SUMMITRIDGE™

ahead of time

Types of Home Health Agency Surveys

SUMMITRIDGE™
ahead of time

Types of Home Health Agency Surveys

1. Initial Certification Survey

This type of survey takes place when an agency applies to join the Medicare program as a certified HHA. The survey may be carried out by State Agencies (SAs) or Accrediting Organizations that have been granted deeming authority by CMS. During the initial certification survey, the agency is evaluated for compliance with all applicable Conditions of Participation.

Before a home health agency can undergo its initial certification survey, it must first receive approval of its enrollment application from the Medicare Administrative Contractor. In addition to this approval, the agency must also meet specific conditions to be eligible for the initial survey:

- The HHA must offer skilled nursing services as well as at least one other qualifying therapeutic service, such as physical therapy, occupational therapy, speech-language pathology, medical social work, or home health aide services.
- The agency must have already delivered care to at least ten patients requiring skilled services. These individuals do not need to be Medicare beneficiaries, but the care provided must comply with the Conditions of Participation. At the time of the initial survey, at least seven of those ten patients must still be receiving skilled services from the agency.

If the HHA has not yet served ten patients with skilled care, the State Agency (SA) or Accrediting Organization must consult with the appropriate CMS Location to determine if the agency operates in a Medically Underserved Area. If the agency is located in an MUA, CMS may allow the minimum patient requirement to be reduced from ten to five. In such cases, at least two of those five patients must still be under the agency's skilled care at the time of the survey.

Change of Ownership (CHOW)

When a home health agency experiences a change in majority ownership through a sale within three years of either its initial Medicare enrollment date or its most recent majority ownership change, it is required to re-enroll in the Medicare program as a new provider. This triggers the need for a new initial certification process unless the situation qualifies for an exemption. As part of this process, the agency must undergo a

new initial certification survey conducted by a State Agency or by an Accrediting Organization that has been granted deeming authority by CMS. This step is essential to confirm that the newly acquired agency continues to meet the Medicare Conditions of Participation.

2. Recertification Survey

Home health agencies are required to undergo a survey within 36 months of the last day of their most recent standard survey. The recertification process starts with a standard survey; however, depending on the findings during the survey, it may be expanded into a partial extended or full extended survey. These survey types and procedures are further explained in Part I, Section C: Survey Protocols – Standard, Partial Extended, and Extended Surveys.

3. Abbreviated Standard Survey

The abbreviated standard survey is a targeted inspection that focuses on assessing an HHA's adherence to particular standards within a Condition of Participation or the CoP as a whole. The scope of this survey depends on the reason it is being conducted. It may be initiated due to complaints filed against the agency, a change in ownership or management, or other specific concerns, such as when the agency reapplies for Medicare billing privileges after a deactivation.

Types of Abbreviated Standard Surveys include:

a. Complaint Survey (Investigation)

This type of survey is carried out to examine specific claims of noncompliance made against an HHA. For more detailed instructions on complaint surveys, refer to Chapter 5 of the State Operations Manual (SOM).

b. Post-Survey Revisit (Follow-up Survey)

If any deficiencies are identified during a survey, the surveyor may perform a follow-up visit to verify whether the agency has adequately addressed and corrected those issues. In cases where deficiencies involve condition-level violations in any Condition of Participation (CoP), an onsite follow-up survey is mandatory to confirm that the agency has resolved the problems. Additional details on revisit surveys can be found in Chapter 2 of the SOM.

4. Validation Survey for Deemed HHAs

Under Section 1865(a)(1) of the Social Security Act, providers and suppliers that have been accredited by a CMS-approved national Accrediting Organization may qualify for exemption from the routine compliance surveys typically conducted by State Agencies, provided they apply for and receive deemed status. However, these deemed HHAs remain subject to validation surveys authorized by CMS, which serve as part of CMS's oversight responsibilities over the AO's accreditation and deeming process.

C. Survey Protocols: Standard, Partial Extended, and Extended Surveys

Section 1891(c)(2) of the Social Security Act outlines the requirements for conducting surveys of home health agencies to assess their compliance with Medicare Conditions of Participation. These requirements are codified in the definitions provided at 42 CFR §488.705, which describe the different types of surveys: standard survey, partial extended survey, and extended survey.

1. Standard Survey

CMS has designated a specific set of requirements, known as Level 1 standards, which are directly linked to an agency's capacity to provide high-quality patient care and services in compliance with the Conditions of Participation. Meeting these Level 1 standards is connected with improved patient care outcomes.

The standard survey primarily assesses compliance with these Level 1 standards. To do this, surveyors review clinical records, conduct home visits to observe care firsthand, and interview both patients and staff. Staff interviews are performed as needed to clarify or gather additional information based on other observations or data collected during the survey.

If, during home visits, clinical record reviews, and interviews with patients and staff, no deficiencies or other issues are found, the home health agency is deemed to be in compliance with the Conditions of Participation. In this case, the surveyors may conclude the survey and end their visit.

However, if any noncompliance is discovered with a Level 1 standard, the survey must be expanded into a partial extended survey to further investigate the problem. If it becomes clear during the survey that there is condition-level noncompliance, the surveyor can immediately switch to an extended survey, which assesses all CoPs.

Although the requirement to submit Outcome and Assessment Information Set (OASIS) data is reviewed during the survey's preparation phase, it is not considered a Level 1

standard. Therefore, a deficiency related to OASIS reporting does not automatically lead to expanding the survey into a partial extended or extended survey.

2. Partial Extended Survey

A partial extended survey takes place whenever a deficiency is found in any of the Level 1 standards. CMS no longer designates certain standards as Level 2; instead, the survey includes a review of all other standards within the same Condition of Participation where the Level 1 deficiency was identified. The purpose is to determine whether the agency is fully compliant with that particular CoP.

3. Extended Survey

Substandard care refers to a failure to comply with one or more of the eight Conditions of Participation examined during the standard survey, including deficiencies that could cause actual or potential harm to patients. If either a standard or partial extended survey uncovers substandard care, the surveyor must expand the review to cover all 15 CoPs. This extended survey can be initiated at any time by the Accrediting Organization, State Agency, or CMS Location, but it is mandatory whenever substandard care is detected.

The extended survey should begin immediately after substandard care is identified. Except for unavoidable delays such as weather or scheduling conflicts, the survey should be finished without interruption. However, the entire extended survey must be completed within 14 calendar days. For example, if a complaint investigation finds condition-level noncompliance, the extended survey must be concluded within this two-week timeframe.

If, during a standard or partial extended survey, the surveyor finds noncompliance that is not related to Level 1 standards, they will decide which other standards and conditions need to be reviewed based on those findings.

Noncompliance at the condition level within Conditions of Participation that do not include Level 1 standards does not automatically require an extended survey. However, the State Agency or CMS Location may choose to upgrade the survey to an extended survey at their discretion at any point.