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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Clinical Standards and Quality/ Survey & Certification Group

Ref: S&C: 12-12-ALL

DATE: **December 9, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey & Certification Group

SUBJECT: Prudent Action for the FY 2012 Medicare Survey & Certification (S&C) Budget

Memorandum Summary

The Challenge of More Providers and an Increased Survey Workload: Since 2001 there has been a 21.4% increase in the overall number of Medicare-certified providers to be surveyed. Among all types of facilities, the numbers of home health agencies (HHAs), ambulatory surgical centers (ASCs), and dialysis facilities (ESRD) have grown the fastest (increasing by 69.3%, 60.8%, and 37.3% respectively, between 2001 and 2010). New and expanded responsibilities have further increased the S&C workload. For example, due to improved Centers for Medicare & Medicaid Services (CMS) quality of care and safety expectations for dialysis facilities, average hours per ESRD survey recently increased by 37%.

FY2012 Budget: The fiscal year 2012 has already begun, and we expect it will still take some time before the full Congress acts on legislation to fund the FY2012 Centers for Medicare & Medicaid budget. However, early indications are that the budget level for Medicare survey & certification (S&C) will most likely be 10%-12% less than the level requested by the President. Therefore, we believe it is prudent to prepare now for a lower FY2012 funding level than previously expected.

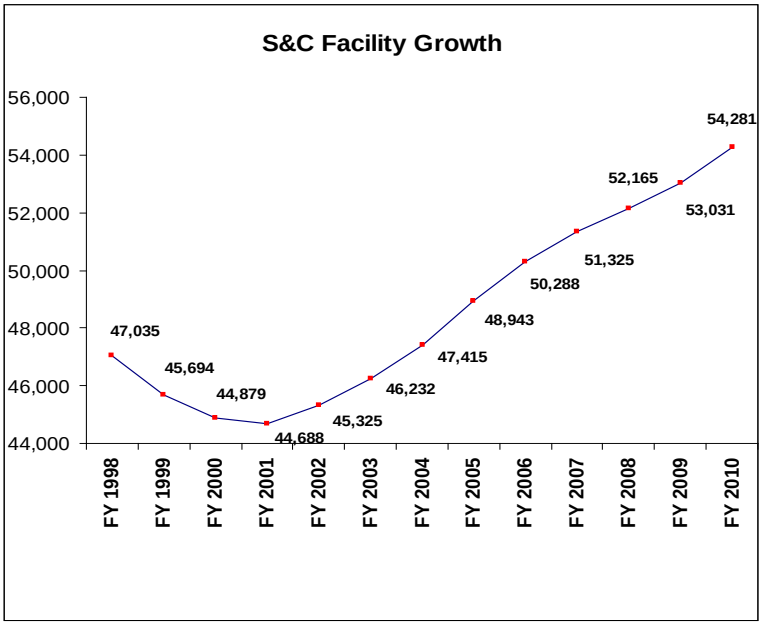
Efficiency + Effectiveness Initiatives: Fortunately, CMS and States have worked to develop a variety of methods to increase efficiency and effectiveness. While these efforts may not entirely address the difference between the requested and likely budget levels, they will mitigate negative effects. Additional efforts will be necessary, and expectations for FY2012 funding will need to be adjusted.

A. Background – Drivers of Increased S&C Workload

Three trends have converged to cause the Medicare and Medicaid survey workload to increase significantly:

1. Increases in Providers: Since 2001 there has been a 21.4% overall increase in the number of Medicare-certified providers and suppliers subject to survey (from 44,688 in FY2001 to 54,261 in FY2010, excluding clinical laboratories). The numbers of HHAs, ASCs, and ESRD facilities have grown the fastest (69.3%, 60.8%, and 37.3% respectively, between 2001 and 2010). These trends continue. The average annual increase in the number of these providers for the most recent three-year period (FY2007-FY2010) for which complete data are available was 7.8% for HHAs, 3.6% for ASCs, and 3.7% for ESRD facilities.

This graph portrays the end-of-year number of all providers and suppliers that are subject to survey & certification, excluding clinical laboratories.



2. Improved Regulations: In recent years CMS revised key regulations to update and improve public protections for beneficiaries. For example, revised ASC and ESRD regulations strengthened infection control expectations and added a requirement for each provider to maintain an internal quality assessment and performance improvement capability (QAPI). Entirely new regulations were implemented for solid organ transplant hospitals, including risk-adjusted, expected outcomes for graft and patient survival of transplant recipients.

3. Improved Survey Processes: CMS has consistently upgraded its surveyor guidance, training, and processes to improve the ability of surveyors and providers to identify quality of care or safety problems. CMS expanded the new Quality Indicator Survey (QIS) and issued many upgrades to the nursing home guidance, such as improvements in detecting the use of unnecessary medications. As a result, the percent of surveys in which nursing homes have been cited for unnecessary use of medications (such as inappropriate use of anti-psychotics) increased from an average of 13% to 19%. Similarly, CMS and States have substantially upgraded the quality of surveys for ASCs and dialysis facilities, particularly in the attention devoted to infection control.

One effect of the upgrades in CMS regulations and survey processes has been an increase in average hours per survey for some of these key provider types, as shown in the following table.

Table: National Increase in Average Standard Survey Time for Certain Types of Providers or Suppliers

Provider Type	Major Type of Improvement	FY 2010 Hours v. Avg Hrs for 2002-2008
Ambulatory Surgical Centers (ASCs)	Regulation and Survey Process Improvement	206.8%[1]
Organ Transplant Hospitals	Entirely New Regulation	100%[2]
Hospice	Regulation Improvement	53.9%[3]
Non-Accredited Hospitals	Survey Process Improvement	28.4%[4]
Dialysis Facilities (ESRD)	Regulation and Survey Process Improvement	37.0%[5]
Home Health Agencies (HHAs)	Regulation Improvement	19.3%[6]
Nursing Homes (SNF/NF)	Survey Process Improvements	8.8%[7]

[1] ASCs: From 27.7 hrs /survey to 84.6 hrs.
[2] Transplant Hospitals: to 158.5 hrs/survey.
[3] Hospices: From 45.5 hrs/survey to 95.9 hrs.
[4] Non-accred.Hospitals: From 181.5 hrs/survey to 235.**5 h**rs. Accredited hospital validation time also increased 29.7%
[5] ESRD Facilities: From 51.1 hrs/survey to 70.0 hrs.
[6] HHAs: From 58.5 hrs/survey to 70.1 hrs.

B. Background – Increasing S&C Efficiency and Effectiveness

We also adopted numerous innovations in the past several years to increase the efficiency and effectiveness of CMS survey and certification functions. These innovations have acted to partially offset the increases in survey workload. For example:

- ***Targeted Surveys:*** We began using performance data to target more frequent surveys to those dialysis facilities and nursing homes whose performance indicates a high risk of quality of care problems.[8] We also strengthened adherence to Federal survey priorities.

- ***Public Information and Market Incentives:*** We created the *Five-Star Quality Rating System* for nursing homes. Each month we publish the ratings on CMS' *Nursing Home Compare* website to assist consumers in making informed choices, increase transparency, and stimulate public and provider attention with regard to the need to improve care in many nursing homes. We also began publishing the names of the Special Focus Facilities (SFF), as well as reaching out to the owners and governing bodies of those SFF nursing homes to help them appreciate the facility's history of persistent poor performance and the imperative for improvement in the quality of care within their nursing home(s).

- ***Provider Attestation with Follow-up:*** We made greater use of attestation in the case of certain providers that newly qualify for exclusion from the inpatient prospective payment system (IPPS).[9]

- ***Regulation Reform:*** Most recently we redoubled our efficiency and effectiveness efforts pursuant to the President's Executive Order entitled *"Delivering an Efficient, Effective, and Accountable Government"* that was published on June 13, 2011.[10] CMS subsequently proposed streamlining a number of regulations.[11] We also revised a number of survey guidelines to improve efficiency.

- ***Collaboration with Consumers, Providers, and Professionals:*** CMS and States redoubled efforts to work with a host of other agencies and organizations who are dedicated to improving quality of care. This includes collaboration with the Department of Health and Human Services (HHS) *Partnership for Patients* to improve hospital safety and adequacy of care transitions, work with each State's Quality Improvement Organization[12] (particularly in working with poorly-performing nursing homes), and with the campaign for Advancing Excellence in America's Nursing Homes.[13] Two examples of the effectiveness of such collaborative efforts have been the reduction in prevalence of pressure ulcers and reduced use of daily restraints in nursing homes. Pressure ulcer prevalence consistently declined from 9.2% of at-risk residents in the first quarter of 2004 to 7.8% in the first quarter of 2010.

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[7] Nursing Homes: From 180.9 hrs/survey to 196.7 hrs.
[8] One initiative focused on nursing homes that manifest persistent poor performance (CMS' *Special Focus Facility* initiative) was later enacted into law as part of the Affordable Care Act of 2010.
[9] See S&C-08-03 (dated November 5, 2007)
[10] http://www.whitehouse.gov/the-press-office/2011/06/13/executive-order-delivering-efficient-effective-and-accountable-governmen
[11] See the proposed rule at http://www.ofr.gov/OFRUpload/OFRData/2011-27176_PI.pdf)
[12] Under contract with CMS' Office of Clinical Standards and Quality (OCSQ).
[13] http://www.nhqualitycampaign.org

Similarly, the percent of residents with daily restraints consistently declined from 7.7% in the first quarter of 2004 to 2.9% in the first quarter of 2010.

An additional imperative for further efficiency and prioritization of our workload can be expected from congressional action on the fiscal year 2012 Federal budget, as well as the President's recent Executive Order to increase efficiency and thereby reduce Federal administrative spending.[14]. While FY2012 has already begun, we expect it will still take some time before the full Congress acts on legislation to fund the FY2012 Centers for Medicare & Medicaid budget. However, early indications are that the budget level for Medicare survey & certification (S&C) will most likely be 10%-12% less than the level requested by the President. This would represent approximately $39-$49 million less than the amount requested by the President.

We therefore believe it is prudent to prepare – now - for a lower FY2012 funding level than previously expected. Such a lower budget level, together with the continued increase in the number of providers and continued increase in S&C responsibilities, indicate the advisability of acting on two sets of endeavors to:

- Adjust State FY 2012 Medicare S&C expected allocations.
- Further advance efficiency and effectiveness initiatives for Medicare survey & certification.

C. State S&C Medicare Allocations

We place a priority on limiting the negative impact on State budgets that may derive from a final funding level that is lower than the President's requested budget. This is because the conduct of objective, onsite surveys by trained State and Federal surveyors (including onsite investigations of serious complaints by the public, beneficiaries and others), remains a top priority to which most other goals will be secondary.

To accomplish this goal we will expand our efficiency initiatives (see section D), strictly enforce CMS S&C policies, and reduce or delay certain CMS central office activities. This will include the delay or stretching out the timetable for certain improvements in the S&C system, such as slowing down the rate at which new States are added to the QIS. It will also require stretching out the timeline for electronic collection of nursing home staffing data, and other initiatives. We continue to make fulfillment of statutorily-required surveys (nursing homes and home health agency surveys) to be the top priority for CMS onsite surveys, as well as sustaining recent survey improvements for other providers (such as better surveillance of infection control lapses among a number of types of providers).

In further reference to priorities, we remind States and providers of the long-standing CMS policy regarding initial surveys for providers that newly seek to participate in Medicare. Essentially, CMS policy is that statutorily-required surveys, targeted surveys of poorly-performing providers, and complaint investigations take precedence over surveys of providers that newly seek Medicare participation. Further, among such initial surveys, CMS gives priority to those provider types (such as ESRD facilities, nursing homes, and transplant centers) that do not have the option to seek Medicare deemed status through certification by a CMS-approved accrediting organization.

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[14] http://www.whitehouse.gov/the-press-office/2011/11/09/executive-order-promoting-efficient-spending, issued Nov. 9, 2011.

CMS does consider exceptions to this tiered priority schedule for initial surveys if there are serious access-to-care issues. While CMS periodically communicates updates in these instructions to States, the key Federal policy for initial surveys can be found at: https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-03.pdf .
Our challenge is to maintain a robust and effective survey & certification system that operates within available resources. We carefully considered the choices that must be made in light of the resource profile for S&C, and have focused on methods that we believe will have the least negative impact on the care of Medicare and Medicaid beneficiaries.

For FY2012 we expect that some States will see a reduction in funds, others will be funded at approximately the FY2011 levels, and some States will see an increase in Medicare S&C funds. These amounts will be based on the State's assessment of needed resources, recent performance, and CMS analysis of the probability that States will reach performance goals and effectively use funds in light of State budget constraints, personnel decisions regarding furloughs, hiring freezes, etc. The basic goal will be to secure maximum use and value in the expenditure of funds.

To achieve the desired value proposition, the CMS Regional Offices (RO) will contact each State and review performance results, needed resources, and plans for the remainder of FY2012. Pertinent to this review will be a discussion of the current prospect in the State for:

- Filling vacancies, and the extent to which furloughs and hiring limits are in effect in the State and are in force with respect to S&C activities;
- Training plans and capabilities, particularly the plans and allowances for new and existing surveyors to secure necessary training through CMS face-to-face and online trainings;
- Completing the CMS workload, in accordance with CMS priorities.

We expect that this review process will be completed by December 22, 2011 and will result in Regional Office recommendations for a FY2012 funding level for each State. We will then finalize and issue revised, expected Medicare S&C funding amounts in January, 2012. We request that each State then submit to the CMS RO by February 28, 2012 a State Medicare budget that is based on the revised projections. As usual, final budget numbers will be dependent upon final action by Congress.

In the February 28, 2012 submission we also request that all States provide a very brief contingency plan in the event that final allocations are either lower or higher (by 2.5%) compared with revised budget targets that we will issue. The contingency plan should focus primarily on the prioritized tasks that would be performed if the final budget were higher or lower than currently anticipated in this memorandum.

D. Efficiency + Effectiveness Initiatives

Within the context of more formidable resource constraints, we apply the following principles to guide our efforts to increase efficiency and effectiveness:

- ***Reduce lower value activities in favor of higher value***: Reduce surveyor time spent on lower value areas in favor of more attention to higher value or higher risk areas.

- ***Strengthen Incentives and Enforcement***: Strengthen incentives and enforcement for providers to improve quality, and to reduce repetition of problems by the same providers.

- ***Use Performance Data to Target Attention to Higher Risk Areas:*** Increasingly use survey information, claims data, complaint information, quality indicators, and other data to improve the ability to direct surveyor attention. Provide increased information and transparency to consumers in user-friendly formats to engender more user and provider attention to quality of care and safety.

- ***Target Technical Assistance to Poorly-Performing Providers:*** Increasingly seek to coordinate with sources of technical assistance (such as the Quality Improvement Organizations (QIOs), ESRD networks, educational institutions, *Advancing Excellence*[15] campaign, and others) so that technical assistance can be more available to persistently poorly-performing providers.

- ***Place a Top Priority on State Onsite Surveys:*** Objective, onsite surveys conducted by trained State and Federal surveyors (including onsite investigations of serious complaints by the public, beneficiaries and others) remains a top CMS priority.

Based on the above principles, we have identified a number of actions for either immediate implementation or consideration for possible action in the near future. The list is not exhaustive. We invite comment and suggestions on these and other potential ideas.

1. Immediate Action: Examples of action we are taking, effective immediately, include the following:

(a) ***IPPS-Excluded Existing Hospitals:*** For existing hospitals that are excluded from the inpatient prospective payment system (IPPS-Excluded Hospitals), such as rehabilitation hospitals or units, and psychiatric hospitals or units - effective immediately - States will not be required to conduct an onsite re-verification of IPPS exclusion criteria for a 5% sample of rehabilitation hospitals, and rehabilitation and psychiatric units within short-term acute care hospitals, when those units have already qualified for IPPS exclusion. This survey practice is not required by statute or regulation.

While the annual 5% sampling of IPPS-excluded hospitals is advisable, we consider it to be a lower priority compared to other survey endeavors that we seek to preserve. These sampled surveys, which (by CMS policy) were to be scheduled at least 90 days prior to the beginning of the hospital cost reporting period, will be suspended indefinitely.

(b) ***QIS Expansion:*** We will stretch out the timeline for adding new States to the Quality Indicator Survey (QIS) for nursing homes, and concentrate on fully and effectively

[15] More information about *Advancing Excellence in America's Nursing Homes* may be obtained at http://www.nhqualitycampaign.org/

implementing the QIS in those States that are already implementing the system. We consider the QIS to add considerable value and prospects for improved consistency in the survey process. These advantages are due to a number of notable design features, such as its greater use of data for each nursing home, greater resident sample sizes, more structured survey protocols, tools for quality improvement, and ability to tailor onsite time according to the seriousness of the initial findings. Heretofore we have also had to accomplish implementation of QIS as a sideline to the survey & certification operational budget, but for the future we will renew efforts to raise the QIS as a stand-alone item worthy of distinct budget treatment. In the meantime, a separate communication will provide the details of the revised schedule for adding new States to the QIS enterprise.

(c) ***Government Accountability Organization (GAO) and Office of the Inspector General (OIG) Recommendations:*** We are deferring into FY2013 or FY 2014 follow-up action on many GAO and OIG recommendations that were otherwise scheduled for action in FY2012, in order to design and implement additional efficiency initiatives[16]. We will prepare a revised schedule of such activities when Congress passes the final FY2012 budget, one which seeks to maintain as much positive momentum as possible for the continued improvement of survey processes. However, there are certain key recommendations that we will continue to advance in FY2012 with vigor.

(d) ***ASC Infection Control Worksheets:*** As of January 1, 2012, SAs will no longer be required to submit a completed ASC infection control worksheet to CMS' contractor (Acumen). We have sufficient data from FY 2010 – FY 2011 to support analysis at this time, and are therefore able to defer this data submission. We continue to expect SAs to continue to use the infection control worksheet to guide their assessment of an ASC's compliance with the infection control regulatory requirements. We continue to place a high priority on addressing infection control problems in ASCs, and continue to maintain survey frequency of once every 4 years in FY2012.

(e) ***ESRD Surveys:*** We are expanding the tier III maximum time interval[17] between surveys of any one dialysis facility to once every 4 years, from once every 3.5 years. However, we retain as a high (tier II) priority for the survey of 50% of those facilities that are in the lowest-performing quintile (20%). Half of the bottom 20% is equal in number to 10% of the total number of all facilities. We also continue to develop other methods to safeguard care for ESRD patients. And we continue to work on performance metrics and improvements to performance transparency for dialysis facilities, as well as improvements to CMS' *ESRD Compare* website at: https://www.cms.gov/DialysisFacilityCompare/

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[16] We will continue work on a limited number of exceptions, such as policies for increased communications with CMS-approved accrediting organizations (AOs) and referral of certain categories of complaints to the AOs.

[17] CMS prioritizes survey activities according to four tiers. Tier I is comprised primarily of statutorily-required surveys of nursing homes and home health agencies, as well as potential immediate jeopardy complaint investigations and certain validation surveys. Tier II is comprised primarily of other complaint investigations and targeted surveys of a sample of providers whose past performance data indicate a high likelihood of non-compliance with CMS quality of care or safety requirements. Tier III is comprised primarily of survey frequency intervals for all providers whose frequency is not specified in law, together with initial surveys of providers newly seeking Medicare participation and who do not have the option of seeking deemed status through accreditation by a CMS-approved accrediting organization. Tier 4 consists primarily of additional survey frequencies for providers, as well as initial surveys of providers newly seeking Medicare participation who do have the option of seeking deemed status through accreditation by a CMS-approved accrediting organization

(f) ***Hospice:*** We are expanding the tier III maximum time interval between surveys of any one Hospice facility to once every 7 years from once every 6.5 years. However, we retain as a high (tier II) priority the survey of a 5% sample of the lowest-performing providers. We continue to examine additional methods to target survey attention to those providers where the risk of non-compliance with CMS quality of care requirements is greatest.

(g) ***Transplant Centers:*** We are expanding the tier III maximum survey interval for surveys of each transplant program to once every 5 years from once every 4 years. However, we are retaining the continuous review of clinical experience and risk-adjusted outcomes. We are also retaining the tier II targeted surveys for transplant programs that have had poor results or significant program change. Additional details will be communicated to States in a separate memorandum.

(h) ***Nursing Home Staffing Data:*** We are stretching out the timeline for the design and implementation of the system identified in section 6106 of the Affordable Care Act for quarterly, electronic collection of staffing information in nursing homes. Such a system requires a considerable investment in a information systems. Such an informational infrastructure must be capable of collecting and processing large amounts of information from 15,800 nursing homes each quarter, and rendering the information in a displayed and usable manner on CMS' *Nursing Home Compare* website. It must also support quarterly calculation of measures and data for use in CMS' *Five-Star Quality Rating System*. Since the sizable resources needed for this enterprise are not likely to be found in the FY2012 budget, we will continue with our design work but stretch out the timeline. As a result, the system will not be implemented by the March 23, 2012 date envisioned by the Affordable Care Act.

2. Additional Steps under Consideration: Examples of initiatives that we are exploring include:

Nursing Homes: We are exploring methods to increase the focus on certain high priority areas. To make possible such increased focus and to accommodate the budget constraints, we are examining ways to reduce surveyor time in areas of lower risk. Particular areas in which we seek to increase the focus include:

- Poorly-Performing Nursing Homes: We are exploring potential expansion of the SFF initiative, as well as methods to coordinate with other entities (such as the QIOs) that can provide increase technical assistance to poorly-performing facilities that serve a high proportion of low-income recipients, or nursing homes in areas where there are access-to-care problems. In addition, we might focus CMS validation surveys on those facilities rated as lower in quality (e.g., the one, two or three-star nursing homes). Further, we might no longer require the LSC portion of the survey for the non-annual (6th-month) survey of Special Focus Facilities (because SFFs are surveyed twice per year).

- Inappropriate Anti-Psychotic Use: In collaboration with consumer groups, nursing homes, educational providers, professionals, QIOs, and others, we are exploring methods to design and implement a multi-faceted program to reduce inappropriate use of medications, particularly inappropriate use of anti-psychotics. We hope that this will include new quality measures that can be posted on the CMS *NH Compare* website and a broad partnership with

consumers, nursing homes, and professionals.

- Avoidable Falls: We are exploring a new measure, and effort, to reduce avoidable falls on the part of nursing home residents.

Areas in which we hope to achieve greater economies so as to enable the above increase attention to high priority areas and address budget constraints include:

- Life-Safety Code (LSC) Evidence: We are exploring methods to reduce the amount of surveyor time required for onsite inspection of life-safety code requirements. An example may be increased documentation and attestation that could be made available to surveyors by the nursing homes that will provide evidence of the regular conduct of maintenance checks, fire drills, emergency preparedness, etc. LSC requirements might conveniently be described as consisting of two major components: (a) structural requirements, such as one-hour fire walls and smoke compartments, and (b) maintenance requirements. Structural configurations change infrequently. Maintenance requirements need continuous, ongoing attention. One example of an efficiency initiative may therefore be extending the time period for which engineer's LSC portion of the survey is valid, and adding some additional checks to the health portion of the annual survey to address the fulfillment of public expectations for continuous maintenance. The August 13, 2013 effective date of CMS' new sprinkler requirement for non-sprinklered facilities or units will also require attention, but in the long run could reduce the amount of surveyor time needed for such facilities.

- Higher-Performing Facilities: To enable more time to focus on poorly-performing facilities, we are exploring methods to reduce the amount of time required for surveys of facilities that are consistently rated as five-star facilities on the CMS' *Five-Star Quality Rating System* published on CMS' *NH Compare* website, except that serious complaints or initial worrisome findings would always trigger the longer survey.

Hospitals: We are retaining our current efforts to support CMS' *Partnership for Patients* initiative through focused surveys related to infection control, discharge planning, and QAPI. We are exploring the following areas to achieve better efficiency, among others:

- Accredited Hospitals-Full Surveys after Complaint Investigations: We are examining alternate methods of targeting both complaint and full surveys. Currently, when a complaint investigation reveals a Condition-level deficiency, CMS removes Medicare deeming and requires that States follows up with a full survey. We are exploring the possibility of treating accredited hospitals in the same manner we treat non-accredited hospitals when Condition-level noncompliance is found. This would mean taking immediate action on the Condition-level deficiency, and proceeding with a full survey based on an assessment of risk, rather than automatically conducting a full survey in every case, as is the current practice. Instead, the hospital would still be subject to a full survey but the actual conduct of a full survey would be based on an assessment of risk, and judgement regarding the adequacy of the hospital's response to the findings that resulted from the complaint investigation.

- Accredited Hospitals – Complaint Investigation Surveys: We are examining methods to increase communication and coordination with CMS-approved accrediting organizations (AOs), including the referral of more complaints for follow-up by the AOs and more information available to the AOs regarding complaints lodged against accredited hospitals.

Dialysis Facilities: We are exploring the potential to apply a basic survey to facilities whose performance data are in the top 33%-50% of all facilities. An extended survey (i.e., the current extended survey) would then apply to (i) any higher-performing facility (top 33%-50%) whose basic survey indicates the probability of a serious deficiency and (ii) all facilities whose performance data falls in the lower 50%-67% of all facilities. A similar approach has been in use with HHA agency surveys for many years.

National Training Institute: We are considering methods to keep momentum for the design and implementation of a national training institute for training surveyors in complaint investigations, in light of the lower funding level expected for FY2012. The importance of such a training institute was identified in section 6703 of the Affordable Care Act, and we consider additional training in this area to be vital.

We invite comments and suggestions regarding methods to increase the efficiency and/or effectiveness of survey and certification functions. Our focus is on increasing efficiencies while maintaining, and where possible strengthening, the protections and quality of care for Medicare and Medicaid beneficiaries. Suggestions and comments may be sent to BetterCare@cms.hhs.gov. In the meantime, those items identified in section D1 of this memorandum ("Immediate Action") are effective immediately.

When FY2012 funding levels are finalized, we will provide further communication clarifying the initiatives that may or may not be amended pursuant to the final outcome of budget negotiations.

E. Other Considerations

It is worth emphasizing a number of items that are not under consideration for change and for which we continue to move forward at full speed. Examples include (but are not limited to):

We are not proposing to change CMS policy on the desired frequency of surveys. So while the tier III expected interval for time between surveys for any single ESRD facility is being changed to once every 4.0 years (from once every 3.5 years), CMS policy (for tier IV) for an overall average frequency for all ESRD facilities remains at 3.0 years.

We continue to move forward on all *Partnership for Patients* initiatives to improve hospital infection control, discharge planning, and QAPI.

With regard to nursing home care, we continue to advance new initiatives with (a) poorly-performing nursing homes, (b) reducing falls (*new*), pressure ulcers, and use of restraints, (c) reducing inappropriate use of anti-psychotic medications (*new*), (d) strengthening the civil monetary payment system (*new*), and (e) making further improvements to the *Five-Star Quality Rating System* and CMS' *NH Compare* website.

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

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management