DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Ref: S&C-03-27

DATE:

FROM: Director
Survey and Certification Group

SUBJECT: State Survey Agency Performance Standards for Fiscal Year (FY) 2003

TO: Survey and Certification Regional Office Management (G-5)
State Survey Agency Directors

The purpose of this memorandum is to transmit the final Centers for Medicare & Medicaid Services' (CMS) FY 2003 State Performance Standards. On March 25, 2003, we provided a draft copy of the FY2003 Performance Standards and Protocols for your comments. Since that time, we have received requested changes and clarifications to specific standards and protocols from state and federal representatives, as well as participants attending the Leadership Summit early April 2003. As a result, aspects of the protocols have been revised and clarifications provided regarding sample sizes, language, and threshold percentages.

The revised standards are attached in five additional files that provide detailed instructions, forms, and worksheets for the review protocols as an accompaniment to this memorandum. A summary of pertinent changes is as follows:

Standard 1 – No revisions.

Standard 2 – No revisions.

Standard 3 – No revisions.

Standard 4 – **Emphasis (B), Threshold Criterion**
Decreased the threshold from 95% to 80%.
Emphasis (C), Threshold Criterion
Decreased the threshold from 95% to 80%.

Standard 5 – No revisions.

Standard 6 – The sample sizes for most emphases were increased to provide a more appropriate sample for evaluation.

Emphasis (A), Threshold Criteria:
Decreased the threshold from 100% to 90%.
Revised the sample to include ten complaints prioritized as Immediate Jeopardy for both nursing homes and nonaccredited hospitals.
Revised the sample to include ten complaints prioritized as actual harm.
Emphasis (B), Sample Size
Revised sample size for accredited hospitals
Emphasis (C), Sample Size
Increased sample size
Emphasis (D), Threshold Criterion
Decreased the threshold from 100% to 90%.
Emphasis (E), Threshold Criterion
Decreased the threshold from 100% to 95%.
Emphasis (F), Threshold Criterion
Decreased the threshold from 100% to 95%.
Emphasis (G), Threshold Criterion
Decreased the threshold from 100% to 90%.
Revised OSCAR entry timeframe from 20 days to 70 days.

Standard 7 – Revised protocol to clarify OSCAR/ASPEN data entry date from 20 days to 70 days, clarification of instructions, and of scoring documents.

Thank you for your continued participation in the performance standard process. Your willingness to develop, implement, and enhance these standards has resulted in an improved method for FY 2003.

For questions concerning the 2003 Performance Standards, please contact Linda Smith at (410) 786-5650 or via email at LSmith2@cms.hhs.gov.

Effective Date: Immediately.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers and the state/RO training coordinator.

/s/
Steven A. Pelovitz

Attachments:
02-FY2003SPSManual.doc (See below)
03-FY2003AppA.doc (See below)
04-FY2003AppB.xls (ZIP 56KB)
05-FY2003AppC.pdf (See below)
06-FY2003AppD.zip (print file PS7_Index.doc first for help in collating your document) (ZIP 73KB)

FY 2003 State Performance Review Protocol Guidance

Centers for Medicare & Medicaid Services
State Performance Measures
May 2003

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Attachments

Appendix A: State Performance Standard Review Protocol Summary

Appendix B: Performance Standard 2 Excel Worksheets

Appendix C: Performance Standard 5 Score Sheet

Appendix D: Performance Standard 7 Worksheets and Instructions

Purpose

This guidance is being issued to set out the performance standards, review protocols and a reporting mechanism for State performance standards.

Background

FY2001 represented the first year of implementation of the new standards. In each of the last two years, the standards have been revised and clarified to enhance the process.

Representatives from both CMS and the Association of Health Facility Survey Agencies (AHFSA) developed the review protocols contained in this guide.

The 1864 Agreement, Article II (J) and the State Operations Manual (SOM) contain the regulatory authority for these review protocols. Specific references to regulations and sections in the SOM are included in the review protocols.

The review forms and worksheets are included.

Scoring should be conducted according to the methodology and calculation sections that are listed within each standard. Scoring sheets for the specific standards are included in the Appendices. CMS Regional Offices submit a completed State Performance Standard Review Summary packet (which includes all seven standards) for each State in the region.

NOTE: To promote consistency in terminology, Long Term Care (LTC) refers to nursing homes and Non Long Term Care (NLTC) refers to all other provider types, i.e., Intermediate Care Facilities for persons with Mental Retardation, (ICFs/MR), Home Health Agencies (HHAs), accredited and nonaccredited hospitals, End-Stage Renal Disease facilities (ESRD), Hospice, Outpatient Rehabilitation, Emergency Medical Treatment and Labor Act (EMTALA) etc., excluding CLIA.

2003 STANDARDS FOR ADEQUATE STATE SURVEY AGENCY PERFORMANCE

Standard 1: Surveys are planned, scheduled and conducted timely.

Emphasis (A):
The State Agency (SA) begins no less than ten percent (10%) of its standard surveys of nursing homes during weekends, holidays, or "off hours."

- Threshold Criterion: In no less than ten percent (10%) of the standard surveys a SA conducts during a twelve month period, the time of day that surveyors begin should extend beyond the business hours of 8:00 am to 6:00 pm and should either incorporate evening hours after 7:00 pm or morning hours before 7:00 am, unless they are started during weekend days i.e., Saturdays, Sundays, and holidays. To count towards the ten percent, once begun, a survey must be conducted on consecutive calendar days, even if those days encompass Sundays and holidays.

- Data Source: User-defined OSCAR reports and SA survey schedules.

- Statutory/Regulatory Citations: 42 CFR 488.307 and Section 7207 B. 2. of the SOM.

Emphasis (B):
The SA complies with requirements for conducting standard surveys of nursing homes within prescribed time limits.

- Threshold Criterion: No less than one hundred percent (100%) of the consecutive standard surveys of nursing homes conducted by the SA are conducted within fifteen (15) months between surveys. The average statewide interval between consecutive standard surveys is no greater than twelve (12) months.

- Data Source: User-defined OSCAR reports, OSCAR Report #27 for LTC survey intervals, and SA schedules.

- Statutory/Regulatory Citations: Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Social Security Act (SSA) and 42 CFR 488.308.

Emphasis (C):
The SA conducts all legislatively mandated surveys within the timeframes established by law.

- Threshold Criteria:
  - All HHAs are recertified every thirty-six months.
  - All ICFs/MR are recertified before the expiration date of the existing time-limited agreement. If a survey is conducted after the original expiration date, the SA must have given the State Medicaid Agency written notice that it should extend the agreement and the recertification survey must have occurred before the expiration date of the extension.
  - Validation surveys are conducted on hospitals selected as part of the 1% sample.

- Data Source: User defined OSCAR reports, SA survey schedules and other records.

- Statutory/Regulatory Citations:
  HHAs – 1891(c)(2)(A)
  ICFs/MR – 42 CFR 442.109, 442.10 and 442.16
  Validation Surveys – Sections 1864c and 1865 of the SSA and 42 CFR 488.7.

Standard 2: Survey findings are supportable.

Emphasis (A):
The SA explains and properly documents all deficiencies on the CMS Form- 2567, Statement of Deficiencies (SOD).

- Threshold Criterion: No less than eighty-five percent (85%) of deficiencies cited on SODs reviewed meet the Principles of Documentation for deficiency citation.

- Data Source: CMS-2567 Statement of Deficiencies for standard and complaint nursing home surveys.

- Statutory/Regulatory Citations: 42 CFR 488.318 and the Principals of Documentation of the SOM.

Standard 3: Certifications are fully documented, and consistent with applicable law, regulations and general instructions.

Emphasis (A):
The SA conducts surveys of nursing homes in accordance with CMS instructions.

- Threshold Criterion: No less than one hundred percent (100%) of nursing home surveys are satisfactorily conducted by effectively achieving the desired outcomes of the survey using Federal standards, protocols and procedures, policies and systems specified in CMS instructions.

- Data Source: Federal Monitoring Survey (FMS) results (Federal Oversight Support Surveys and Comparative Surveys).

- Statutory/Regulatory Citations: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the SSA.

Standard 4: When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to. (Excludes CLIA)

Emphasis (A):
"Immediate Jeopardy" cases involving LTC and NLTC Providers and Suppliers are processed timely.

- Threshold Criterion: In ninety-five percent (95%) of the SA's determinations that there is Immediate Jeopardy to resident and patient health and safety in a provider or supplier that was not abated (removed) onsite (prior to the end of the survey), the SA adheres to the 23-day termination process as outlined in 42 CFR 488.410 and 42 CFR 489.53.

- Data Source: SA Provider certification files and OSCAR reports.

- Statutory/Regulatory Citations:
  Sections 1819(h)(2)(A)(1), 1919(h)(1)(A), 1919(h)(3)(B)(1), 1866(b) of the SSA; and 42 CFR 488.410 and 42 CFR 489.53.

Emphasis (B):
Denial of Payments for New Admissions (DPNA) must be imposed by the third month when a LTC facility is not in substantial compliance for 3 months after the date of the original survey. The SA adheres to the enforcement processing timeframes.

- Threshold Criterion: In eighty percent (80%) of the cases, revisits are conducted by the 60th day and the enforcement packet is sent to CMS or notice is sent by the State to the provider by the 70th day.

- Data Source: Enforcement tracking system reports and SA provider certification files.

- Statutory/Regulatory Citations: Section 1819(h)(2)(D) & (E) and 1919(h)(2)(C) & (D) of the SSA; and 42 CFR 488.417(b)

Emphasis (C)
Noncompliance with one or more Conditions of Participation or Conditions of Coverage and cited deficiencies limit capacity of the provider/supplier to furnish adequate level or quality of care. **(NLTC providers only, excluding CLIA)**

- Threshold Criterion: In eighty percent (80%) of the cases which cite condition-level noncompliance on the part of a provider or supplier the SA adheres to the ninety (90) day termination process described in Section 3012 of the SOM.

- Data Source: CMS and SA provider survey and certification files and CMS tracking systems.

- Statutory/Regulatory Citations: Section 1866 (b) of the SSA and 42 CFR 489.53.

Standard 5: All expenditures and charges to the program are substantiated to the Secretary's satisfaction.

Emphasis (A):
The SA employs an acceptable process for charging the Federal programs.

- Threshold Criterion: The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its Title XVIII and XIX expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.

- Data Source: The CMS Budget Call Letter, the form CMS-435 State Survey Agency Budget/Expenditure Report and the form CMS-434 State Survey Agency Workload Report.

- Statutory/Regulatory Citations: Sections 1864 and 1902 of the Act provide the basis for agreements and plans with states under which CMS pays states for costs incurred in performing survey and certification functions.

Emphasis (B):
The SA has an acceptable method for monitoring its current rate of expenditures and planned workload.

- Threshold Criterion: The SA monitors and analyzes both its spending and workload progress throughout the fiscal year to ensure that the program priorities are accomplished within its approved budget.

- Data Source: The OSCAR 10, 15 and 25 Reports, the form CMS-435 State Survey Agency Budget/Expenditure Report and the form CMS-434 State Survey Agency Workload Report.

- Statutory/Regulatory Citations: Sections 1864 and 1902 of the Act provide the basis for agreements and plans with States under which CMS pays States for costs incurred in performing survey and certification functions.

Standard 6: The conduct and reporting of complaint investigations, both Long Term Care and hospital complaints, including hospital federal allegation and EMTALA complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures.

Prior to the review of this standard, appropriate staff from CMS must schedule a meeting or discussion with each SA. The purpose of the meeting is to discuss and review any revisions to the State's complaint triage and prioritization policy. This review should include policies and procedures for complaints referred to another agency or entity (e.g., law enforcement, ombudsman, licensure agency, etc). Refer to the October 14, 1999 memorandum from Rachel Block to State Survey Agency directors.

Emphasis (A):
The SA maintains and follows guidelines for the prioritization of complaints.

- Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints.

- Data Source: OSCAR/ASPEN Central Office, SA complaint log(s) and/or ACTS.

- Statutory/Regulatory Citations:
  SOM 3260, SOM 3262, SOM 3280; Section 1819 (g) (4) and Section 1919 (g) (4) of the SSA; and 42 CFR 488.332, and SOM 7700.

Emphasis (B):
The SA investigates all complaints it receives for Medicare/Medicaid certified facilities in LTC and accredited and non-accredited hospitals alleging "Immediate Jeopardy" to resident and/or patient health and safety within prescribed time limits.

- Threshold Criterion: The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities for all LTC and accredited and non-accredited hospitals where it determines there is a present or ongoing Immediate Jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA.

- Data Source: OSCAR/ASPEN Central Office reports, CMS and SA complaint log(s) and/or ACTS.

- Statutory/Regulatory Citations:
  Section 1819(g)(4) and Section 1919(g)(4) of the Act; 42 CFR 488.332; Section 7700(G)(1), 3262, and 3281 of the SOM.

Emphasis (C): The SA investigates all EMTALA complaints referred by CMS within prescribed time limits.

- Threshold Criterion: The SA investigates one hundred percent (100%) of all EMTALA complaints within 5 working days consistent with CMS and State policy.

- Data Source: CMS EMTALA logs and completed survey packets sent to CMS.

- Statutory/Regulatory Citations:
  Section 1819(g)(4) and Section 1919(g)(4) of the Act; Section 3406(B) of the SOM; and Article II (A)(2) of the 1864 Agreement.

Emphasis (D):
The SA investigates all certified accredited hospital "non-Immediate Jeopardy" complaints that allege non-compliance with Conditions of Participation within prescribed time limits.

- Threshold Criterion: The SA investigates ninety percent (90%) of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with Conditions of Participation within 45 calendar days consistent with CMS policy.

- Data Source: CMS and SA complaint log(s) and/or ACTS.

- Statutory/Regulatory Citations: SOM 3260; SOM 3262; and SOM 3280.

Emphasis (E):
The SA investigates the Medicare/Medicaid certified LTC complaints it receives alleging "actual harm" to residents, within prescribed time limits.

- Threshold Criterion: The SA investigates ninety-five percent (95%) of the complaints for Medicare and Medicaid certified facilities it receives alleging or involving actual harm to residents consistent with CMS and state policy.

- Data Source: ASPEN/OSCAR Central Office, SA complaint log(s) and/or ACTS.

- Statutory/Regulatory Citations: Sections 1819(g)(4) and 1919(g)(4) of the Act, 42 CFR 488.332 and Section 7700 of the SOM.

Emphasis (F):
The SA maintains and follows guidelines for the investigation of LTC complaints, which do not allege or involve immediate jeopardy, or actual harm to residents.

- Threshold Criterion: The SA initiates an investigation for ninety-five percent (95%) of the complaints consistent with CMS and State policy for complaints that do not allege or involve immediate jeopardy or actual harm to individuals.

- Data Source: OSCAR/ASPEN Central Office reports, SA complaint logs and/or ACTS

- Statutory/Regulatory Citations: Section 1819(g)(4) and Section 1919(g)(4) of the Act; 42 CFR 488.332, Article II (A)(2) of the 1864 Agreement; and State Agency Director letters dated March 16, 1999 and October 14, 1999.

Emphasis (G):
The SA enters appropriate (certification-related) complaint data into the OSCAR complaint subsystem.

- Threshold Criteria: No less than ninety percent (90%) of SA citations from complaint investigations, that are violations of Federal requirements (deficiencies cited), are encoded into OSCAR in accordance with SOM 3281-3284. The average time from the latest date of the SA's completion of the investigation to entry into OSCAR/ASPEN Central Office does not exceed 70 calendar days**.

- Data Source: OSCAR/ASPEN Central Office and Onsite sample reviews

- Statutory/Regulatory Citations: Article II (J) of the 1864 Agreement and SOM 3281-3284.

****Due to the implementation of ACTS, the State will meet this Emphasis if the complaints are entered into the system by the end of the fiscal year.**

Standard 7: Accurate and timely data is entered into online survey and certification data systems. (Excludes CLIA)

Emphasis (A):
Certification kits for recertified non-accredited hospitals and nursing homes are entered into the OSCAR\ASPEN Central Office system on a timely basis.

- Threshold Criterion: The average time from the latest date of the SA survey completion date (L34) to entry into OSCAR\ASPEN Central Office does not exceed seventy (70) calendar days.

- Data Source: OSCAR\ASPEN Central Office reports and Oversight Monitoring Reports (OMRs).

- Statutory/Regulatory Citations: Article II (J) of the 1864 Agreement.

Emphasis (B):
The SA enters data accurately into OSCAR\ASPEN Central Office for recertified non-accredited hospitals and nursing homes.

- Threshold Criterion: No less than eighty-five percent (85%) of cases reviewed demonstrate that data is entered into OSCAR\ASPEN Central Office accurately.

- Data Source: OSCAR\ASPEN Central Office reports and OMRs

- Statutory/Regulatory Citations: Article II (J) of the 1864 Agreement.

Note: Data entry and its associated aspects for "complaints" are referenced separately in Standard 6.

Standard 1: Surveys are planned, scheduled and conducted timely.

Emphasis (A): The SA begins no less than **ten** percent (10%) of its standard surveys of nursing homes during weekends or "off hours."

a) Threshold Criterion: In no less than ten percent (10%) of the standard surveys a SA conducts during a twelve month period, the time of day that surveyors begin should extend beyond the business hours of 8:00 a.m. to 6:00 p.m. and should either incorporate evening hours after 7:00 p.m. or morning hours before 7:00 a.m., unless they are started during weekend days i.e., Saturdays and Sundays. To count towards the ten percent, once begun, a survey must be conducted on consecutive calendar days, even if those days encompass Sundays and holidays.

b) Data Source: User-defined OSCAR reports and SA survey schedules.

c) Method of Evaluation: Report the percentage of staggered surveys conducted from the OSCAR report provided. If the percentage of nursing home surveys conducted during the off-hour timeframes is equal to or greater than 10%, this Emphasis is scored as "Met."

Emphasis (B): The SA complies with requirements for conducting standard surveys of **nursing homes** within prescribed time limits.

a) Threshold Criterion: No less than one-hundred percent (100%) of the consecutive standard surveys of nursing homes conducted by the SA, are conducted within fifteen (15) months between surveys. The average statewide interval between consecutive standard surveys is no greater than twelve (12) months.

b) Data Source: User-defined OSCAR reports and SA survey schedules.

c) Method of Evaluation: Report at least two numbers here from the OSCAR reports provided: (1) The average statewide interval between consecutive surveys and (2) The maximum number of months between standard surveys. For surveys that are conducted beyond the maximum 15 months, also report the number of surveys exceeding the 15 months interval. The average statewide interval and the maximum number of months between surveys must both be met for this Emphasis to be scored as "Met."

Emphasis (C): The SA conducts all legislatively mandated surveys within the timeframes established by law.

a) Threshold Criterion:
- All HHAs are recertified every thirty-six months.
- All ICFs/MR are recertified before the expiration date of the existing 12-month time-limited agreement. If a survey is conducted after the original expiration date, the SA must have given the State Medicaid Agency written notice that it should extend the agreement and the recertification survey must have occurred before the expiration date of the extension.
- Validation surveys are conducted on hospitals selected as part of the 1% sample.

b) Data Source: User-defined OSCAR reports and SA survey schedules and other records.

c) Method of Evaluation: Report three numbers here from the OSCAR reports: (1) Percent of HHAs recertified every 36 months; (2) Percent of ICFs/MR recertified before the expiration date of the existing time-limited agreement; and (3) Percent of validation surveys conducted on hospitals selected as part of the 1% sample.

NOTE: If all ICFs/MR have not been recertified, provide a narrative describing whether or not the State Medicaid Agency received written notice for an extension of the agreement and that a survey was subsequently conducted before the end of the extension.

HHA's, ICFs/MR and hospitals must all meet the threshold for this Emphasis to be scored as "Met."

Standard 2: Survey findings are supportable.

Emphasis (A): The SA explains and properly documents all deficiencies on the CMS Form 2567, Statement of Deficiencies (SOD).

a) Threshold Criterion: No less than eighty-five percent (85%) of deficiencies cited on SODs reviewed meet the Principles of Documentation (POD) for deficiency citation.

b) Data Source & Method of Evaluation: Review of at least ten percent (10%) or a maximum of forty (40) CMS Form-2567s, of which 75% are recertification surveys and 25% are complaint surveys, following the "Standard Review Protocol" in Attachment B.

Note: For those states that have less than fifty nursing homes, the 10% guidance would not allow for adequate review. Therefore, a minimum of five SODs would be reviewed for each of these states during the fiscal year.

Sample Selection:

1. Copy and save into your OSCAR Report Library, the User Defined Extract OSCAR reports entitled, PERF STAND 2 and PERF STAND 2 COMPLT, from GG68. Select the report and modify it for your Region/States. Download the report saving it as a text file.

   These reports contain: Provider Number, Facility Name, current survey date, all "D" or above deficiencies cited for the specified time period (all or part of the fiscal year under review), and the scope/severity for each deficiency.

Note: In those states where OSCAR data is inadequate for sample selection, the Regional Office may use other methods to determine which recertification surveys, and complaint surveys have been completed by the state. The sample should be randomly selected.

2. Import the data from the OSCAR report into an Excel spreadsheet columns A through Columns F and then follow the instructions below to select your random sample:

- The data file downloaded from OSCAR into Excel contains the following data in the following columns.
  - Column A – Provider Number
  - Column B – Facility Name
  - Column C – City
  - Column D – State
  - Column E – TAG
  - Column F – S&S
  - Column G – Empty. To be used in the process to identify duplicates.
  - Column H – Empty. To be used in the process for random number generation.

- Select all of the data and sort by State (Column D) then by Provider Number (Column A)

- Identify duplicate facilities by placing the following formula into Column G of the first line of data.

  =IF (A2=A1, “Duplicate”,”Original”)

***Note that A2 is the provider number included on line two, and is being compared to the provider number on line 1. If they are equal, the word “Duplicate” will be placed in column G2. If they are not equal, the word “Original” will be placed in G2. This formula should be copied into each cell in column G resulting in the words “Duplicate” or “Original” placed in each cell.**

- Copy Column G and “Paste Special” as values. This removes the formula and allows for sorting. Sort all of the data by Column G descending, then by Column D ascending. The original facilities are now sorted by state at the top of the spreadsheet. The duplicates are now at the bottom of the spreadsheet. Identify where the duplicates begin and place new (empty) rows between the original and duplicative data. The duplicate facilities will not be included in the rest of the process.

- Insert the following formula into the first open cell in Column H.

  =RAND ()

  Copy the formula into each cell in Column H. Once the formula is in each cell in Column H, copy the entire column and "Paste Special" as values. The result will be a randomly generated number in each cell that does not change.

- Sort by Column D ascending then by Column H ascending. The spreadsheet now has a randomly ordered list of facilities for each state.

3. Determine the sample size needed for each State**.** The sample size should be ten percent of the total number of nursing homes and distinct part skilled nursing facilities per State. This will equate to a minimum of 5 or a maximum of 40 SODs per State per Fiscal Year. An additional 10% oversample should be selected to use for substitution if needed. Determine the number of recertification surveys (75%) and the number of complaint surveys (25%) for the sample.

4. Begin with the first facility on the randomly ordered list of surveys. Select one to four tags per SOD for review. When possible, select tags from the following:

   - Tags on a SOD with scope and severity rating of “D” or above.
   - Tags with the highest Scope and Severity ratings on the CMS-2567.

   When possible, include tags from the following regulatory groupings:
   - Residents Rights tags (F151, 155, 157, 164).
   - Facility Practice tags (F221, 223, 224, 225, 226).
   - Quality of Life tags (F241, 242, 246).
   - Process tags (F272, 278, 279, 280, 281).
   - Quality of Care tags, (F314, 324, 325, 326, 327, 329).
   - Additional review tags: F698, F000, and F999.

Conducting the Review

- The review is conducted by one person with at least one additional person reviewing all criteria rated a “No.”
- All “No” ratings must have a specific objective explanation in the comment section.
- The reviewer should base their score on the written documentation of the SOD without assuming additional information. The citation should answer the questions of who, what, when, where and how.

- The review is recommended semi-annually and onsite at the SA.
- Include use of the following references:
  - The Principles of Documentation
  - Appendix P and Q of the State Operations Manual
  - Applicable Regional Letters or Guidance

Data Sheet/Scoring

A data sheet is provided for collection of data and automatic scoring. For each tag, review the criterion and mark a "Y" for each yes answer and an "N" for each no answer. The Excel database (st2 datasheet fy2003 scoring temp) will provide, for each facility, a cumulative score and a separate score for each criterion.

For all citations, always review criteria 1, 2, and 3. If criteria 1-3 are all scored “yes,” then continue to score criteria 4-7. If either criteria 1, 2, or 3 is rated a “no” then the review is complete for the citation.

Yes = 1 point. Documentation meets the scoring guidance in each criterion. No = 0 point.

Regions may make additional copies of the data page into the folder and add formulas for overall cumulative scores or:

- To obtain an **overall score** for the review, add the “yes” responses and divide by the total number of “yes” and “no” responses. **This overall score will be used to determine whether the Standard was met (85% or higher)**. This percentage should be an annual number and reported on the reporting tool.

- Score each by criteria, add the number of “yes” responses and divide by the number of “yes” and “no” responses. These scores may be used for performance improvement.

Evaluation Criteria

	Criteria	Guidance and References
1	Evidence supports determination of noncompliance at the cited regulation.	Score 1 when the citation contains at least one deficient practice with findings that support the deficient practice at the cited regulation. See POD #3
2	Evidence demonstrates current noncompliance or past noncompliance at F698.	Score 1 when the evidence demonstrates noncompliance at the time of the survey. If the noncompliance is egregious past noncompliance, it should be cited at tag F698. SOM, 7510B, p. 7-64.
3	Includes regulatory reference.	Score 1 when the regulatory reference is composed of: 1) a survey data tag number, 2) the CFR or LSC reference number, 3) the language from the regulatory reference, and 4) an explicit statement that the requirement was "NOT MET." See POD #3.
4	Each deficient practice statement clearly states a specific deficient practice.	Score 1 when the deficient practice statement(s) precedes the findings and explains in specific terms what the entity did or did not do. When appropriate, the deficient practice statement(s) describes the outcome or actual harm to residents. See POD #3
5	The severity rating accurately reflects the findings.	Score 1 when the facts in the citation support the severity rating (severity is the level of outcome or potential/actual harm to residents) assigned by the state. See POD #3 and SOM, Appendix P, revision 10, page P-71.
6	The scope accurately reflects the findings.	Score 1 when the facts in the citation support the scope rating (isolated, pattern or widespread) assigned by the state. See POD #3 and SOM, Appendix P, revision 10, page P-72.
7	The sources and identifiers in the deficient practice statement match the sources and identifiers in the findings.	Score 1 when all the sources and resident identifiers in the findings match those in the deficient practice statement. See POD #3.

Standard 3: Certifications are fully documented and consistent with applicable law, regulations and general instructions.

Emphasis (A): The SA survey teams conduct surveys of nursing homes in accordance with CMS instructions.

a) Threshold Criterion: No less than one hundred percent (100%) of nursing home surveys are satisfactorily conducted, by effectively achieving the desired outcomes of the survey, using Federal standards, protocols and procedures, policies and systems specified in CMS instructions.

b) Data Source: Federal Monitoring Survey (FMS) results (Federal Oversight Support Surveys and Comparative Surveys).

c) Method of Evaluation: The following reports will be generated quarterly from the national FMS (FOSS/Comparative Access) database.

Report #1 – Rating Per Measure. This report is a listing for each measure, which shows the average rating per measure. This report would furnish the CMS Office and the SA with an overview of the State's strengths and weaknesses for outcome achievement within the survey process. Summary analysis of narrative comments is available for low scored measures and should furnish examples of State teams' weaknesses relative to the behavioral descriptions of performance.

For each measure, an average score of less than 3.0 would be considered unsatisfactory for purposes of meeting the threshold criterion of this standard. There is not an overall survey score.

Calculation: The calculation is based on the total number of surveys (that rated the measure) in a fiscal year, the total number of each measure rated and the number of measures rated as < 3.0.

Calculation: Total number of measures <3.0/total number of measures x 100 = % of measures not meeting the satisfactory level. In order to meet the standard, 80% of measures should be greater than or equal to 3.0.

Report #2 – Changes in the severity level of tags between Deficiency Determination (Measure 6), and the facility copy of the CMS-2567. This report would list the deficiencies for each survey conducted by a State for which there were variations in the determinations of non-compliance made on-site versus the facility CMS-2567. Satisfactory performance is defined as an unjustified discrepancy rate of 20% or less for the aggregate of surveys conducted in a fiscal. Refer to the individual FOSS report for the narrative comments for each tag in which a variation was noted.

Example of discrepancy rate determination: Of the 20 tags a SA decided to cite during its deficiency determination, three (3) were not documented on the CMS-2567, although onsite information supported the tags being cited. There were 2 tags that had severity level changes from "G" to "D" although onsite information supported the higher severity level. Source of information: SA Task 6 and SA CMS-2567.

Calculation: Total number of tags = 20, 5 severity level changes (three dropped, 2 reduced); 5/20 = .25 x 100 = 25%.

While this example pertains to one survey, the overall scores will be determined by aggregating the total number of tags for all FOSS surveys by the fiscal year.

Report #3 – Deficiencies for which there was a disagreement between the SA and the RO on the CMS-2567. This report would list the tags on the CMS-2567 for which there were discrepancies****** between what the SA cited and what CMS RO believed they should have cited.

****Note: Discrepancy is defined as variations between the citing or not citing of deficiencies and/or severity level differences. Discrepancies would be deficiencies that CMS thought should have been on the CMS-2567 but were not and for which findings were not put in another citation that was appropriate OR deficiencies where CMS disagrees with the SA S/S level.**

When there is a variation between CMS and the State regarding the Statement of Deficiencies, the State may be requested to provide a written response/explanation. Individual FOSS reports supply narrative comments for each tag/deficiency in which a variation was noted. Satisfactory performance is defined as having a discrepancy rate of 20% or less for the fiscal year.

Calculation: In order to determine the discrepancy rate for each survey, the calculation is: For each FOSS survey – total the number of tags on the CMS-2567 that CMS did not agree with the citation or severity level /the total # of tags cited on the CMS 2567 x100 = % (percentage). Then, to determine the % of surveys with a 20% or greater discrepancy rate, take the number of surveys with a discrepancy rate of 20% or greater/total number of surveys done in the fiscal year x 100 = %

Report #4 – Outcomes of Comparative Surveys. This report would list the discrepancy rate between deficiencies found during CMS office surveys (comparatives) and those found by the SA in the same facility. There will be two types of discrepancies: 1) Deficiencies cited, and 2) Scope and Severity levels. Satisfactory performance is defined by a discrepancy rate of 20% or less for any deficiency that should have been found or any instance of immediate jeopardy failing to be identified.

Calculation:

1a. Number of tags, which CMS cited that the SA did not/total number of tags cited by CMS. (this will not feed into scoring)

1b. Number of tags CMS cited that the SA should have been responsible for citing.

2. Number of tags with different S/S level from SA survey at or above level 2 severity/total number of tags cited by CMS.

3. Any instance of the SA failing to identify Immediate Jeopardy when present onsite during the time of their survey.

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The following report is NOT required for evaluation of this standard and is recommended for use to assist in identifying training needs and areas for improvement.

Report #5 – Areas of "Needed Improvement" identified by the Federal Surveyors. This report would list the FOSS indicators, and percentage of surveys that indicators were identified for performance improvement. The indicators are separated into specific measure sections; however, there is some overlap. Specifics about the indicators can be found in the individual FOSS reports-narrative section.

While this report will not be used to determine satisfactory versus unsatisfactory performance it is intended to be routinely monitored by the regional office for trends and patterns of training that may need to be provided. When such trends or patterns are identified in one or more measures, i.e., Concern Identification, Sample Selection, General Investigation, etc. Trends may assist in the identification of necessary training programs to be conducted by the State, Region or Central Office.

Scoring:

Each report is scored as "Met" or "Not Met." Use the following chart to determine the overall score for the standard:

- If 4 of 4 reports are scored as "Met," the standard is scored as "Met"
- If 3 of 4 reports are scored as "Met," the standard is scored as "Partially Met."
- If 2 of 4 reports are scored as "Met," the standard is scored as "Partially Met."
- If 1 of 4 reports is scored as "Met," the standard is scored as "Partially Met."
- If none of the reports receives a score of "Met," the standard is scored as "Not Met."

Standard 4: When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to. (Excludes CLIA.)

Emphasis (A): "Immediate Jeopardy" cases involving LTC and NLTC Providers and Suppliers are processed timely. (Excludes CLIA cases.)

a) Threshold Criterion: In ninety-five percent (95%) of the SA's determinations that there is an Immediate Jeopardy to resident and/or patient health and safety in a provider or supplier that was not abated (removed) onsite (prior to the end of the survey), the SA adheres to the twenty-three (23) day termination process as outlined in 42 CFR 488.410 and 42 CFR 489.53.

b) Data Source: OSCAR reports and SA provider certification files. Although CMS may utilize information from the Long Term Care Enforcement Tracking system as an internal reference for Immediate Jeopardy cases in nursing homes, CMS will measure overall timeliness rather than individual steps in the 23-day termination process.

c) Method of Evaluation: This emphasis evaluates the SA's performance for **all** Immediate Jeopardy cases not abated (removed) for both LTC and NLTC surveys. We are determining the timeliness of notifications by the SA to CMS and the timeliness of provider revisits prior to the 23-day termination date. The overall evaluation will include:

   1) assessment of whether CMS received prompt notification of the visit date when Immediate Jeopardy was discovered to be able to notify the provider of a 23-day termination action;

   2) timely revisit by the SA upon receipt of a credible allegation of IJ abatement (removal));

   3) notification to CMS of whether or not Immediate Jeopardy has been abated (removed).

d) Timeframes: For LTC, the notification of Immediate Jeopardy removal must be no less than 3 working days prior to the termination date. CMS needs to provide the required public notice at least two days prior to the effective date of termination in all cases in which Immediate Jeopardy has not been abated (removed).

   For NLTC, the SA follows SOM time frames and CMS guidance for notification of Immediate Jeopardy and termination processes.

Methodology:

OSCAR data and the Long Term Enforcement Tracking System can be used to identify **all** LTC Immediate Jeopardy cases in the 23-day (IJ) time line to be evaluated by CMS. Initially OSCAR reports 17 and 43 data can be used for identification of all noncompliance cases in NLTC Providers and Suppliers. CMS has discretion to review this information quarterly or biannually. However, CMS must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining the 95% or above adherence rate.

Failure to meet any of the above timeframes in each specific case will result in the SA failing to meet this emphasis in the case under review.

Calculation:

(1) Using the identified data sources (OSCAR data, information in the enforcement database, and/or provider certification files), identify all IJ cases that were not abated (removed) onsite.

(2) Determine in how many of these cases the State 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 abated (removed) within prescribed timeframes.

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than 95%, Emphasis A is scored as "Met."

Emphasis (B): Denial of Payments for New Admissions (DPNA) must be imposed by the third month when a Long-Term Care facility is not in substantial compliance for 3 months after the date of the original survey. SA adheres to the enforcement processing timeframes.

a) Threshold Criterion: In eighty percent (80%) of the cases, revisits are conducted by the 60th day and the enforcement packet is sent to CMS or notice is sent by the State to the provider by the 70th day.

b) Data Source: Enforcement Tracking System Reports and SA provider certification files.

c) Method of Evaluation: This emphasis evaluates a SA's performance for sending notice to CMS or provider for timely imposition of statutory DPNA. The overall evaluation will include: the SA conducts the first revisit for "Opportunity to Correct" cases by the 60th day; and the SA sends the enforcement packet for all cases (not Immediate Jeopardy) to CMS or the SA sends the notice to the provider by the 70th day. SA notice to CMS can occur via whatever means the SA and CMS agrees (telephone, e-mail, in writing, etc.).

Methodology:

1. The specific custom report capturing the critical dates from the Enforcement Tracking System (or manual retrieval of these critical dates) will provide the detail for each case in this evaluation process.

2. CMS will evaluate the following key dates: (a) the SA conducts the first revisit for "opportunity to correct cases" no later than 60 days after the initial enforcement survey; and (b) CMS receives notification from the SA of continuing non-compliance no later than 70 days after the initial survey that determines substantial non-compliance; or (c) if applicable, the SA sends notification to the provider no later than 70 days after the initial survey that determined substantial non-compliance.

3. CMS has discretion to review this information quarterly or biannually. However, the RO must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining, the 80% adherence rate.

Failure to meet any of the above timeframes in a case will result in the SA failing to meet the emphasis in the case under review.

Calculation:

(1) Using the identified data sources (information in the enforcement data base, and/or provider certification files), identify all LTC facilities that would have faced a mandatory DPNA if they did not come into substantial compliance within 90 days of the date of the original survey. This is the Emphasis B universe.
(2) Determine in how many of these cases the State carried out timely actions (i.e., conducted the first revisit for "Opportunity to Correct" cases

by the 60th day and sent enforcement packets to CMS or sent notices directly to the provider within the timeframes specified).

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than 80%, Emphasis B is scored as "Met."

Emphasis (C): Noncompliance with one or more Conditions of Participation or Conditions of Coverage and cited deficiencies limit capacity of the provider/supplier to furnish adequate level or quality of care. (NLTC providers, excluding CLIA)

a) Threshold Criterion: In eighty percent (80%) of the cases which cite Condition level noncompliance on the part of a provider or supplier the SA adheres to the ninety (90) day termination process described in Section 3012 of the SOM.

b) Data Source: CMS and SA provider survey and certification files, and CMS tracking systems.

c) Method of Evaluation: This emphasis evaluates the SA's performance for the following parameters: (1) the SA conducts a revisit by the 45th day if the provider has submitted a credible allegation of compliance; and (2) The SA sends notice to CMS, the provider, and the SMA for providers participating in Medicaid by the 55th day for all NLTC cases for which termination is recommended.

> **Note:** The 90-day termination process, with the exception of EMTALA cases, begins the date the entire survey is completed onsite regardless of when the exit conference is held. In the case of EMTALA violations, the 90 day termination process begins on the date CMS makes the determination of noncompliance with 42 CFR 489.24 and/or the related requirements of 42 CFR 489.20 and the violation is not considered an immediate and serious threat to patient health and safety.

If the provider has made a credible allegation of compliance, the SA conducts a revisit by the 45th day to determine whether compliance or acceptable progress has been achieved. If Condition level compliance is not determined at the 45-day revisit, the SA sends the 90-day

termination packet to CMS by the 55th day from the last day of the survey that found condition level non-compliance. At the same time, the SA notifies the provider that termination is recommended.

CMS and SA provider survey and certification files and CMS tracking systems can be used to identify all 90-day NLTC cases. CMS has discretion to review this information quarterly or biannually, but must complete an assessment no less than annually to see what can be recommended to the SA to reduce or eliminate the outliers and move toward, or continue maintaining the 80% or above adherence rate.

Calculation:

(1) Using the identified data sources (provider files or other CMS tracking systems), identify the total universe of NLTC cases in which a facility had Condition level deficiencies cited placing the facility on a 90-day termination track during the fiscal year under review.

(2) Determine in how many of these cases the State carried out timely actions (i.e., conducted a visit by the 45th day to determine if compliance or acceptable progress had been achieved or sent CMS a 90-day termination packet within the specified time frame).

(3) In cases where timely actions were not taken, CMS should consider whether there were extenuating circumstances.

(4) Determine the total number of cases in #2 and #3 above. This will give you the total number of cases in which the State's performance was acceptable.

(5) Divide #4 by #1 and convert to a percentage format. If the resulting percentage is equal to or greater than 80%, Emphasis C is scored as "Met."

Standard 5: All expenditures and charges to the program are substantiated to the Secretary's satisfaction

Emphasis (A): The SA employs an acceptable process for charging the Federal programs.

a) Threshold Criteria: The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its Title XVIII and XIX expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.

b) Data Source: The CMS Budget Call Letter, the CMS-435 State Survey Agency Budget/Expenditure Report and the CMS-434 State Survey Agency Workload Report.

c) Method of Evaluation: The SA is evaluated on the 12 items listed below:

- The SA meets CMS assigned due dates for its budget request and proposed work plan.
- The SA meets CMS assigned due dates for budget-related data requests
- The SA submits all the attachments and documents required by applicable program instructions to support its budget request.
- Budget documents submitted are completed correctly.
- The type and amount of work projected is in accordance with applicable program instructions.
- The justification for each line item and cost, on the budget request, is reasonable and based on applicable program instructions.
- Program cost shares approved by CMS are appropriately applied to all line-items and costs on the budget request.
- The SA submits required expenditure and workload reports in a timely manner. (Quarterly reports are due 45 days after the close of the quarter and year-end cumulative reports are due 60 days after the close of the fiscal year.)
- The SA submits the required quarterly and cumulative expenditure and workload reports that are completed in accordance with applicable program instructions.
- The SA submits quarterly Title XIX budget estimates in accordance with applicable program instructions.
- The SA provides reasonable assurances to CMS Office that costs shown on all budget/expenditure reports are appropriately applied to the Medicare, Medicaid and State Licensure programs across facility and program types.

- Reported FTEs and dollar amounts are reasonable and consistent with the State's budget approval. Line item amounts generally conform to the approved budget, except for good cause.

Scoring:

Attached is a score sheet to be used by the reviewer. For each item, a "Met" answer equals a score of 1 and a "Not-Met" answer equals a score of 0. In order for the State to receive an overall "Met" for this emphasis, the State must have a score of 10 or above.

Emphasis (B): The SA has an acceptable method for monitoring its current rate of expenditures and planned workload.

a) Threshold Criteria: The SA monitors and analyzes both its spending and workload progress throughout the fiscal year to ensure that the program priorities are accomplished within its approved budget.

b) Data Source: The OSCAR 10, 15, and 25 Reports, the CMS-435 State Survey Agency Budget/Expenditure Report and the CMS-434 State Survey Agency Workload Report.

c) Method of Evaluation:

- Quarterly Analysis: The SA prepares a brief analysis that summarizes the status of its spending and work completion in relation to meeting the budgeted dollar and workload amounts for the fiscal year.
- Annual Analysis: The SA prepares a brief analysis which analyzes the fiscal year and compares actual expenditures and accomplished workload to the amount budgeted and the planned workload.
- The State takes appropriate action to ensure program priorities are accomplished within the approved budget amount.
- If necessary, the SA prepares and justifies a supplemental budget.

Scoring:

This Emphasis is scored as "Met" if quarterly and annual analyses are verified by CMS Office.

Standard 6: The conduct and reporting of complaints investigations, both Long Term Care and hospital complaints, including hospital federal allegation and EMTALA complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures.

Prior to the review of this Standard, appropriate staff from CMS must arrange a meeting or have discussions with each SA. The purpose of the meeting is to discuss and review any revisions to the SA's policies and procedures for the investigation of complaints including Long Term Care (SNF/NF) complaints, complaints involving both accredited and non-accredited hospitals, and EMTALA investigations. This meeting should also include a discussion on the triaging of facility self-reported complaints and complaints referred to another agency or entity (e.g., law enforcement, ombudsmen, licensure agency, etc.). A mutual decision should be made on how facility self-reported complaints are triaged prior to commencing the reviews.

Refer to October 14, 1999 memorandum from Rachel Block to State Survey Agency Directors on the investigation of LTC complaints.

Emphasis (A): The SA maintains and follows guidelines for the prioritization of complaints.

a) Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints.

b) Data Source: OSCAR/ASPEN Central Office, SA complaint log(s), ACTS, SOM 3260, 3262, and 3280.

c) Method of Evaluation: Complaints for long term care and nonaccredited hospitals are evaluated.

1. Long Term Care

Sample Size: (Medicare/Medicaid certified Facilities Only). The sample is drawn from all SA complaint/investigation log(s) or ACTS complaint inputs. Pull a random sample from all complaints received, but if sampled cases do not include immediate jeopardy and actual harm cases, expand the sample until it includes at least a minimum of **ten** immediate jeopardy cases and **ten** actual harm cases, if possible**.** If the sample is expanded in order to include immediate jeopardy and actual harm complaints, drop the appropriate number of "other" cases to achieve the required sample size.

Universe	Sample Size
70 or greater	10% of all Medicare/Medicaid certified facility complaints with a maximum of 40
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

This sample will be used for Emphases A –LTC, B-LTC, E, and F.

The random sample for the first semi-annual review is pulled from complaints received beginning October 1, 2002 through the first review date. The second semi-annual review sample should be pulled from complaints received starting from the first semi-annual review date to the date of the second semi-annual review, not to exceed September 30, 2003.

Methodology:

Review each sampled case to determine if the SA appropriately triaged the complaint using the immediate jeopardy, actual harm and State policy and procedure criteria.

CMS will use the final triage rating assigned by the State after their review of the complaint intake data.

If there is disagreement between the SA and CMS as to the assigned category, discuss with the SA the factors taken into account when the triage assignment was made. If there is still disagreement between CMS and SA triage assignment, refer the case to CMS for a second independent review.

2. Non-accredited Certified Hospitals

Universe	Sample Size
70 or greater	10% of all Medicare/Medicaid certified facility complaints with a maximum of 40
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

This sample will also be used for Emphases B - nonaccredited hospitals

Methodology:

(Medicare/Medicaid non-accredited Certified Facilities Only). The sample is drawn from all SA complaint/investigation log(s) or ACTS complaint inputs. Pull a random sample from all complaints received, but if sampled cases do not include immediate jeopardy cases, expand the sample until it includes at least a minimum of **ten** immediate jeopardy cases.

The random sample for the first semi-annual review is pulled from complaints received beginning October 1, 2002 through the first review date. The second semi-annual review should be pulled from complaints received starting from the first semi-annual review date to the second semi-annual review, not to exceed September 30, 2003.

Review Methodology:

Review each sampled case to determine if the State Agency appropriately triaged the complaint using the immediate jeopardy, and State policy and procedure criteria.

If there is a disagreement between the SA and CMS as to the assigned category, discuss with the SA the factors taken into account when the triage assignment was made. If there is still disagreement between CMS and SA triage assignment, refer the case to CMS for a second independent review.

Overall Scoring for Emphasis A

- If both LTC and Non-accredited Hospitals are scored as "Met," then the overall score for Emphasis A is scored as **"Met."**
- If Emphasis A – LTC is "Met" and Emphasis A - Hospitals is "Not Met," then the overall score for Emphasis A is scored as **"Not Met."**
- If Emphasis A – LTC "Not Met" and Emphasis A - Hospitals is "Met", then the overall score for Emphasis A is scored as **"Not Met."**
- If Emphasis A – LTC and Emphasis A – Hospitals are both scored as "Not Met," then the overall score for Emphasis A is scored as **"Not Met."**

Emphasis (B): The SA investigates all complaints it receives for Medicare/Medicaid certified facilities in LTC and accredited and non-accredited hospitals alleging "immediate jeopardy" to resident and patient health and safety within prescribed time limits.

a) Threshold Criterion: The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities for all LTC and accredited and non-accredited Hospitals where it determines there is a present or ongoing immediate jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA.

b) Data Source: OSCAR/ASPEN Central Office reports, CMS and SA complaint log(s) and/or ACTS.

c) Method of Evaluation:

1. Long Term Care

Sample Size: *Using the random sample pulled for Emphasis A,* include all LTC (SNF/NF) cases that the **State** triaged as "Immediate Jeopardy" for each semi-annual review. (minimum of ten cases, if possible)

Review Methodology:

Review to determine that the onsite entrance date was no more than two working days from the date the complaint was received by the SA. Obtain the complaint receipt date from the SA complaint log(s). Date of entry is obtained from CMS-670, Survey Team Composition and Workload Report, for the complaint investigation.

Date of complaint intake is counted as day zero.

Scoring for Emphasis B – LTC
One LTC complaint not investigated within two (2) working days will result in Emphasis B – LTC being scored as "Not Met."

2. Hospitals

Data Source: OSCAR/ASPEN Central Office, CMS and SA complaint log(s) and/or ACTS

a) Accredited Hospitals: The sample can be obtained from CMS and SA complaint logs and OSCAR/ACTS tracking systems.

Universe	Sample Size
70 or greater	5% of all Medicare/Medicaid certified facility complaints with a maximum of 20
7 to 69	Six (6)
1 to 6 complaints	Entire universe – Review all

The random sample for the first semi-annual review is pulled beginning October 1, 2002 through the review date. The second semi-annual review sample should be pulled from cases starting from the first semi-annual review date to the date of the second semi-annual review, not to exceed September 30, 2003.

Review to determine that the onsite entrance date was no more than two working days from the date the CMS-2802 authorizing the investigation was received or issued by the SA. Date of entry is obtained from CMS-670 for the complaint investigation.

b) Non-accredited Hospitals: *Using the random sample pulled for Emphasis A – non-accredited hospitals*, review all complaints that the **State** triaged as "Immediate Jeopardy" for each semi-annual review.

For complaints that the **State** triaged as "immediate jeopardy," review to determine that the onsite entrance date was no more than two working days from the date the complaint was received by the SA. Date of entry is obtained from CMS-670 for the complaint investigation. This portion may be reviewed at the CMS Office using the OSCAR user-defined report.

Date of complaint intake is counted as day zero.

Scoring for Emphasis B – Hospitals:
One complaint not investigated within two (2) working days will result in Emphasis B – Hospitals being scored as "Not Met."

Overall Scoring for Emphasis B:

- If Emphasis B – LTC and Emphasis B – Hospitals are both scored as "Met" then the overall score for Emphasis B is scored as "**Met**."
- If Emphasis B – LTC is scored as "Not Met" and Emphasis B – Hospitals is scored as "Met" then the overall score for Emphasis B is scored as "**Not Met**."
- If Emphasis B – LTC is scored as "Met" and Emphasis B – Hospitals is scored as "Not Met" then the overall score for Emphasis B is scored as "**Not Met**."

Emphasis (C): The SA investigates all EMTALA complaints referred by the CMS Office within prescribed time limits.

a) Threshold Criterion: The SA investigates one hundred percent (100%) of all EMTALA complaints within 5 working days consistent with CMS and State Policy.

b) Data Source: CMS Office EMTALA logs and Completed Survey Packets by the SA sent to CMS.

Sample Size:

Universe	Sample Size
70 or greater	10% of all Medicare/Medicaid certified facility complaints with a maximum of 40
7 to 69	Six (6)
1 to 6	Entire universe – Review all complaints

A random sample of all EMTALA complaints that were referred by CMS for investigation will be selected from the CMS EMTALA log.

The random sample for the first semi-annual review is pulled beginning October 01, 2002 through the first semi-review date. The second semi-annual review sample should be pulled from cases starting from the first semi-annual review date to the date of the second semi-annual review, not to exceed September 30, 2003.

Methodology:

The review will be performed in the CMS Office semi-annually and reported annually.

For EMTALA complaints granted extensions by CMS, review against the CMS approved date instead of 5 working days. Timeframes are calculated from date of CMS notification to the first onsite entrance date.

Count the day of CMS notification to the SA as day zero.

Date of Entry is obtained from SA survey Packet, CMS-670.

Review Example: If CMS grants an extension date from May 1st to May 10th, for an authorized EMTALA complaint, and the SA's onsite investigation starts May 10th, then May 10th is used as the approved date for which the SA will be evaluated.

Scoring:

If 100% of all EMTALA complaints first onsite investigation were within five (5) working days of CMS' authorized date or approved extension date, Emphasis C is scored as "MET."

Emphasis (D): The SA investigates all certified accredited hospital "non-immediate jeopardy" complaints that allege non-compliance with Conditions of Participation within prescribed time limits.

a) Threshold Criterion: The SA investigates ninety percent (90%) of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with Conditions of Participation within 45 calendar days consistent with CMS policy.

b) Data Source: CMS and SA complaint log(s), ACTS

Sample Size: 5% or a maximum of 10 Medicare certified accredited hospital complaints.

Exclude all complaints that were triaged as an IJ from this sample. (This was scored in Emphasis B)

The random sample for the first semi-annual review is pulled beginning October 01, 2002 through the first review date. The second semi-annual review sample should be pulled from cases starting from the first semi-annual review date to the date of the second semi-annual review, not to exceed September 30, 2003.

Methodology:

Review to determine that the onsite entrance date was no more than 45 calendar days from the date the state received the CMS-2802 authorization to investigate the complaint. Date of entry is obtained from CMS-670 for the complaint investigation.

Date of CMS-2802 receipt is counted as day zero. During the initial meeting prior to the first semi-annual review, CMS will determine with the State how the CMS-2802 receipt date is captured.

Scoring:

If 90% of all certified accredited hospital complaints were investigated within 45 calendar days, Emphasis D is scored as "**MET**."

Emphasis (E): The SA investigates the Medicare/Medicaid certified LTC complaints it receives alleging "actual harm" to resident s within prescribed time limits.

a) Threshold Criterion: The SA investigates ninety-five percent (95%) of the complaints it receives alleging or involving actual harm to residents consistent with CMS and State policy.

b) Data Source: ASPEN/OSCAR Central Office, SA complaint log(s) and/or ACTS

Sample Size: *Using the random sample pulled for Emphasis A,* include all LTC (SNF/NF) complaints that the **State** triaged as "actual harm" for each semi-annual review.

Methodology:

Review to determine that the on-site entrance date was no more than (ten) 10 working days from the date the complaint was received by the SA. Complaint receipt date is obtained from SA complaint log(s) and ACTS. Date of entry is obtained from CMS-670 for the complaint investigation.

Date of complaint intake is counted as day zero.

Scoring:

If 95% of complaints alleging actual harm were investigated within 10 working days, Emphasis E is scored as **"Met."**

Emphasis (F): The SA maintains and follows guidelines for the investigation of LTC complaints, which do not allege or involve immediate jeopardy or actual harm to residents.

a) Threshold Criterion: The SA initiates an investigation for ninety-five percent (95%) of the complaints consistent with CMS and State policy for complaints that do not allege or involve immediate jeopardy or actual harm to residents.

b) Data Source: OSCAR/ASPEN Central Office reports and SA complaint logs and/or ACTS.

Sample Size: *Using the random sample pulled for Emphasis A,* include all LTC (SNF/NF) cases that the **State** triaged as **not** alleging or involving immediate jeopardy or actual harm.

Methodology:

Review to determine that the onsite entrance date was consistent with the SA's written procedures for complaint handling/investigation.

Complaint receipt date is obtained from SA complaint log(s).

Date of entry is obtained from CMS-670 for the complaint investigation.

Date of complaint receipt is counted as day zero.

Scoring:

If 95% of all complaints were investigated according to State Policy, Emphasis F is scored as **"Met."**

Emphasis (G): The SA enters appropriate (certification-related) complaint data into the OSCAR complaint subsystem.

a) Threshold: No less than ninety percent (90%) of SA citations from complaint investigations, which are violations of federal requirements (deficiencies cited), are encoded into OSCAR in accordance with SOM 3281- 3284. The average time from the latest date of the SA's completion of the investigation to entry into OSCAR does not exceed 70 calendar days**.

****Due to the implementation of ACTS, the State will meet this Emphasis if the complaints are entered into the system by the end of the fiscal year.**

b) Data Source: OSCAR/ASPEN Central Office and Onsite sample reviews

Methodology:

Use the sample for Emphases B, E, and F – include all complaints where an investigation was completed and deficiencies were written. (Exclude accredited hospitals from Emphasis B)

Review OSCAR/ASPEN Central Office to determine if the complaint investigation was entered into OSCAR.

Scoring:**

If 90% of all complaints were encoded into OSCAR, Emphasis G is scored as **"MET."**

****Provide SAs with the average number of days for encoding complaints into OSCAR, for information only, in preparation for the 2004 Performance Standards.**

Standard 7: Accurate and timely data is entered into online survey and certification data systems. (Excludes CLIA)

Emphasis (A): Certification kits for recertified non-accredited hospitals and nursing homes are entered into the OSCAR\ASPEN Central Office system on a timely basis.

a) Threshold Criterion: The average time from the latest date of the SA survey completion date (L34) to entry into OSCAR\ASPEN Central Office does not exceed seventy (70) calendar days.

b) Data Source: OSCAR Report #9 and OSCAR User Defined Reports.

Method of Evaluation:

A. Subpart Measures:

Subpart A1. The timeliness of data entry of Nursing Home recertification actions from October 1, 2002 to September 30, 2003.

- For SNF and SNF/NF recertifications, the average time from the SA survey completion date entered on the CMS 1539 (L34) to entry into ODIE (transaction date) does not exceed seventy (70) calendar days.

- For NF recertifications, the average time from the State survey completion date (L34) to entry into ODIE (transaction date) does not exceed seventy (70) calendar days.

Subpart A2. The timeliness of data entry of non-accredited hospital recertification actions from October 1, 2002 to September 30, 2003.

- For non-accredited hospitals, the average time from the SA survey completion date (L34) to entry into ODIE (transaction date) does not exceed seventy (70) calendar days.

- Forms needed for completing this Emphasis may be found in Appendix D.

B. Definitions:

Note: SOM 7319 A, #5, indicates that "…certification information…" is to be entered "…as soon as substantial compliance is achieved." However, data entry of certification surveys should not be delayed until a facility achieves compliance. Rather, data field L12 of the CMS-1539 should be coded "B"

for noncompliance cases. Once compliance is achieved, the entry should be changed to the appropriate code. (Cross-refer to SOM 2764, Item 10.) In addition, SOM 7212, #6, requires data entry of surveys regardless of IDR requests.)

Transaction Date**:** The date that a survey is first entered into the ODIE system.

C. Frequency of Review*:*

CMS will review LTC surveys entered and nonaccredited hospital surveys entered during the semi-annual reviews. Onsite reviews are discretionary.

D. Universe:

The universe for Emphasis A is all non-accredited hospital, SNF, SNF/NF and NF recertification surveys entered into OSCAR during the fiscal year. Initial surveys are excluded.

E. Review/Scoring:

1. For each State in the region generate the applicable **OSCAR 9 Reports**. From screen 1.1.9, change the default from “accepted records” to “use pending if available else use acceptable.” The report should be run using the default of “survey record accretion date.” Enter the applicable dates in the "from" and "to" fields. The processing time for this standard will be found on the page of the report, which contains “Excluding Initials” in the heading.

    a. For SNF and non-accredited hospital recertifications the average number of days from the State Agency survey completion date (L34) to entry into ODIE (transaction date) is on line 11.

    b. For NF recertifications, the average number of days from SA survey completion date (L34) to entry into ODIE (transaction date) is on line 12.

    Note: For surveys entered using ASPEN, it is possible that the calculated average interval between completion date and transaction date will be longer than the actual average interval due to the inclusion of kits with potential errors that resulted in the need for CMS involvement.

2. Complete the "Performance Standard 7 – Emphasis A, Timeliness of Data Entry" Excel report, for the State being reviewed. This will provide a State-specific summary report for Emphasis A. ***If the score does not exceed 70 calendar days for either LTC or hospitals, Emphasis A is Met. If either LTC or hospitals is scored as Not Met, Emphasis A is scored as Not Met.***

   Enter the score for each subpart reviewed on the "Performance Standard 7 Summary."

3. For States that do **not** **meet** Emphasis A, create a list of surveys that exceeded 70 processing days. Copy and save from **GB17**'s library the OSCAR Report(s) applicable to the needed provider type (**PS7EA SNF** and/or **PS7EA NF** and/or **PS7EA HOSP**) into your OSCAR library. The report is **Type: U** and **Suffix: P**. These reports will create separate listings by provider type for the certification actions that exceeded 70 calendar days to data entry. Each report will also include a summary of the total number of cases, the minimum/maximum number of days to data entry (i.e., range) and the average number of days to data entry. The data from each of these reports should be copied to the appropriate EXCEL spreadsheet ("…Data Entry Exceeding 70 Calendar Days").

   Detailed instructions for downloading OSCAR extract reports and converting the downloaded reports to EXCEL are located in Appendix D. Attachment AB, "Performance Standard 7 – Instructions For Copying User-Defined OSCAR Reports From GB17 Library," describes the procedure for downloading a pre-defined user defined OSCAR extract report. Attachment AA, "Instructions For Converting PS7EA Reports to an Excel Format," describes the procedure for converting the downloaded file into a usable Excel spreadsheet.

Feedback to SA:

Send the Emphasis A Scoresheet together with the listing(s) of surveys exceeding 70.0 processing days, if appropriate, within fifteen (15) days of completing the first semiannual review. The end of year reports will be transmitted to the SAs with the draft report.

If the SA determines that a recertification kit with an IDR was entered into the data system timely and can submit acceptable evidence to confirm the timeliness, this information will be considered when calculating the data entry interval. It may require the data entry interval to be recalculated without using an existing software program.

Emphasis (B): The SA enters data accurately into OSCAR\ASPEN Central Office for recertified non-accredited hospitals and nursing homes.

a) Threshold Criterion: No less than eighty-five percent (85%) of cases reviewed, demonstrate that data is entered into OSCAR\ASPEN Central Office accurately.

b) Data Sources: OSCAR/ASPEN Central Office, OSCAR user-defined reports; ODIE inquiry screens; hard copy of nursing home and non-accredited hospital recertification kits; CMS-1539 (C&T) for actions subsequent to the certification kit; SA Informal Dispute Resolution (IDR) log or documents; SA staggered survey log.

Method of Evaluation:

Use statistically valid random samples of nursing home and non-accredited hospital recertification surveys to determine the data entry accuracy rate. Compare all selected forms and/or data fields directly against the ODIE inquiry screens, SA IDR log and SA staggered survey log. Forms needed for completing this Emphasis may be found in Appendix D. This emphasis will be evaluated in two parts.

A. Subpart Measures:

Subpart B1. For SNF and SNF/NF recertifications entered into ASPEN/ODIE between October 1, 2002 and September 30, 2003, no less than eighty-five per cent (85%) of cases reviewed demonstrate that data is entered accurately.

Subpart B2. For non-accredited hospitals, no less than eighty-five per cent (85%) of recertifications reviewed demonstrate that data is entered into OSCAR accurately.

B. Definitions:

Data entry fields: The data entry fields appearing in ODIE for the forms comprising nursing home and non-accredited hospital recertification kits. See the attached lists (Attachments B1 and B2) for forms and fields to be reviewed for each emphasis.

Error case: A case will be considered to not meet Subparts B1, or B2 (i.e., is an error case) if the reviewer finds:

- Two (2) or more data entry errors or omissions in data fields designated as "substantive" **or**

- Five (5) or more data entry errors or omissions in nonsubstantive data fields **or**
- One (1) substantive plus four (4) nonsubstantive errors or omissions in data fields.

Substantive Data Field: A field that has been deemed of particular importance to either the State Agency or CMS Office operations. (See Attach B1 and B2.)

C. Frequency of Review:

CMS will conduct these reviews semi-annually. Onsite reviews are discretionary.

D. Universe:

For nursing homes, the universe is all recertification surveys entered into OSCAR/ASPEN Central Office from October 1, 2002 through September 30, 2003. For non-accredited hospitals, the universe is all recertification surveys entered into OSCAR from October 1, 2002 through September 30, 2003. To select a sample for each subpart, copy and save the OSCAR Report(s), **PS7EB NH** and **PS7EB HOSP**, if needed from GB17's library. The report is **Type: U** and **Suffix: P**

A document containing detailed instructions on how to copy and run the OSCAR report is located in Appendix D. The document, Attachment AB, "Performance Standard 7 – Instructions For Copying User-Defined OSCAR Reports From GB17 Library" describes the procedure for downloading a pre-defined user defined OSCAR extract report.

E. Sample Size:

The sample sizes for nursing homes and for hospitals are as follows:

Universe	Sample Size
70 or greater	10% with a maximum of 40
7 to 69	6
1 to 6	Entire universe

For each semi-annual review, the number of recertifications reviewed should not exceed 20. If the universe of surveys for any subpart is greater than six, the reviewer must use a random sample to select the surveys to be reviewed for that subpart.

F. Random Sample Selection:

Draw a statistically valid random sample for each review. Detailed instructions are available on Attachment BB in Appendix D. Attachment BB, "Performance Standard 7 – Emphasis B, Instructions for Converting Raw OSCAR Data to an Excel Format and Drawing the Random Sample", contains instructions on how to manipulate the downloaded user defined OSCAR report. It takes the reviewer from formatting the downloaded report in Excel to generating the random sample and transferring the data to the "Random Sample Review Results Worksheet," which generates case/error counts, error ranges, error averages and the score for the Subpart.

Note: For some states a random selection will not have to be selected for non-accredited hospitals since the entire universe of surveys will be less than seven.

G. Sample Review:

Follow the steps below when conducting the review.

1. Check the accuracy of the data entry by comparing each data field on the hardcopy of each required certification form against the ODIE inquiry screen (or equivalent print screen) and each required data field from the ODIE inquiry screen (or equivalent print screen) against the hard copy form.

2. Refer to the appropriate subpart document titled "List of Data Fields for Review …" (AttachB1_datafields.doc and AttachB2_datafields.doc) to identify substantive and all other fields to be reviewed.

3. Complete the "Performance 7 Random Sample Case Review Worksheet" for each case. The results annotated on this form will be used to complete the EXCEL spreadsheets "Performance Standard 7- Emphasis B, Subpart B_, Random Sample/Review Results." (See scoring, below.)

4. Conduct IDR and staggered survey reviews as follows:

    a. IDR Review:

        1. For surveys that indicate that an IDR was requested (found on ODIE screen 4.2.2 - CMS-671), compare the IDR request and completion date with the dates in the State's IDR log. Also, check to see that any changes made as a result of the IDR have been entered into ODIE. (**Note:** If a

tag has been deleted by IDR, it should **not** appear on the CMS-2567 ODIE screen. Similarly, the ODIE screen should reflect any change(s) made in deficiency tags and scope and severity.)

2. Determine if ODIE does <u>not</u> indicate an IDR was performed, but the IDR log Indicates otherwise. The omission of IDR entry into ODIE is considered a **nonsubstantive error**.

3. If a survey does not appear on the State's IDR log, all deficiencies appearing on the hard copy of the CMS 2567 and/or CMS 2567B should appear in ODIE.

b. <u>Staggered Survey Review</u>:

1. Verify that the staggered survey field (ODIE screen 3.2.2 – CMS 671) agrees with the State's staggered survey log. For example, if the staggered survey field is blank in ODIE, the survey should not appear on the State's staggered survey log.

2. For Subpart B1 the ODIE screen should contain a **Y** if a staggered survey was performed. (The reviewer may determine if the survey was morning, evening or weekend by reviewing the columns related to staggered surveys (columns I, J and K) on the spreadsheet containing the surveys randomly selected for review.)

H. <u>Scoring:</u>

1. Complete a separate "Random Sample Review Results" report (PS7EB_summary.xls) for each subpart. Results for each subpart will be summarized and **automatically scored.** Enter the following information into the report:
   a. Basic information at the top of the form, including whether the Threshold Criterion is met (i.e., accurate case score is 85% or higher) or not met (i.e., accurate case score is 84% or less).
   b. Number of errors, broken out by substantive and nonsubstantive, for each sample case.
   c. Error Case or Accurate Case designation for each sample case.
   d. Universe of cases (count), which is available at the bottom of the randomly sorted Excel sheet by state.

2. Transfer the findings for each Subpart reviewed from the "Random Sample Review Results " to the "Performance Standard 7 Summary" (PS7_FY03summary.doc).

   If both subparts are met (accuracy rate of 85% or better), Emphasis B is "Met." If one or both of the subparts are not met, Emphasis B is "Not Met."

Feedback to SA:

Send the following documents to the SA, together with any other pertinent data, within 15 days of completing the semiannual review:

- "Random Sample Case Review Worksheet." Forward a copy of the worksheet for each survey reviewed that contained a data entry error. Include screen prints of all data entry errors if the SA has requested them in advance of the review.

- "Performance Standard 7 – Emphasis 2, Random Sample/Review Results" report. This lists and counts all sample cases (including IDR and staggered survey cases), the number of substantive/nonsubstantive errors per case, the error case and accurate case designation per case, the total number of error and accurate cases, a count of the universe of cases, the total number of errors, minimum/maximum number of errors (i.e., range), average number of errors and the score (%).

Standard 7 Feedback to SA

In addition to the documents specified under each emphasis, send the following documents to the SA:

1. "Performance Standard 7 Review Summary." A 1-page sheet that specifies whether the Standard is met, partially met or not met; whether each Emphasis is met or not met and the score for each Emphasis. Complete this summary after the reviews for both Emphasis A and Emphasis B are completed.

2. A request for a corrective action plan addressing any problems noted. Include the date the plan is due.

Reporting Requirements

Timeline

September 30, 2003	End of Evaluation Period
December 5, 2003	CMS ROs send Draft Report to CO
December 17, 2003	CO sends comments on Draft Reports to CMS ROs
January 7, 2004	CMS ROs send Draft Report to SAs
February 6, 2004	SAs send comments on the Draft Reports to CMS ROs
March 15, 2004	CMS ROs send Final Report to SAs and CO

Reconsideration

There is no formal appeal of findings relative to this Report of State Agency Performance since the assessment is umbrellaed under 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 15 calendar days of the date the SA received the draft report.

Contacts

- Performance Standard # 1 (Required Survey Intervals and Surveying During “Off-Hours”): Please direct any questions relative to this standard to Linda Smith (LSmith2) (410) 786-5650.

- Performance Standard # 2 (Survey Findings are Supportable): Please direct any questions relative to this standard to Kathleen Pozek or call (816) 426-2011 x 3209.

- Performance Standard # 3 (Certifications Documented and Consistent) Please direct any questions relative to this standard to Alisa Overgaard (410) 786-2167.

- Performance Standard # 4 (Certifications of Noncompliance and Adverse Action Procedures): Please direct any questions relative to this standard to Isabella Ray (IRay) at (404) 562-7469.

- Performance Standard # 5 (Expenditures and Charges Substantiated): Please direct any questions relative to this standard to Kirsten Jensen at (410) 786-1095.

- Performance Standard # 6 (Complaint Investigations and Handling): Please direct any questions relative to this standard to Sherry Pater at (816) 426-2408.

- Performance Standard # 7 (Entry of Accurate and Timely Data): Please direct any questions relative to this standard to Maria Neff (312) 886-5203

APPENDIX A

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 1: Surveys are planned, scheduled and conducted timely.

Results: Standard ____*(Indicate Met, Partially Met, or Not Met)*

Emphasis A: The State Agency (SA) begins no less than ten percent (10%) of its standard surveys of nursing homes during weekends, holidays, or "off hours."

Threshold Criterion: In no less than ten percent (10%) of the standard surveys a SA conducts during a twelve month period, the time of day that surveyors begin should extend beyond the business hours of 8:00 am to 6:00 pm and should either incorporate evening hours after 7:00 pm or morning hours before 7:00 am, unless they are started during weekend days i.e., Saturdays, Sundays, and holidays. To count towards the ten percent, once begun, a survey must be conducted on consecutive calendar days, even if those days encompass Sundays and holidays.

Results: Criterion _____ *(Indicate Met or Not Met)*

Score: ____% of standard surveys were staggered.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis B: The SA complies with requirements for conducting standard surveys of nursing homes within prescribed time limits.

Threshold Criterion: No less than one hundred percent (100%) of the consecutive standard surveys of nursing homes conducted by the SA are conducted within fifteen (15) months between surveys. The average statewide interval between consecutive standard surveys is no greater than twelve (12) months.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ___ % of consecutive standard surveys of nursing homes were conducted within fifteen (15) months between surveys. ____ nursing homes exceeded the fifteen-month requirement. The maximum number of months between standard surveys is _____ months. The average statewide interval between consecutive standard surveys is ____ months.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis C: The SA conducts all legislatively mandated surveys within the timeframes established by law.

Threshold Criterion:

1. All HHAs are recertified every thirty-six (36) months.
2. All ICFs/MR are recertified before the expiration date of the existing time-limited agreement. If a survey is conducted after the original expiration date, the SA must have given the state Medicaid agency written notice that it should extend the agreement and the recertification survey must have occurred before the expiration date of the extension.
3. Validation surveys are conducted on hospitals selected as part of the 1% sample.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score:

1. ___% of HHAs were recertified every thirty-six (36) months.
2. ___% of ICFs/MR recertified before the expiration date of the existing time limited agreement or the two-month approved extension date.
   ___ providers received a written two-month extension notice.
   ___ surveys were conducted after the original expiration date.
3. ___ % of validation surveys were conducted on hospitals as part of the 1% sample

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 2: Survey findings are supportable.

Results: **Standard ____*(Indicate Met or Not Met)***

Emphasis A: The SA explains and properly documents all deficiencies on the CMS Form 2567, Statement of Deficiencies (SOD).

Threshold Criterion: No less than eighty-five percent (85%) of deficiencies cited on SODs reviewed meet the Principles of Documentation for deficiency citation.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ___% of the SOD measures rated met the POD for deficiency citation.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 3: Certifications are fully documented and consistent with applicable law, regulations and general instructions.

Results: **Standard ____*(Indicate Met, Partially Met, or Not Met)***

Emphasis A: The SA conducts surveys of nursing homes in accordance with CMS instructions.

Threshold Criterion: No less than one hundred percent (100%) of nursing home surveys are satisfactorily conducted by effectively achieving the desired outcomes of the survey using Federal standards, protocols and procedures, policies and systems specified in CMS instructions.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: Report #1: _____% of measures met the satisfactory score of 3.0 or greater. (The score must be an overall score of 80% or higher to be considered "Met" for this report.)

Results: Criterion_____*(Indicate Met or Not Met)*

Score: Report #2: There is a _____% unjustified discrepancy rate between Measure 6-Deficiency Determination and the facility's copy of the CMS 2567. (The score represents the aggregate of FOSS surveys conducted in the fiscal year.)

Results: Criterion____*(Indicate Met or Not Met)*

Score: Report #3: There is a ___% unjustified discrepancy rate for disagreements with deficiencies between the Regional Office and the State Agency. (The score represents the aggregate of FOSS surveys conducted in the fiscal year.)

Results: Criterion____*(Indicate Met or Not Met)*

Score: Report #4: The RO identified _____ IJs at _____ facilities at which it conducted comparative surveys. The SA correctly identified _____ IJs at the same facilities. This represents _____ %.

Report #5: Areas for Improvement. (This is a supplemental report, which may be provided to the State Agencies on a quarterly or annual basis. Record fiscal year findings under "Narrative of Findings").

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 4: When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to.

Results: **Standard ____*(Indicate Met, Partially Met, or Not Met)***

Emphasis A: "Immediate Jeopardy" cases involving LTC and non-long term care (NLTC) Providers and Suppliers are processed timely.

Threshold Criterion: In ninety-five percent (95%) of the SA's determinations that there is Immediate Jeopardy to resident and patient health and safety in a provider or supplier that was not abated (removed) onsite (prior to the end of the survey), the SA adheres to the 23-day termination process as outlined in 42 CFR 488.410 and 42 CFR 489.53.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: The SA adhered to the twenty-three (23) day termination process in ____% of cases where there were no extenuating circumstances.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis B: Denial of Payments for New Admissions (DPNA) must be imposed by the third month when a LTC facility is not in substantial compliance for 3 months after the date of the original survey. The SA adheres to the enforcement processing timeframes.

Threshold Criterion: In eighty percent (80%) of the cases, revisits are conducted by the 60th day and the enforcement packet is sent to CMS or notice is sent by the State to the provider by the 70th day.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ____% of cases, where there were no extenuating circumstances, have revisit surveys conducted by the 60th day and the enforcement packets sent to CMS or have notices sent by the State to the provider no later than the 70th day.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis C: Noncompliance with one or more Conditions of Participation or Conditions of Coverage and cited deficiencies limit capacity of the provider/supplier to furnish adequate level or quality of care. **(NLTC providers only, excluding CLIA)**

Threshold Criterion: In eighty percent (80%) of the cases which cite condition-level noncompliance on the part of a provider or supplier the SA adheres to the ninety (90) day termination process described in Section 3012 of the SOM.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: The SA adhered to the ninety (90) day termination process in ___% of the cases where there were no extenuating circumstances. _____ cases were reviewed. _____ cases met the requirements.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 5: All expenditures and charges to the program are substantiated to the Secretary's satisfaction.

Results: **Standard ____*(Indicate Met, Partially Met, or Not Met)***

Emphasis A: The SA employs an acceptable process for charging the Federal programs.

Threshold Criterion: The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its Title XVIII and XIX expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: The score is ____. (The score must be an overall score of 10 or above to be considered "Met" for this emphasis).

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis B: The SA has an acceptable method for monitoring its current rate of expenditures and planned workload.

Threshold Criterion: The SA monitors and analyzes both its spending and workload progress throughout the fiscal year to ensure that the program priorities are accomplished within its approved budget.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: The quarterly, annual analysis, and supplemental budget ___ *(was or was not)* verified by the RO.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 6: The conduct and reporting of complaint investigations, both long term care and hospital complaints, including hospital federal allegation and EMTALA complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures.

Results: **Standard ____*(Indicate Met, Partially Met, or Not Met)***

Emphasis A: The SA maintains and follows guidelines for the prioritization of complaints.

Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ____% of long term care complaints were prioritized and/or categorized according to SA written criteria.

LTC: ____complaints were reviewed. ____ complaints were prioritized and/or categorized in accordance with the State's written criteria.

Hospitals: _____complaints were reviewed. ____ complaints were prioritized and/or categorized in accordance with the State's written criteria.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis B: The SA investigates all complaints it receives for Medicare/Medicaid certified facilities in LTC and accredited and non-accredited hospitals alleging "Immediate Jeopardy" to resident and/or patient health and safety within prescribed time limits.

Threshold Criterion: The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities for all LTC and accredited and non-accredited Hospitals where it determines there is a present or ongoing Immediate Jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: LTC: ____ IJ complaints were reviewed. ____ IJ complaints were investigated within two working days. ___% of IJ complaints are investigated within two working days.

Hospitals: ____ IJ complaints were reviewed. ____ IJ complaints were investigated within two working days. ___% of IJ complaints are investigated within two working days.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis C: The SA investigates all EMTALA complaints referred by CMS within prescribed time limits.

Threshold Criterion: The SA investigates one hundred percent (100%) of all EMTALA complaints within 5 working days consistent with CMS and State policy.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ___ EMTALA complaints were reviewed. ___ EMTALA complaints were investigated within five working days. ___% of EMTALA complaints were investigated within five working days or the approved date for extensions granted by the RO. _____ EMTALA complaints were granted extensions by the RO.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis D: The SA investigates all certified accredited hospital "non-Immediate Jeopardy" complaints that allege non-compliance with conditions of participation within prescribed time limits.

Threshold Criterion: The SA investigates ninety percent (90%) of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with Conditions of Participation within 45 calendar days consistent with CMS policy.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: The SA investigated ____% of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within 45 working days consistent with CMS policy. ____cases were reviewed. _____cases were investigated within 45 working days.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis E: The SA investigates the Medicare/Medicaid certified Long Term Care complaints it receives alleging "actual harm" to residents, within prescribed time limits.

Threshold Criterion: The SA investigates ninety-five percent (95%) of the complaints for Medicare and Medicaid certified facilities it receives alleging or involving actual harm to residents consistent with CMS and state policy.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ____ complaints alleging "actual harm" to patient health and safety were reviewed. ____% of complaints alleging "actual harm" to patient health and safety were investigated within 10 working days from the date that the SA received the complaint.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis F: The SA maintains and follows guidelines for the investigation of Long Term Care complaints, which do not allege or involve immediate jeopardy, or actual harm to residents.

Threshold Criterion: The SA initiates an investigation for ninety-five percent (100%) of the complaints consistent with CMS and State policy for complaints that do not allege or involve immediate jeopardy or actual harm to individuals.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: ___ complaints, which do not allege or involve immediate jeopardy, were reviewed. _____% of complaints, which do not allege or involve immediate jeopardy, were investigated according to State policy.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis G: The SA enters appropriate (certification-related) complaint data into the OSCAR complaint subsystem.

Threshold Criterion: No less than ninety percent (90%) of SA citations from complaint investigations, that are violations of Federal requirements (deficiencies cited), are encoded into OSCAR in accordance with SOM 3281-3284. The average time from the latest date of the SA's completion of the investigation to entry into OSCAR/ASPEN Central Office does not exceed 70 calendar days**.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: _____complaint cases were reviewed. ____ % of complaints investigated by the State were entered into OSCAR.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

STATE: _____
STATE PERFORMANCE STANDARD REVIEW SUMMARY
REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)

STANDARD 7: Accurate and timely data is entered into online survey and certification data systems. (Excludes CLIA)

Review Results: **Standard ____*(Indicate Met, Partially Met, or Not Met)***

Emphasis A: Certification kits for recertified non-accredited hospitals and nursing homes are entered into the OSCAR\ASPEN Central Office system on a timely basis.

Threshold Criterion: The average time from the latest date of the SA survey completion date (L34) to entry into OSCAR\ASPEN Central Office does not exceed seventy (70) calendar days.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: _____ calendar days is the average time from the State Agency survey completion date (L34) to entry into OSCAR/ASPEN Central Office for nursing home recertification actions.

_____ calendar days is the average time from the State Agency survey completion date (L34) to entry into OSCAR/ASPEN for non-accredited hospital recertification actions.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Emphasis B: The SA enters data accurately into OSCAR\ASPEN Central Office for recertified non-accredited hospitals and nursing homes.

Threshold Criterion: No less than eighty-five percent (85%) of cases reviewed demonstrate that data is entered into OSCAR\ASPEN Central Office accurately.

Results: Criterion ____ *(Indicate Met or Not Met)*

Score: _____ % of the nursing home recertifications reviewed were entered into OSCAR/ASPEN Central Office accurately.

_____ % of the non-accredited hospital recertifications reviewed were entered into OSCAR/ASPEN Central Office accurately.

Narrative of Findings:

Action(s) Taken: (Include CMS and SA actions)

Standard 5 Score Sheet

	State:	Fiscal Year: 2003		
Item No.	Emphasis A Review Items	Met	Not Met	
	a) The SA submits its budget request, including proposed workload, its quarterly Title XIX budget estimates, and its expenditure and workload reports in accordance with the requirements contained in the SOM, the budget call letter and other related program instructions.			
1	□ The SA meets CMS assigned due dates for its budget request and proposed work plan.			
2	The SA submits its budget request and proposed work plan in a timely manner.			
3	The SA submits all the attachments and documents required by applicable program instructions to support its budget request.			
4	Budget documents submitted are completed correctly.			
5	The type and amount of work projected is in accordance with applicable program instructions.			
6	The justification for each line item and cost, on the budget request, is reasonable and based on applicable program instructions.			
7	Program cost shares approved by the RO are appropriately applied to all line- items and costs on the budget request.			
8	The SA submits required expenditure and workload reports in a timely manner. (Quarterly reports are due 45 days after the close of the quarter and year-end cumulative reports are due 60 days after the close of the fiscal year.			
9	The SA submits the required quarterly and cumulative expenditure and workload reports that are completed in accordance with applicable program instructions.			
10	The SA submits the required quarterly and cumulative expenditure and workload reports that are completed in accordance with applicable program instructions.			
11	The SA provides reasonable assurances to the Regional Office that costs shown on all budget/expenditure reports are appropriately applied to the Medicare, Medicaid and State Licensure programs across facility and program types.			
12	Reported FTEs and dollar amounts are reasonable and consistent with the State's budget approval. Line item amounts generally conform to the approved budget, except for good cause.			

Standard 5 Score Sheet

Item No.	Emphasis B Review Items	Met	Not Met	Not Applicable
1	Quarterly Analysis: The SA prepares a brief analysis which summarizes the status of its spending and work completion in relation to meeting the budgeted dollar and workload amounts for the fiscal year.			
2	Annual Analysis: The SA prepares a brief analysis which analyzes the fiscal year and compares actual expenditures and accomplished workload to the amount budgeted and the planned workload.			
3	The State takes appropriate action to ensure program priorities are accomplished within the approved budget amount.			
4	If necessary, the SA prepares and justifies a supplemental budget request in accordance with the SOM and other applicable guidance.			