



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 17-20-NH

DATE: March 2, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update

Memorandum Summary

- **Total SFF slots and candidates for each State:** The number of designated slots and candidates for FY 2017 (see Appendix A) will not change from those effective since May 1, 2014.
- **Initial selection notice:** The State Survey Agency (SA) must notify the provider in writing of their SFF selection and conduct a meeting (either onsite or via telephone) with the nursing home's accountable parties, and the Centers for Medicare & Medicaid Services (CMS) Regional Office (RO), if the RO wants to be included.
- **Graduation from the SFF program:** Once an SFF has completed two consecutive standard surveys with no deficiencies cited at a scope and severity of "F" or greater (or "G" or greater for Life Safety Code (LSC) deficiencies), and has had no complaint surveys with deficiencies at "F" or greater (or "G" or greater for Life Safety Code (LSC) deficiencies) in between those two standard surveys, the facility will graduate from the SFF program. However, if the only deficiency preventing graduation is an "F" level deficiency for food safety requirements (42 CFR §483.60(i) Tag F371), the RO has discretion to allow the facility to graduate from the SFF program. F371 deficiencies at a "G" level or greater will prevent the facility from graduating from the SFF program.
- **Authority for termination:** Consistent with longstanding authority, the CMS ROs may use discretionary termination for SFFs (or any facility) if necessary to protect resident health and safety.

Background

The SFF program focuses on nursing homes that have a persistent record of poor care. Although such facilities sometimes improve enough to achieve substantial compliance on one survey, they have frequently manifested many problems on a subsequent survey, often for the same or similar deficiencies as before. Facilities with this type of "yo-yo" compliance history have often not addressed the underlying systemic problems that result in repeated cycles of serious deficiencies.

Once a facility is selected as an SFF, the SA conducts a standard survey not less than once every six months and recommends progressive enforcement until the nursing home either (1) graduates from the SFF program; or (2) is terminated from the Medicare and/or Medicaid program(s). Details of the progressive enforcement process are presented in Section III of this memo.

The SFF program is primarily focused on issues affecting the quality of life and quality of care of residents. To this end, LSC surveys are not used in determining the list of facilities that are candidates for the SFF program. However, LSC surveys will be conducted at the same frequency as the health surveys (i.e., at least once every six months), and any LSC finding of actual harm or greater on the most recent survey will be taken into account in determining graduation from the SFF program, as described in Section IV of this memo.

SECTION I: SFF CANDIDATE LIST

Each SA selects new SFFs from a list of candidates that CMS supplies. The number of nursing homes on the candidate list is based on five candidates for each SFF slot, with a minimum candidate pool of five nursing homes and a maximum of 30 per State. A list of the number of SFF slots and candidates by State is included in Appendix A. The number of slots and candidates per state has not changed since May 1, 2014.

The names of SFF candidates are issued monthly with the *Five-Star Quality Rating* updates. The methodology for selecting replacement facilities for the SFF program has been harmonized with the methodology of the health inspection domain of the *Five-Star Quality Rating System*. The Design for Nursing Home Compare Five-Star Quality Rating System can be found at <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf>.

CMS informs candidate nursing homes of their inclusion on the SFF candidate list in the monthly preview of the *Five-Star Quality Rating System*. CMS will continue to provide the monthly *Five-Star* rating system preview to nursing home providers via their electronic connection to their state servers for submission of Minimum Data Set (MDS) data. Providers must log into the CASPER (Certification and Survey Provider Enhanced Reports) System to retrieve their preview, as described in policy memorandum S&C 09-17 available on the CMS website at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-17.pdf>.

SECTION II: INITIAL SELECTION OF SFF

A. Selection

The SA makes a recommendation as to which of the candidates on the SFF candidate list should be selected for the SFF program, and the CMS RO provides final approval. Prior to making its recommendation, the SA should check to make sure there are no appeals, settlements or requests for Informal Dispute Resolution (IDR) or Independent Informal Dispute Resolution (IIDR) that may impact its decision to recommend a particular facility as an SFF. If an IDR, IIDR,

settlement, or result of an appeal are likely to occur after notice of SFF selection has been given, there is no need for additional checking and the facility is properly included in the SFF program.

When an SFF slot is open due to the termination or graduation of a facility in the SFF program, the SA must select a new facility from the candidate list for the SFF program within 21 calendar days from the date the slot opens.

B. Notification to Facility of Initial Selection

The SA notifies the facility and all accountable parties (see section II.C below) by letter (and any additional means chosen by the SA):

- That the facility has been selected as an SFF;
- That the facility's selection in the program is due to a persistent pattern of poor quality on its last three standards surveys and complaint surveys;
- That the facility must provide the following information to the SA and the RO within five business days of receiving notice of selection to the SFF program: The names, telephone numbers, email addresses and physical addresses of the Chairperson of the Governing Body, holder of the provider agreement, any party who owns five percent or more of the facility, the management company (if applicable), the facility's landlord(s) (if any), the facility's mortgage holder, and any corporate owner(s) for chain-operated nursing homes;
- That the facility must inform the residents and resident representatives, as well as their families (including the resident council and/or family council primary contacts), that it has been selected as an SFF due to a persistent pattern of poor quality on its last three standards surveys and complaint surveys and the facility must provide them with the contact information for individuals that residents/representatives or interested parties may contact with questions;
- That the facility will graduate from the SFF program once it has completed two consecutive standard surveys with no deficiencies cited at a scope and severity level of "F" or greater (or "G" or greater for life safety code deficiencies) and has no complaint surveys with deficiencies cited at "F" or greater (or "G" or greater for life safety code deficiencies) in between those two standard surveys. However, if the only "F" level deficiency is for food safety requirements (42 CFR §483.60(i), tag F371), the facility may graduate from the SFF program at the discretion of the RO. F371 deficiencies at "G" level or greater will prevent the facility from graduating from the SFF program;
- That CMS or the SA will impose an immediate remedy or remedies on an SFF that fails to achieve and maintain significant improvement in correcting deficiencies on the first and each subsequent survey after a facility becomes an SFF. Significant improvement is defined as the ability of an SFF to demonstrate that its practices have resulted in no deficiencies with a S/S rating above an "E" (or above an "F" for life safety code deficiencies);

- That CMS enforcement remedies will be of increasing severity for SFFs that do not make significant improvement with each standard survey and intervening complaint survey that starts a new enforcement cycle. Remedies include, but are not limited to, a Civil Money Penalty (CMP), discretionary Denial of Payment for New Admissions (DPNA), Directed Plan of Correction (DPOC), and Temporary Management;
- That for nursing homes remaining in the SFF program after three consecutive standard surveys, where the most recent standard survey results in noncompliance deficiency cited at a scope and severity level of “F” or greater (or “G” or greater for LSC deficiencies), the SA will schedule a “last chance survey”, which is a standard survey;
- That the facility’s selection as an SFF cannot be appealed but that it will still have the right to IDR/IIDR, as allowed by 42 CFR §488.331 and §488.431, and to appeal the noncompliance resulting in an enforcement remedy determined under an SFF survey to an Administrative Law Judge of the Department of Health and Human Services Departmental Appeals Board;
- That Section 1819(h)(2)(C) of the Social Security Act (the Act) requires any nursing home that does not achieve substantial compliance with the Federal requirements within six months to be terminated from participation in the Medicare and /or Medicaid programs 42 CFR. § 488.450(d);
- That Denial of Medicare and Medicaid payment for new resident admissions (DPNA) under sections 1819(h)(2)(D) and 1919(h)(2)(C) of the Act and 42 CFR is required for failure to achieve substantial compliance within three months 42 CFR §§ 488.412(c) and 488.417(b); and,
- That, in addition to the remedies required by the Act, CMS may terminate the facility’s provider agreement at any time prior to six months if the facility is not in substantial compliance, irrespective of the presence of immediate jeopardy, in accordance with 42 CFR. §488.456(b) and §489.53.

A model letter to facilities selected for the SFF program is included in Appendix B. The SA may make additions to the letter to accommodate for any special features for facilities in the state. Further, the SA may require additional measures as part of the notification process. The official date of enrollment of an SFF is the date on the Initial Selection Notice.

C. Accountable Parties

All communications to SFF facilities should include copies to all of the following parties, since they are all accountable and in a position to effect necessary improvements:

Administrator, Chairperson of the Governing Body, holder of the provider agreement, any party who owns more than a five percent interest in the facility, the management company (if applicable), facility landlord(s), the mortgage holder, and corporate owner(s) for chain-operated nursing homes.

D. Notification to Additional Parties

The SA must include the CMS RO SFF coordinator in any communications to the SFF. The SA must also provide a copy of the notice of facility SFF program selection to the State Ombudsman's Office, the State Medicaid Director, and the applicable Quality Improvement Network (QIN) or Quality Improvement Organization (QIO). All survey outcomes for an SFF selected facility should be reported to the RO SFF coordinators. If the results of any survey reveal that the facility continues to practice a level of care that has resulted in harm to residents or put residents in immediate jeopardy, then the SA should notify the RO SFF coordinator as soon as possible.

E. Meeting to Discuss Significance of SFF Selection

In conjunction with notice of the initial SFF selection, a meeting (either face-to-face or via telephone) must be held between the SA, the nursing home's accountable parties (as identified in Section II.C above), and the RO, if the RO wants to be included, to ensure that the seriousness and the consequences of SFF designation is adequately understood. The purpose of the meeting is to explain the SFF program, the steps necessary for a facility to graduate from the program, and to inform SFFs that they will be terminated if they do not graduate.

SECTION III: PROGRESSIVE ENFORCEMENT

While a nursing home is in the SFF Program, the SA will survey the facility at least once every six months, as required by §1819(f)(8) of the Act, **and** must recommend progressively stronger enforcement actions in the event of continued failure to meet the requirements for participation with the Medicare and Medicaid programs. The timing of these standard surveys must be as *unpredictable* as possible.

Remedies must be imposed immediately, without an opportunity to correct, any time an SFF has a health or complaint survey with deficiencies cited at a scope and severity level of "F" or higher or LSC surveys with deficiencies cited at "G" or higher. Further, if subsequent surveys also result in the citation of deficiencies at these levels, the enforcement remedies imposed must be of increasing severity. For example, if a CMP was imposed for an "F" level deficiency cited in the first standard survey, and a subsequent survey finds another deficiency of "F" or greater, the CMS RO could impose a CMP **and** a discretionary DPNA. The CMS RO could also impose a CMP **and** a DPOC. Increasing severity can mean a higher CMP than was imposed for the earlier noncompliance or it can mean increasing from one remedy to more than one remedy being imposed. The CMS ROs should use their discretion to determine what remedies are most appropriate given the survey results, but the remedies must be of increasing severity under this policy. Discretionary termination should be considered if survey results warrant the use of this remedy.

Enforcement remedies must be imposed with a 15 calendar day formal notice of remedies before the effective date, with the exception of a CMP that requires no advanced notice or remedies for deficiencies related to Immediate Jeopardy that require a two-day notice. Enforcement remedies that are required to be imposed by law or CMS policy should never be delayed because a facility is in the SFF program. Enforcement remedies include CMPs, discretionary DPNA, discretionary

termination, DPOC, or Directed In-Service Training (see Section 7400 of the State Operations Manual (Internet Only Manual, Pub. 100-07) for more information on enforcement remedies).

The SFF program does not supplant the six-month mandatory termination required in §1819(h)(2)(C) or §1919(h)(3)(D) of the Act, or the mandatory DPNA under §1819(h)(2)(D) or §1919(h)(2)(C) where it applies. In other words, a facility cannot continue to participate in Medicare or Medicaid if the facility does not achieve substantial compliance within six months of the date of the first findings of noncompliance and it cannot avoid a mandatory DPNA remedy imposed at the third month of continued failure to achieve substantial compliance. The three-month mandatory DPNA must be built into the progressive enforcement action of the SFF program and the six-month statutory termination requirement will supersede any other provisions of this SFF policy if it applies to the nursing home.

SECTION IV: GRADUATION FROM THE SFF PROGRAM

Once an SFF has completed two consecutive standard surveys with no deficiencies cited at a scope and severity of “F” or greater (or “G” or greater for LSC deficiencies), and has had no complaint surveys with deficiencies cited at “F” or greater (or “G” or greater for LSC deficiencies) in between those two standard surveys, the facility will graduate from the SFF program. The only exception to this rule is if the **only** deficiency preventing an SFF from graduating is an “F” level deficiency at 42 CFR §483.60(i) (tag F371). If an F371 tag cited at an “F” level is the only deficiency preventing graduation, the RO should review the F371 deficiency findings and decide they warrant keeping the facility in the SFF program.

The results of complaint surveys cannot be a basis for finding that the facility has shown significant improvement, however, complaint surveys can show the failure of a facility to show significant improvement. If a facility had, for example, an “E” level deficiency cited on the first standard survey, then a “G” level deficiency was found on a complaint survey, the facility could not graduate until it had at least two more consecutive standard surveys with no deficiencies cited at a scope and severity of “F” or greater (or “G” or greater for LSC deficiencies).

Any standard surveys counting towards the graduation of a facility from the SFF Program must have occurred after the facility has been selected as an SFF. The monthly SFF postings, available at the CMS website at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf>, are updated to reflect newly added facilities to the SFF program, facilities that have and have not shown improvement, and facilities that recently graduated from the SFF program. Graduation from the SFF Program is noted on the Nursing Home Compare website for six months. A facility’s SFF designation on Nursing Home Compare will be removed in the month following the facility’s graduation from the SFF program or its provider agreement termination for failing to achieve substantial compliance with the requirements.

Once the facility has successfully met the criteria for graduation from the SFF program and thus removal of its name from the candidate list, the SA should notify: (1) The facility and its Accountable Parties; (2) the CMS RO; (3) the State Ombudsman’s Office, and (4) the State Medicaid Director. The official graduation date is the date of the notice letter informing the facility and its accountable parties of the nursing home’s removal from the SFF program.

SECTION V: AUTHORITY TO TERMINATE

Facilities selected for the SFF program have a persistent pattern of poor quality on their last three standards surveys and complaint surveys. The SFF program provides a mechanism for the SA and the RO to provide additional attention and resources to these facilities for the purpose of improving their quality of care and protecting residents. However, the RO may consider using its longstanding authority to terminate an SFF's provider agreement when the RO believes it is appropriate to use this remedy.

SECTION VI: OPERATIONAL PROCEDURES

For facilities that have not graduated after two standard surveys, the following guidance applies:

- A. For Nursing Homes remaining in the SFF program after two standard surveys, the SA must develop a plan:** The SA must develop a coordinated plan outlining further action to be taken by the SA and/or the CMS RO to identify the issues that are preventing the facility from graduating and what steps the SA and CMS RO should take accordingly. Part of this plan must include a conference call between the SA and the nursing home's accountable parties (i.e. Administrator, Director of Nursing, Medical Director, Owner/Executive Officer of the Corporation, if applicable) to address the problems that are preventing the facility from graduating from the SFF program.
- B. Nursing Homes remaining in the SFF program after three standard surveys, where the most recent standard survey results in deficiencies at a scope and severity of "F" or greater (or "G" or greater for LSC deficiencies) must undergo a "last chance survey":** The SA must schedule an onsite standard survey ("last chance survey") for such a facility and have a conference call with the RO to discuss the reasons the facility is being scheduled for a "last chance survey." The "last chance survey" may coincide with the next planned onsite survey or occur earlier if SA monitoring continues to indicate a lack of significant improvement by the facility. If a complaint allegation requiring an onsite survey arises before the "last chance survey" is conducted, it is recommended that the SA also conduct the "last chance survey" (which is a full standard survey) in conjunction with the complaint survey, if possible. The SA is not required to seek advance approval to reschedule the "last chance survey" in this manner but must inform the CMS RO when the survey will occur. All surveys must be unannounced. SAs may inform facilities that the next survey will be the "last chance survey" and the actions that may be taken if noncompliance is found. However, under no circumstances should the SA inform the facility of the timing of the "last chance survey."
- C. Communication between the SA and CMS RO required by sections A and B above:**

Discuss progress: Before the initiation of the third standard survey (subsection A) and the "last chance survey" (subsection B), the SA must discuss with the CMS RO, at a minimum, the following points to assess the extent to which the facility has demonstrated improved compliance:

- a. What other contact, if any, occurred with the facility besides the onsite surveys?
- b. Is there a pattern of repeated deficiencies being cited since the facility became a SFF candidate and was selected as an SFF?
- c. What progress towards improvement has the facility accomplished, if any, and what evidence exists indicating it can sustain such improvement?
- d. Based on the SA's interviews with facility staff responsible for Quality Assurance, has the facility instituted a system to address all present and potential noncompliance deficiencies?

D. If the “last chance survey” results in the citation of any deficiencies with a scope and severity level of “E” or less (or “F” or less for LSC deficiencies): Within 10 business days of the “last chance survey” exit date, the SA must review the survey findings with the RO on a conference call to determine if a six month termination letter would be issued or if another remedy such as an earlier termination, a DPOC, Temporary Management, or Systems Improvement Agreement (SIA) may be warranted. Facilities with deficiencies cited at scope and severity level of A, B, or C are considered to be in “substantial compliance.” Based on the questions and answers from the discussion (See Section C.1.a through d.) and the past facility history that indicates a “yo-yo” compliance performance, the CMS RO and the SA should determine if they feel confident that the facility will be able to graduate from the SFF program on the next survey and take appropriate enforcement actions based on their conclusion.

E. If the “last chance survey” results in the citation of any deficiencies with scope and severity level of “F” or greater (or “G” or greater for LSC deficiencies): No more than 10 calendar days from the exit date of the “last chance survey” and before the CMS Form 2567 (Statement of Deficiencies) is issued to the facility, the SA, CMS Central Office (CO) and CMS RO must hold a conference call to review the CMS Form 2567 and any other information necessary to determine whether the facility's provider agreement should be terminated without the opportunity to correct as set forth in 42 C.F.R. 489.53. Factors bearing on the decision to terminate or not include, but are not limited to, special needs or characteristics of the resident population making it difficult for them to be transferred, bed availability in the local area, whether the facility will be changing ownership or management, and any other development that indicates timely and enduring improvement in the quality of care or safety is likely.

If the facility is given an opportunity to correct its non-compliance, the CMS RO must use the available enforcement remedies and tools to establish an extensive quality improvement regimen for the facility to address the underlying issues (i.e., DPOC, Temporary Management, or Systems Improvement Agreement (SIA)). This regimen should also include onsite revisits to monitor that deficiencies have been corrected. Even with the implementation of such an extensive quality improvement regimen, the

CMS RO will still issue a six month termination notice. ROs do not have the discretion to graduate SFFs with an F371 tag at an “F” level scope and severity on the “last chance survey”, because the SFF would not have had two consecutive standard surveys of “E” or less deficiencies (or “F” or less for LSC) at this time.

An SIA is a legally binding agreement voluntarily entered between CMS and a facility which requires the facility to engage in a structured regimen of quality improvement activities that includes, but is not limited to, a root cause analysis of the systemic issues that are preventing the facility from attaining/maintaining substantial compliance, an action plan to address these issues, and ongoing reporting and communication with CMS. CMS only offers a provider/supplier an SIA under certain conditions and a provider/supplier whose termination is imminent should not expect to be offered an SIA. The SIA is evaluated on a case by case basis with CO concurrence.

Tracking Results of Programmatic Adjustments: CMS CO, along with CMS ROs, routinely track the status of SFFs.

Contact: For questions about the program please contact the CMS SFF mailbox at SFF@cms.hhs.gov.

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

/s/
David R. Wright

Attachment(s):
Attachment 1- Appendix A
Attachment 2- Appendix B

cc: Survey and Certification Regional Office Management

The contents of this letter support activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.