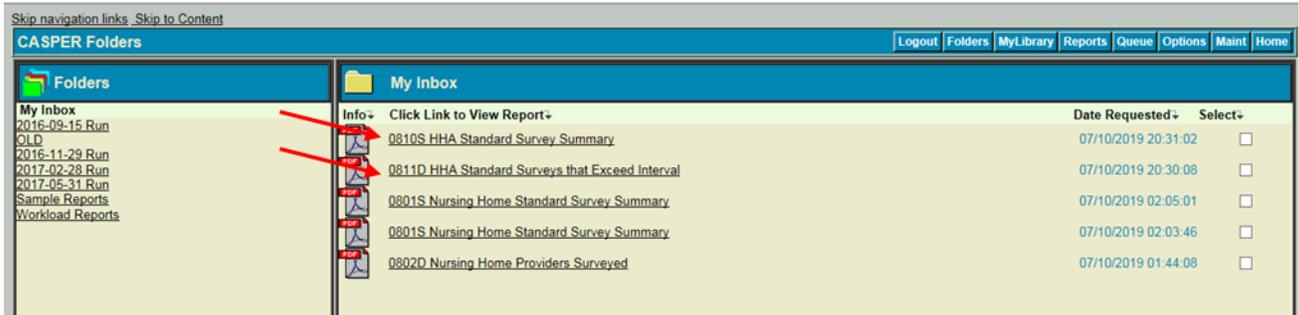
From the 0811D- HHA Standard Surveys that Exceed Interval page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Submit.



Once the report has been submitted, select the Folders Icon.



Once both reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.



From the CASPER Report 0810S HHA Standard Survey Summary, identify the number of active providers (call this [a]) and number of providers surveyed (call this [b]) from the columns labeled "# of Active Providers" and the "# of Providers Surveyed."

From the CASPER Report 0811D HHA Standard Surveys that Exceed Interval, identify the number of providers that exceeded the 36.9 months (call this [c]) from the "Total Providers for [State] = X" row.

- ▶ To calculate the HHA frequency measure, subtract [c] from [b], divide by [a] and multiply by 100

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

To meet this Performance Measure, the percentage Recertified must equal 100 percent.

## Notes - HHA

CMS will not do an associated non-delivery notice nor penalize the State Survey Agency on the SPSS for not making the 36.9 maximum survey interval on a particular survey if the State Survey Agency:

- can produce documentation that they received notification that an HHA has dropped their AO status at 60 days or less from the maximum 36-month survey interval date, and
- was unable to schedule and complete the re-certification survey within the required timeframe as result of that late notification.

If the State Survey Agency received notification that a HHA/Hospice has dropped their deemed status at 61-90 days from the maximum survey interval, and the State Agency provides documentation that they received such notification, these cases can be excluded from the sample, depending on the circumstances during the time of notification - as determined by the Regional Office. These will be determined by the RO on a case-by-case basis.

## ICFs/IID

---

### 1. Data Source(s)

CASPER Report 0820S- ICFs/IID Standard Survey Summary

CASPER Report 0821D- ICFs/IID Providers Surveyed

CASPER Report 0822D- ICFs/IID Providers Not Surveyed

### 2. Method

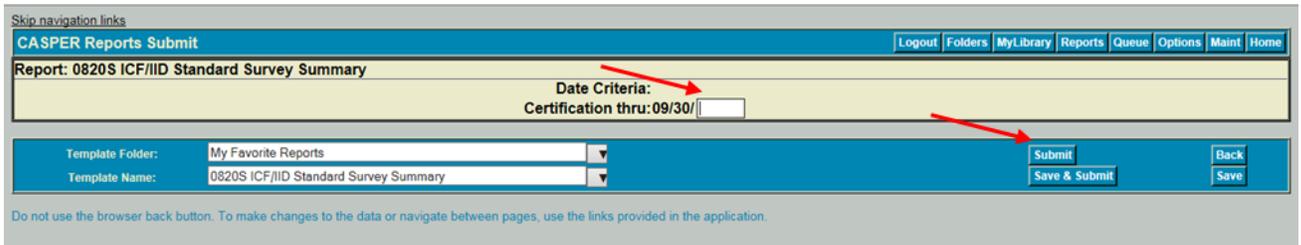
To calculate the F3.1 ICFs/IID measures, both the 0820S and the 0821D reports must be generated. From the CASPER Home Page, select Reports.



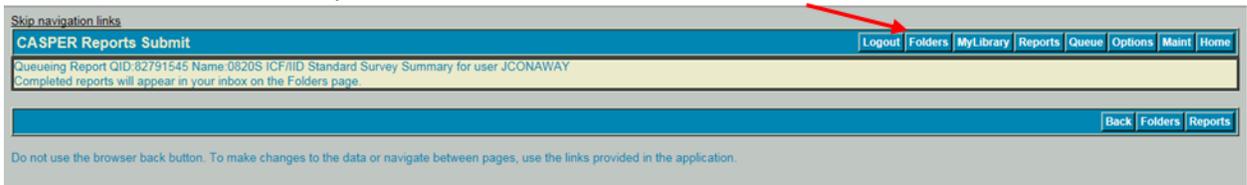
From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0820S- ICFs/IID Standard Survey Summary.



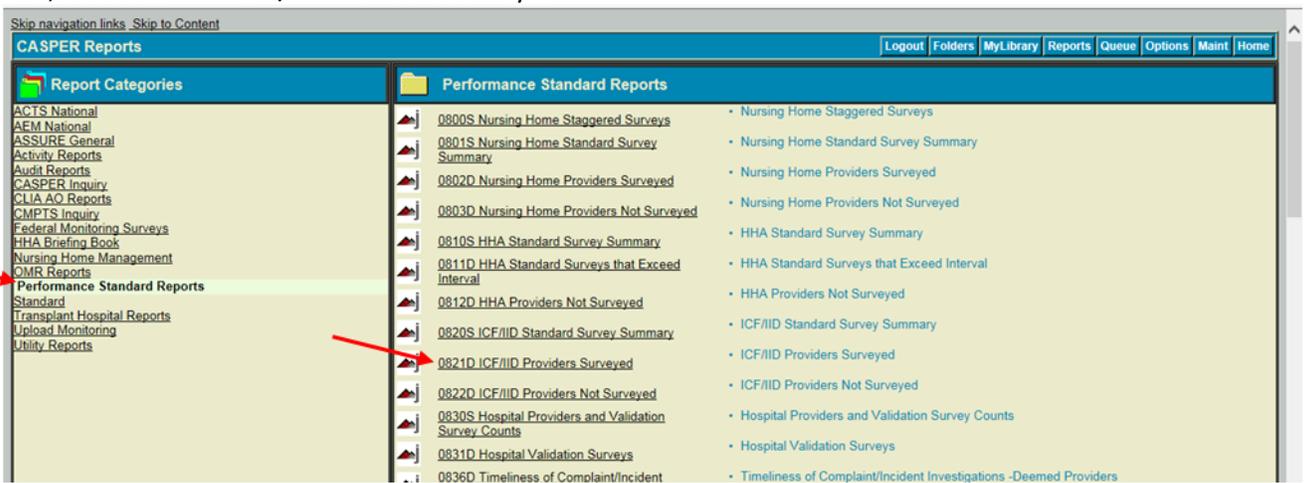
From the 0820S- ICFs/IID Standard Survey Summary page, enter the appropriate Fiscal Year. Then select Submit.



Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0821D- ICFs/IID Providers Surveyed.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0821D- ICFs/IID Providers Surveyed.



From the 0821D- ICFs/IID Providers Surveyed page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Submit.

Once the report has been submitted, select the Folders Icon.

Once both reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.

Info-	Click Link to View Report+	Date Requested+	Select+
	0821D ICF/IID Providers Surveyed	07/10/2019 21:27:57	<input type="checkbox"/>
	0820S ICF/IID Standard Survey Summary	07/10/2019 21:16:57	<input type="checkbox"/>
	0810S HHA Standard Survey Summary	07/10/2019 20:31:02	<input type="checkbox"/>
	0811D HHA Standard Surveys that Exceed Interval	07/10/2019 20:30:08	<input type="checkbox"/>
	0801S Nursing Home Standard Survey Summary	07/10/2019 02:05:01	<input type="checkbox"/>
	0801S Nursing Home Standard Survey Summary	07/10/2019 02:03:46	<input type="checkbox"/>
	0802D Nursing Home Providers Surveyed	07/10/2019 01:44:08	<input type="checkbox"/>

From the CASPER Report 0820S ICF/IID Standard Survey Summary, identify the number of active providers (call this [a]) and number of providers surveyed (call this [b]) from the columns labeled "# of Active Providers" and the "# of Providers Surveyed."

From the CASPER Report 0821D ICF/IID Providers Surveyed, count the number of providers that exceeded the 36.9 months (call this [c]) from the "# of Months Between Surveys" column.

CCN	Provider Name	Survey Date	Prior Survey Date	# of Months Between Surveys
33H380	NEW HOPE COMMUNITY, INC	03/01/2018		
33H370	NEW HOPE COMMUNITY, INC	03/14/2018		
33H371	NEW HOPE COMMUNITY, INC	02/01/2018		
33H372	NEW HOPE COMMUNITY, INC	02/15/2018		
33H373	NEW HOPE COMMUNITY, INC	03/09/2018		
33H374	NEW HOPE COMMUNITY, INC	02/18/2018		
33H375	UPSTATE CEREBRAL PALSY, INC	07/18/2018	07/20/2017	11.7
33H376	UPSTATE CEREBRAL PALSY, INC	07/11/2018	07/08/2017	11.9
33H378	NEW HOPE COMMUNITY, INC	07/12/2018	07/20/2017	11.5
33H379	NEW HOPE COMMUNITY, INC	07/08/2018	07/07/2017	11.7
33H380	NEW HOPE COMMUNITY, INC	08/01/2018	08/01/2017	11.7
33H383	THE CENTER FOR DISCOVERY, INC	01/18/2018		
33H384	PATHWAYS, INC	01/28/2018		
33H385	N Y S A R C CATTARAUGUS NIAGARA CNTY	09/07/2018	09/22/2017	11.2
33H386	THE CENTER FOR DISCOVERY, INC	03/07/2018		
33H387	THE CENTER FOR DISCOVERY, INC	03/07/2018		

To calculate the ICFs/IID frequency measure, subtract [c] from [b], divide by [a] and multiply by 100  
 percent Recertified =  $\frac{(b)-(c)}{(a)} \times 100$

From the CASPER Report 0820S ICF/IID Standard Survey Summary, identify the statewide average interval requirement using the "Average Interval" column.

To meet this Performance Measure, the percentage Recertified must equal 100 percent and the Statewide Average must be less than or equal to 12.9 months.

**Notes – ICFs/IID**

- ▶ In the CASPER Reports, survey intervals are calculated using the Oracle function called "Months\_Between." A full description of the function can be found at this site: [http://download.oracle.com/docs/cd/B19306\\_01/server.102/b14200/functions089.htm](http://download.oracle.com/docs/cd/B19306_01/server.102/b14200/functions089.htm)

# Non-Deemed Hospices

## 1. Data Source(s)

CASPER Report 0840S – Performance Standard Survey Summary

CASPER Report 0841D – Providers Surveyed

CASPER Report 0842D – Providers Not Surveyed

## 2. Method

To calculate the F3.1 non-deemed hospice measure, the 0840S report must be generated.

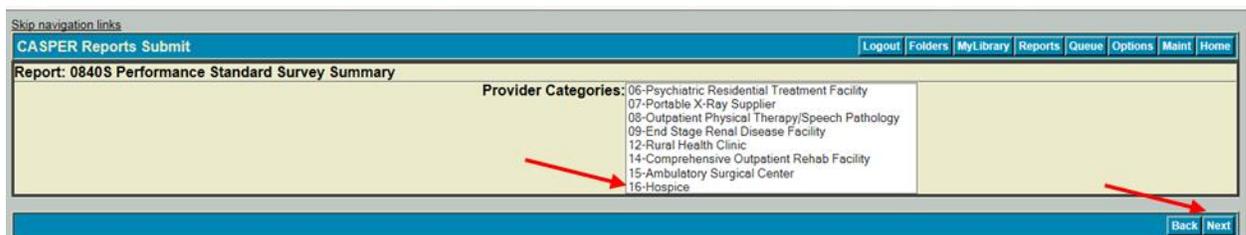
From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0840S – Performance Standard Survey Summary.



From the 0840S – Performance Standard Survey Summary page, select Provider Category: 16-Hospice. Then select Next.



From the 0840S – Performance Standard Survey Summary page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.

Skip navigation links

CASPER Reports Submit [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Report: 0840S Performance Standard Survey Summary

Date Criteria:  
Certification thru: 09/30/

Provider Deemed Status:  Deemed  Non-Deemed  Both

Template Folder: My Favorite Reports

Template Name: 0840S Performance Standard Survey Summary

[Submit](#) [Back](#)  
[Save & Submit](#) [Save](#)

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0843D – Standard Surveys Exceed Interval.

Skip navigation links

CASPER Reports Submit [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Queueing Report QID 82796117 Name 0840S Performance Standard Survey Summary for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

[Back](#) [Folders](#) [Reports](#)

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0843D – Standard Surveys Exceed Interval report.

Nursing Home Management  
OMR Reports  
Performance Standard Reports  
Standard  
Transplant Hospital Reports  
Upload Monitoring  
Utility Reports

- 0811D HHA Standard Surveys that Exceed Interval
- 0812D HHA Providers Not Surveyed
- 0820S ICF/IID Standard Survey Summary
- 0821D ICF/IID Providers Surveyed
- 0822D ICF/IID Providers Not Surveyed
- 0830S Hospital Providers and Validation Survey Counts
- 0831D Hospital Validation Surveys
- 0836D Timeliness of Complaint/Incident Investigations - Deemed
- 0837D Timeliness of Complaint/Incident Investigations - Non-Deemed
- 0838D Timeliness of Complaint/Incident Investigations - Nursing Homes
- 0840S Performance Standard Survey Summary
- 0841D Providers Surveyed
- 0842D Providers Not Surveyed
- 0843D Standard Surveys Exceed Interval
- 0844S Short-term Acute Care Hospitals
- 0845S All Hospitals

- HHA Standard Surveys that Exceed Interval
- HHA Providers Not Surveyed
- ICF/IID Standard Survey Summary
- ICF/IID Providers Surveyed
- ICF/IID Providers Not Surveyed
- Hospital Providers and Validation Survey Counts
- Hospital Validation Surveys
- Timeliness of Complaint/Incident Investigations - Deemed Providers
- Timeliness of Complaint/Incident Investigations - Non-Deemed Providers
- Timeliness of Complaint/Incident Investigations - Nursing Homes
- Performance Standard Survey Summary
- Providers Surveyed
- Providers Not Surveyed
- Standard Surveys Exceed Interval
- Short-term Acute Care Hospitals
- All Hospitals
- Targeted Providers

From the 0843D – Standard Surveys Exceed Interval page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate provider category. Then select Next.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0843D Standard Surveys Exceed Interval

Geographical Breakdown:  Nation  Region  State

\* States: Alabama, Alaska, American Samoa, Arizona, Arkansas

Provider Categories: 01-Hospital, 08-Outpatient Physical Therapy/Speech Pathology, 09-End Stage Renal Disease Facility, 12-Rural Health Clinic, 14-Comprehensive Outpatient Rehab Facility, 15-Ambulatory Surgical Center, 16-Hospice

\* To select multiple items, hold down the Ctrl key and click the desired items

Back Next

From the 0843D – Standard Surveys Exceed Interval page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0843D Standard Surveys Exceed Interval

Date Criteria: Certification thru: 09/30/

Provider Deemed Status:  Deemed  Non-Deemed  Both

Template Folder: My Favorite Reports Submit Back

Template Name: 0843D Standard Surveys Exceed Interval Save & Submit Save

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Folders Icon.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Queueing Report QID:82793164 Name:0843D Standard Surveys Exceed Interval for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

Back Folders Reports

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once both reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.

Skip navigation links [Skip to Content](#)

CASPER Folders Logout Folders MyLibrary Reports Queue Options Maint Home

Info-	Click Link to View Report-	Date Requested-	Select-
	0843D Standard Surveys Exceed Interval	07/11/2019 02:33:19	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 23:14:46	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/10/2019 21:59:40	<input type="checkbox"/>
	0841D Providers Surveyed	07/10/2019 21:59:03	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 21:57:01	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:47:36	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:41:33	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:27:57	<input type="checkbox"/>
	0820S ICF/IID Standard Survey Summary	07/10/2019 21:16:57	<input type="checkbox"/>
	0810S HHA Standard Survey Summary	07/10/2019 20:31:02	<input type="checkbox"/>
	0811D HHA Standard Surveys that Exceed Interval	07/10/2019 20:30:08	<input type="checkbox"/>

From the CASPER Report 0840S Performance Standard Survey Summary, identify the number of active providers (call this [a]) and number of providers surveyed (call this [b]) for the specified State using the “# of Active Providers” and “# of Providers Surveyed” columns.

From the CASPER Report 0843D Standard Surveys that Exceed Interval, identify the number of providers that exceeded the 36-month interval (call this [c]) from the “Total Providers for [State] = X” row.

To calculate the Hospice frequency measure, subtract [c] from [b], divide by [a] and multiply by 100

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

To meet this Performance Measure, the percentage Recertified must equal 100 percent.

## Deemed Hospitals

### 1. Data Source(s)

CASPER Report 0831D- Hospital Validation Surveys  
Form CMS-2802 (Request for Validation of Accreditation Survey)

### 2. Method

To calculate the F3.1 deemed hospital measure, the 0831D report must be generated. From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0831D- Hospital Validation Surveys.



From the 0831D- Hospital Validation Surveys page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Submit.

Once the report has been submitted, select the Folders Icon.

Once the report is complete, it will appear on the Folders Page. Click on the Report to either Open or Save it.

From the CMS-2802s determine the hospitals sampled for the FY. Determine if the sampled hospitals were surveyed within 60 days of the accrediting organization's survey using the CMS-2802s and the Validation Survey Date from the 0831D- Hospital Validation Surveys report.

To meet the Performance Measure: # Validation Surveys Conducted  $\geq$  # Deemed Hospitals Sampled in the FY.

**Notes – Deemed Hospitals**

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

## Non-Deemed ESRD (Initial Surveys)

---

### 1. Data Source(s)

Quality and Certification Oversight Reports  
Medicare Enrollment Applications (CMS-855) for ESRD providers

### 2. Method

Use the following procedure to identify new ESRD providers

- Go into ARO
- Select applicable State Profile
- Select “Tracking” tab on top of page
- Select “Certifications”
- Select “091 END STAGE RENAL DISEASE FACILITIES MEDICARE”
- Select “STATUS 01 OPEN”
- Select appropriate time period and hit “Set”
- Filter the list by Certification Type

Select a random sample of these ESRD providers using the table below. (call this [a])

Total New Active ESRD Providers in the Fiscal Year	Total Sample Size
10 or Less	All ESRD Providers
10 or more	10 ESRD Providers

Review the file of each selected ESRD provider to identify the date the Medicare Enrollment Application (CMS-855) was determined to be approved by the Medicare Administrative Contractor and the date of the initial survey during the period of evaluation.

Calculate the number of days between the date the Medicare Administrative Contractor determined the application was approved and the initial survey date. For example, if the approval date is June 26, 2019 and the initial survey date is September 21, 2019, the total number of days is 87 days. (That is, the count begins on June 27.)

Count the number of new ESRD providers in the sample that were surveyed within 90 days of the Medicare Administrative Contractor determining the Medicare Enrollment Application was completed. (call this [b])

To calculate this measure, divide [b] by [a] and multiply by 100

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

To meet the Performance Measure, the number of new ESRDs surveyed within 90 days of Medicare Administrative Contractor approval must equal 100 percent

# Deemed ASCs

## 1. Data Source(s)

QBIC – F31 – Deemed ASCs Report

CMS ASC Validation Survey Assignments

## 2. Method

Enter QBIC

Select the Reports drop-down menu. Select the Reports Library

The screenshot shows the QIES Business Intelligence Center interface. At the top, there is a navigation bar with 'Home', 'Reports', 'User Tools', and 'Help'. The 'Reports' menu is open, showing options for 'Run Reports' (Report Designer, Report Library, Report Packages) and 'View Reports' (Job Queue). Below the menu, there is a table of available reports. The table has columns for NAME, ACTIONS, REPORT LIBRARY, TYPE, OWNER, SHARED, and DATE MODIFIED. The reports listed are Active Providers, Provider\_Certification\_Details, Provider, ASPEN IDs, and Provider Characteristics (Draft). A URL is visible at the bottom left: <https://portal.qualitynet.org/qbic/flow/reports/report-designer>.

NAME	ACTIONS	REPORT LIBRARY	TYPE	OWNER	SHARED	DATE MODIFIED
Active Providers	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/21/2019 16:43:37
Provider_Certification_Details	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 12:43:03
Provider	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 11:55:17
ASPEN IDs	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/04/2019 15:50:03
Provider Characteristics (Draft)	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/01/2019 04:15:22

Click on the three dots beside the F31 – Deemed ASC Validation Surveys Report. Select Submit from the pop-up menu.

Filtered by: Report Library: System Default Library Visible Items

REPORT DESIGNER

AVAILABLE REPORTS Explain This...

Filter by Report Name, Report Library, Report Type, Modified

NAME	ACTIONS	TYPE	OWNER	SHARED	DATE MODIFIED
F31 - Deemed ASC Validation Surveys	...	Detail	COMPHER, CHRISTINA (**PHER)	No	09/22/2019 13:00:33
ASC - Validation Test 2	...	Detail	COMPHER, CHRISTINA (**PHER)	No	09/22/2019 12:14:21
ASCs - Validation Test	...	Extract	COMPHER, CHRISTINA (**PHER)	No	09/20/2019 17:27:09
Deemed ASCs - Validation Surveys	...	Extract	COMPHER, CHRISTINA (**PHER)	No	09/20/2019 17:21:33
Deficiencies	...	Extract	GRAY, JAMIE (**AYJL)	Yes	09/17/2019 15:57:28
Surveys	...	Extract	GRAY, JAMIE (**AYJL)	Yes	09/17/2019 15:53:53
CMHCs	...	Detail	COMPHER, CHRISTINA (**PHER)	Yes	09/13/2019 16:49:35
NH Surveys	...	Extract	COMPHER, CHRISTINA (**PHER)	No	09/17/2019

Available Actions

- Copy
- Modify
- Move
- Delete
- Package Designer
- Share
- View Summary
- Submit

Click Run Report

What report specifications would you like to use for the job submission? Explain This... \* indicates required field(s)

Job Submission Parameters

Job Name: \* F31 - Deemed ASC Validation Surveys

Maximum Rows: Enter Maximum Row Count

Counts Only

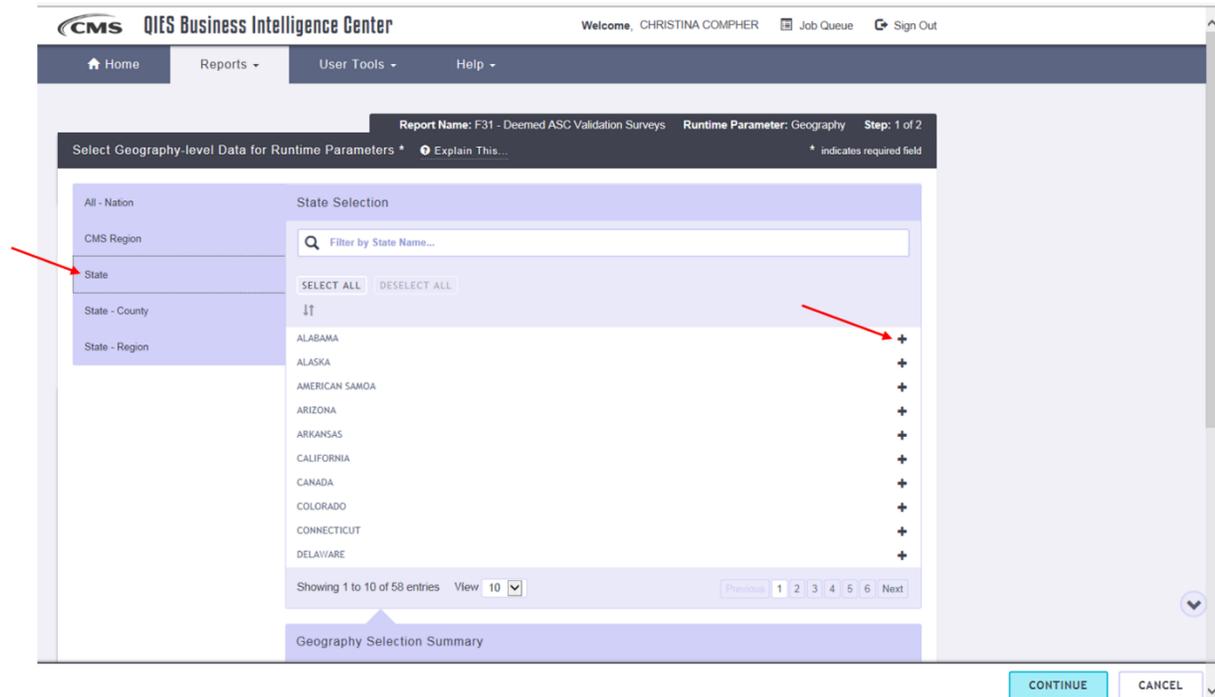
Email Notification

Job Description: \* This report provides an output of the number of active deemed ASCs with the dates of the most recent validation surveys.

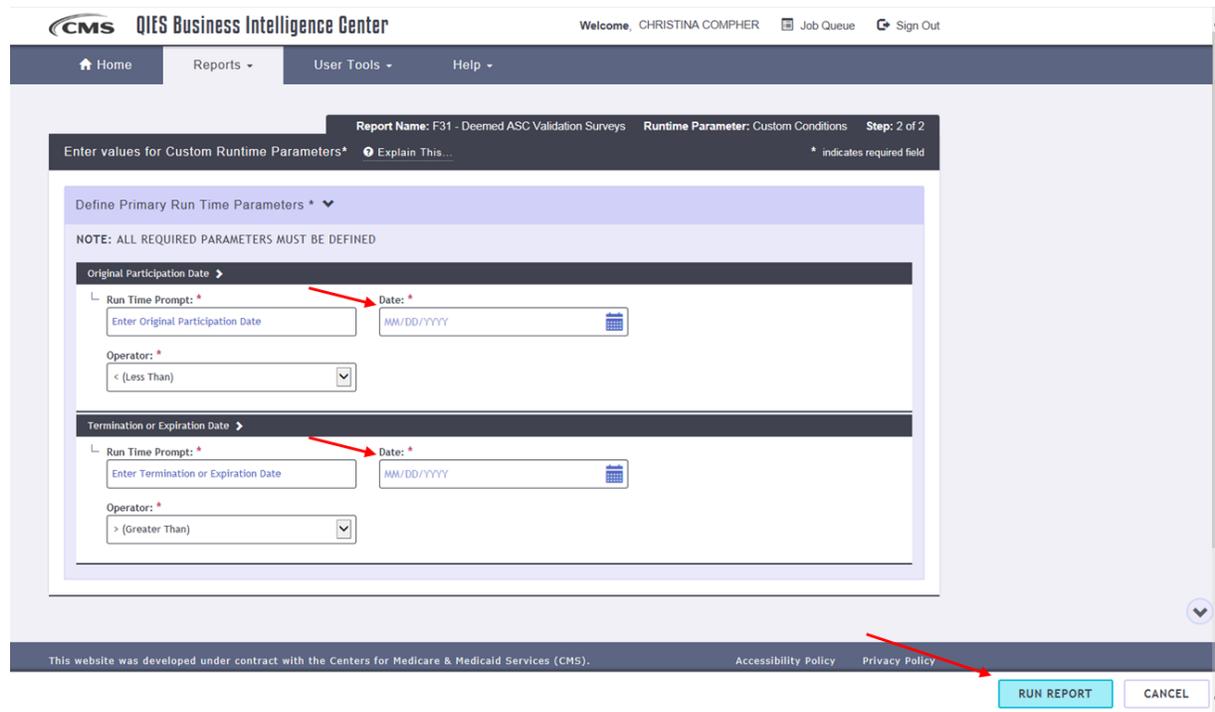
Run Position: \* ASAP

RUN REPORT CANCEL

Select State as the Geography-level Data from the left-hand panel. Then select the appropriate States using the State + icons from the selection window. Once all States are selected, click Continue.



Enter the first day of the appropriate fiscal year in the Original Participation Date field. For example, for Fiscal Year 2019, enter 10/01/2018. Enter the last day of the appropriate fiscal year in the Termination Date or Expiration Date field. For example, for Fiscal Year 2019, enter 09/30/2018. Click Run Report.



Once the report begins running, the user will be auto-directed to the Job Queue. Once the report is available the Status will indicate Complete.

Filtered by:  
Limit Date: 09/16/2019 to 09/22/2019

REPORT DESIGNER

JOB QUEUE Explain This...

REPORT LIBRARY

Filter by Job Name, Report Type, Status, Position, Running Time, Submitter, Count, Job Number or Last Posted Date

NAME ↑↓	ACTIONS	TYPE ↑↓	STATUS ↑↓	POS/TIME ↑↓	SUBMITTER ↑↓	COUNT ↑↓	JOB # ↑↓	POSTED ↑↓
F31 - Deemed ASC Validation Surveys	...	Detail	Complete	0:00:23	COMPHER, CHRISTINA (**PHER)	1877	49125	09/22/2019 13:02:55
F31 - Deemed ASC Validation Surveys	...	Detail	Complete	0:00:38	COMPHER, CHRISTINA (**PHER)	1877	49124	09/22/2019 13:01:41
F31 - Deemed ASC Validation Surveys	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49123	09/22/2019 12:58:24
Deemed ASCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49122	09/22/2019 12:50:24
Deemed ASCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49121	09/22/2019 12:45:54
Deemed ASCs	...	Detail	Complete	0:00:21	COMPHER, CHRISTINA (**PHER)	121	49120	09/22/2019

Click on the three dots beside the report and select Download.

Filtered by:  
Limit Date: 09/16/2019 to 09/22/2019

REPORT DESIGNER

JOB QUEUE Explain This...

REPORT LIBRARY

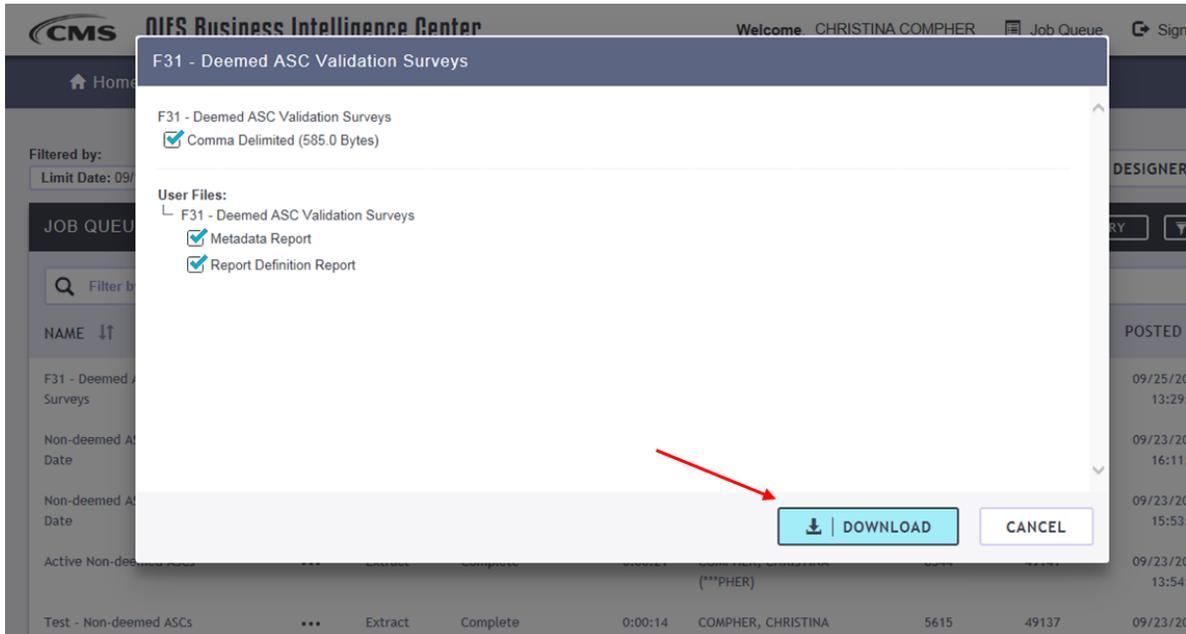
Filter by Job Name, Report Type, Status, Position, Running Time, Submitter, Count, Job Number or Last Posted Date

NAME ↑↓	ACTIONS	TYPE ↑↓	STATUS ↑↓	POS/TIME ↑↓	SUBMITTER ↑↓	COUNT ↑↓	JOB # ↑↓	POSTED ↑↓
F31 - Deemed ASC Validation Surveys	...			0:00:23	COMPHER, CHRISTINA (**PHER)	1877	49125	09/22/2019 13:02:55
F31 - Deemed ASC Validation Surveys	...			0:00:38	COMPHER, CHRISTINA (**PHER)	1877	49124	09/22/2019 13:01:41
F31 - Deemed ASC Validation Surveys	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49123	09/22/2019 12:58:24
Deemed ASCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49122	09/22/2019 12:50:24
Deemed ASCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA (**PHER)	115	49121	09/22/2019 12:45:54

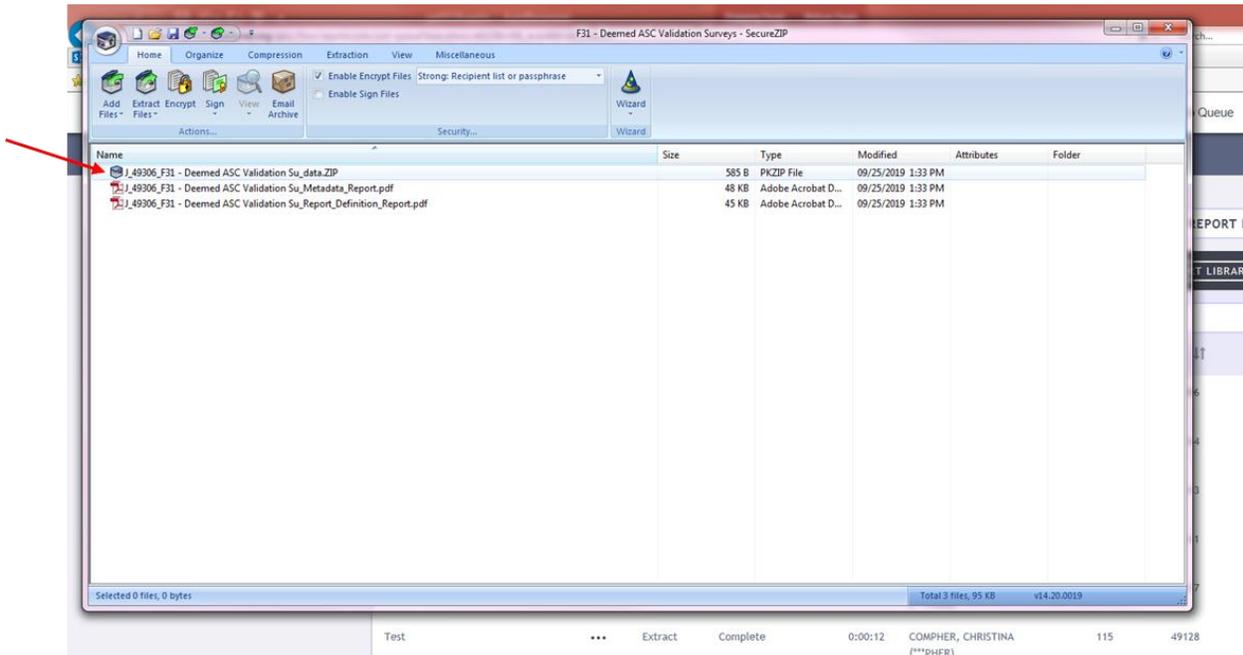
Available Actions

- Delete
- Download
- View (PDF)
- Status Report
- View Summary

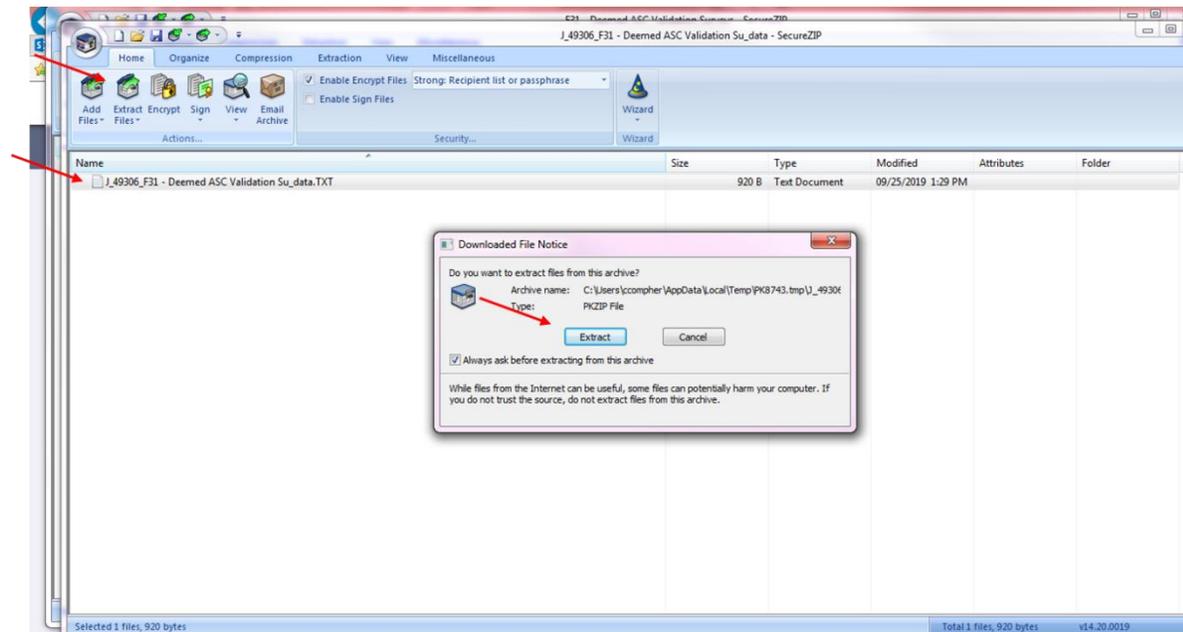
Click on Download.



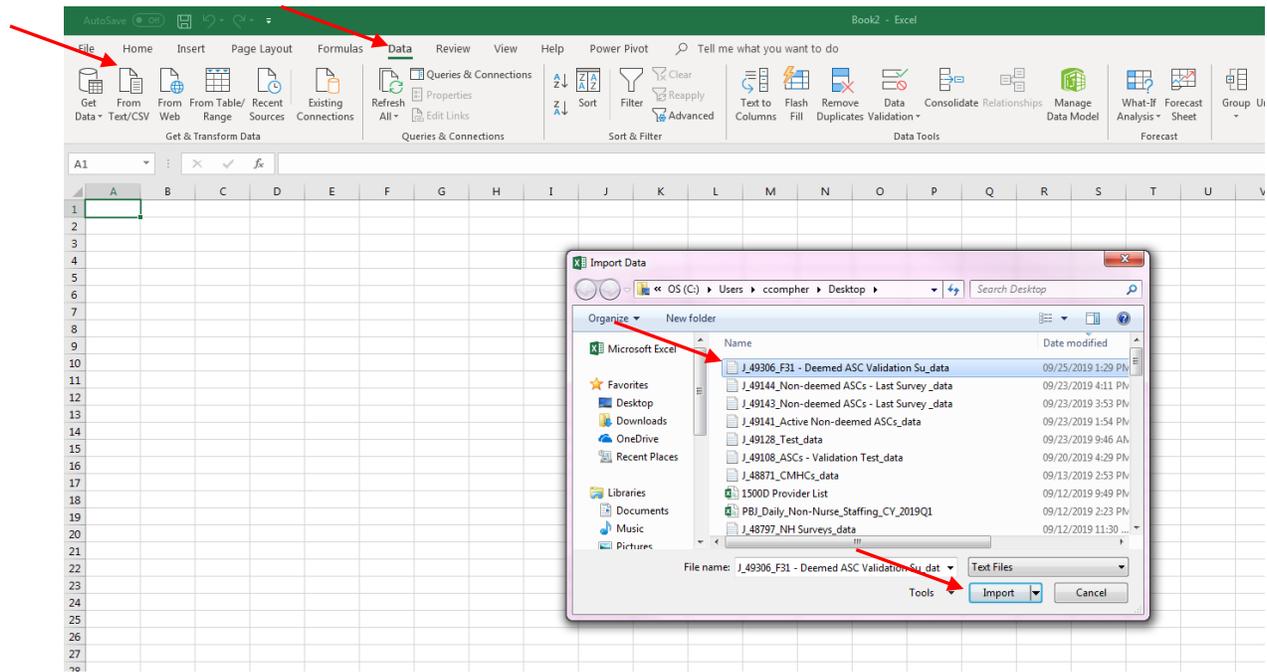
Once the zipped file has downloaded, click on the F31 – Deemed ASC Validation Survey.Zip file where the data file is located.



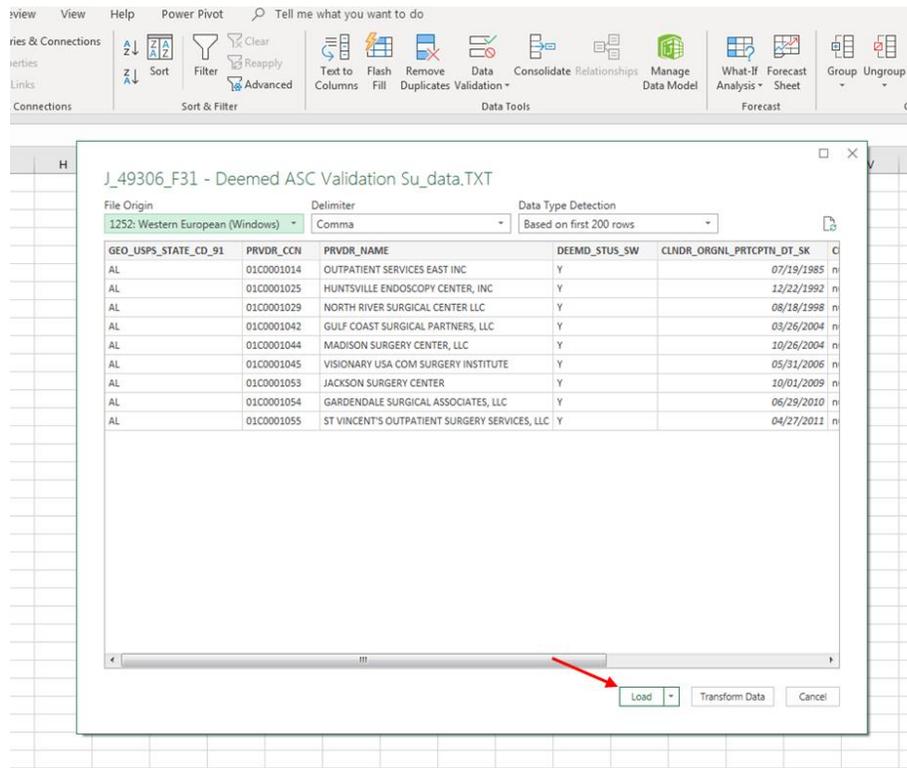
Extract the data file to a location on your Computer.



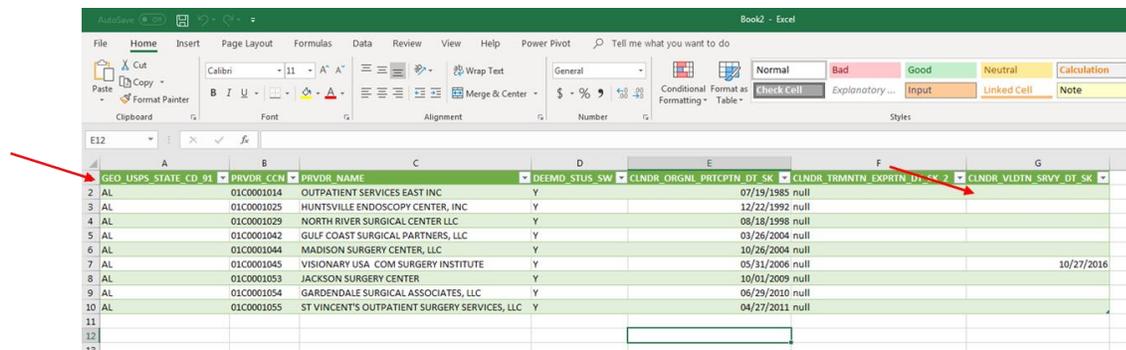
Open Excel and click on the Data tab. From the Data menu, click on From Text/CSV. From the pop-up menu, navigate to the F31 – Deemed ASC Validation Survey text file and select Import.



Once the data preview opens, click Load.



From the F31 – Deemed ASC Validation Survey Report, count the number of deemed ASCs associated with the appropriate State (call this [a]). From the F31 – Deemed ASC Validation Survey Report, count the number of deemed ASCs with a validation survey that was conducted within the appropriate State during the fiscal year (call this [b]). Verify that each of the validation surveys conducted were assigned by CMS using the CMS ASC Validation Survey Assignments based on AO survey schedules.



To calculate the F3.1 Deemed ASC Validation Survey measure, divide the verified [b] count by [a] and multiply by 100

$$\text{Percent of Deemed ASCs with a Validation Survey} = \frac{(b)}{(a)} \times 100$$

To meet the F3.1 performance measure, States must conduct validation surveys of between 5%-10% of the deemed ASCs assigned by CMS based on AO survey schedules.

## Appendix 4: F3.2 Frequency of Non-Nursing Home Surveys – Tier 2 & Tier 3

---

These measures score the following providers: OPT, CORF, RHC, ASC, ESRD, PRTF, CMHC, and non-deemed hospitals included in Tier 2 and Tier 3 work.

### OPTs, CORFs, RHCs, PRTFs, and CMHCs

---

#### 1. Data Source(s)

CASPER Reports for each provider type (OPT, CORF, and RHC):

CASPER Report 0840S – Performance Standard Survey Summary

CASPER Report 0841D – Providers Surveyed

CASPER Report 0842D – Providers Not Surveyed

CASPER Report 0843D – Standard Surveys Exceed Interval

#### 2. Method

To calculate the F3.2 and F3.3 OPT, CORF, and RHC measures, the 0840S and 0843D reports must be generated for each provider type.

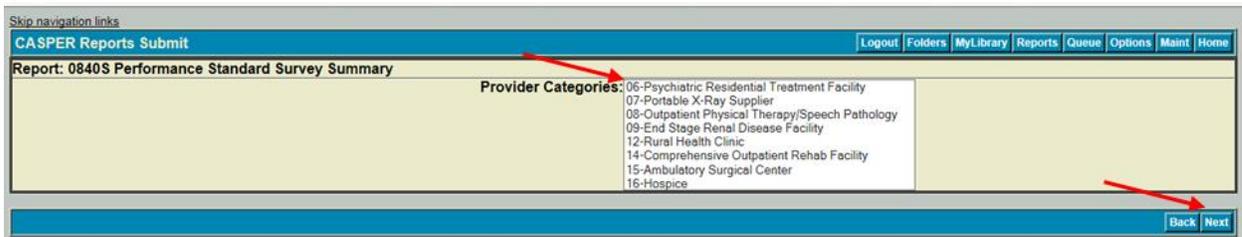
From the CASPER Home Page, select Reports.



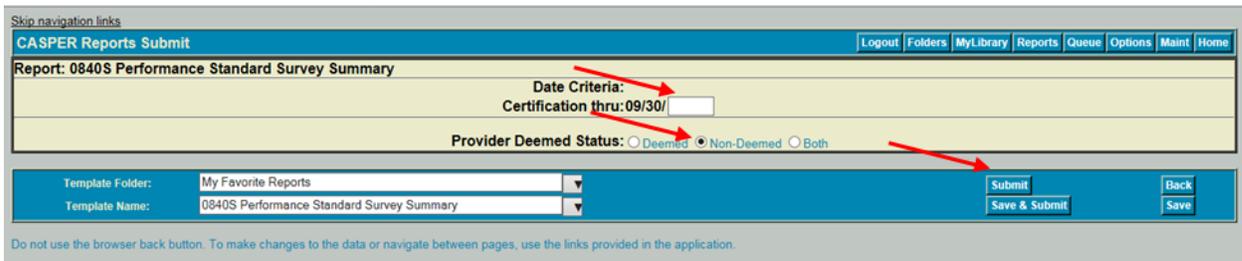
From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0840S – Performance Standard Survey Summary.



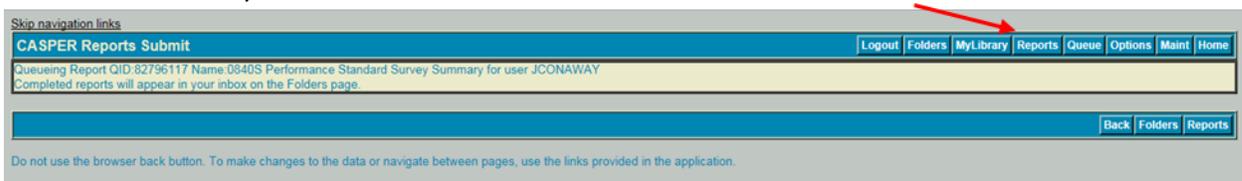
From the 0840S – Performance Standard Survey Summary page, select the appropriate provider category. Then select Next.



From the 0840S – Performance Standard Survey Summary page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.



Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0843D – Standard Surveys Exceed Interval.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0843D – Standard Surveys Exceed Interval report.

Nursing Home Management	0811D HHA Standard Surveys that Exceed Interval	• HHA Standard Surveys that Exceed Interval
OMR Reports	0812D HHA Providers Not Surveyed	• HHA Providers Not Surveyed
Performance Standard Reports	0820S ICF/IID Standard Survey Summary	• ICF/IID Standard Survey Summary
Standard	0821D ICF/IID Providers Surveyed	• ICF/IID Providers Surveyed
Transplant Hospital Reports	0822D ICF/IID Providers Not Surveyed	• ICF/IID Providers Not Surveyed
Upload Monitoring	0830S Hospital Providers and Validation Survey Counts	• Hospital Providers and Validation Survey Counts
Utility Reports	0831D Hospital Validation Surveys	• Hospital Validation Surveys
	0836D Timeliness of Complaint/Incident Investigations - Deemed	• Timeliness of Complaint/Incident Investigations - Deemed Providers
	0837D Timeliness of Complaint/Incident Investigations - Non-Deemed	• Timeliness of Complaint/Incident Investigations - Non-Deemed Providers
	0838D Timeliness of Complaint/Incident Investigations - Nursing Homes	• Timeliness of Complaint/Incident Investigations - Nursing Homes
	0840S Performance Standard Survey Summary	• Performance Standard Survey Summary
	0841D Providers Surveyed	• Providers Surveyed
	0842D Providers Not Surveyed	• Providers Not Surveyed
	0843D Standard Surveys Exceed Interval	• Standard Surveys Exceed Interval
	0844S Short-term Acute Care Hospitals	• Short-term Acute Care Hospitals
	0845S All Hospitals	• All Hospitals
		• Targeted Providers

From the 0843D – Standard Surveys Exceed Interval page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate provider category. Then select Next.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0843D Standard Surveys Exceed Interval

Geographical Breakdown:  Nation  Region  State

States: Alabama, Alaska, American Samoa, Arizona, Arkansas

Provider Categories: 01-Hospital, 08-Outpatient Physical Therapy/Speech Pathology, 09-End Stage Renal Disease Facility, 12-Rural Health Clinic, 14-Comprehensive Outpatient Rehab Facility, 15-Ambulatory Surgical Center, 16-Hospice

\* To select multiple items, hold down the Ctrl key and click the desired items

[Back](#) [Next](#)

From the 0843D – Standard Surveys Exceed Interval page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0843D Standard Surveys Exceed Interval

Date Criteria: Certification thru: 09/30/

Provider Deemed Status:  Deemed  Non-Deemed  Both

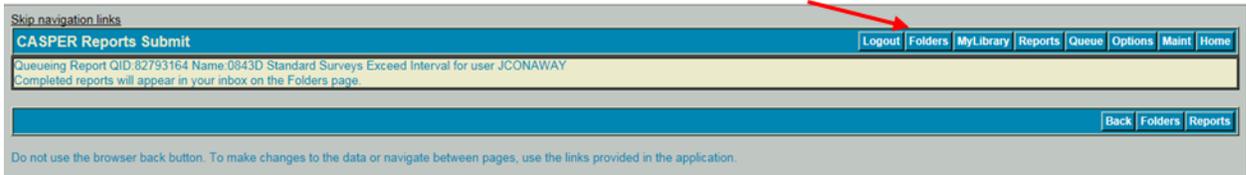
Template Folder: My Favorite Reports

Template Name: 0843D Standard Surveys Exceed Interval

[Submit](#) [Save & Submit](#) [Back](#) [Save](#)

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Folders Icon.



Once both reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.



From the 0840S – Performance Standard Survey Summary, identify the "# of Active Providers" (call this [a]) and the "# of Providers Surveyed" (call this [b]).



**CASPER Report 0840S**  
**Performance Standard Survey Summary**  
**Certification from 10/01/2017 thru 09/30/2018**  
**Rural Health Clinic**  
**Non-Deemed**

Run Date: 06/10/2019  
 Job # 81748247  
 Last Update: 06/09/2019  
 Page 1 of 2

Region/ State	# of Active Providers	# of Providers Surveyed	% of Providers	Interval > 7 years	# of Providers Not Surveyed
01 CT	0	0	0.0	0	0
ME	38	2	5.3	0	36
MA	0	0	0.0	0	0
NH	13	3	23.1	0	10
RI	0	0	0.0	0	0
VT	9	1	11.1	0	8
<b>Region 01</b>	<b>60</b>	<b>6</b>	<b>10.0</b>	<b>0</b>	<b>54</b>
02 NJ	0	0	0.0	0	0
NY	4	3	75.0	0	1
PR	0	0	0.0	0	0
<b>Region 02</b>	<b>4</b>	<b>3</b>	<b>75.0</b>	<b>0</b>	<b>1</b>
03 DE	0	0	0.0	0	0
DC	0	0	0.0	0	0

To calculate the F3.2 OPT, CORF, and RHC measures, divide [b] by [a] and multiply by 100

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

To meet these F3.2 performance measures, the percentage Surveyed must be greater than or equal to 5 percent.

From the 0843D – Standard Surveys Exceed Interval, count the number of providers that exceeded the 7.0 year interval.



CASPER Report 0843D  
 Standard Surveys Exceed Interval  
 Certification from 10/01/2017 thru 09/30/2018  
 Chicago Regional Office - Minnesota  
 Rural Health Clinic  
 Non-Deemed

Run Date: 07/11/2019  
 Job # 82793108  
 Last Update: 07/10/2019  
 Page 1 of 1

CCN	Prior Survey	Years Between	Provider Name	City
243856	02/01/2001	17.3	HEALTH CARE TODAY/AVERA HEALTH	SLAYTON

Total Providers for Minnesota = 1  
 Total Providers for Chicago Regional Office = 9  
 Total Providers for Nation = 251

To calculate the F3.3 OPT, CORF, and RHC measures, count the number of providers exceeding the maximum interval.

To meet the F3.3 performance measures, the number of providers/suppliers that exceed the 7.0-year interval must equal zero.

**Notes – OPT, CORF, and RHC**

If the State Survey Agency does not have any active providers/suppliers, then the F3.2 for that provider/supplier type would be scored as Nonapplicable.

If the State Survey Agency has *fewer than 7 active providers*, then F3.2 for that provider/supplier type would be scored as Nonapplicable.

**Non-Deemed ASCs**

**1. Data Source(s)**

- CASPER Report 0840S – Performance Standard Survey Summary
- CASPER Report 0841D - Providers Surveyed
- CASPER Report 0842D – Providers Not Surveyed
- CASPER Report 0843D – Standard Surveys Exceed Interval
- QBIC Report – F32 Non-deemed ASCs Report
- Chapter 5 of the State Operations Manual

**2. Method**

To calculate the F3.2 and F3.3 ASC measures, the 0840S, 0841D, and 0843D reports must be generated from CASPER and the F32 Non-deemed ASCs report from QBIC must be generated for ASCs.

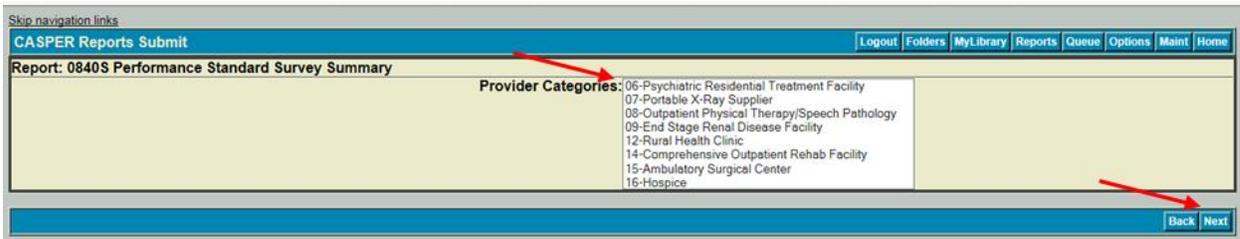
From the CASPER Home Page, select Reports.



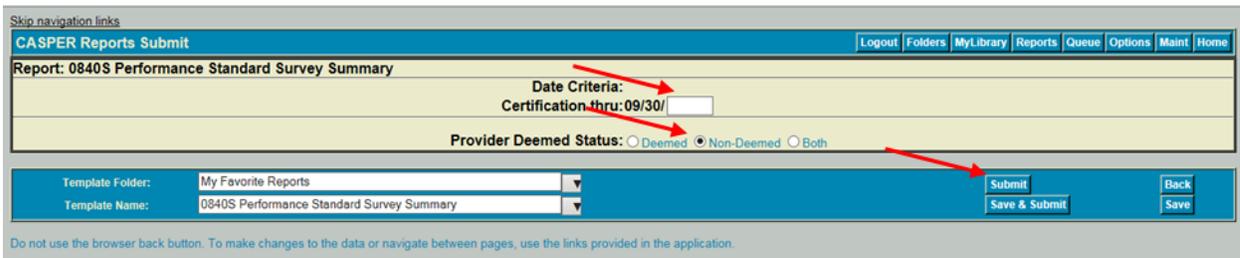
From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0840S – Performance Standard Survey Summary.



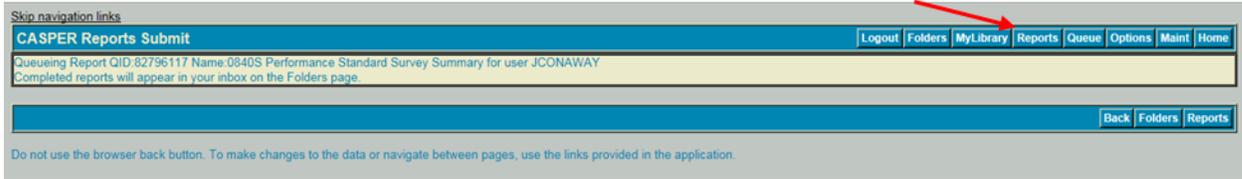
From the 0840S – Performance Standard Survey Summary page, select 15 Ambulatory Surgical Center. Then select Next.



From the 0840S – Performance Standard Survey Summary page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.



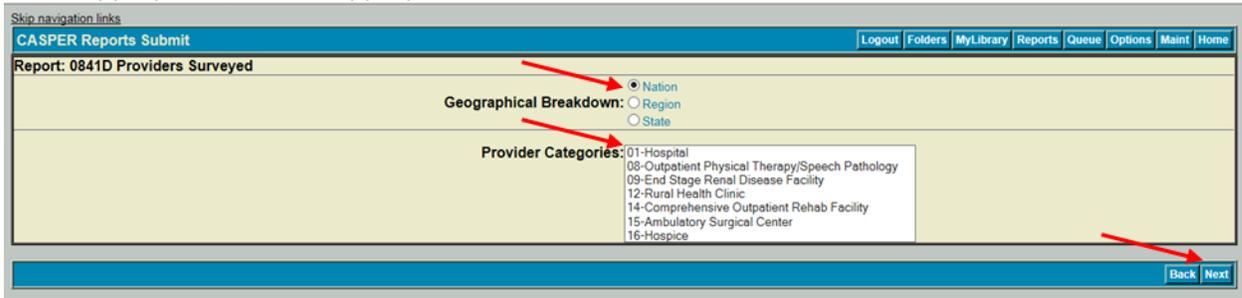
Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0841D – Providers Surveyed report.



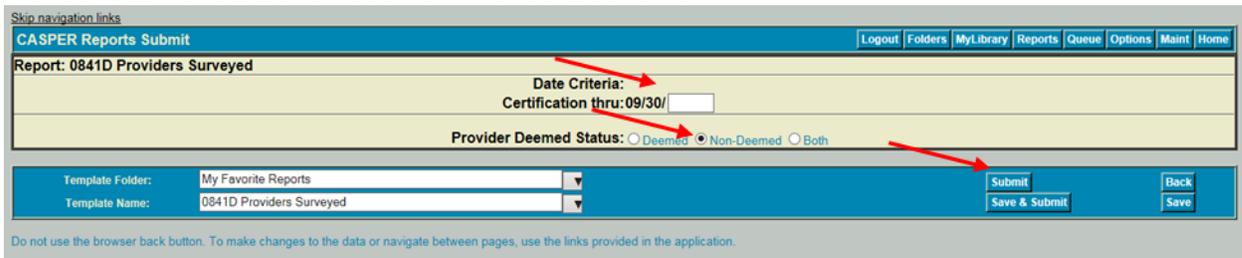
From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0841D – Providers Surveyed report.



From the 0841D – Providers Surveyed page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Next.



From the 0841D – Providers Surveyed page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.



Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0843D – Standard Surveys Exceed Interval.

Skip navigation links

**CASPER Reports Submit** Logout Folders MyLibrary **Reports** Queue Options Maint Home

Queueing Report QID:82804752 Name:0841D Providers Surveyed for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

[Back](#) [Folders](#) [Reports](#)

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0843D – Standard Surveys Exceed Interval report.

Nursing Home Management	0811D HHA Standard Surveys that Exceed Interval	HHA Standard Surveys that Exceed Interval
OMR Reports	0812D HHA Providers Not Surveyed	HHA Providers Not Surveyed
<b>Performance Standard Reports</b>	0820S ICF/IID Standard Survey Summary	ICF/IID Standard Survey Summary
Standard	0821D ICF/IID Providers Surveyed	ICF/IID Providers Surveyed
Transplant Hospital Reports	0822D ICF/IID Providers Not Surveyed	ICF/IID Providers Not Surveyed
Upload Monitoring	0830S Hospital Providers and Validation Survey Counts	Hospital Providers and Validation Survey Counts
Utility Reports	0831D Hospital Validation Surveys	Hospital Validation Surveys
	0836D Timeliness of Complaint/Incident Investigations - Deemed	Timeliness of Complaint/Incident Investigations - Deemed Providers
	0837D Timeliness of Complaint/Incident Investigations - Non-Deemed	Timeliness of Complaint/Incident Investigations - Non-Deemed Providers
	0838D Timeliness of Complaint/Incident Investigations - Nursing Homes	Timeliness of Complaint/Incident Investigations - Nursing Homes
	0840S Performance Standard Survey Summary	Performance Standard Survey Summary
	0841D Providers Surveyed	Providers Surveyed
	0842D Providers Not Surveyed	Providers Not Surveyed
	<b>0843D Standard Surveys Exceed Interval</b>	<b>Standard Surveys Exceed Interval</b>
	0844S Short-term Acute Care Hospitals	Short-term Acute Care Hospitals
	0845S All Hospitals	All Hospitals
		Targeted Providers

From the 0843D – Standard Surveys Exceed Interval page, select the geographical breakdown, the Region(s) or State(s), if appropriate, and the appropriate Fiscal Year. Then select Next.

Skip navigation links

**CASPER Reports Submit** Logout Folders MyLibrary Reports Queue Options Maint Home

Report: 0843D Standard Surveys Exceed Interval

**Geographical Breakdown:**  Nation  Region  State

**States:** Alabama, Alaska, American Samoa, Arizona, Arkansas

**Provider Categories:** 01-Hospital, 08-Outpatient Physical Therapy/Speech Pathology, 09-End Stage Renal Disease Facility, 12-Rural Health Clinic, 14-Comprehensive Outpatient Rehab Facility, 15-Ambulatory Surgical Center, 16-Hospice

\* To select multiple items, hold down the Ctrl key and click the desired items

[Back](#) [Next](#)

From the 0843D – Standard Surveys Exceed Interval page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.

Skip navigation links

CASPER Reports Submit [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Report: 0843D Standard Surveys Exceed Interval

Date Criteria:  
Certification thru: 09/30/

Provider Deemed Status:  Deemed  Non-Deemed  Both

Template Folder: My Favorite Reports  
Template Name: 0843D Standard Surveys Exceed Interval

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Folders Icon.

Skip navigation links

CASPER Reports Submit [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Queueing Report QID:82793164 Name:0843D Standard Surveys Exceed Interval for user JCONAWAY  
Completed reports will appear in your inbox on the Folders page.

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

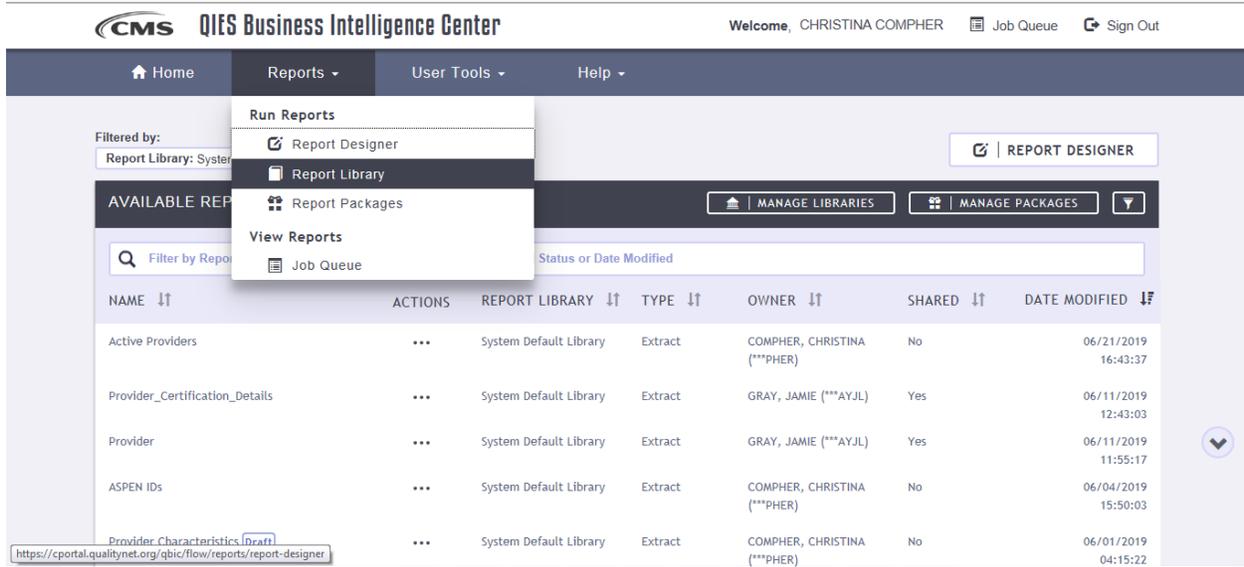
Once all reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.

Skip navigation links [Skip to Content](#)

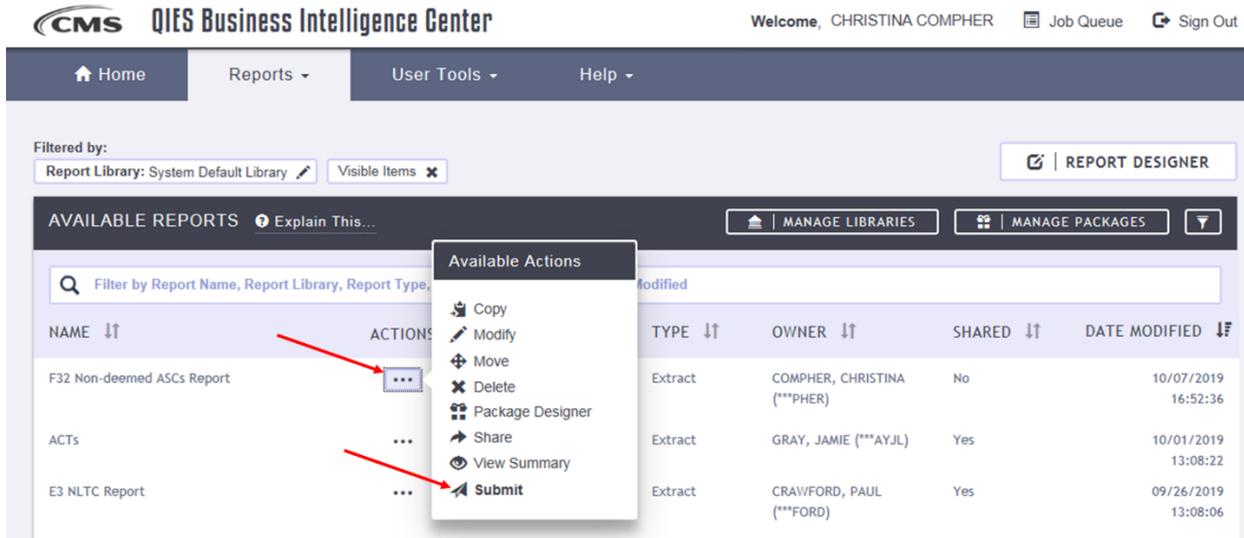
CASPER Folders [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Info	Click Link to View Report	Date Requested	Select
	0841D Providers Surveyed	07/11/2019 11:52:58	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/11/2019 08:47:48	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/11/2019 08:41:31	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/11/2019 03:11:30	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/11/2019 02:33:19	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 23:14:46	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/10/2019 21:59:40	<input type="checkbox"/>
	0841D Providers Surveyed	07/10/2019 21:59:03	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 21:57:01	<input type="checkbox"/>
	0821D ICF/ID Providers Surveyed	07/10/2019 21:47:36	<input type="checkbox"/>
	0821D ICF/ID Providers Surveyed	07/10/2019 21:41:33	<input type="checkbox"/>
	0821D ICF/ID Providers Surveyed	07/10/2019 21:27:57	<input type="checkbox"/>
	0820S ICF/ID Standard Survey Summary	07/10/2019 21:16:57	<input type="checkbox"/>

Enter QBIC  
 Select the Reports drop-down menu. Select the Reports Library



Click on the three dots beside the F32 Non-deemed ASCs Report. Select Submit from the pop-up menu.



## Click Continue

**CMS QIS Business Intelligence Center** Welcome, CHRISTINA COMPHER Job Queue Sign Out

Home Reports User Tools Help

What report specifications would you like to use for the job submission? \* [Explain This...](#) \* indicates required field(s)

**Job Submission Parameters**

**Job Name:** \*  **Maximum Rows:**   Counts Only  Email Notification

**Job Description:** \*   
This report generates the active non-deemed ASC providers that were not surveyed in the previous four fiscal years. This report is needed to calculate

**Run Position:** \*

« Back to Previous Page Additional Steps: 1 Runtime Parameter pages. **CONTINUE** CANCEL

## Select the appropriate Geography-level. Click Continue.

Select Geography-level Data for Runtime Parameters \* [Explain This...](#) \* indicates required field

All - Nation CMS Region State State - County State - Region

**State Selection**

Filter by State Name...

SELECT ALL DESELECT ALL

ALABAMA ALASKA AMERICAN SAMOA ARIZONA ARKANSAS CALIFORNIA CANADA COLORADO CONNECTICUT DELAWARE

« Back to Previous Page **CONTINUE** CANCEL

In the Termination Date field, enter the first day of the upcoming fiscal year. For example, if calculating measures associated with Fiscal Year 2019, enter 10/01/2019. In the Survey Date fields, enter the first day of fiscal year four years prior to the current fiscal year as the Start Date and enter the last date of the previous fiscal year as the End Date. For example, if calculating measures associated with Fiscal Year 2019, enter 10/01/2014 as the Start Date and 09/30/2018 as the End Date. In the Original Participation Date field, enter the first day of fiscal year four years prior to the current fiscal year. For example, if calculating measures associated with Fiscal Year 2019, enter 10/01/2014.

Click Run Report

Report Name: F32 Non-deemed ASCs Report Runtime Parameter: Custom Conditions Step: 1 of 1

Enter values for Custom Runtime Parameters\* Explain This... \* indicates required field

Define Primary Run Time Parameters \*

NOTE: ALL REQUIRED PARAMETERS MUST BE DEFINED

**Termination or Expiration Date**

Run Time Prompt: \* Enter Termination or Expiration Date Date: \* MM/DD/YYYY

Operator: \* >= (Greater Than or Equal)

**Survey Date**

Run Time Prompt: \* Enter Survey Date Start Date: \* MM/DD/YYYY

Operator: \* NOT BETWEEN (Not Between) End Date: \* MM/DD/YYYY

**Original Participation Date**

Run Time Prompt: \* Enter Original Participation Date Date: \* MM/DD/YYYY

Operator: \* < (Less Than)

Back to Previous Page RUN REPORT CANCEL

Once the report begins running, the user will be auto-directed to the Job Queue. Once the report is available the Status will indicate Complete.

Home Reports User Tools Help

Welcome, CHRISTINA COMPHER Job Queue Sign Out

Filtered by: Limit Date: 10/01/2019 to 10/07/2019

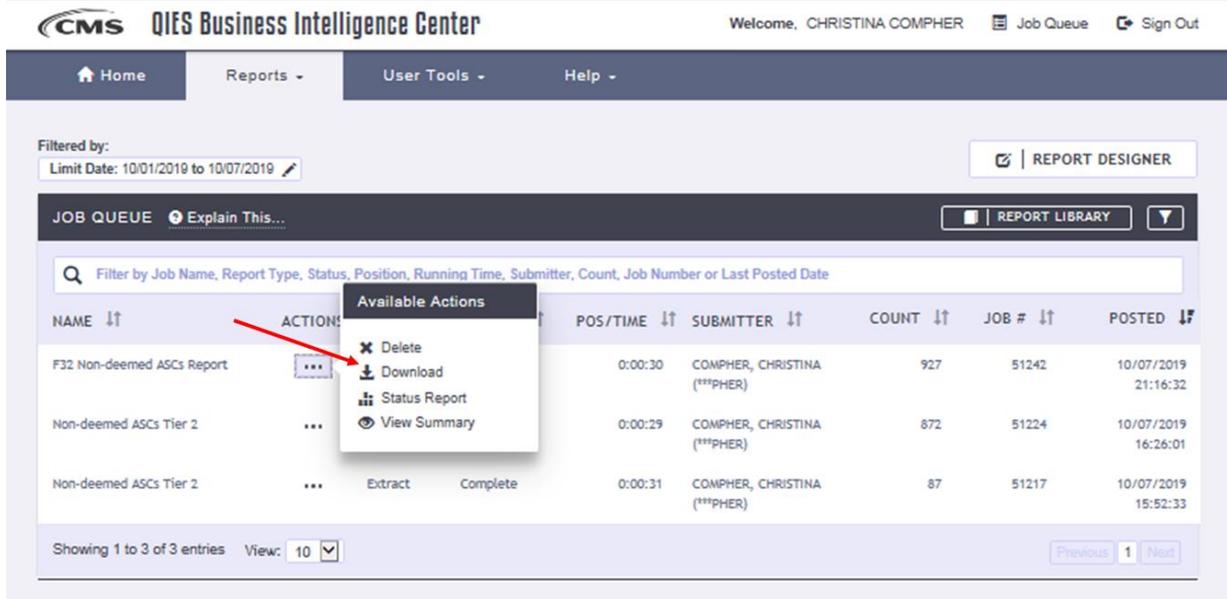
JOB QUEUE Explain This... REPORT DESIGNER REPORT LIBRARY

Filter by Job Name, Report Type, Status, Position, Running Time, Submitter, Count, Job Number or Last Posted Date

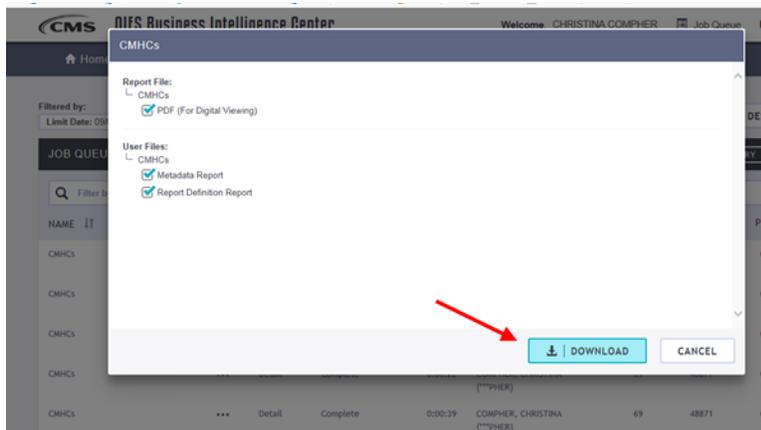
NAME	ACTIONS	TYPE	STATUS	POS/TIME	SUBMITTER	COUNT	JOB #	POSTED
F32 Non-deemed ASCs Report	...	Extract	Complete	0:00:30	COMPHER, CHRISTINA (***PHER)	927	51242	10/07/2019 21:16:32
Non-deemed ASCs Tier 2	...	Extract	Complete	0:00:29	COMPHER, CHRISTINA (***PHER)	872	51224	10/07/2019 16:26:01
Non-deemed ASCs Tier 2	...	Extract	Complete	0:00:31	COMPHER, CHRISTINA (***PHER)	87	51217	10/07/2019 15:52:33

Showing 1 to 3 of 3 entries View: 10 Previous 1 Next

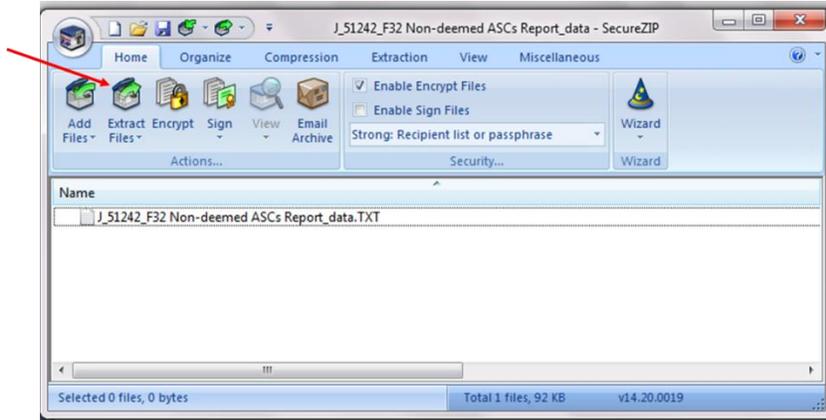
Click on the three dots beside the report and select Download.



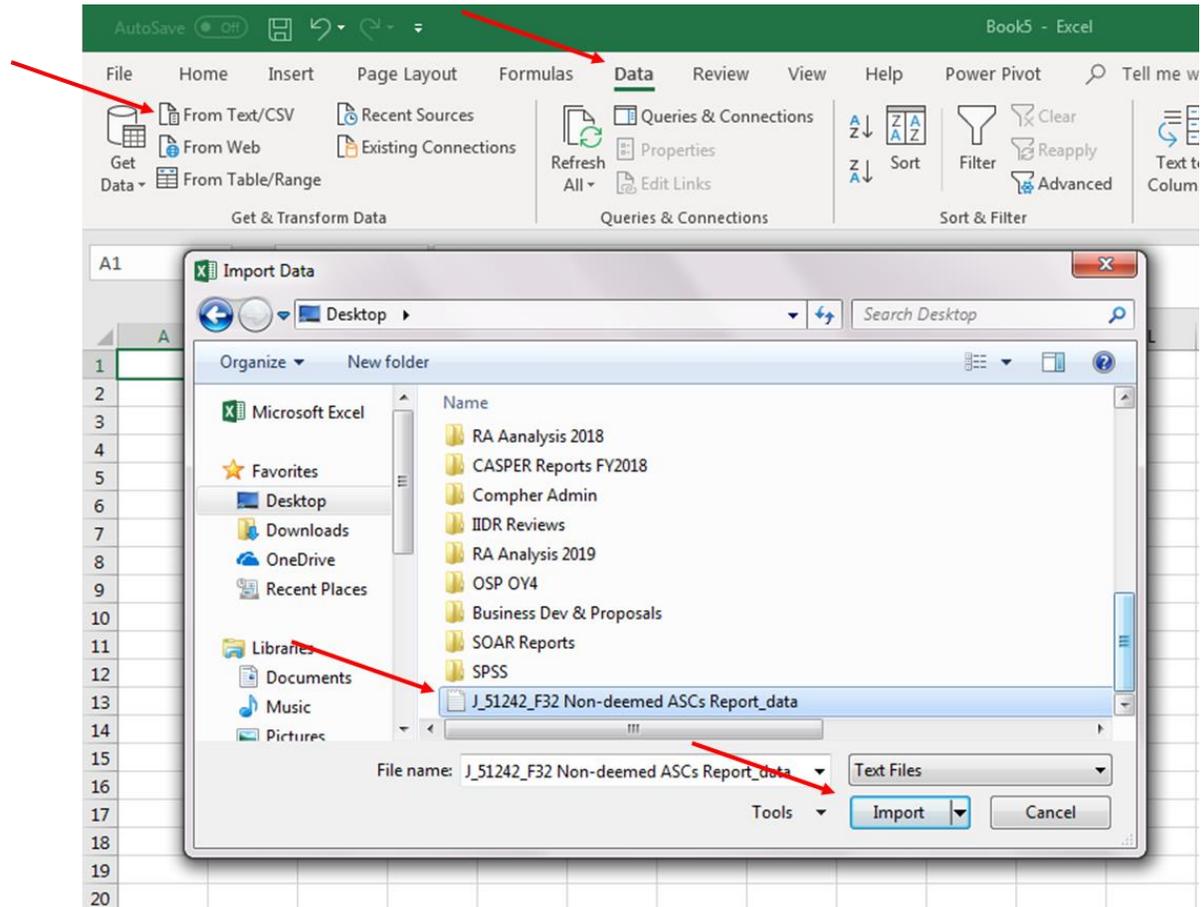
Click on Download



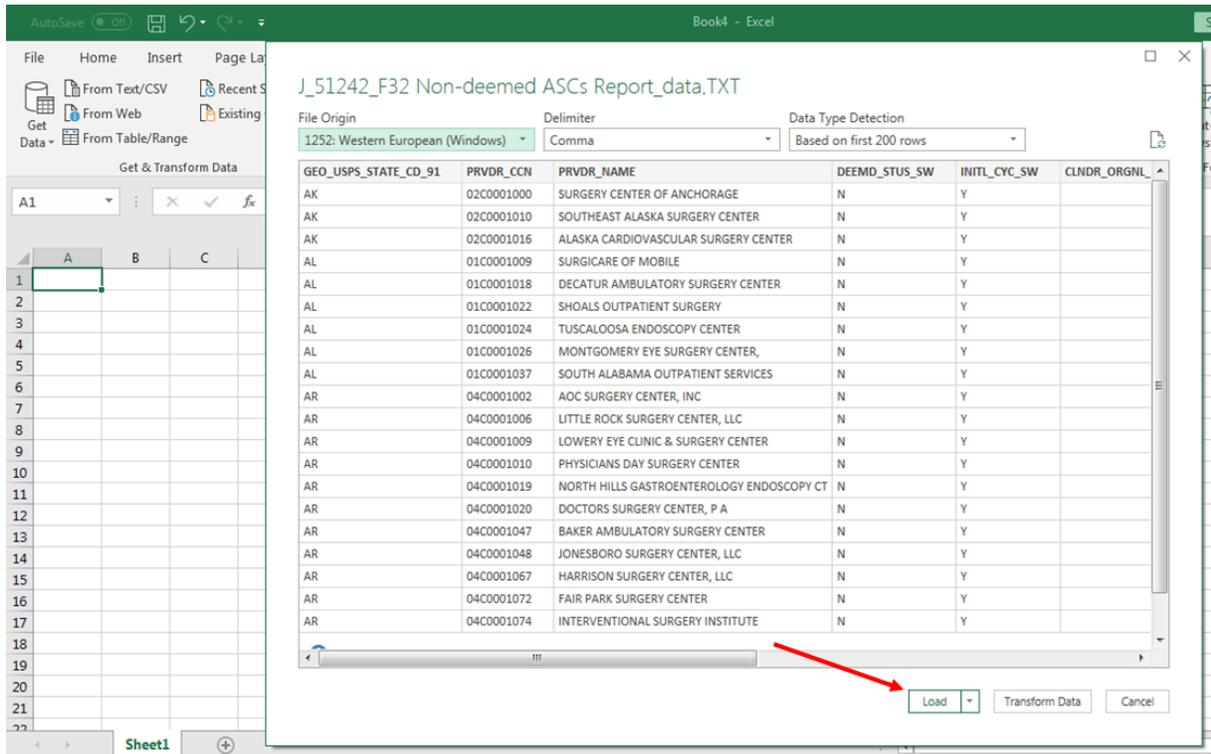
Once the zipped file has downloaded, click on the F32 Non-deemed ASCs Report data file and select Extract files to download the report. Extract the data file to a location on your Computer.



Open Excel and click on the Data tab. From the Data menu, click on From Text/CSV. From the pop-up menu, navigate to the F32 Non-deemed ASCs Report data file and select Import.



Once the data preview opens, click Load.



From the 0840S – Performance Standard Survey Summary, identify the "# of Active Providers" (call this [a]).



**CASPER Report 0840S**  
**Performance Standard Survey Summary**  
**Certification from 10/01/2017 thru 09/30/2018**  
**Ambulatory Surgical Center**  
**Non-Deemed**

Run Date: 07/11/2019  
 Job # 82796117  
 Last Update: 07/10/2019  
 Page 1 of 2

Region/ State	# of Active Providers	# of Providers Surveyed	% of Providers	Interval > 6 years	# of Providers Not Surveyed
01 CT	42	11	26.2	0	31
ME	13	4	30.8	0	9
MA	30	9	30.0	1	21
NH	15	5	33.3	0	10
RI	7	0	0.0	0	7
VT	0	0	0.0	0	0
<b>Region 01</b>	<b>107</b>	<b>29</b>	<b>27.1</b>	<b>1</b>	<b>78</b>
02 NJ	146	40	27.4	5	106
NY	43	9	20.9	1	34
PR	18	0	0.0	5	18
<b>Region 02</b>	<b>207</b>	<b>49</b>	<b>23.7</b>	<b>11</b>	<b>158</b>
03 DE	12	5	41.7	0	7
DC	3	0	0.0	0	3
MD	283	89	31.4	0	194

The F3.2 Non-deemed ASCs Report identifies the non-deemed ASCs that were not surveyed during the previous four fiscal years. Compare the ASCs identified on this report to the ASCs surveyed this year from the 0841D – Providers Surveyed report. Count the number of providers listed on the 0841D – Providers Surveyed report that are also listed on the F32 Non-deemed ASCs Report (call this [b]).



**CASPER Report 0841D**  
**Providers Surveyed**  
 Certification from 10/01/2018 thru 09/30/2019  
 Boston Regional Office - Connecticut  
 Ambulatory Surgical Center - Non-Deemed

Run Date: 10/07/2019  
 Job # 85570457  
 Last Update: 10/08/2019  
 Page 1 of 82

CCN	Survey in FY	Provider Name	City
07C0001004	10/28/2018	EYE SURGERY CENTER, THE	BLOOMFIELD
07C0001024	04/03/2019	FAIRFIELD SURGERY CENTER	FAIRFIELD
07C0001027	02/28/2019	CONNECTICUT G I ENDOSCOPY CTR	BLOOMFIELD
07C0001042	11/08/2018	MIDDLESEX ENDOSCOPY CENTER	MIDDLETOWN
07C0001048	03/27/2019	NORTH HAVEN SURGERY CENTER, LLC	NORTH HAVEN
07C0001053	07/10/2019	GLASTONBURY ENDOSCOPY CENTER, LLC	GLASTONBURY
07C0001060	01/31/2019	SOUTHINGTON SURGERY CENTER	SOUTHINGTON

Total Providers for Connecticut = 7  
 Total Providers for Boston Regional Office = 16  
 Total Providers for Nation = 822

GEO_USPS	STATE_CD	CD_91	PRVDR_CCN	PRVDR_NAME	DEEMD_STUS_SW	INITL_CYC_SW	CLNDR_ORGNL_PRTCPN_DT_SK	CLNDR_TRM
CT			07C0001004	EYE SURGERY CENTER, THE	N	Y	05/22/1986	null
CT			07C0001024	FAIRFIELD SURGERY CENTER	N	Y	03/27/2000	null
CT			07C0001027	CONNECTICUT G I ENDOSCOPY CTR	N	Y	09/08/2000	null
CT			07C0001034	FAIRFIELD COUNTY ENDOSCOPY CEN	N	Y	03/06/2003	null
CT			07C0001040	NAUGATUCK VALLEY ENDOSCOPY CENTER, LLC	N	Y	10/28/2004	null
CT			07C0001042	MIDDLESEX ENDOSCOPY CENTER	N	Y	05/17/2005	null
CT			07C0001048	NORTH HAVEN SURGERY CENTER, LLC	N	Y	05/24/2007	null
CT			07C0001053	GLASTONBURY ENDOSCOPY CENTER, LLC	N	Y	04/01/2009	null

To calculate the F3.2 ASC measure, divide [b] by [a] and multiply by 100

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

To meet these F3.2 performance measures, the percentage surveyed must be greater than or equal to 25 percent.

From the 0843D – Standard Surveys Exceed Interval, count the number of providers that exceeded the 6.0 year interval.



**CASPER Report 0843D**  
**Standard Surveys Exceed Interval**  
 Certification from 10/01/2017 thru 09/30/2018  
 Atlanta Regional Office - Georgia  
 Ambulatory Surgical Center  
 Non-Deemed

Run Date: 07/11/2019  
 Job # 82796310  
 Last Update: 07/10/2019  
 Page 1 of 1

CCN	Prior Survey	Years Between	Provider Name	City
11C0001341	08/25/2010	8.1	NORTHWEST ENDOSCOPY CENTER, LLC	MARIETTA
11C0001346	08/28/2010	7.9	GA UROLOGY, PA GWINNETT AMBULATORY SURGERY CTR	LAWRENCEVILLE
11C0001376	08/30/2011	7.0	GWINNETT SURGERY CENTER, LLC	LAWRENCEVILLE
11C0001379	02/07/2012	6.5	GASTROINTESTINAL DIAGNOSTIC ENDO WOODSTOCK, LLC	WOODSTOCK

Total Providers for Georgia = 4  
 Total Providers for Atlanta Regional Office = 12  
 Total Providers for Nation = 99

To calculate the F3.3 ASC measures, count the number of providers exceeding the maximum interval. To meet the F3.3 performance measures, the number of providers/suppliers that exceed the 6.0-year interval must equal zero.

## Notes - ASCs

If the State Survey Agency does not have any active providers/suppliers, then both F3.2 and F3.3 for that provider/supplier type would be scored as Nonapplicable.

States that have 7 or fewer non-deemed ASCs must survey at least one facility in the current FY unless all such ASCs were surveyed in the previous two FYs.

## ESRD Facilities

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### 1. Data Source(s)

CASPER Report 0841D – Providers Surveyed

CASPER Report 0842D – Providers Not Surveyed

CASPER Report 0843D – Standard Surveys Exceed Interval

CASPER Report 0846S – Targeted Providers ESRD Facility

### 2. Method

To calculate F3.2 and F3.3, the current FY Outcomes List must be downloaded from the secure DialysisData.org website and the 0841D – Providers Surveyed report must be generated for ESRD Facilities.

From DialysisData.org, login using your email address and password.

Select the Profiles tab

Download the State-specific Outcomes List by using the checkbox next to the respective States.

Select “Create Archive of Selected Reports”.

Enter File name and select Next.

Select link to download and view reports.

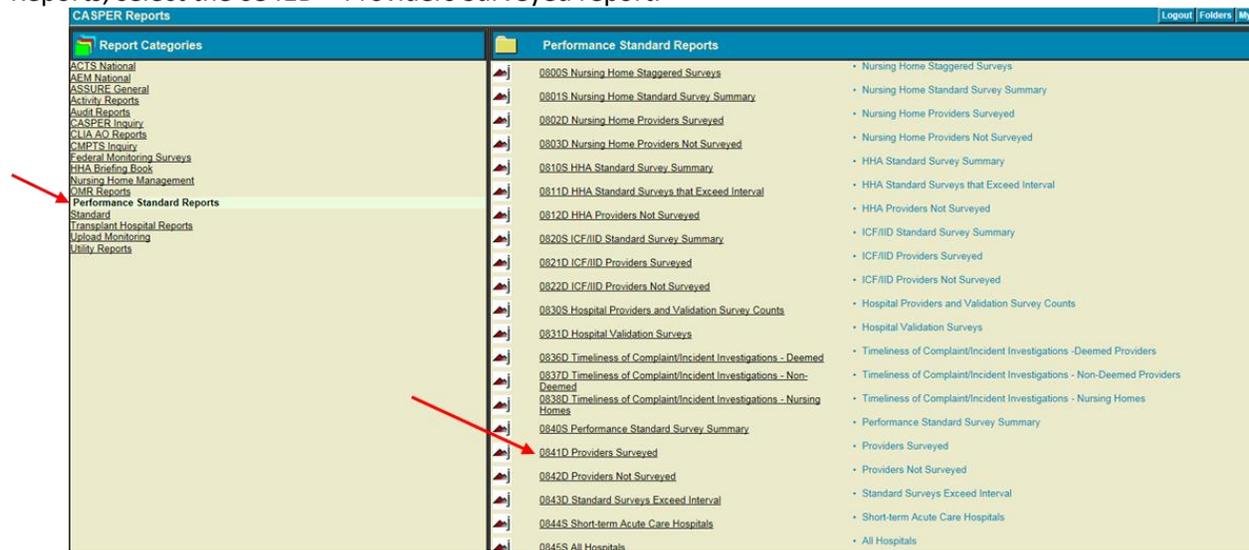
If there are no facilities in your State that were identified as a Tier 2 facility, then F3.2 for ESRD facilities would be scored as ‘not applicable’, likewise for Tier 3.

To calculate the F3.2 and F3.3 ESRD measures, the 0843D and 0846S reports must be generated for ESRDs.

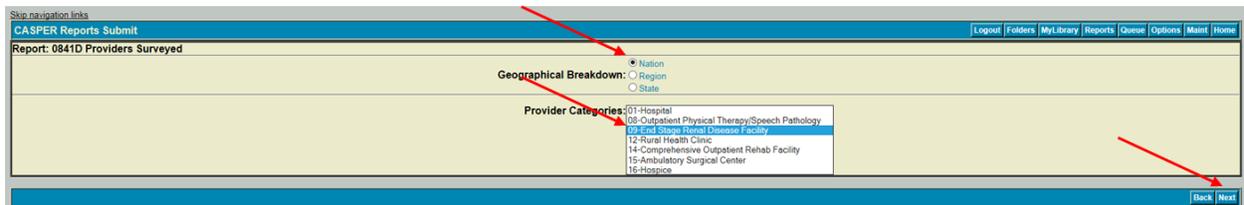
From the CASPER Home Page, select Reports.



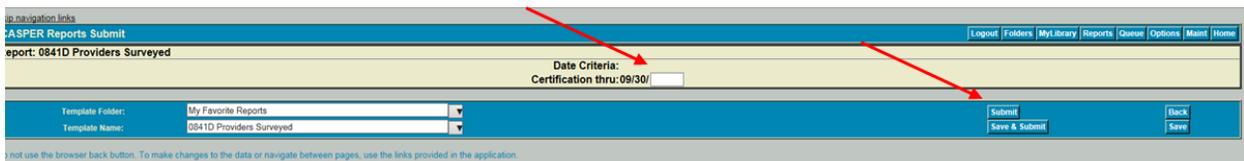
From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0841D – Providers Surveyed report.



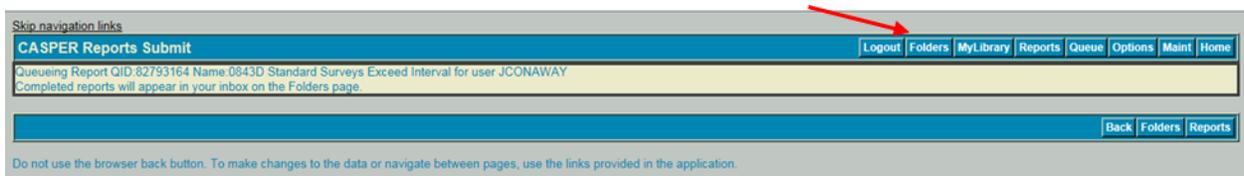
From the 0841D – Providers Surveyed page, select the 09 End State Renal Disease Facility. Then select Next.



From the 0841D – Providers Surveyed page, second screen, select the appropriate Fiscal Year. Then select Submit.



Once the report has been submitted, select the Folders Icon.



Once the report is completed, it will appear on the Folders Page. Click on the Report to either Open or Save them.

Click Link to View Report-	Date Requested-	Select-
0843D Standard Surveys Exceed Interval	10/01/2019 12:02:59	<input type="checkbox"/>
0841D Providers Surveyed	10/01/2019 11:58:10	<input type="checkbox"/>
0311S Survey Citation Patterns	09/29/2019 00:47:50	<input type="checkbox"/>
0350S Scope and Severity	09/29/2019 00:46:57	<input type="checkbox"/>
0705D Enforcement Case Counts	09/29/2019 00:32:14	<input type="checkbox"/>
0350S Scope and Severity	09/29/2019 00:28:26	<input type="checkbox"/>
0004D Provider Full Profile	09/28/2019 23:28:17	<input type="checkbox"/>
0803D Nursing Home Providers Not Surveyed	09/28/2019 23:04:23	<input type="checkbox"/>
0843D Standard Surveys Exceed Interval	09/28/2019 22:55:44	<input type="checkbox"/>
0844S Short-term Acute Care Hospitals	09/28/2019 22:54:49	<input type="checkbox"/>
0845S All Hospitals	09/28/2019 22:54:08	<input type="checkbox"/>

Using the State-specific Outcomes List, determine the number of facilities that were identified as a Tier 2 facility (call this [a]).

Calculate the number of ESRD facilities surveyed from the 0841D – Providers Surveyed report that were surveyed during the FY and are considered to be a Tier 2 facility. (call this [b]).

To calculate the F3.2 ESRD Facility measure, divide [b] by [a] and multiply by 100.

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

To meet the F3.2 performance measure, the percentage surveyed must be equal to 100 percent.

To calculate the F3.3 ESRD measure, count the number of providers exceeding the maximum interval. To meet the F3.3 performance measure, the number of providers/suppliers that exceed the 3.5-year interval must equal zero.

### Notes - ESRD

If the State Survey Agency does not have any active ESRDs, then F3.2 and F3.3 are nonapplicable for ESRDs.

## Non-Deemed Hospitals (NDH)

### 1. Data Source(s)

- CASPER Report 0841D – Providers Surveyed
- CASPER Report 0842D – Providers Not Surveyed
- CASPER Report 0845S – All Hospitals, including psychiatric hospitals

### 2. Method

To calculate the F3.2 and F3.3 non-deemed hospitals measures, the 0844S and 0845S reports must be generated.

From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0844S – Short-term Acute Care Hospitals report.



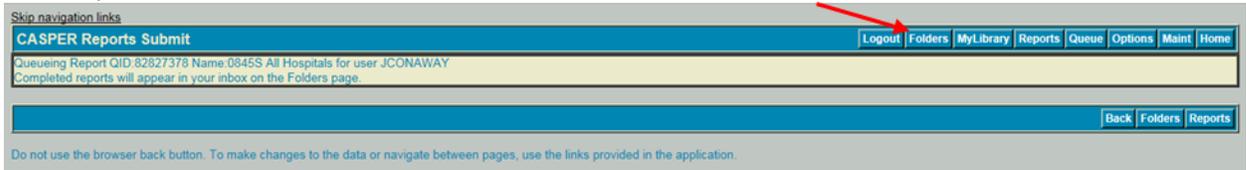
From the 0844S – Short-term Acute Care Hospitals page, select the appropriate Fiscal Year. Then select Submit.

Once the report has been submitted, select the Reports Icon to return to the Reports Page to run the 0845S – All Hospitals report.

From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select the 0845S – All Hospitals report.

From the 00845S – All Hospitals page, select the appropriate Fiscal Year. Then select Submit.

Once the report has been submitted, select the Folders Icon.



Once all reports are completed, they will appear on the Folders Page. Click on each Report to either Open or Save them.



From the 0844S – Short Term Acute Care Hospitals report, identify the " percent of providers surveyed."



**CASPER Report 0844S**  
**Short-term Acute Care Hospitals**  
**Certification from 10/01/2017 thru 09/30/2018**  
**Non-Deemed**

Run Date: 07/11/2019  
 Job # 82826914  
 Last Update: 07/10/2019  
 Page 1 of 1

Region/ State	# of Active Providers	# of Providers Surveyed	% of Providers Surveyed	# of Providers Not Surveyed
01 CT	2	0	0.0	2
ME	1	0	0.0	1
MA	1	0	0.0	1
NH	1	0	0.0	1
RI	0	0	0.0	0
VT	1	0	0.0	1
<b>Region 01</b>	<b>6</b>	<b>0</b>	<b>0.0</b>	<b>6</b>
02 NJ	0	0	0.0	0
NY	10	1	10.0	9
PR	15	0	0.0	15
<b>Region 02</b>	<b>25</b>	<b>1</b>	<b>4.0</b>	<b>24</b>
03 DE	0	0	0.0	0
DC	0	0	0.0	0
MD	1	0	0.0	1
PA	19	3	15.8	16

From the 0845S – All Hospitals report, identify the number of providers that exceeded the 5.0 year interval.

		CASPER Report 0845S All Hospitals Certification from 10/01/2017 thru 09/30/2018 Non-Deemed		Run Date: 06/28/2019 Job # 82367639 Last Update: 06/27/2019 Page 1 of 1	
Region/ State	# of Active Providers	# of Providers Surveyed	Interval > 4 years	Interval > 5 years	
01 CT	3	0	0	0	
ME	16	3	0	0	
MA	5	2	0	0	
NH	13	1	0	0	
RI	0	0	0	0	
VT	8	3	0	0	
<b>Region 01</b>	<b>45</b>	<b>9</b>	<b>0</b>	<b>0</b>	
02 NJ	4	1	0	0	
NY	18	2	4	1	
PR	17	0	12	12	
<b>Region 02</b>	<b>39</b>	<b>3</b>	<b>16</b>	<b>13</b>	
03 DE	0	0	0	0	
DC	1	0	0	0	
MD	1	0	0	0	
PA	42	10	0	0	

To calculate the F3.3 non-deemed hospital measure, identify the percentage of short term care acute care hospitals surveyed and count the number of providers exceeding the maximum interval.

To meet the F3.2 performance measure, the number of Short Term Acute Care hospitals surveyed is greater than 5 percent and the number of providers/suppliers that exceed the 5.0 year interval must equal zero.

From the 0845S – All Hospitals report, identify the number of providers that exceeded the 4.0 year interval.

		CASPER Report 0845S All Hospitals Certification from 10/01/2017 thru 09/30/2018 Non-Deemed		Run Date: 06/28/2019 Job # 82367639 Last Update: 06/27/2019 Page 1 of 1	
Region/ State	# of Active Providers	# of Providers Surveyed	Interval > 4 years	Interval > 5 years	
01 CT	3	0	0	0	
ME	16	3	0	0	
MA	5	2	0	0	
NH	13	1	0	0	
RI	0	0	0	0	
VT	8	3	0	0	
<b>Region 01</b>	<b>45</b>	<b>9</b>	<b>0</b>	<b>0</b>	
02 NJ	4	1	0	0	
NY	18	2	4	1	
PR	17	0	12	12	
<b>Region 02</b>	<b>39</b>	<b>3</b>	<b>16</b>	<b>13</b>	
03 DE	0	0	0	0	
DC	1	0	0	0	
MD	1	0	0	0	
PA	42	10	0	0	

To calculate the F3.3 non-deemed hospital measure, count the number of providers exceeding the maximum interval.

To meet the F3.3 performance measure, the number of providers/suppliers that exceed the 4.0 year interval must equal zero.

**Notes – Non-deemed Hospitals**

If the State Survey Agency does not have any active NDHs, then F3.2 and F3.3 for non-deemed hospitals are scored as Nonapplicable.

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

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

# Psychiatric Residential Treatment Facilities (PRTFs)

## 1. Data Source(s)

CASPER Report 0840S – Performance Standard Survey Summary

## 2. Method

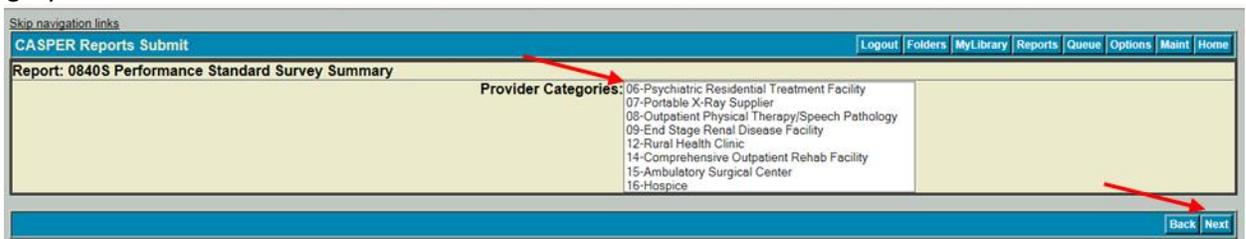
To calculate the F3.2 PRTF measure, the 0840S report must be generated for PRTFs. From the CASPER Home Page, select Reports.



From the CASPER Reports Categories select Performance Reports. From the Performance Standards Reports, select 0840S – Performance Standard Survey Summary.



From the 0840S – Performance Standard Survey Summary page, select the appropriate provider category. Then select Next.



From the 0840S – Performance Standard Survey Summary page, second screen, select the appropriate Fiscal Year and select the Provider Deemed Status non-deemed. Then select Submit.

Skip navigation links

**CASPER Reports Submit** [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Report: 0840S Performance Standard Survey Summary

Date Criteria:  
Certification thru: 09/30/

Provider Deemed Status:  Deemed  Non-Deemed  Both

Template Folder: My Favorite Reports    
 Template Name: 0840S Performance Standard Survey Summary

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report has been submitted, select the Folders Icon.

Skip navigation links

**CASPER Reports Submit** [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Queueing Report QID:82793164 Name:0843D Standard Surveys Exceed Interval for user JCONAWAY  
 Completed reports will appear in your inbox on the Folders page.

[Folders](#) [Reports](#)

Do not use the browser back button. To make changes to the data or navigate between pages, use the links provided in the application.

Once the report is completed, it will appear on the Folders Page. Click on the Report to either Open or Save it.

Skip navigation links\_Skip to Content

**CASPER Folders** [Logout](#) [Folders](#) [MyLibrary](#) [Reports](#) [Queue](#) [Options](#) [Maint](#) [Home](#)

Info+	Click Link to View Report+	Date Requested+	Select+
	0843D Standard Surveys Exceed Interval	07/11/2019 02:33:19	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 23:14:46	<input type="checkbox"/>
	0843D Standard Surveys Exceed Interval	07/10/2019 21:59:40	<input type="checkbox"/>
	0841D Providers Surveyed	07/10/2019 21:59:03	<input type="checkbox"/>
	0840S Performance Standard Survey Summary	07/10/2019 21:57:01	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:47:36	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:41:33	<input type="checkbox"/>
	0821D ICF/IID Providers Surveyed	07/10/2019 21:27:57	<input type="checkbox"/>
	0820S ICF/IID Standard Survey Summary	07/10/2019 21:16:57	<input type="checkbox"/>
	0810S HHA Standard Survey Summary	07/10/2019 20:31:02	<input type="checkbox"/>
	0811D HHA Standard Surveys that Exceed Interval	07/10/2019 20:30:08	<input type="checkbox"/>

From the 0840S – Performance Standard Survey Summary report, identify the number of providers that exceeded the 5.0 year interval.



**CASPER Report 0840S**  
**Performance Standard Survey Summary**  
 Certification from 10/01/2018 thru 09/30/2019  
 Psychiatric Residential Treatment Facility

Run Date: 09/13/2019  
 Job # 84861019  
 Last Update: 09/12/2019  
 Page 1 of 2

Region/ State	# of Active Providers	# of Providers Surveyed	% of Providers	Interval > 5 years	# of Providers Not Surveyed
01 CT	4	1	25.0	0	3
ME	0	0	0.0	0	0
MA	0	0	0.0	0	0
NH	0	0	0.0	0	0
RI	0	0	0.0	0	0
VT	0	0	0.0	0	0
<b>Region 01</b>	<b>4</b>	<b>1</b>	<b>25.0</b>	<b>0</b>	<b>3</b>
02 NJ	0	0	0.0	0	0
NY	20	4	20.0	7	16
PR	0	0	0.0	0	0
<b>Region 02</b>	<b>20</b>	<b>4</b>	<b>20.0</b>	<b>7</b>	<b>16</b>
03 DE	0	0	0.0	0	0
DC	0	0	0.0	0	0

To calculate the F3.2 PRTF measure, count the number of providers exceeding the maximum interval.

To meet the F3.2 performance measure, the percentage of providers/suppliers that are within the 5.0 year interval must be at least 20%.

# Community Mental Health Centers (CMHCs)

## 1. Data Source(s)

QBIC - CMHCs

## 2. Method

Enter QBIC

Select the Reports drop-down menu. Select the Reports Library

The screenshot displays the QIES Business Intelligence Center interface. At the top, the header includes the CMS logo, the text "QIES Business Intelligence Center", and a user welcome message: "Welcome, CHRISTINA COMPHER". There are also links for "Job Queue" and "Sign Out". The main navigation bar contains "Home", "Reports", "User Tools", and "Help". The "Reports" menu is open, showing options: "Run Reports" (with sub-items "Report Designer" and "Report Library"), "Report Packages", and "View Reports" (with sub-item "Job Queue").

Below the menu, there is a section for "AVAILABLE REPORTS". It includes a search bar "Filter by Report" and a "Status or Date Modified" filter. A table lists the following reports:

NAME	ACTIONS	REPORT LIBRARY	TYPE	OWNER	SHARED	DATE MODIFIED
Active Providers	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/21/2019 16:43:37
Provider_Certification_Details	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 12:43:03
Provider	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 11:55:17
ASPEN IDs	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/04/2019 15:50:03
Provider Characteristics (Draft)	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/01/2019 04:15:22

A URL is visible at the bottom left: <https://portal.qualitynet.org/qbic/flow/reports/report-designer>

Click on the three dots beside the CMHCs Report. Select Submit from the pop-up menu.

Success: The sharing options for CMHCs have been successfully saved.

Filtered by: Report Library: System Default Library Visible Items

REPORT DESIGNER

AVAILABLE REPORTS Explain This...

MANAGE LIBRARIES MANAGE PACKAGES

Filter by Report Name, Report Library, Report Type

NAME	ACTIONS	TYPE	OWNER	SHARED	DATE MODIFIED
CMHCs	...	Detail	COMPHER, CHRISTINA [***PHER]	Yes	09/13/2019 16:49:35
NH Surveys	...	Extract	COMPHER, CHRISTINA [***PHER]	No	09/12/2019 12:24:58
ACTS	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/20/2019 12:21:33
E3 NLTC Report	...	Extract	CRAWFORD, PAUL [***FORD]	Yes	08/12/2019 12:51:48
Deficiencies	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/07/2019 12:45:24
Surveys	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/07/2019 12:42:11
ACTS Allegation Detail	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/07/2019 12:38:05
Provider	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/07/2019 12:33:49
Provider_Certification_Details	...	Extract	GRAY, JAMIE [***AY,J]	Yes	08/07/2019 12:31:34

Available Actions

- Copy
- Modify
- Move
- Delete
- Package Designer
- Share
- View Summary
- Submit

Click Run Report

What report specifications would you like to use for the job submission? Explain This... \* indicates required field(s)

Job Submission Parameters

Job Name: \*  
CMHCs

Maximum Rows: \*  
Enter Maximum Row Count

Counts Only   
Email Notification

Job Description: \*  
CMHCs

Run Position: \*  
ASAP

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Back to Previous Page

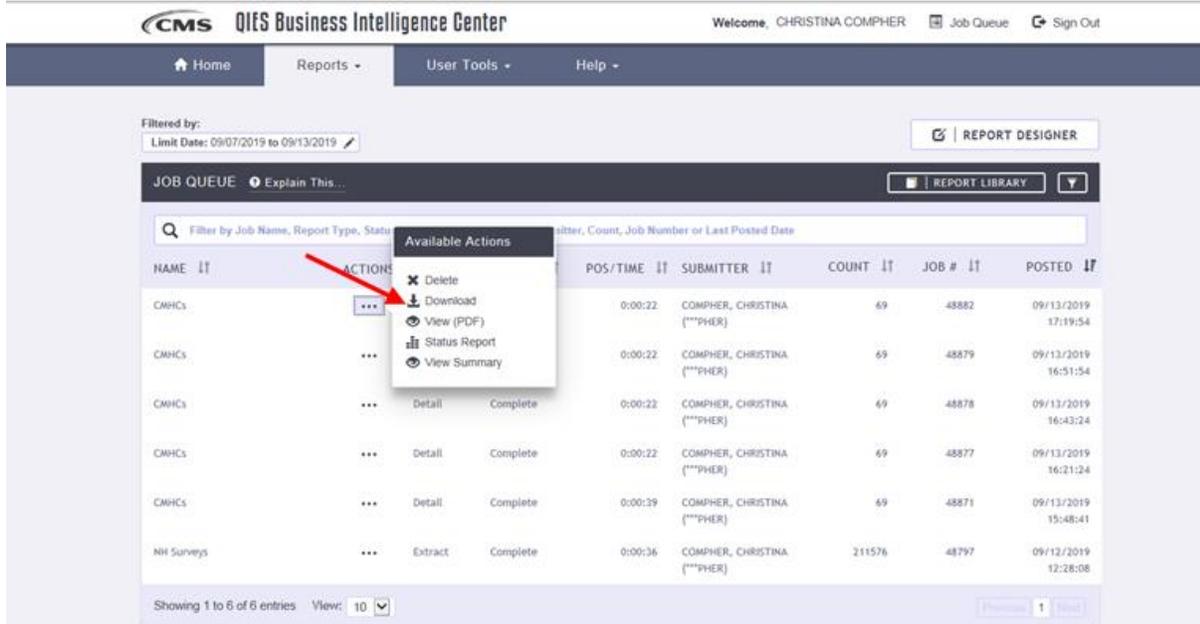
RUN REPORT CANCEL

Once the report begins running, the user will be auto-directed to the Job Queue. Once the report is available the Status will indicate Complete.



NAME	ACTIONS	TYPE	STATUS	POS/TIME	SUBMITTER	COUNT	JOB #	POSTED
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48882	09/13/2019 17:19:54
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48879	09/13/2019 16:51:54
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48878	09/13/2019 16:43:24
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48877	09/13/2019 16:21:24
CMHCs	...	Detail	Complete	0:00:29	COMPHER, CHRISTINA	69	48871	09/13/2019

Click on the three dots beside the report and select Download.



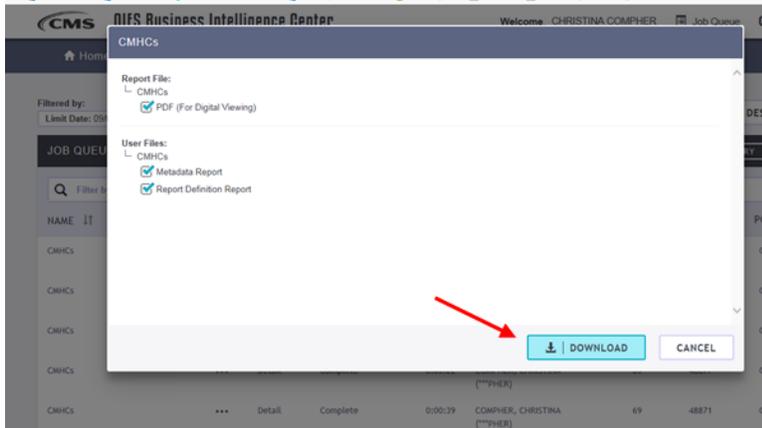
Available Actions

- Delete
- Download
- View (PDF)
- Status Report
- View Summary

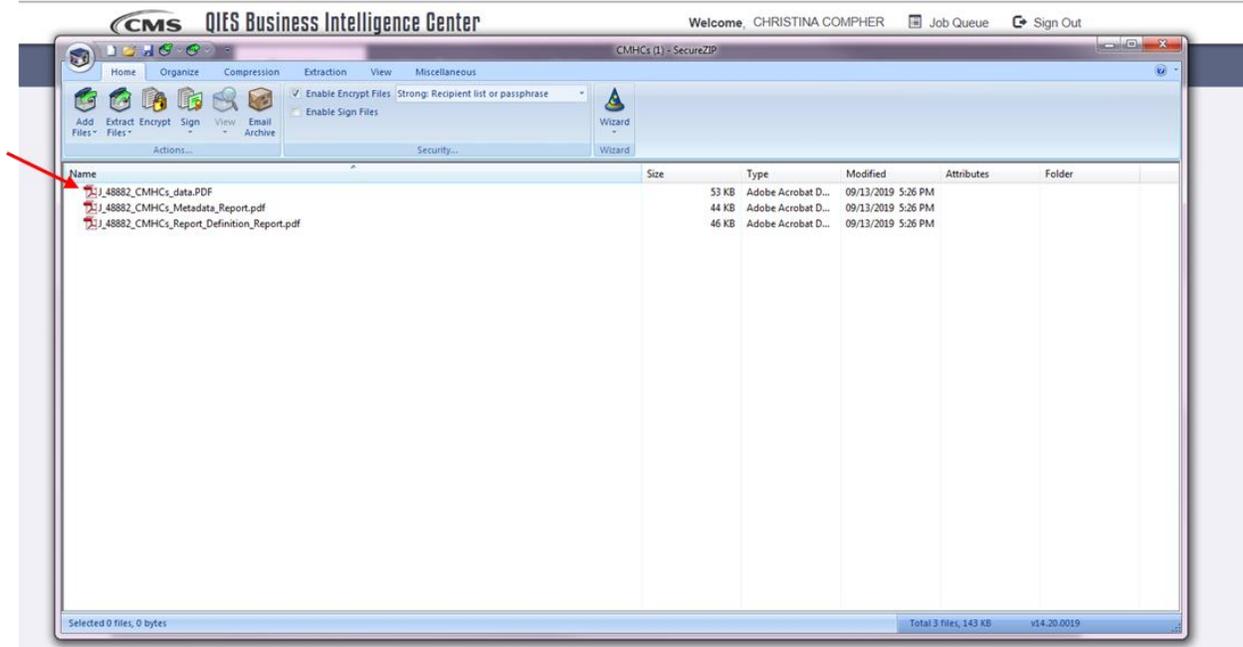
NAME	ACTIONS	TYPE	STATUS	POS/TIME	SUBMITTER	COUNT	JOB #	POSTED
CMHCs	...			0:00:22	COMPHER, CHRISTINA ("PHER)	69	48882	09/13/2019 17:19:54
CMHCs	...			0:00:22	COMPHER, CHRISTINA ("PHER)	69	48879	09/13/2019 16:51:54
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48878	09/13/2019 16:43:24
CMHCs	...	Detail	Complete	0:00:22	COMPHER, CHRISTINA ("PHER)	69	48877	09/13/2019 16:21:24
CMHCs	...	Detail	Complete	0:00:29	COMPHER, CHRISTINA ("PHER)	69	48871	09/13/2019 15:48:41
NH Surveys	...	Extract	Complete	0:00:36	COMPHER, CHRISTINA ("PHER)	211576	48797	09/12/2019 12:28:08

Showing 1 to 6 of 6 entries View: 10

Click on Download



Once the zipped file has downloaded, click on the CMCH data file and select Open from the pop-up menu..



From the CMHC Report, identify the number of providers that exceeded the 5.0 year interval within the appropriate State.

**CMHCs**

CERTIFICATION STATE ABBREVIATION	CCN	FACILITY NAME	CERTIFICATION DATE	# Years Between Surveys
AZ	034662	FRIENDSHIP COMMUNITY MENTAL HEALTH CENTER	08/14/2018	2.1
AZ	034664	HD RECOVERY AND WELLNESS CENTER	02/05/2019	1.7
CA	054654	LA CHEM BEHAVIORAL HEALTH SERVICES, VALPER CMHC	06/25/2015	5.1
CA	054662	PORTIA BELL HOME BEHAV HLTH &	01/19/2017	3.7
CT	074609	RUSHFORD CENTER INC	08/26/2016	4.1
FL	101437	HEALTHY CONNECTIONS CMHC INC	05/01/2018	2.4
FL	101447	ST PETE BEHAVIORAL HEALTH CENTER INC	02/15/2019	1.6
FL	101454	DADE FAMILY COUNSELING CMHC, INC	08/31/2016	4.1
FL	104768	CORAL CMHC	06/05/2019	1.3
FL	104664	NEW ERA HEALTH CENTER	06/02/2019	1.2
FL	684603	MORNING STAR CENTERS, INC	07/13/2017	3.2
FL	684614	CENTRAL FLORIDA RECOVERY CENTERS INC	02/07/2017	3.6
FL	684616	PEACEFUL RIDGE RECOVERY LLC	04/12/2018	2.5
FL	684617	TRANSITION HOUSE INC, THE	08/15/2018	2.1
FL	684618	TRANSITION HOUSE INC, THE	09/26/2018	2.0
FL	684619	COMMUNITY CONNECTIONS FOR LIFE INC	10/18/2018	2.0
GA	114623	TANOU INC- WATERS PLACE	06/18/2015	5.3
GA	114624	TANOU INC-FORSYTH STREET	04/14/2015	5.5
GA	114625	POSITIVE GROWTH INTERVENTION & EDUCATION CENTER	04/30/2015	5.4
GA	114626	POTTER HOUSE FAMILY & CHILDREN TREATMENT CTR	06/26/2017	3.3
GA	114627	BROADVIEW CENTER - BEHAVIORAL HEALTH SERVICES	12/15/2017	2.8
GA	114628	ATLANTA QUALITY CARE SOLUTIONS, LLC	06/08/2018	2.3
IL	144649	ROBERT YOUNG CENTER	07/23/2015	5.2
IL	144650	ALEXAN BROTHERS CENTER FOR MENTAL HEALTH	07/31/2015	5.2
NY	144666	188PDR1 R	06/16/2017	1.1

To calculate the Tier 2 and Tier 3 F3.3 CMHC measures, count the number of providers exceeding the maximum interval.

The Tier 2 CMHC measure is 5% targeted sample surveys. The Tier 3 measure is 20% of providers in a 5.0-year interval.

## Appendix 5: F4 Timeliness of Upload into CASPER of Standard Surveys for Nursing Homes and Non-Deemed Hospitals

---

### 1. Data Source(s)

QCOR

### 2. Method

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

1. For nursing homes, enter QCOR and click on "Nursing Home Providers." For non-deemed hospitals, enter QCOR and click on "Hospital Providers."

Follow steps #2-4 for both nursing homes and hospitals.

2. Under "Survey Reports," click on "Frequency of Data Entry (F4)" link.
3. Enter the selection criteria for each field as described below and click "Run Report."
4. Year Type: "Fiscal Year" (default)
5. Begin Year: "2019" (default)
6. End Year: "2019" (default)
7. Display multiple years: "empty" (default)
8. Define Outliers: "70" days (default)
9. Provider Type(s): For nursing homes, select all four provider types.
10. After selecting "Run Report," the program then advances to a page providing results separately by Regional Office. The program creates rows below that Regional Office, separating the results by the State Survey Agencies in that Regional Office. The page will have the following columns:
  11. Region: Click once on your region name to get to the specific State Survey Agency in your Regional Office. When you click once on the State Survey Agency name, this provides a listing of all providers within that State Survey Agency that are outliers.
  12. Number of Surveys Entered
  13. Mean # of Days to Data Entry
  14. Data Entry Exceeds 70 Days (percent of Surveys)
  15. Print this page separating the results by State Survey Agency. Utilizing this QCOR output from the column marked "Number of Surveys Entered" and "Mean # of Days to Data Entry," record this data for nursing homes and non-deemed hospitals for each State Survey Agency.

To meet the F4 performance measures, the average is less than or equal to 70 calendar days for data entry of both nursing home and non-deemed hospital (including non-deemed CAHs) surveys.

## Appendix 6: F5. Special Focus Facilities for Nursing Homes

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### 1. Data Source(s)

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

### 2. Method

An active SFF must have **one standard survey at least each six months** from the time of selection into the SFF program.

Once a facility has been selected for the SFF program, the SA must conduct a standard survey within six months of that selection date, but with an interval of no more than 15.9 months from the last standard survey.

A reasonable degree of unpredictability in these surveys must be maintained.

For the purposes of the State Performance Standards, States must complete one standard survey at least each six months per SFF slot. Slots are determined by the number of SFFs assigned to each State as designated in policy memorandum S&C-17-20.

For example, if a State has five SFF slots, we would expect there would be 10 standard surveys conducted on the SFFs in that State in a given fiscal year, with each facility being surveyed at least once every six months. Similarly, if a State has one SFF slot, we would expect that there would be two standard surveys conducted on that SFF in a given fiscal year, with each survey conducted not less than once every six months.

When one SFF is removed either through termination or graduation, then another SFF is selected within 21 days as a replacement so all the SFFs slots are filled. For terminations, it would be 21 days from the effective date of termination. For graduations, it would be the date of the letter the State Survey Agency sent to the graduating SFF of its removal from the SFF program.

For example, if SFF-A graduates on March 1st and is replaced within two weeks by SFF-B, then SFF-B should have a standard survey no later than September 15th to meet both the requirements of the SFF program and the State Performance Standards. In this example, the standard survey was conducted within six months of the selection date and therefore would meet the requirement. However, if the second survey was not completed until October it would not meet the performance measure because the survey occurred in over six months. If the selection of a replacement SFF occurs after 21 days, the SA would not meet the performance measure.

LSC and EP surveys will be conducted at the same frequency as the health surveys (i.e., not less than once every six months).

# Appendix 7: Q1. Standard Survey. Documentation of Deficiencies for Nursing Homes, ICFs/IID and Non-deemed ESRD Facilities, HHAs, ASCs, Hospice, and Hospitals

---

## 1. Data Source(s)

- For nursing homes - The RO can include any of the following surveys in the sample, as long as at least 50% of the surveys include deficiencies that are no higher than Severity Level 2:
  - Enforcement cases that are transferred to the RO,
  - Comparative surveys, and
  - Random sample of surveys (CMS Central Office may assist in creating this sample of CMS-2567s from recertification surveys and tags to be reviewed).
- This review is conducted on standard surveys but does not include any resulting revisit surveys.

For non-nursing homes - CMS Central Office will create the sample of CMS-2567s from recertification surveys and tags to be reviewed.

## 2. Method

Regional offices will conduct a review mid-year and end-of-year.

### *Nursing Homes – Sample Characteristics*

Date Range:

The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.

The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Nursing Homes State Sample Size:

Total Surveys Conducted in the Previous FY	Mid-Year Review Sample Size	End-of-Year Review Sample Size	Total Sample Size
10 or fewer	All surveys by mid-year	All surveys after mid-year	All surveys
11 to 100	5 surveys	5 surveys	10 surveys
101 to 300	10 percent of surveys by mid-year	10 percent of surveys after mid-year	10 percent of surveys
Greater than 300	15 surveys	15 surveys	30 surveys

Note: Survey(s) refers to standard surveys conducted and uploaded to the national database  
If the survey sample size is a non-whole number, round to the nearest whole number.

The sample will only contain recertification surveys that found at least one deficiency at scope and severity of D or above.

Review a maximum of four tags at scope and severity of D or above for each case. If fewer than four tags at scope and severity of D or above exist, only review those tags.

Tag Selection Criteria:

- If the survey includes both a LSC component and an emergency preparedness (EP) component, at least one deficiency tag (at scope and severity of D or above) from each will be selected.
- If the survey includes only LSC components or EP components, select at least one LSC or EP tag at scope and severity of D or above.
- At least one **quality of care** tag will be selected, if present.
- At least one **immediate jeopardy** tag will be selected, if present.

**Non-Nursing Homes – Sample Characteristics**

Date Range:

- The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.
- The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Non-Nursing Homes — Sample Size per Provider Type:

Total Surveys Conducted in the previous FY	Mid-Year Review Sample Size	End-of-Year Review Sample Size	Total Sample Size
2 or fewer	All surveys by mid-year	All surveys after mid-year	All surveys
3 to 20	1 survey by mid-year	1 survey after mid-year	2 surveys
21-100	10 percent of surveys by mid-year	10 percent of surveys after mid-year	10 percent of surveys
100+	5 surveys	5 surveys	10 surveys

Note: The sample sizes indicated in this table are per non-nursing home provider type. For each State Agency, there will be up to 6 different samples of CMS-2567s to review.

Survey(s) refers to standard surveys uploaded to the national database

If zero surveys are conducted in a FY, the sample size is zero.

If the survey sample size is a non-whole number, round to the nearest whole number.

Up to 50 percent of the sample can include enforcement cases that are referred to the Regional Office.

This review should only be conducted on the first survey that began the enforcement case (LTC). The cases applicable to the mid- or end-year review will need to be submitted by Regional Offices prior to the beginning of the mid-year review or end-of-year review.

- For the mid-year and end-of-year reviews, select at least one survey for each non-nursing home provider type, if applicable, in accordance to the above table.
- The sample will only contain surveys that lead to a deficiency.
- The sample will exclude surveys for EMTALA cases.
- Four tags will be selected for review from each case in the sample. If there are four or fewer tags, all tags will be selected.
- Tag Selection Criteria:
- If the survey includes both a health LSC component and an emergency preparedness (EP) component, at least one deficiency tag from each will be selected. If the survey includes only an LSC or an EP (but not both), there should be a corresponding LSC tag or an EP tag.
- At least one condition-level deficiency tag per CMS-2567 in the sample will be selected, if present.

# Appendix 8: Q1. Complaint/FRI Surveys. Documentation of Deficiencies for Nursing Homes, ICFs/IID, ASCs, ESRD Facilities, HHAs, Hospice and Hospitals

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## 1. Data Source(s)

- For nursing homes - The RO can include any of the following surveys in the sample, as long as at least 50% of the surveys include deficiencies that are no higher than Severity Level 2:
  - Enforcement cases that are transferred to the RO,
  - Comparative surveys, and
  - Random sample of surveys (CMS Central Office may assist in creating this sample of CMS-2567s from recertification surveys and tags to be reviewed).
- This review is conducted on complaint surveys but does not include any resulting revisit surveys.

For non-nursing homes - CMS Central Office will create the sample of CMS-2567s from recertification surveys and tags to be reviewed.

## 2. Method

Regional offices will conduct a review mid-year and end-of-year.

### *Nursing Homes – Sample Characteristics*

Date Range:

- The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.
- The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Nursing Homes — State Sample Size:

Total Surveys Conducted in the previous FY	Mid-Year Review Sample Size	End-of-Year Review Sample Size	Total Sample Size
2 or fewer	All surveys by mid-year	All surveys after mid-year	All surveys
3 to 20	1 survey by mid-year	1 survey after mid-year	2 surveys
21-100	10 percent of surveys by mid-year	10 percent of surveys after mid-year	10 percent of surveys
Greater than 100	5 surveys	5 surveys	10 surveys

Note: Survey(s) refers to intake surveys conducted and uploaded to the national database  
If the survey sample size is a non-whole number, round to the nearest whole number.

This review should only be conducted on the first survey that began the enforcement case. These cases will need to be submitted by Regional Offices prior to the beginning of the end-of-year review.

The sample will only contain complaint or FRI surveys that found at least one deficiency at scope and severity of D or above.

Four tags will be selected for review from each case in the sample. If there are four or fewer tags, all tags will be selected.

Tag Selection Criteria:

- At least one quality of care tag will be selected, if present.
- At least one immediate jeopardy tag will be selected, if present.
- If the survey includes both a health LSC component and an emergency preparedness (EP) component, at least one deficiency tag from each will be selected. If the survey includes only an LSC or an EP (but not both), there should be a corresponding LSC tag or an EP tag.

**Non-Nursing Homes – Sample Characteristics**

Date Range:

- The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.
- The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Non-Nursing Homes — Sample Size per Provider Type:

Total Surveys Conducted in the previous FY	Mid-Year Review Sample Size	End-of-Year Review Sample Size	Total Sample Size
2 or fewer	All surveys by mid-year	All surveys after mid-year	All surveys
3 to 20	1 survey	1 survey	2 surveys
21-100	10 percent of surveys by mid-year	10 percent of surveys after mid-year	10 percent of surveys
100+	5 surveys	5 surveys	10 surveys

Note: The sample sizes indicated in this table are per non-nursing home provider type. For each State Agency, there will be up to 6 different samples of CMS-2567s to review.

Survey(s) refers to intake surveys uploaded to the national database

If zero surveys are conducted in a FY, the sample size is zero.

If the survey sample size results in a non-whole number, round to the nearest whole number.

Up to 50 percent of enforcement cases randomly selected that are referred to the Regional Office may be used.

- The sample will only contain surveys that lead to a deficiency.
- The sample will exclude surveys for EMTALA cases.
- Four tags will be selected for review from each case in the sample. If there are four or fewer tags, review all available tags.

Tag Selection Criteria:

- At least one condition-level deficiency tag per CMS-2567 in the sample will be selected, if present.
- If the survey includes both a health LSC component and an emergency preparedness (EP) component, at least one deficiency tag from each will be selected. If the survey includes only an LSC or an EP (but not both), there should be a corresponding LSC tag or an EP tag.

# Appendix 9: Q1 Conduct of Reviews and Review Requirements

## 1. Conducting the Reviews from the Random Sample

- Reviewers will review the deficiency tag text associated with each tag listed in SharePoint using the guidance criteria provided below to answer each question. Reviewers will review up to four tags for each survey. If the survey includes both a health LSC and EP component, there will be at least one deficiency tag from the LSC component and one deficiency tag from the EP component, if there is a tag cited, to count in the four tags.
- Reviewers should indicate a "Yes" or "No" for whether the deficiency tag text met each guidance criterion. The reviewer should base his or her rating on the written documentation on the CMS-2567 without assuming additional information.
- If a reviewer rates the deficiency tag text as not meeting the specific criterion ("No"), the reviewer must provide an explanation within the provided text field.
- NOTE: Further instructions for conducting reviews on these surveys as well as surveys that were part of an enforcement case or a comparative survey will be provided separately to the Regional Offices.

## 2. Review Requirements

The purpose of the review is to assess whether each tag on the CMS-2567 is consistent with the Federal regulation at which it was cited and contains sufficient information to support the finding of noncompliance. The sample of CMS-2567s for review may include contractor surveys that are arranged by the State Survey Agency but should exclude federal contractor surveys.

Review requirements, guidance, and references are summarized in tables 7 and 8. If Requirement 1 is scored "No" for a specific tag, all other requirements (2 through 5 for nursing homes and 2 and 5 for non-nursing homes) are scored "N/A" for that specific tag. Likewise, if Requirement 2 is scored "No" for a specific tag, all remaining requirements (4 and 5 for nursing homes and 5 for non-nursing homes) are scored "N/A" for that specific tag.

Requirements 1-2 are related to guidance found in the Principles of Documentation. Requirements 3-5 are related to the categorization of a deficiency as it relates to the documented findings.

**Table 7. Requirements for Principles of Documentation**

Requirement	Guidance and References
<p><b>1.</b> There is sufficient evidence on the CMS-2567 to support a citation.</p>	<p>Score Yes when:</p> <ul style="list-style-type: none"> <li>● There is evidence to support a citation of noncompliance.</li> <li>● All relevant what, who, where, when, and how questions are answered for the evidence that supports the finding of noncompliance:               <ul style="list-style-type: none"> <li>○ What entity practice was noncompliant;</li> <li>○ Who were the residents/patients/clients or staff involved;</li> <li>○ Where the deficient practice occurred, e.g., specific locations in the entity or documents;</li> <li>○ When (e.g., for how long) the problem occurred.</li> </ul> </li> </ul> <p>Additional Guidance:</p>

	<ul style="list-style-type: none"> <li>This criterion is scored “Yes” if you can understand how the evidence presented on the CMS-2567 supports a finding of noncompliance on the part of the provider, regardless of the regulation cited.</li> <li>If there are minor errors in the documentation that do not impact the ability to demonstrate noncompliance, this criterion should still be scored “Yes.”</li> <li>This criterion is scored “No” when the documentation of evidence is unclear or vague such that it impacts the ability to demonstrate noncompliance.</li> </ul>
2. The appropriate regulation was cited based on the evidence provided on the CMS-2567.	<p>Score Yes when:</p> <ul style="list-style-type: none"> <li>The noncompliance is cited at the correct requirement/condition.</li> </ul> <p>Additional Guidance:</p> <ul style="list-style-type: none"> <li>This criterion is scored “Yes” if the findings are appropriate for the tag being reviewed not necessarily what the deficient practice statement (DPS) indicates the facility failed to do.</li> <li>If the tag is appropriate but not necessarily the “best” tag, this criterion should be scored “Yes.”</li> <li>This criterion is also scored “No” when the tag is not appropriate for the noncompliance described.</li> </ul>

**Table 8. Requirements for Assessment of the Level of Deficiencies**

Requirement	Guidance and References
3. <i>Nursing homes only:</i> There is sufficient evidence to support the assigned severity rating as documented on the CMS-2567.	<p>Score Yes when:</p> <ul style="list-style-type: none"> <li>The evidence in the citation supports the assigned severity rating (severity is the level of outcome or potential/actual harm to residents).</li> </ul> <p>Additional Guidance: Refer to the SOM Chapter 7, section 7410.2.2; Long Term Care Survey Process Procedure Guide; Appendix PP for severity guidance on specific tags; and Appendix Q.</p>
4. <i>Nursing homes only:</i> The scope rating of the citation accurately reflects the number of residents who are, or may be, affected by the deficient practice as documented on the CMS-2567.	<p>Score Yes when:</p> <ul style="list-style-type: none"> <li>The evidence in the citation supports the assigned scope rating (isolated, pattern, or widespread) based on the number of residents who are, or may be, affected by the deficient practice.</li> </ul> <p>Additional Guidance: Refer to scope guidance in the Nursing Home Survey Resources folder on the CMS Website, Scope and Severity Grid document.</p>
5. <i>Non-nursing homes only:</i> The level of citation (Condition, Standard, or Element level) accurately reflects the evidence presented as documented on the CMS-2567.	<p>Score Yes when:</p> <ul style="list-style-type: none"> <li>The condition, standard, or element identifies noncompliance at the level cited and the actual and/or potential outcome to patients/clients. That is, the impact of the evidence/outcome is consistent with the level of citation.</li> </ul> <p>Additional Guidance:</p> <ul style="list-style-type: none"> <li>A condition-level deficiency is cited when “the deficiencies ... adversely affect the health and safety of patients.” 42 CFR §§ 488.24(b) and 488.26(b).</li> <li>If a condition-level deficiency exists, the CMS-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance.</li> </ul>

- 
- |  |  |
|--|--|
|  | <ul style="list-style-type: none"><li>○ If these practices refer to requirements specified at standards or other subsidiary requirements, the deficient practices and individual findings are cited at the relevant requirements.</li><li>○ The findings under these subsidiary requirements may be referenced under the condition-level citation.</li><li>● For a condition-level deficiency, the findings explain how the degree and manner of the deficient practice justifies a conclusion of noncompliance at the condition-level.</li><li>● When a condition-level deficiency is reviewed, the Regional Office reviews its accompanying standard or other subsidiary deficiency(ies).</li><li>● Each deficiency tag will be counted individually for this review (e.g., if one condition-level deficiency is reviewed with its two subsidiary deficiencies, this counts as three tags reviewed).</li></ul> |
|--|--|
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## **Appendix 10: Q2. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS**

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### **1. Data Source(s)**

Federal Monitoring Survey (FMS) Access Database

### **2. Method**

For Health concerns, the following report is generated from the FMS Access Database:

- Pass/Partial/Fail Ratings Per Concern Area. This report shows the percentage of concerns per State that either Meet, Partially Meet, or Fail FCS criteria for each concern area and the percentage among all concerns investigated. One report is generated for Health concerns and one is generated for LSC concerns.
- A State Survey Agency will receive an overall FOSS FCS score and a score for each concern area investigated in this FY. The overall FOSS FCS score is a composite measure of all current FY concern areas. A State Survey Agency meets this measure if it achieves a score of 80 percent or more. The FOSS FCS score for each individual concern area is constructed separately by concern area.

## Appendix 11: Q3. Identification of Health, LSC, and Emergency Preparedness (EP) Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results

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### 1. Data Source(s)

FMS database reports.

### 2. Method

#### *Citation Accuracy Chart*

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

#### **Notes**

The following circumstances are not considered in the scoring (i.e., do not count in the numerator or denominator):

- The State Survey Agency does not cite any tags and Regional Office determined the State Survey Agency should not have found the deficiency (Should Have Found (SHF) =No)
- The Regional Office was unable to determine if the deficiency should have been cited by State Survey Agency (SHF=unable to determine)
- The Regional Office was unable to determine if State Survey Agency understated the severity level (understatement=unable to determine)

For “F” SQC, the State Survey Agency had to cite the same findings at an “F” or higher to be scored as having cited at the same or higher severity

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

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

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

Lower Severity Includes deficiencies the State Survey Agency cited at severity levels 1, 2 or 3 that are at a severity level less than what the Regional Office cited and deficiencies that were not cited at all.

Similar findings mean that both the Federal and State survey findings included similar issues around the same topic areas, such as falls, pressure ulcers, infection control, etc. For example, both the State Survey Agency and Regional Office may cite F700. However, the findings would not be similar if the Regional Office identified only failure to prevent elopements and the State Survey Agency identified only failure to prevent falls.

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

### **Calculation**

There is only one calculation for this measure. It includes all the deficiencies that apply, i.e., health, emergency preparedness, and life safety code deficiencies are combined into one score.

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

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

$$\text{Percentage Agreement Rate} = \frac{\text{Numerator}}{\text{Denominator}} \times 100$$

## Appendix 12: Q4. Prioritizing Complaints and FRIs

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### 1. Data Source(s)

The Q4 sample is a random sample of intakes created by CMS Central Office. The reviewers are to use ASPEN Complaint/Incidents Tracking System (ACTS) and State Agency intake documentation in their assessment.

### 2. Method

Regional offices will conduct a review mid-year and end-of year.

#### *Conducting the Reviews*

- ▶ Reviewers should use the following sources to conduct their assessment:
  - Intake data in ACTS
  - State Survey Agency intake documentation, if available
- ▶ After completing the assessment, reviewers should assign a prioritization level using the criteria for each of the levels listed in Chapter 5, section 5075 of the SOM.
- ▶ If the SA assigned a higher prioritization level for an intake than the RO, the RO will not score this against the SA.
- ▶ NOTE: CMS may also request and review cases not entered into ACTS to determine if there are other intakes that were triaged appropriately. For example, based on low rates of intakes reported in the SPSS performance indicators, CMS may review intakes in state systems or documents to determine if there are other intakes that should have been entered in ACTS, and triaged and investigated appropriately.
- ▶ NOTE: Further instructions for conducting reviews on these intakes as well as intakes that were a part of an enforcement case that were transferred to the Regional Office or complaints/FRIs that were investigated during a comparative survey will be provided separately to the Regional Offices.

#### *Nursing Homes – Sample Characteristics*

Date Range:

- The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.
- The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Nursing Homes — State Sample Size:

Total Intakes Received in Prior Fiscal Year	Mid-Year Review	End-of-Year Review	Total Sample Size
10 or Less	All intakes by mid-year	All intakes after mid-year	All Intakes
11 to 100	5 intakes by mid-year	5 intakes after mid-year	10 intakes

101 to 400	10 percent of intakes by mid-year	10 percent of intakes after mid-year	10 percent of intakes
Greater than 400	20 intakes	20 intakes	40 intakes

Note: Intake(s) refers to intake surveys uploaded to the national database

If zero intakes are received in a FY, the sample size is zero.

If the intake sample size results in a non-whole number, round to the nearest whole number.

The sample includes complaints and FRIs, regardless of whether an onsite survey is conducted. Up to 50 percent of the sample may be composed of complaints/FRIs that are a part of an enforcement case that is transferred to the Regional Office or a comparative survey. These cases will need to be submitted by Regional Offices prior to the beginning of the end-of-year review.

***Non-Nursing Homes – Sample Characteristics***

Date Range:

- The mid-year review sample will be based on CMS-2567 dates from October 1, 2019 through March 31, 2020.
- The end-of-year review sample will be based on CMS-2567 dates from April 1, 2020 through September 30, 2020.

Non-Nursing Homes — Sample Size per Provider Type:

Total Intakes Received in Previous FY	Mid-Year Review	End-of-Year Review	Total Sample Size
2 or fewer	All intakes by mid-year	All intakes after mid-year	All intakes
3 to 20	1 intake by mid-year	1 intake after mid-year	2 intakes
21-100	10 percent of intakes by mid-year	10 percent of intakes after mid-year	10 percent of intakes
Greater than 100	5 intakes	5 intakes	10 intakes

Note: The sample sizes indicated in this table are per non-nursing home provider type. For each State Agency, there will be up to 6 different samples of CMS-2567s to review.

Intake(s) refers to intake surveys uploaded to the national database

If zero intakes are received in a FY, the sample size is zero.

If the intake sample size results in a non-whole number, round to the nearest whole number.

The sample will include complaints and FRIs, regardless of whether an onsite survey is conducted. Hospital Intakes with an allegation of restraint/seclusion death will be excluded. Intakes related to EMTALA and Organ Transplant Programs will be excluded.

## Appendix 13: Q5. Timeliness of Complaint and Facility Reported Incident Investigations

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### 1. Data Source(s)

ACTS Federal Investigation Timeframe Reports, or CASPER reports 0836D, 0837D, and 0838D

### 2. Method

The procedure for running the ACTS Federal Investigation Timeframe Reports is as follows:

- The time interval is measured from the “Received End Date” which is the date there was sufficient information to prioritize the complaint/incident.
- The Regional Office accounts for State holidays and office closures in its working day calculation.
- If the intake involves a Restraint/Seclusion Death for a hospital, the intake should be removed from the sample.
- Include all ACTS generated reports with the report that goes to the State Survey Agency for comment.

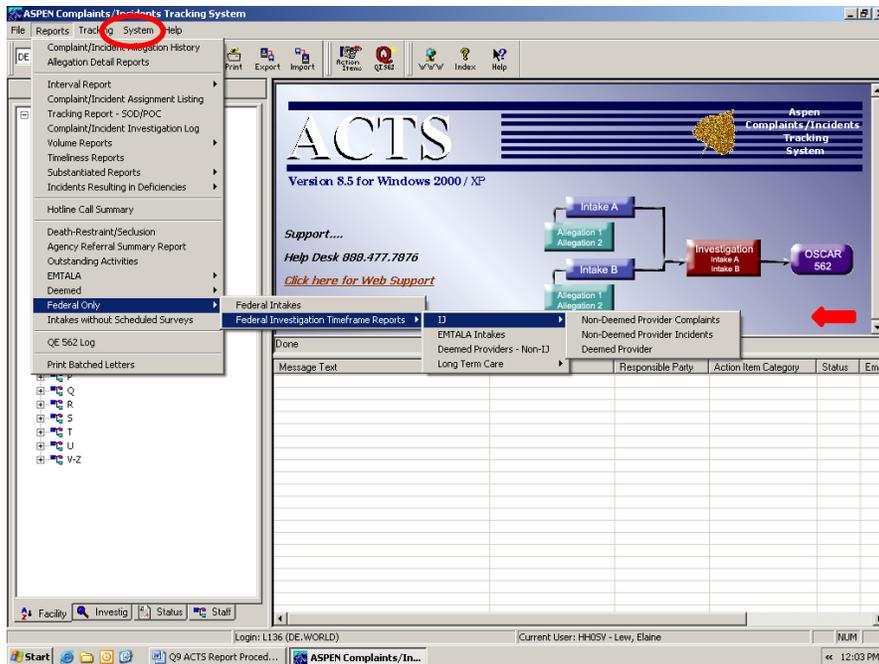
Note: CMS may determine that a state has not met this measure based on its review of cases during normal, day-to-day operations. For example, this measure is calculated via an automated data pull from a database (ACTS). We note that, as part of normal operations, CMS staff review cases when imposing enforcement for certain types of noncompliance identified on a complaint or FRI survey. If, during the course of their review, they identify issues with a state not investigating complaints or FRIs within the required timelines (e.g., due to incorrect data entry, incorrect triaging, or general delays in responding), CMS may deem a state as not having met this measure.

#### **a. ACTS Reports Procedures**

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

#### **b. IJ Complaints: Non-Deemed Providers**

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



4. Change the following filters:

- a. Report Date Range (for Received End Date): Start Date =10/1/2019
- b. Report Date Range (for Received End Date): End Date = 9/30/2020
- c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151  
(Deselect all other types- scrolling across the field may be necessary)
- d. Intake Type = Complaint
- e. Intake Subtype= A Federal COPs, CFCs, RFPs, EMTALA

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

**c. IJ Incidents: Non-Deemed Providers**

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports IJ Non-Deemed Provider Incidents.
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date=10/1/2019
  - b. Report Date Range (for Received End Date): End Date= 9/30/2020
  - c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151 (Deselect all other types- scrolling across the field may be necessary)
  - d. Intake Type = Incident
  - e. Intake Subtype:
    - 1 = Federally-required, entity-reported

2 = State-req, potential Fed noncompliance, entity-reported

3 = State-required, all other, entity-reported

4 = Reported by other agencies

5 = None of the above

Onsite/Offsite = 1 Onsite Survey Performed

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

**d. IJ: Deemed Providers**

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports  IJ  Deemed Provider.
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date= 10/1/2019
  - b. Report Date Range (for Received End Date): End Date= 9/30/2020
  - c. Provider Type= 011, 012, 013, 014, 015, 016, 051, 052, 151 (Deselect all other types- scrolling across the field may be necessary)
5. Click OK.
6. Click the Printer icon and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was not initiated within two working days:
  - a. Total number of federal intakes
  - b. Total number of federal intakes where the Regional Office approval and survey start dates are more than 2 working days

**e. Non-IJ High: Nursing Homes**

1. Open ACTS.
2. Connect to the appropriate State server.

3. Go to the Reports Menu and select Federal Investigation Timeframe Reports → Long Term Care → Non-IJ High.
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date=10/1/2019
  - b. Report Date Range (for Received End Date): End Date= 9/30/2020
5. Click OK.
6. Click the Printer icon and click OK to print the report.
7. At the end of the report, use the following fields for calculating the percentage of intakes where an onsite survey was not initiated within 10 working days:
  - Total number of NIJH triaged federal intakes
  - Total number of NIJH triaged federal intakes where the received end and survey start dates are more than 10 working days

**f. Non-IJ: Deemed Providers**

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Federal Investigation Timeframe Reports → Deemed Providers- Non-IJ.
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date=10/1/2019
  - b. Report Date Range (for Received End Date): End Date= 9/30/2020
  - c. Provider Type= 011, 012, 013, 014, 015, 016 (Deselect all other types- scrolling across the field may be necessary)
  - d. Priority= B Non-IJ High
5. Click OK.
6. Click the Printer icon and click OK to print the report.
7. Use the following data to calculate the percentage of intakes where an onsite survey was not initiated within 45 calendar days:
  - a. Total number of federal intakes
  - b. Total number of federal intakes where the Regional Office approval through the survey start dates are greater than the Investigation Within values specified (Check to see whether the Investigation Within value for each intake is 45 days.)

The following two reports (IJ: Intakes Without a Scheduled Survey and Non-IJ High: Long Term Care Intakes without a Scheduled Survey) can assist in identifying intakes that may be outstanding.

**g. IJ: Intakes Without a Scheduled Survey**

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Intakes without Scheduled Surveys
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date=10/1/2019
  - b. Report Date Range (for Received End Date): End Date=9/30/2020
  - c. Provider Type = 011, 012, 013, 014, 015, 016, 021, 022, 023, 024, 051, 052, 091, 151 (Deselect all other types- scrolling across the field may be necessary)
  - d. Intake Subtype
    - 1 = Federally-required, entity-reported
    - 2 = State-req, potential Fed noncompliance, entity-reported
    - 3 = State-required, all other, entity-reported
    - 4 = Reported by other agencies
    - 5 = None of the above- A Federal COPs, CFCs, RFCs, EMTALA(Deselect all other types-- scrolling across the field may be necessary)
  - e. Priority = IJ (Deselect all other types)
  - f. Onsite/Offsite = 2 No survey performed, 3 Offsite survey performed (Deselect 1 Onsite survey performed)
5. Click OK.
6. Click the Printer icon and click OK to print the report.
7. Include these intakes in the calculation of the percentage of intakes where an onsite survey was not initiated within two working days.

**h. Non-IJ High: Long Term Care Intakes without a Scheduled Survey**

1. Open ACTS.
2. Connect to the appropriate State server.
3. Go to the Reports Menu and select Intakes without Scheduled Surveys
4. Change the following filters:
  - a. Report Date Range (for Received End Date): Start Date=10/1/2019
  - b. Report Date Range (for Received End Date): End Date= 9/30/2020
  - c. Provider Type = 021, 022, 023, 024(Deselect all other types- scrolling across the field may be necessary)

d. Intake Subtype

1 = Federally-required, entity-reported

2 = State-req, potential Fed noncompliance, entity-reported

3 = State-required, all other, entity-reported

4 = Reported by other agencies

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

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

e. Priority = Non-IJ High (Deselect all other types)

f. Onsite/Offsite = 2 No survey performed, 3 Offsite survey performed (Deselect 1 Onsite survey performed)

5. Click OK.

6. Click the Printer icon and click OK to print the report.

7. Include these intakes in the calculation of the percentage of intakes where an onsite survey was not initiated within 10 working days.

## Appendix 14: Q6. Quality of EMTALA Investigations

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### 1. Data Source(s)

ACTS, CMS-2567, and completed survey packets sent to CMS

### 2. Method

#### a. Sampling

A random sample of all EMTALA complaints that were authorized by the Regional Office for investigation will be selected from ACTS. The universe is all intakes with a received start date from October 1, 2019 through September 30, 2020. If the survey for the intake is conducted in FY2019 the Regional Office will keep the intake in the sample for the fiscal year under review. If the survey has not been conducted by the time the performance review occurs or it was conducted in the subsequent Fiscal Year, the Regional Office should replace the intake.

The random sample includes intakes received from October 1, 2019 through September 30, 2020. Base the sample on the number of intakes received in the previous year.

#### b. Sample Size

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

#### c. Requirements

Review each sampled case to determine if the SA investigated the EMTALA complaint in accordance with CMS policy. For each case selected, review the complaint investigation packet using the attached worksheet.

1. Was the onsite complaint investigation initiated within 2 business days of RO Approval Date/Extension Date when prioritized as IJ or within 45 calendar days of RO Approval Date/Extension Date when prioritized as non-IJ High?
  - a. Timeframes are calculated from date of Regional Office EMTALA investigation approval date to the survey initiation date.
  - b. Count the day of Regional Office notification to the State Survey Agency as day zero.
  - c. Survey entrance date is obtained from the State Survey Agency survey packet in the CMS-670.

- d. The Regional Office accounts for State holidays and office closures in its working day calculation.
2. Timeframes are calculated from date of RO EMTALA investigation approval/extension date to the survey initiation date. Count the day of RO notification to the SA as day zero. Survey entrance date is obtained from the SA survey packet in the CMS-670. The RO accounts for State holidays and office closures in its business day calculation. Was a completed packet sent to the Regional Office within 10 working days following the survey exit date when a suspected violation is identified or 15 working days when no violation was found?
  3. Note: For each item listed below (2.1 to 2.8) to be scored “yes,” the document(s) being referred to need to have been submitted timely and complete. If the item was not submitted timely and/or was not complete, the corresponding element in number 2 should be scored “no.” A complete packet is defined as containing the items listed below:
    - i. 3.1 CMS-562 sent to Regional Office/Data entered into ACTS
    - ii. 3.2 CMS-670 sent to Regional Office/Data entered into ACTS
    - iii. 3.3 A completed CMS-2567
    - iv. 3.4 CMS-1541B with recommendation for action included or sent in the survey packet
    - v. 3.5 Written summary of interviews – can be in the narrative or surveyor notes
    - vi. 3.6 Copies of pertinent hospital policies and procedures that relate to the identified deficiencies
      - Note: If a violation is found, policies and procedures must be submitted with the packet. If they are required but not included, score “NO.” If no violation is found, policies and procedures are not required to be submitted with the packet. If they are not required, score “YES” whether submitted or not.
    - vii. 3.7 Summary listing of all patients comprising the sample (including an explanation of how and why the sample patients were selected for review)
    - viii. 3.8 Copies of medical records for substantiated cases, medical records of individuals named in complaints and other medical records in accordance with the QIO physician review checklist
  4. Was the sample selection based on the case selection methodology outlined in Appendix V, Task 2 of the SOM?
  5. Did the CMS-2567 require no revisions or only minor revisions by the State Survey Agency after review by the Regional Office?
    - Score “yes” if the CMS-2567 required no revisions or only minor revisions or the only revisions were beyond the State Survey Agency’s control (E.g., as a result of the QIO review).
    - Score “no” if the CMS-2567 required major revisions that were within the State Survey Agency’s control, including failure to follow the Principles of Documentation.
  6. Was a complete Complaint Investigation Narrative included with the State Survey Agency packet that was sent to the Regional Office?

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

#### ***d. Scoring***

The total overall score for all requirements combined must be 90 percent or above to meet this measure. The separate requirement percentages are for analysis purposes only. Each requirement is worth 4 points. The eight individual elements of requirement 2 are worth 0.5 points each.

1. Total the possible points obtained for each sample case.
2. Total the points for all sample cases.
3. Divide number of points obtained by the total number of points possible to determine the final score.

#### ***Example 1***

Sample size = 10

Total points obtained = 220

Total points possible = 240

$220/240 = 91.67$  percent

Measure is scored as “Met”

#### ***Example 2***

Sample size = 4

Total points obtained = 68

Total points possible = 96

$68/96 = 70.8$  percent

Measure is scored as “Not Met”

# Appendix 15: Q7. Quality of Complaint/Facility Reported Incident Investigations for Nursing Homes, Hospice, and Acute Care Hospitals – (formerly Q9) Developmental in FY2020

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## A. Details for Nursing Homes

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### 1. Data source(s)

Datasets to identify cases for review will be created by CMS Central Office and distributed to the Regional Offices. The ROs are to use ACTS/ASPEN/ARO and survey documentation (e.g., CMS-2567, surveyor worksheets, intake/investigation notes) in their assessment. The ROs should not request information that is already available in CMS systems from States. If more information is needed, it should be transmitted in an electronic format that is usable by the RO whenever possible.

### 2. Sample Sizes for Nursing Homes

The mid-year review sample will be based on completed complaint surveys from October 1, 2019 through March 31, 2020. The end-of-year review sample will be based on completed complaint surveys from April 1, 2020 through September 30, 2020.

Nursing Homes Sample Size

Total Complaint Completed during FY 2019	Sample Size
10 or Less	All
11 to 100	10
101 to 400	10 percent of the number of intakes
Greater than 400	40

Note: Each nursing home intake used for the review must contain at least one “Abuse,” “Neglect,” “Misappropriation of Resident Property,” “Injury of Unknown Source,” “Quality of Care,” “Accidents,” “Nursing Services,” “Pharmaceutical Services,” or “Admission/Transfer/Discharge Rights” allegation. If the projected sample size results in a non-whole number, round to the nearest whole number. The Regional Office will complete half of all reviews for the mid-year review and the other half for the end-of-year review.

### 3. Review Requirements

Requirement	Guidance and References
1. The investigation is conducted in an appropriate manner.	Score “Yes” when: <ul style="list-style-type: none"> <li>• The surveyor investigated the appropriate care areas/specific F-tags based on the complaint allegations.</li> </ul>

	<ul style="list-style-type: none"> <li>• The surveyor conducted interviews with:             <ol style="list-style-type: none"> <li>1. The complainant (unless anonymous)</li> <li>2. The resident/resident representative/family member named in the allegation</li> <li>3. Other residents (if applicable)</li> <li>4. Staff</li> </ol> </li>   <li>• The onsite survey is conducted within the same timeframe of the allegations.             <ol style="list-style-type: none"> <li>1. Even if the allegation occurred during the weekend/night shift.</li> <li>2. Observations were conducted on an appropriate day and/or appropriate time based on the intake information.</li> <li>3. The surveyor attempted to interview staff who were working at the time that the allegation occurred.</li> </ol> </li>   <li>• The investigation included an appropriate resident sample related to the allegations as per the guidance in Chapter 5 of the SOM.</li>   <li>• Documentation included (based on the Critical Element Pathways/Investigative Protocols):             <ol style="list-style-type: none"> <li>1. Observations</li> <li>2. Interviews</li> <li>3. Record reviews</li> </ol> </li>   <li>• A written report was sent to the complainant after the complaint investigation was completed, per State procedures. (unless complaint was anonymous)</li> </ul> <p><u>Additional Guidance</u></p> <p>The criterion is scored “No” when</p> <ul style="list-style-type: none"> <li>• The investigation was not conducted according to CMS procedures as described above.</li>   <li>• The determination of “No” should indicate which part of the investigation was deemed inappropriate by the RO review in order to provide the SA feedback on how to improve.</li> </ul>
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<p>2. There is sufficient evidence to support the decision to cite or not cite deficiencies.</p>	<p>For each allegation and deficiency cited, score “Yes” when:</p> <ul style="list-style-type: none"> <li>• Each allegation was investigated with supportive documentation. If the allegation of noncompliance is substantiated, the surveyor follows the CE pathways to determine the potential citations and clearly document for each deficiency. If the allegation of noncompliance is unsubstantiated, the surveyor clearly documents the rationale.</li> <li>• The surveyor drew conclusions for each allegation and deficiency based on the evidence collected during the investigation.</li> </ul> <p><u>Additional Guidance</u></p> <p>This criterion is scored “Yes” if you can understand how the evidence presented supports the conclusions for each allegation and each deficiency cited, when applicable. If there are minor errors in the documentation that do not impact the ability to demonstrate whether an allegation is substantiated or a deficiency is cited, this criterion should still be scored “Yes.”</p> <p>This criterion is scored “No” when the documentation of evidence is unclear or vague such that it impacts the ability to demonstrate an allegation is substantiated or a deficiency should be cited.</p>
<p>3. If a deficiency(ies) is cited, the correct severity level is assigned to the deficiency.</p>	<p>Score “Yes” when:</p> <p>The evidence in the citation supports the assigned severity rating (severity is the level of outcome or potential/actual harm to residents).</p> <p><u>Additional Guidance:</u></p> <p>Refer to the SOM Chapter 7, section 7410.2.2; long term care survey process procedure guide; Appendix PP for severity guidance on specific tags; and Appendix Q.</p>

## B. Details for Hospice and Acute Care Hospitals

### 1. Data source(s)

Datasets to identify cases for review will be created by CMS Central Office and distributed to the Regional Offices. The ROs are to use ACTS/ASPEN/ARO and survey documentation (e.g., CMS-2567, surveyor worksheets, intake/investigation notes) in their assessment. The ROs should not request information that is already available in CMS systems from States. If more information is needed, it should be transmitted in an electronic format that is usable by the RO whenever possible.

### 2. Sample Sizes for Hospice and Acute Care Hospitals

The mid-year review sample will be based on completed complaint surveys from October 1, 2019 through March 31, 2020. The end-of-year review sample will be based on completed complaint surveys from April 1, 2020 through September 30, 2020.

#### Hospice Sample Size

Total Complaint Completed during FY 2019	Sample Size
10 or Less	All
11 to 100	10
101 to 200	10 percent of the number of intakes
Greater than 200	20

Note: Include both deemed and non-deemed hospices in the total complaint completed count.

#### Acute Care Hospital Sample Size

Total Complaint Completed during FY 2019	Sample Size
10 or Less	All
11 to 100	10
101 to 200	10 percent of the number of intakes
Greater than 200	20

Note: Acute care hospitals excludes ASCs, CAHs, and psychiatric hospitals. Include both deemed and non-deemed acute care hospitals in the total complaint completed count.

### 3. Review Requirements

Requirement	Guidance and References
1. Past provider and supplier noncompliance records were reviewed prior to the investigation.	Score "yes" if surveyor documentation confirms past records, such as past survey history, were reviewed prior to conducting the onsite complaint survey.

<p>2. The complainant was contacted to gather additional information, if applicable.</p>	<p>Score “yes” if there is documented evidence that the State Agency contacted the complainant to gather information prior to the investigation.</p> <p>Documented evidence of the attempt(s) to contact the complainant, but complainant was unreachable should be scored as “yes”.</p> <p>Score “not applicable” if the complaint is made anonymously.</p>
<p>3. Federal requirements were assigned for each allegation to be investigated.</p>	<p>Score “yes” if applicable Conditions for Coverage or Conditions of Participation were designated for each allegation to be investigated. These designations shall be focus areas during the investigative survey.</p>
<p>4. The patient sample selection included characteristics that were similar to the patient affected by the complaint.</p>	<p>Score “yes” if during the investigation, patterns of similarity in the patient sample selection were established to ensure reliability and extent of the allegations.</p> <p>For example:</p> <p>Patients requiring wound care should be included in the patient sample for allegations relating to lack of wound care management;</p> <p>Complaints related to medication errors should include those patients who might be taking similar medications in the sample selection; and</p> <p>Complaints related to falls and injury should include those patients identified to be at risk of falls in the sample selection.</p>
<p>5. Interviews, medical record reviews and observations were conducted with patient(s) and staff during the investigation.</p>	<p>Score “yes” if surveyor notes and documentation confirms information gathering was completed and collected from all of the following:</p> <ul style="list-style-type: none"> <li>• Complainant</li> <li>• Other patients with similar characteristics</li> <li>• Caregiver(s), if applicable</li> <li>• Staff</li> <li>• Administrator.</li> </ul>
<p>6. There is sufficient evidence to support the decision to cite at the level indicated in the statement of deficiencies.</p>	<p>Score ‘yes’ if:</p> <ul style="list-style-type: none"> <li>• The evidence in the citation supports the level of noncompliance, based on the scope and/or number of patients affected, or had the potential to be affected by the deficient practice.</li> <li>• All relevant what, who, where, when, and how questions are answered for the evidence that supports the finding of noncompliance: <ul style="list-style-type: none"> <li>- What entity practice was noncompliant;</li> <li>- Who were the patients/clients or staff involved;</li> </ul> </li> </ul>

	<ul style="list-style-type: none"><li>- Where the deficient practice occurred, e.g., specific locations in the entity or documents;</li><li>- When (e.g., for how long) the problem occurred;</li><li>- How the deficiency was determined and how the evidence relates to the requirement.</li></ul>
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#### 4. References

Chapter 5, Appendix A (Hospital), Appendix M (Hospice) and Appendix X (Determining Immediate Jeopardy) of the State Operations Manual

#### 5. Timeframe

Regional Offices will conduct a review at mid-year and end-of-year.

## Appendix 16: Q8. State-specific Measure

State Performance Indicators will provide a resource to Regional Offices and State Survey Agencies that may help to better understand how State Survey Agencies perform in real time. These indicators would be specific to State Survey Agencies and mapped to Scoring Measures. Regional Offices and State Survey Agencies will select one or more of these measures as their State-specific measure to be continually monitored and evaluated for improvement over a 2-year cycle. The lists of measures identified on Tables 9 through 12 represent a first wave of state performance indicators with additional waves to be released during this fiscal year.

**Table 9. State Performance Indicators related to the Quality of Standard Surveys**

State Performance Indicator	Definition
Standard deficiency citation rate <sup>‡</sup>	Number of deficiencies by the total number of standard surveys
Percent of deficiency-free standard surveys <sup>‡</sup>	Number of standard surveys that did not have any citations by the total number of standard surveys
Proportion of standard survey citations by scope and severity <sup>†</sup>	Number of standard survey citations grouped by scope and severity level
Proportion of citations at the condition level <sup>†</sup>	Number of standard survey condition level citations compared to all citations
Discharge citations per 100 surveys <sup>†</sup>	Total number of discharge citations on standard surveys
Abuse citations per 100 surveys <sup>†</sup>	Total number of abuse citations on standard surveys

Notes: State performance indicators will be provided individually for each of the following provider types unless otherwise indicated: nursing homes, ESRDs, HHAs, Hospice, Hospitals, and ICF/IIDs.

<sup>†</sup>State performance indicators specific to nursing homes only.

<sup>‡</sup> For nursing homes, these indicators will be reported in the SOAR report. They will also be reported for non-nursing homes.

**Table 10. State Performance Indicators related to the Quality of Intake Surveys**

State Performance Indicator	Definition
Distribution of intakes	Proportion of intakes that are FRIs versus the proportion that are complaints
Intake rate by active providers for non-nursing homes	Total number of intakes divided by total number of active providers
Intake rate by facility census by complaint and FRI for nursing homes	Total number of intakes by facility census or size by complaint and FRI
Distribution of intake prioritization	Percentage of intakes grouped by Intake Priority level (IJ, non-IJ high, non-IJ medium, and non-IJ low)
Citations rates of intakes for IJ and non-IJ priority categories	Number of citations by number of intakes for intakes prioritized as IJ and prioritized as non-IJ
Percent of IJ and non-IJ High intake surveys not completed within 5 or 10 days	Percentage of surveys not completed within 5 or 10 days for intakes prioritized as IJ and for intakes prioritized as non-IJ High

Notes: State performance indicators will be provided individually for each of the following provider types unless otherwise indicated: nursing homes, ESRDs, HHAs, Hospice, Hospitals, and ICF/IIDs.

**Table 11. State Performance Indicators related to the Quality of Complaint Surveys**

Complaint deficiency citation rate	Number of deficiencies by the total number of complaint surveys
Percent deficiency-free complaint surveys	Number of complaint surveys that did not have any citations by the total number of complaint surveys
Proportion of complaint survey citations by scope and severity <sup>†</sup>	Number of complaint survey citations grouped by scope and severity level
Proportion of complaint citations at the condition level	Number of complaint survey condition level citations compared to all citations
Percentages of complaint surveys with 3 or more IJs cited*	Percentages of complaint surveys with 3 or more IJs cited out of all surveys when an IJ is cited

Notes: State performance indicators will be provided individually for each of the following provider types unless otherwise indicated: nursing homes, ESRDs, HHAs, Hospice, Hospitals, and ICF/IIDs.

<sup>†</sup>State performance indicators that are specific to nursing homes only.

\*For nursing homes, this indicator will be reported on the Enforcement report.

**Table 12. State Performance Indicator in the Coordination of Provider Noncompliance Domains.**

State Performance Indicator	Definition
Enforcement case transfer	Percentage of cases transferred to CMS for enforcement per policy (e.g., immediate imposition of remedies*, discharge violations, unnecessary medications (antipsychotics))

Notes: State performance indicators will be provided individually for each of the following provider types unless otherwise indicated: ESRDs, HHAs, Hospice, Hospitals, and ICF/IIDs.

\*See the SOM Chapter 7 section 7304 for specific criteria required.

## State-specific Measures Guidance

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An addition to the SPSS is a state-specific scoring measure in the Quality domain based primarily on SPSS state performance indicators. This new scored and flexible SPSS component will identify and focus on opportunities for State Survey Agency performance improvement. For this measure, State Survey Agencies and Regional Offices will collaborate to identify areas of concern for states to target. Regional Offices and State Survey Agencies will jointly determine areas for improvement and monitor progress over an 12- to 18-month period. It is anticipated that some State Survey Agencies may not have a targeted state-specific measure. This appendix provides:

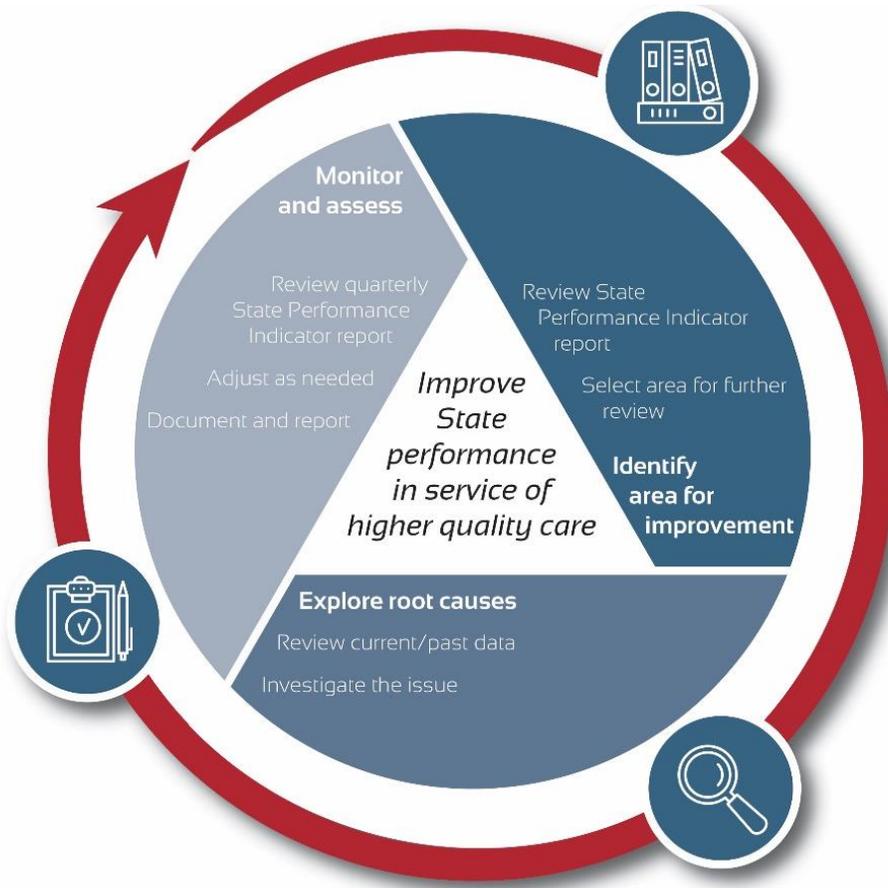
- Information on requirements for the SPSS state-specific Quality domain measure for this year
- Guidance on how to implement the state-specific measure, including a step-by-step overview of the process
- Tools to assist Regional Offices and State Survey Agencies in documenting and monitoring the state-specific measure
- Documentation requirements
- Examples of how Regional Offices and State Survey Agencies might use state performance indicators for the state-specific measure

### Requirements

In the current FY, Regional Offices and State Survey Agencies are expected to collaborate on improving the quality of the survey process by selecting one state-specific measure for focus. This measure of State Survey Agency performance is developmental and will be evaluated throughout this FY for its feasibility.

This state-specific measure improvement activity will be enabled by the new State Performance Indicator reports that Regional Offices and State Survey Agencies will begin to receive on a quarterly basis. From these reports, Regional Offices and State Survey Agencies can identify one state-specific measure, if indicated, in any area of concern among state performance indicators in the SPSS Quality Domain. Figure 1 below provides an overview of the steps in this process and the timeframe for compliance with this revision.

**Figure 1. General Approach to Implementing the State-specific Measure Guidance**



### **General Steps to Identify a State-specific Measure**

There are three high-level steps to identify areas for State Survey Agency focus based on state performance indicators.

#### **Step 1: Determine the state-specific area of focus**

Regional Offices will identify potential concern areas for State Survey Agencies upon receipt of the state performance indicators. Areas of concern may be identified where the State is an outlier nationally, regionally, and/or compared to its peer group;

- the State has changed position markedly compared to previous years; or
- the State’s report has had no change compared to previous years and warrants further investigation because no movement in any indicator could potentially be of concern.

#### **Step 2: Explore root causes**

State Survey Agencies and Regional Offices will discuss potential root causes of identified areas of concern; root causes will vary based on the issue.

Review of historical data to determine if the issue is new or recurring.

Identification of changes that have occurred at the regional or state level that could have precipitated the issue.

Identification of a timeline that led to the situation and contributing factors that may have led to it.

***Step 3: Monitor and Assess Progress***

State Survey Agencies and Regional Offices will periodically assess the extent to which state performance indicator data or other data are being used to identify areas of concern.

The State Survey Agency can monitor areas of concern by reviewing quarterly data provided by CMS on state performance indicators or by collecting its own information if its measure is not already a specified state performance indicator.

The Regional Office can review the State Survey Agency Areas of Concern report and check in with the State Survey Agency to ask about the status of that concern area.

The Regional Office will provide an update to CMS Central Office on a quarterly basis to note the areas of concern that State Survey Agencies have identified.

It is anticipated that communication will occur between all stakeholders involved on a quarterly basis; however, the extent of communication is at the discretion of the Regional Office and State Survey Agency.

At the end of the 12- to 18-month timeframe, Regional Offices will determine if State Survey Agencies have acted on concern areas and the State Survey Agency will be scored as having met or not met this requirement. This conclusion should be drawn based on two findings:

- ▶ Whether an area or areas of concern were identified; and
- ▶ Whether the area or areas of concern changed as a result of identification and data analysis activities.

The state-specific measure identification process should be documented and correctly filed with CMS Central Office for future reference.

The State-specific measure report is required documentation.

In future years (FY2021 and beyond), return to step 1 to determine other areas of concern for the next year.

# Appendix 17: Q9. Implementation of IJ Template (Developmental)

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## 1. Data Source(s)

ASPEN, Immediate Jeopardy Templates

## 2. Method

### *Sample Selection*

1. Using ASPEN, run a report of all surveys with an associated immediate jeopardy.
2. Using the table below, randomly select survey cases. (call this [a])

Total Immediate Jeopardies Cited in Prior FY	Sample Size
1 to 20	All
Greater than 20	20

3. Retrieve the Immediate Jeopardy Templates from ASPEN Central Office/ASPEN Regional Office (ACO/ARO) for each instance of Immediate Jeopardy in the sample.
4. In the event that the State Survey Agency did not attach the Immediate Jeopardy Template to ACO/ARO, request the Immediate Jeopardy Template from the State Survey Agency.

### *Immediate Jeopardy Template Provided to Nursing Home and Non-Nursing Homes Evaluation<sup>5</sup>*

1. Review each Immediate Jeopardy Template and determine if the Immediate Jeopardy Template was provided to nursing home or non-nursing home entity at or prior to the exit conference. [call this (b)]
2. To calculate this measure, divide [b] by [a] and multiply by 100

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

### *Immediate Jeopardy Template Completed Appropriately Evaluation*

1. Review each section of the Immediate Jeopardy Template to ensure it was completed appropriately using the following criteria:
  - a. In the *Noncompliance* section was the tag identified and were the issues that led to the determination that the entity was noncompliant provided? This includes the action(s), error(s), or lack of action, and the extent of the noncompliance (for example, number of cases).

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<sup>5</sup> EMTALA is excluded for non-nursing homes.

- b. In the *Serious injury, serious harm, serious impairment or death* section did the summary provided support that a serious adverse outcome occurred, or a serious adverse outcome was likely?
- c. In the *Need for Immediate Action* section did the summary explain why the entity needed to take immediate action to correct noncompliance that caused or was likely to cause serious injury, serious harm, serious impairment, or death?
  - 2. Count the number of cases where all criteria are met. (call this [c]).
  - 3. To calculate this measure, divide [c] by [a] and multiply by 100

$$\text{Proportion Completed Appropriately} = \frac{(c)}{(a)} \times 100\%$$

Note: SAs and ROs are now required to attach the IJ template to the survey package when uploading to ASPEN Central Office/ASPEN Regional Office (ACO/ARO) for each instance of Immediate Jeopardy. For more information on the procedures for attaching documents, see the ACO Procedures Guide ([https://qtso.cms.gov/system/files/qtso/ACO\\_PG\\_11.7.0.2\\_FINAL.pdf](https://qtso.cms.gov/system/files/qtso/ACO_PG_11.7.0.2_FINAL.pdf)).

# Appendix 18: CPN1. Nursing Homes. Timeliness of Processing Immediate Jeopardy (IJ) Cases

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## 1. Data Source(s)

ASPEN Enforcement Manager (AEM) Immediate Jeopardy Timeline Report is used.  
Notes section of the AEM case

## 2. Method

Use the ASPEN Enforcement Manager (AEM) Immediate Jeopardy Timeline report and the Notes section of the AEM case identify IJ cases that were processed timely. Using these reports assess whether the following three actions were completed:

1. The State Survey Agency promptly notified CMS of the survey date when an IJ was discovered so that the provider can be notified of the 23-day termination action.
  - For nursing homes, the State Survey Agency notifies the Regional Office no later than two calendar days after the last day of the survey that identified the IJ (SOM Chapter 7, section 7309).
  - The Regional Office accounts for State holidays and office closures in its working day calculation.
2. The State Survey Agency conducted a timely revisit upon receipt of a credible allegation of IJ removal. The Notes section of the AEM case should provide the date the State Survey Agency received the notification of alleged removal.
3. The State Survey Agency notified CMS of whether or not IJ had been removed.
  - For nursing homes, the notification of whether or not IJ has been removed must be no less than three working days prior to the termination date.
  - The Regional Office accounts for State holidays and office closures in its working day calculation.
  - The Notes section of the AEM case should provide the date the State Survey Agency notified the Regional Office of the actual IJ removal.

### Calculation

1. Identify all IJ cases that were not removed onsite.
2. Determine the total number of acceptable cases. That is, determine how many of these cases met all the following criteria:
  - the State Survey Agency notified CMS of the IJ in a timely manner,
  - conducted a timely revisit upon receipt of a credible allegation of compliance,
  - and notified CMS whether or not the IJ was removed within prescribed timeframes.
3. Divide #2 by #1 and convert to a percentage format.
4. If the resulting percentage is  $\geq 95$  percent, this measure is scored as “Met.”

# Appendix 19: CPN2. Non-Nursing Homes. Timeliness of Processing Immediate Jeopardy (IJ) Cases except for EMTALA

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## 1. Data Source(s)

CASPER Report 0017D (Providers with Selected Requirements Out of Compliance) for recertification surveys

CASPER Report 0043D (Requirements Out of Compliance) for complaint surveys

ASPEN Central Office Tracking Report- CoPs Out of Compliance

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

## 2. Method

Use the 0017D, 0043D, and the ASPEN Central Office Tracking Report -CoPs Out of Compliance to identify non-nursing home surveys where CoP were cited.

Once identified, the SA and RO should then determine which of these CoP's were cited as IJ. This assessment excludes EMTALA cases.

Track the following information concerning each case:

- Provider name and CCN
- Start date of the IJ situation
- End date of the IJ situation
- Survey exit date where the IJ was discovered
- Date the SA notified the RO of the IJ situation
- 23-day termination date
- Date the SA received the credible allegation of compliance
- Survey exit date where the IJ was determined to be removed
- Date the RO was notified of the IJ removal

This information should be exchanged between the SA and RO on a quarterly basis to ensure accuracy and allow the SA time to correct potential issues. ROs will provide this spreadsheet to CMS Central Office at the mid-year and end-of-year periods. The spreadsheet template will be available on the CMS SPSS SharePoint site.

Data gathered in this spreadsheet will be used to assess whether the following three actions were completed:

1. The SA promptly notified CMS of the survey date when an IJ was discovered so that the provider can be notified of the 23-day termination action.
  - For non-nursing homes, the SA notifies the RO no later than two working days after the survey date (SOM, Chapter 3, section 3010).
  - The RO accounts for State holidays and office closures in its working day calculation.
2. The SA conducted a timely revisit upon receipt of a credible allegation of IJ removal.
3. The SA notified CMS of whether or not IJ had been removed.

- For non-nursing homes, the SA follows SOM timeframes and CMS guidance for the notification of IJ and the termination process, so that termination takes effect timely, unless the IJ has been removed.
- The RO accounts for State holidays and office closures in its working day calculation.

### **Calculation**

1. Identify all IJ cases that were not removed onsite.
2. Determine the total number of acceptable cases. That is, determine how many of these cases met all of the following criteria:
  - the SA notified CMS of the IJ in a timely manner,
  - the SA conducted a timely revisit upon receipt of a credible allegation of compliance, and
  - the SA notified CMS whether or not the IJ was removed within prescribed timeframes.
3. Divide #2 by #1 and convert to a percentage format.
4. If the resulting percentage is  $\geq 95$  percent, this measure is scored as "Met."

## Appendix 20: CPN3. Timeliness of Mandatory DPNA Notification for Nursing Homes

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### 1. Data Source(s)

AEM Reports - Mandatory DPNA Timeline and Surveys Not in AEM Case Reports.

### 2. Method

This measure evaluates whether the State Survey Agency transfers the enforcement case to CMS by the 70th day or the State Survey Agency sends the imposition notice to the provider by the 70th day.

1. Using AEM, identify all enforcement cases where the nursing home was not in substantial compliance within 70 days of the date of the original survey (as verified by a revisit occurring on or before day 70) and all enforcement cases where, on the 70th day, it was not known whether the facility had achieved substantial compliance (e.g., a revisit had not occurred and the State Survey Agency has not verified compliance). If the Regional Office conducted a Federal Monitoring Survey during the enforcement cycle, then the enforcement case should be excluded from the review. The Regional Office will review enforcement cases where the original survey occurred between July 1, 2019 and June 30, 2020.
2. CMS will evaluate the following key dates:
  - Date of State Survey Agency notification to the Regional Office of continuing noncompliance, no later than 70 days after the original survey that determined noncompliance; or
  - Date of State Survey Agency notification to the provider of imposition of DPNA, no later than 70 days after the original survey that determined noncompliance.
3. Determine in how many of these cases the State Survey Agency carried out timely actions (i.e., sent enforcement packets to CMS or sent notices directly to the provider within the timeframes specified). Determine the total number of acceptable cases.
4. Divide #2 by #1 and convert to a percentage format.
5. If the resulting percentage is greater than or equal to 80 percent, this measure is scored as “Met.”

#### *How to Identify the Universe of Cases for Review*

1. In ASPEN, make sure that My Selections filters have either been deactivated, or select for only SNFs, SNF/NFs, and distinct part SNF/NFs.
2. Run the AEM Mandatory DPNA Timeline Report with the following filters (see image below):

Category	Select
Date	Date Range
First Date	07/01/2019

Last Date	06/30/2020
Based On	Cycle Start Date
FMS Surveys	Exclude
Compliance within 70	Exclude
Facility Type	021 NURSING HOME (NH) SNF/NF DUAL CERT 022 NURSING HOME (NH) SNF/NF DISTINCT PART 023 NURSING HOME (NH) SNF ONLY
Case Type	1 Opportunity to Correct 2 No Opportunity to Correct

3. This report identifies the enforcement cycles where
  - The most recent visit of the enforcement cycle occurred after the 70th day, or
  - It was not known on the 70th day whether or not the facility was in substantial compliance. (This includes cases in which the compliance date is on or prior to the 70th day, but the compliance date was determined after the 70th day)
4. This report is a list of the universe of cases to be reviewed for E2 of the State Performance Standards. However, the following enforcement cases should be excluded from the universe of cases to be reviewed:
  - Cases in which a revisit occurred and substantial compliance is determined by the 70th day, but additional visits were added to the enforcement cycle due to State licensure activities.

- Cases in which substantial compliance is determined on or before the 70th day and a waived LSC tag is contributing to the compliance. This is legitimate compliance, but the system may not recognize this.
- Cases in which an enforcement cycle is prolonged by data entry errors (e.g., surveys are added to enforcement cycle after substantial compliance is achieved). Data entry errors should be identified and corrected.

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

5. The Surveys Not in an AEM Case Report may identify other enforcement cases that should have been included in the review. Run this report with the following filters:

Category	Select
First Date	07/01/2019
Last Date	06/30/2020
Based On	Survey Exit Date
Survey Type	Fed. Surveys
Highest S/S	D+ Above

Review these to see if an enforcement case should have been created and whether the enforcement case should have been referred to the Regional Office.

6. In order for a case to be scored as “Met,” one of the following three actions must have occurred on or prior to the 70th day,
  - The State Survey Agency sent a DPNA imposition letter to the nursing home.
  - The State Survey Agency transferred the case to the Regional Office (as indicated by the “Initial Transfer to Regional Office” field).
  - The Regional Office sent a DPNA imposition letter.

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

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

## Continuous Monitoring

State Survey Agencies have the ability to monitor their progress.

1. In ASPEN, make sure that My Selections filters have either been deactivated, or select for only SNFs, SNF/NFs, and distinct part SNF/NFs.
2. Run the **AEM Mandatory DPNA Timeline Report** with the following filters:

Category	Select
FMS Surveys	Exclude
Compliance within 70	Include
Federal Case Status	Open-Active
Facility Type	021 NURSING HOME (NH) SNF/NF DUAL CERT 022 NURSING HOME (NH) SNF/NF DISTINCT PART 023 NURSING HOME (NH) SNF ONLY
Case Type	1 Opportunity to Correct 2 No Opportunity to Correct
Date Range Based On	Cycle Start Date

**AEM Mandatory DPNA Timeline Report**

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

Report Order: Cycle Start Date  
 Fed Case Status: Open - Active  
 State Case Status: All  
 Chain ID: All  
 State Region: All  
 Initial Transfer to RD: All  
 Compliance Status: All

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

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

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

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

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

Report Settings  
 Save Setting as:   
 Stored Settings:   
 Public (\*)   
 Delete

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

Print Options: Detail, Summary and Definitions   
 OK   
 Cancel

Do not select Exclude cases with 1st Revisit

For the State Survey Agency, this report identifies:

1. Whether a revisit needs to be conducted and entered into ACO/AEM, if the nursing home has not achieved substantial compliance.

2. Cases that need to be transferred to the Regional Office (or the State Survey Agency needs to issue an imposition notice), if a revisit has not been conducted by the 70th Day.
3. Cases that need to be transferred to the Regional Office (or the State Survey Agency needs to issue an imposition notice), if the Compliance Date is after the 70th Day.

# Appendix 21: CPN4. Processing of Termination Cases for Non-Nursing Home Providers/Suppliers

## 1. Data Source(s)

QBIC - CPN- NLTC Report

Provider certification files (ACO / ACTS) and Regional Office tracking systems

## 2. Method

Enter QBIC

Select the Reports drop-down menu. Select the Reports Library

The screenshot displays the QIES Business Intelligence Center interface. At the top, the CMS logo and 'QIES Business Intelligence Center' are visible, along with a user welcome message for CHRISTINA COMPHER and links for Job Queue and Sign Out. The navigation bar includes Home, Reports, User Tools, and Help. The Reports dropdown menu is open, showing options: Run Reports (Report Designer, Report Library, Report Packages) and View Reports (Job Queue). A red arrow points to the Reports menu, and another points to the Report Library option. Below the menu, a table lists available reports with columns for Name, Actions, Report Library, Type, Owner, Shared, and Date Modified. A URL for 'Provider Characteristics Draft' is highlighted at the bottom left.

NAME	ACTIONS	REPORT LIBRARY	TYPE	OWNER	SHARED	DATE MODIFIED
Active Providers	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/21/2019 16:43:37
Provider_Certification_Details	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 12:43:03
Provider	...	System Default Library	Extract	GRAY, JAMIE (**AYJL)	Yes	06/11/2019 11:55:17
ASPEN IDs	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/04/2019 15:50:03
Provider Characteristics Draft	...	System Default Library	Extract	COMPHER, CHRISTINA (**PHER)	No	06/01/2019 04:15:22

<https://cportal.qualitynet.org/qbic/flow/reports/report-designer>

Click on the three dots beside the CPN– NLTC Report. Select Submit from the pop-up menu.

Filtered by: Report Library: System Default Library Visible Items

REPORT DESIGNER

AVAILABLE REPORTS Explain This...

MANAGE LIBRARIES MANAGE PACKAGES

Filter by Report Name, Report Library, Report Type, Report Modified

NAME	ACTIONS	TYPE	OWNER	SHARED	DATE MODIFIED
CPN4 - NLTC	...	Extract	COMPHER, CHRISTINA (**PHER)	No	10/08/2019 14:31:02
E3 NLTC Report	...	Extract	CRAW/FORD, PAUL (**FORD)	Yes	10/08/2019 12:54:46
F32 Non-deemed ASCs Report	...	Extract	COMPHER, CHRISTINA (**PHER)	No	10/07/2019 22:18:10
ACTs	...	System Default Library	GRAY, JAMIE (**AYJL)	Yes	10/01/2019 13:08:22
F31 - Deemed ASC Validation Surveys	...	System Default Library	COMPHER, CHRISTINA (**PHER)	No	09/25/2019 13:28:56
Non-deemed ASCs - Last Survey Date	...	System Default Library	COMPHER, CHRISTINA (**PHER)	No	09/23/2019 16:10:25

Available Actions

- Copy
- Modify
- Move
- Delete
- Package Designer
- Share
- View Summary
- Submit

Select Continue

What report specifications would you like to use for the job submission? \* Explain This... \* indicates required field(s)

Job Submission Parameters

Job Name: \* CPN4 - NLTC

Maximum Rows: Enter Maximum Row Count

Counts Only

Email Notification

Job Description: \* Identifies the surveys with condition level deficiencies that have not been corrected within 55 days of the survey date. This report is used in the

Run Position: \* ASAP

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Additional Steps: 2 Runtime Parameter pages. CONTINUE CANCEL

Select CMS Region. Then click on the + beside the appropriate Region and click Continue.

Select Geography-level Data for Runtime Parameters \* Explain This... \* indicates required field

Report Name: CPN4 - NLTC Runtime Parameter: Geography Step: 1 of 2

All - Nation CMS Region State State - County State - Region

State Selection

Filter by State Name...

SELECT ALL DESELECT ALL

ALABAMA ALASKA AMERICAN SAMOA ARIZONA ARKANSAS CALIFORNIA CANADA COLORADO CONNECTICUT DELAWARE

Showing 1 to 10 of 58 entries View 10 Previous 1 2 3 4 5 6 Next

Geography Selection Summary

SELECT ALL DESELECT ALL

SELECTED GEOGRAPHIC LOCATIONS

CONTINUE CANCEL

In the Start Date, enter the first day of the fiscal year. In the End Date, enter the last day of the fiscal year. Click Run Report.

CMS QIES Business Intelligence Center Welcome, CHRISTINA COMPHER Job Queue Sign Out

Home Reports User Tools Help

Report Name: CPN4 - NLTC Runtime Parameter: Custom Conditions Step: 2 of 2

Enter values for Custom Runtime Parameters \* Explain This... \* indicates required field

Define Primary Run Time Parameters \*

NOTE: ALL REQUIRED PARAMETERS MUST BE DEFINED

Survey Date

Run Time Prompt: \* Enter Survey Date

Start Date: \* MM/DD/YYYY

Operator: \* BETWEEN (Between)

End Date: \* MM/DD/YYYY

This website was developed under contract with the Centers for Medicare & Medicaid Services (CMS). Accessibility Policy Privacy Policy

RUN REPORT CANCEL

Once the report begins running, the user will be auto-directed to the Job Queue. Once the report is available the Status will indicate Complete.

Filtered by: Limit Date: 10/02/2019 to 10/08/2019

REPORT DESIGNER

JOB QUEUE Explain This...

REPORT LIBRARY

Filter by Job Name, Report Type, Status, Position, Running Time, Submitter, Count, Job Number or Last Posted Date

NAME	ACTIONS	TYPE	STATUS	POS/TIME	SUBMITTER	COUNT	JOB #	POSTED
CPN4 - NLTC	...	Extract	Complete	0:00:35	COMPHER, CHRISTINA (**PHER)	3221	51550	10/08/2019 14:43:36
CPN4 Test	...	Extract	Complete	0:00:39	COMPHER, CHRISTINA (**PHER)	3221	51492	10/08/2019 13:39:41
E3 NLTC Report	...	Extract	Complete	0:00:32	COMPHER, CHRISTINA (**PHER)	1785	51468	10/08/2019 12:56:05
F32 Non-deemed ASCs Report	...	Extract	Complete	0:00:25	COMPHER, CHRISTINA (**PHER)	927	51244	10/07/2019 22:18:57

Click on the three dots beside the report and select Download.

Filtered by: Limit Date: 10/02/2019 to 10/08/2019

REPORT DESIGNER

JOB QUEUE Explain This...

REPORT LIBRARY

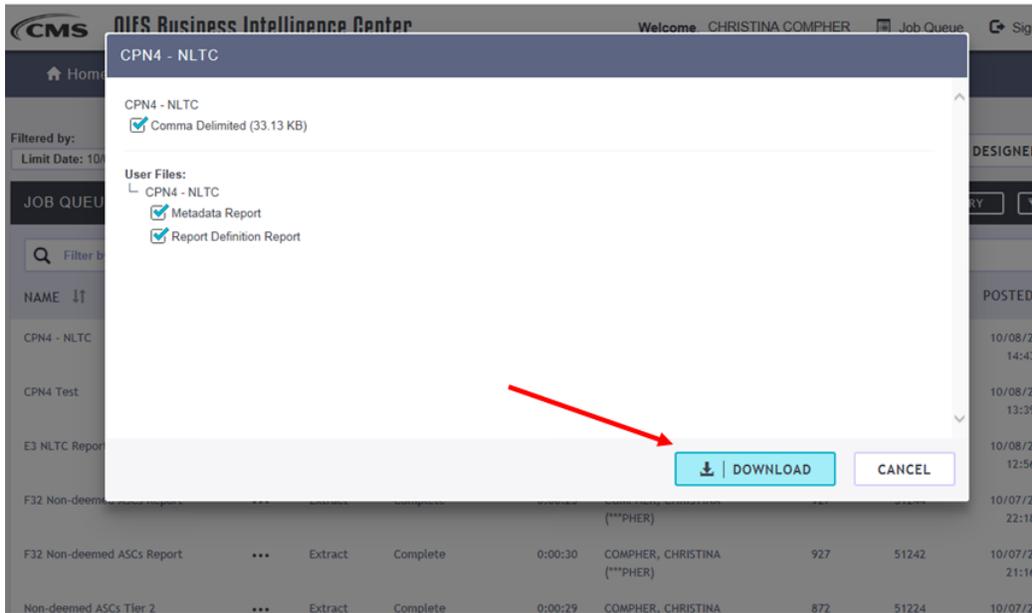
Filter by Job Name, Report Type, Status, Position, Running Time, Submitter, Count, Job Number or Last Posted Date

NAME	ACTIONS	TYPE	STATUS	POS/TIME	SUBMITTER	COUNT	JOB #	POSTED
CPN4 - NLTC	...			0:00:35	COMPHER, CHRISTINA (**PHER)	3221	51550	10/08/2019 14:43:36
CPN4 Test	...			0:00:39	COMPHER, CHRISTINA (**PHER)	3221	51492	10/08/2019 13:39:41
E3 NLTC Report	...	Extract	Complete	0:00:32	COMPHER, CHRISTINA (**PHER)	1785	51468	10/08/2019 12:56:05
F32 Non-deemed ASCs Report	...	Extract	Complete	0:00:25	COMPHER, CHRISTINA (**PHER)	927	51244	10/07/2019 22:18:57

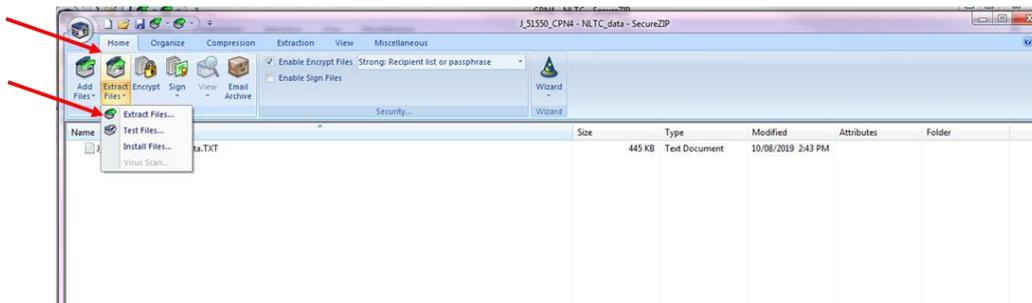
Available Actions

- Delete
- Download
- Status Report
- View Summary

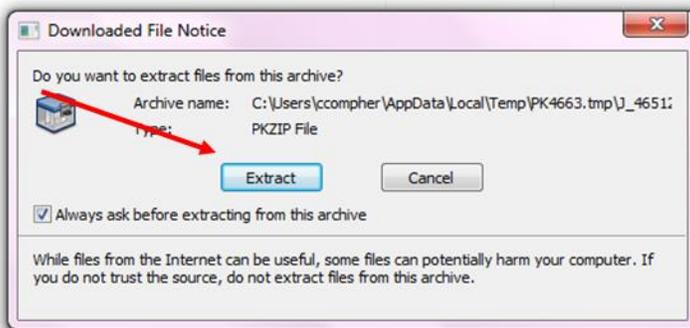
Click on Download



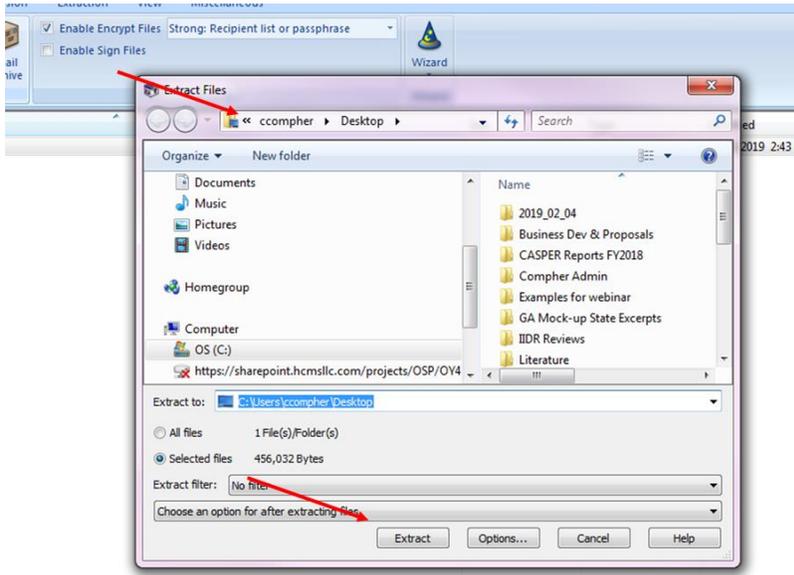
Once the zipped file has downloaded, click on the zipped data file inside the original data file and select Open. Highlight the file and click on Extract Files. From the drop-down menu select Extract Files.



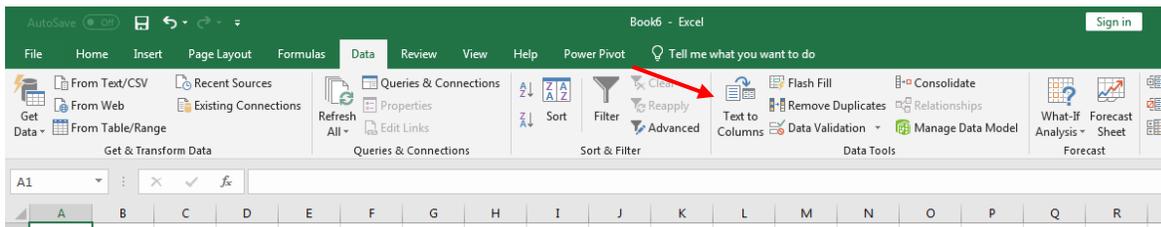
Click on Extract



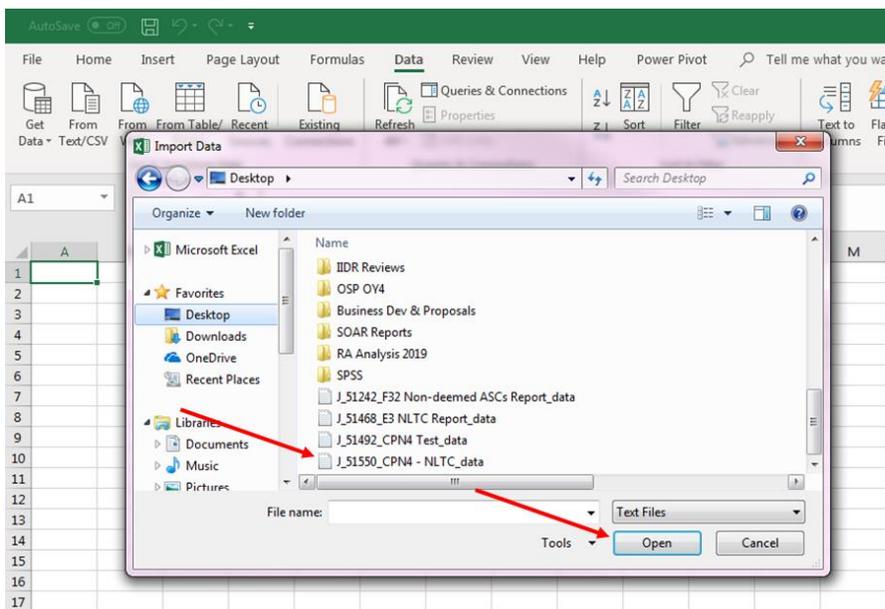
Navigate to a location to save the file. Then click Extract.



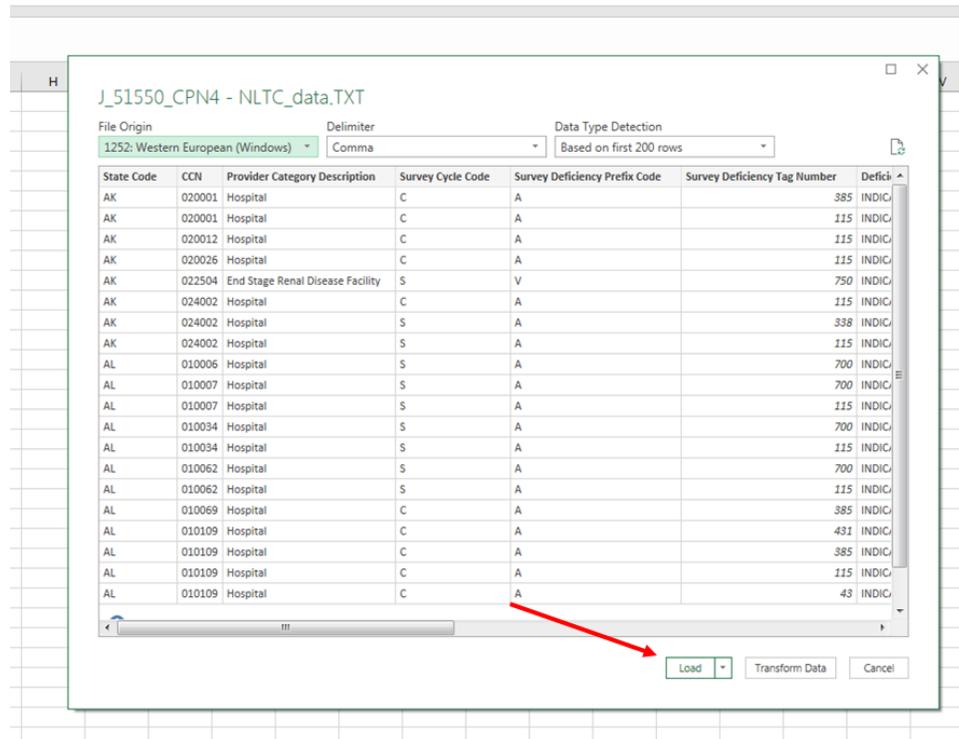
Open Excel and Navigate to the Data menu. Click on From Text/CSV.



From the pop-up Import window, navigate to the location the report was saved and select it. Click Open.



Click Load.



Once the data has been imported, use the generated report to complete the following steps:

1. Count the number of surveys with a condition level deficiency associated with the state. Make sure to de-duplicate surveys using the CCN and Survey Date fields (call this [a]).
2. Count the number of surveys with a condition level deficiency where the "Days between Survey and Survey Deficiency Status" was less than or equal to 55 (call this [b]).
3. Use Regional Office survey files to verify that the State submitted the information required for processing the termination of the provider to the Regional Office by the 55th day following the Survey Date. Count all cases where the State Agency submitted the information by the 55<sup>th</sup> day to the Regional Office (call this [c]).

To calculate CPN4, add [b] and [c], divide the sum by [a], and multiple by 100.

**Percentage of Condition-Level Cases within Compliance or Transferred to the RO within 55 days =**

$$\frac{(b+c)}{(a)} \times 100$$

If the resulting percentage is  $\geq$  80 percent, this measure is scored as "Met."

## Appendix 22: Rounding Issues

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

**Sample Selection (Q1, Q4, Q6, Q7):** When pulling a random sample, the sample size should always be rounded **up** to the nearest whole number. Rounding down in sample selection results in less than the required sample size.

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

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

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

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

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

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

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

**SPS Q2** - Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS FCS. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS Q3** - Identification of Health, LSC, and EP Deficiencies and Emergency Preparedness (EP) on Nursing Home Surveys as Measured by Federal Comparative Survey Results. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS Q4** - Prioritizing Complaints and Incidents. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS Q5** - Timeliness of Complaint and Incident Investigations. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS Q6** - Timeliness of EMTALA Investigations. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS Q7** - Quality of Investigation. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.

**SPS CPN1-CPN4** – Coordination of Provider Noncompliance. See above comment regarding sample selection. Rounding is not allowed in determining whether the SA met or did not meet the threshold criterion.