DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Clinical Standards and Quality

Admin Info: 24-02-ALL

DATE: October 6, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Fiscal Year (FY) 2024 State Performance Standards System (SPSS) Guidance

Memorandum Summary

- CMS is releasing the Fiscal Year 2024 guidance for the State Performance Standards System (SPSS), the process used to oversee State Survey Agency performance for ensuring Medicare/Medicaid certified providers and suppliers are compliant with federal requirements to improve and protect the health and safety of Americans.

Background:
Every year, CMS conducts a formal assessment of each State Survey Agencies' performance relative to measures included in the SPSS program. CMS works with the State Survey Agencies to strengthen oversight so that the care provided in nursing homes and other acute and continuing care providers and suppliers is of the highest quality.

Discussion:
The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve the health and safety of Americans such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents. The three domains of the SPSS for the 2024 fiscal year include:

- Survey and Intake Process
- Survey and Intake Quality
- Noncompliance Resolution

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

Contact:
For questions or concerns relating to this memorandum, please contact the SPSS team at spss_team@cms.hhs.gov.

Effective Date:
October 1, 2023. Please communicate to all appropriate staff within 30 days.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

Resources to Improve Quality of Care:
Check out CMS's new Quality in Focus interactive video series. The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid. Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the Quality, Safety, & Education Portal Training Catalog, and select Quality in Focus.

Fiscal Year 2024

State Performance Standards

System Guidance

September 29, 2023

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Introduction

CMS actively evaluates the State Performance Standards System (SPSS) to improve its efficiency, consistency, and relevance in the assessment of State Survey Agency performance. The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve health and safety of Americans such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents. The SPSS Fiscal Year 2024 (FY24) guidance is meant to ensure State Survey Agencies are consistently monitoring compliance of health care facilities.

A. Primary changes to the SPSS for Fiscal Year 2024

Like Fiscal Year 2023 SPSS, the FY24 SPSS measures are organized by the following three domains: Survey and Intake Process, Survey and Intake Quality, and Noncompliance Resolution. CMS has added four measures in the Survey and Intake Process domain including Emergency Medical Treatment and Labor Act (EMTALA) complaints prioritized as Immediate Jeopardy (IJ) and Non-IJ High conducted within the required time period; Off-Hour Surveys for Nursing Homes; Frequency of Nursing Home Recertification Surveys; and Frequency of Tier 1 Acute and Continuing Care Recertification (ACC) Surveys. To streamline the SPSS performance measure set, CMS has removed the Recertification Survey Completion Rate (S5) from SPSS for FY24 because it overlaps with the frequency measures. To take into consideration the small sample sizes associated with the Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys (SPSS FY23 Q1) and the Assessment of Deficiency Identification using Federal Comparative Surveys (SPSS FY23 Q2), these two measures have been combined into one measure for SPSS FY24. New to the FY24 guidance is Appendix 7, which provides a summary table of SPSS measure data sources, specifications, and reports for measure monitoring. This Appendix was added in response to feedback for additional information on how measures are calculated.

B. Ongoing Activities

CMS will monitor survey and certification guidance to ensure FY24 measures remain in alignment with current guidance. In conducting oversight activities, CMS will continue to provide ongoing monitoring and support and will proactively identify priorities and measures to consider for Fiscal Year 2025 (FY25) SPSS. CMS will also continue to work with State Survey Agencies to address their performance as assessed by the SPSS measures during this fiscal year. If you have questions or feedback related to the SPSS, please contact us via email at SPSS_Team@cms.hhs.gov.

C. Fiscal Year 2024 SPSS Measures[1]

The FY24 SPSS includes 13 measures across the three domains: Survey and Intake Process (measures S1-S9); Survey and Intake Quality (measures Q1-Q3); and Noncompliance Resolution (measure N1). Eight of these measures were included in FY23. One new measure consolidates two measures from FY23, the Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys measure and the Assessment of Deficiency Identification using Federal Comparative Surveys measure, into one measure (measure Q1). The four remaining new measures include: EMTALA prioritized as IJ and Non-IJ High conducted within the required time period (S5); Off-Hour Surveys for Nursing Homes (S7); Frequency of Nursing Home Recertification Surveys (S8); and Frequency of Tier 1 ACC Recertification Surveys (S9). The following list summarizes each FY24 SPSS measure by domain.

Survey and Intake Process

- S1. Surveys of Nursing Home Special Focus Facilities (SFF)
  - CMS will assess the frequency of recertification surveys conducted for SFFs and the addition of new facilities to the SFF list. State Survey Agencies must conduct a recertification survey with each SFF at least once every six months and a new SFF must replace a facility that graduates from the SFF program or is terminated within 21 calendar days.
- S2. Timeliness of Upload of Recertification Surveys
  - CMS will assess the time from survey completion to successful data upload into the National Database for surveys uploaded this fiscal year. The average number of days to upload should not exceed 70 calendar days. CMS will assess whether states uploaded recertification surveys within 70 days of survey exit on average. CMS will assess this measure for the following provider types: community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, outpatient physical therapy/speech language pathology providers, psychiatric residential treatment facilities, and rural health clinics.
- S3. Use of the Immediate Jeopardy (IJ) Template
  - CMS will assess the mandatory use of the IJ template by State Survey Agencies. State Survey Agencies should include this template with documentation for at least 80% of all IJ deficiencies. CMS will assess this measure for ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals, intermediate care facilities for individuals with intellectual disabilities, and nursing homes.
- S4. Intakes Overdue for Investigation
  - CMS will assess the number of complaints/facility-reported incidents (FRIs) entered that have been triaged for investigation and are overdue for investigation. Between October 1, 2023, and September 30, 2024, State Survey Agencies should reduce the number of complaints/FRIs overdue for investigation by at least 35%. CMS will assess this measure for the following provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, organ procurement

[1] SPSS FY24 measures will be calculated for all providers during the transition period from QIES to iQIES.

organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

- S5. EMTALA complaints prioritized as IJ and Non-IJ High conducted within the State Operations Manual (SOM) timeframe – *new measure for FY24*
  - CMS will assess whether IJ EMTALA complaint investigations are started within the required two business days of CMS Location authorization and non-IJ high EMTALA complaint investigations are started within 45 days of CMS Location authorization.

- S6. Intakes prioritized as Immediate Jeopardy (IJ) started within the required time period
  - CMS will assess whether IJ intake investigations are started within the required time period per Chapter 5 guidance of the SOM. CMS will assess this measure for the following provider types: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes.

- S7. Off-Hour Surveys for Nursing Homes – *new measure for FY24*
  - CMS will assess whether (1) at least 10% of nursing home health recertification surveys are started during off-hours; (2) at least 50% of the required number of off-hour surveys are started on weekends; and (3) at least 80% of off-hours weekend surveys are conducted among facilities with potential staffing issues.

- S8. Frequency of Nursing Home Recertification Surveys – *new measure for FY24 (reintroduced)*
  - CMS will assess whether nursing home recertification health surveys are conducted within the maximum time interval of 15.9 months.

- S9. Frequency of Tier 1 Acute and Continuing Care (ACC) Provider Recertification Surveys – *new measure for FY24 (reintroduced)*
  - CMS will assess whether Tier 1 recertification surveys are conducted within the maximum time intervals for ACC providers. Tier 1 includes recertification health surveys for non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities.

Survey and Intake Quality

- Q1. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys – *new measure for FY24*
  - CMS will assess whether State Survey Agency nursing home compliance, recertification, and revisits are being conducted in compliance with Federal standards, protocols, forms, methods, and procedures specified by CMS using the Federal Monitoring Survey (FMS) Focus Concern Surveys (FCS) results. CMS will also assess whether State Survey Agencies are identifying the same or similar citations at severity and scope levels at or greater than CMS Locations find during Federal Comparative Surveys. State Survey Agencies should achieve a composite score of 75% or higher.

- Q2. Nursing Home Tags Downgraded/Removed by Informal Dispute Resolution (IDR) or Independent IDR (IIDR) and Unresolved IDRs/IIDRs – *previously Q3*
  - CMS will assess the number of tags that have been downgraded or removed via IDR/IIDR and the number of surveys where an IDR/IIDR has been requested but has not been completed. This measure includes the following two sub-measures:

        - Tags cited on the CMS-2567 from surveys conducted in FY24 for nursing homes are downgraded or removed due to IDR/IIDR 40% or less of the time.
        - Surveys with unresolved IDRs/IIDRs may not exceed 5% of all surveys with a requested IDR/IIDR conducted between FY22 and FY24.
- Q3. Data Submission – *previously Q4*
    - CMS will assess whether nursing home surveys have not been uploaded to QIES and of nursing home surveys that have been uploaded whether those surveys are missing CMS-2567 text. This measure includes two sub-measures:
        - Nursing home surveys that have not been uploaded to the QIES may not exceed 5% of all surveys conducted between FY22 and FY24.
        - Nursing homes surveys missing CMS-2567 text uploaded to QIES may not exceed 1% of all surveys conducted between FY22 and FY24.

Noncompliance Resolution

- N1. Timeliness of Revisits
    - CMS will assess the percentage of onsite revisits that State Survey Agencies conducted within the required timeframes. For nursing homes, onsite revisits should be conducted no more than 60 days after the survey exit date for those surveys citing deficiencies at a severity and scope of F with substandard quality of care or higher. For non-deemed acute and continuing providers, State Survey Agencies should conduct onsite revisits no more than 45 days after the survey exit date for those surveys citing condition-level deficiencies. CMS will assess this measure for the following provider types: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes.

General Instructions

This year's SPSS Guidance provides instructions to CMS Locations and State Survey Agencies on how CMS will evaluate State Survey Agency performance. CMS will use available data to construct 12 of 13 SPSS measures and part of the remaining 13th measure. CMS will construct the IJ template measure from existing data for nursing homes and with data reported by CMS Location staff for acute and continuing care providers.

CMS will calculate measures according to the specifications for each measure. In cases where a threshold criterion is not applicable to a State Survey Agency, this will be noted, and the State Survey Agency will not receive a score for that measure. For example, some States do not have special focus facilities and, hence, CMS will not score those States on the special focus facility SPSS measure.

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

Timeline

The FY24 SPSS evaluation period is October 1, 2023, through September 30, 2024, with milestone dates as follows:

Milestone Dates for SPSS FY24

Activity	Approximate Date
FY24 SPSS Results available for State Survey Agency review and Informal Requests for Reconsideration (IRR) begins	January 17, 2025
Deadline for State Survey Agencies to submit IRR	February 7, 2025
FY24 SPSS Results Finalized	February 27, 2025
Corrective Action Plans Due from States	March 14, 2025

SPSS Scoring

CMS will score State Survey Agency performance on SPSS measures as Met, Partially Met, and Not Met. The Partially Met scoring category was added in FY23 to recognize State Survey Agencies that make progress from year to year and to encourage continued progress towards established SPSS measure thresholds. A summary of how CMS will assign scores to each State Survey Agency, including the Partially Met category, and a detailed description of how State Survey Agencies can achieve specific scoring categories for each SPSS measure are provided below.

- **Met.** A State Survey Agency can achieve a score of Met for a FY24 SPSS measure if the end of fiscal year value of that measure meets or exceeds the threshold identified in the FY24 SPSS Guidance.
- **Partially Met.** A State Survey Agency can achieve a score of Partially Met for a FY24 SPSS measure if:
  - that measure in FY23 was Met and the FY24 measure value is slightly below the established FY24 threshold; or
  - that measure in FY23 was Not Met or Partially Met and the FY24 measure value demonstrates substantial progress from FY23; or
  - that measure in FY23 was scored as not applicable (N/A) and the FY24 measure value is at or above the Partially Met threshold established for that measure for FY24; or
  - that measure was not included in the FY23 SPSS but the FY24 measure value is at or above the Partially Met threshold established for that measure for FY24.
- **Not Met.** A State Survey Agency achieves a score of Not Met for a FY24 SPSS measure if the FY24 measure value does not meet the Met threshold identified in the FY24 Guidance and does not meet the conditions necessary to qualify as Partially Met.
- **N/A (Not applicable).** There are some circumstances under which CMS will not score a SPSS measure, primarily based on a small number of applicable cases for any specific measure.

Corrective Action Plan

For each measure that is scored as "Not Met" at the end of the fiscal year, the State Survey Agency will develop and implement a corrective action plan that will address identified problems. A State Survey Agency must also submit a corrective action plan if it received a score of Partially Met on the same measure in both FY23 and FY24. The CMS Location will review and follow-up to ensure that the State Survey Agency is progressing toward making corrections. In some instances, a State Survey Agency may not be expected to fully improve their performance on a measure due to the timing of the final report for a given fiscal year.

A corrective action plan should also consider previous years' corrective actions. For example, if a State Survey Agency did not meet a measure two years in a row, but still improved during the second year as a result of the first year's corrective action plan, CMS should recognize that the corrective actions from the first year had a positive impact on the State Survey Agency's performance on that measure.

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

CMS Locations are required to monitor the implementation of State Survey Agency corrective action plans on a quarterly basis. CMS Locations must ensure that State Survey Agencies' corrective action plans address all failures to meet performance measures and describe specific actions State Survey Agencies plan to take to improve State performance. If a State Survey Agency has not met a performance measure in two or more consecutive years, the correction action plan must include an evaluation of the previous corrective action plan and explain why it did not result in adequate State performance improvement. CMS Locations will save final approved corrective action plans on a designated CMS SharePoint site.

Informal Reconsideration Request

There is no formal appeal of findings relative to this Report of State Survey Agency Performance since the assessment is under the umbrella of the "Evaluation" Article (Article V) of the §1864 Agreement. However, where the State Survey Agency and CMS Location cannot come to a final agreement on findings, the State Survey Agency may ask CMS for informal reconsideration. CMS will provide instructions for submitting reconsideration requests to State Survey Agencies when FY24 SPSS Results are made available for State Survey Agency review, anticipated for release in mid-January 2025. State Survey Agencies will have 15 business days from receipt of FY24 SPSS Results to submit an Informal Reconsideration Request.

Contacts

For State Survey Agencies, please contact your CMS Location if you have questions about this guidance document. If CMS Locations receive questions on which they require clarification or assistance, please send a request via email to SPSS_Team@cms.hhs.gov.

S1. Surveys of Nursing Home Special Focus Facilities (SFF)

Threshold Criteria

Each State Survey Agency shall conduct one recertification survey of each designated Special Focus Facility (SFF) at least once every six months. For example, if the last recertification survey's exit date is October 8, 2023, then the next recertification survey's start date may be no later than April 7, 2024.

When one SFF is removed either through termination or graduation, then another SFF is selected within 21 calendar days as a replacement, so all the SFF slots are filled. The selection date is considered the date the State Survey Agency sends its selection notification letter to the new SFF. For terminations, calendar days are calculated from the effective date of termination to the selection date. For graduations, calendar days are calculated from the date of the letter the State Survey Agency sent to the graduating SFF informing it of its removal from the SFF program to the selection date.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) it conducts a standard survey for each SFF in its State at least once every six months and (2) SFFs that are removed—due to either termination or graduation from the program—from the list are replaced within 21 calendar days.

Partially Met. A State Survey Agency achieves a score of Partially Met if it meets the requirements for at least one of the two sub-measures that make up this score.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the requirements for either sub-measure.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has no SFF slots allocated to it.

If this measure is Not Met in FY24 or was Partially Met in both FY23 and FY24, a Corrective Action Plan will be required.

Evaluation

See Appendix 1. Special Focus Facilities for Nursing Homes (S1)

References

CMS Memo QSO-23-01-NH

Survey and Certification Group Letter: S&C 17-20

Survey and Certification Group Letter: S&C-14-20

Special Focus Facilities Group Letter: S&C-10-32-NH

S2. Timeliness of Upload of Recertification Surveys

Threshold Criterion

This performance measure evaluates the timeliness of recertification survey uploads for the following providers: community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, outpatient physical therapy/speech language pathology providers, psychiatric residential treatment facilities, and rural health clinics.[2] The measure is focused on non-deemed providers and health surveys only.

For each provider type, CMS will calculate the average number of days between the survey exit date and survey upload date across all recertification surveys conducted during this fiscal year. The average number of days to upload must be less than or equal to 70 days for each provider type. Surveys with a condition-level deficiency are excluded from this calculation. In cases where no recertifications surveys were conducted in the fiscal year for a specific provider type in any given State, that State Survey Agency will not receive a score for that provider type.

Scoring

This measure is scored as two separate measures: one for nursing homes and one for non-deemed acute and continuing care providers.

Met. A State achieves a score of Met if the average number of days to upload recertification surveys is 70 calendar days or less.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met and the FY24 measure value is not greater than 73 days.
- The FY23 score was Partially Met or Not Met; the FY24 measure value is at least 10 days less than its FY23 measure value; and the FY24 measure value is 90 days or less.
- The FY23 measure value was N/A and the FY24 measure value is 90 days or less.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency receives a score of N/A if the number of recertification surveys conducted in FY24 is less than 5.

A corrective action plan will not be required for this measure in FY24.

Evaluation

See Appendix 2. Timeliness of Upload of Recertification Surveys (S2)

References

Article II (J) of the 1864 Agreement

State Operations Manual, Chapter 7, Section 7410

[2] Any provider that migrates from ASPEN to iQIES will be excluded from this measure following migration.

S3. Use of the IJ template

Threshold Criterion

When an immediate jeopardy (IJ) is determined during a survey, the State Survey Agency must provide a completed IJ Template for each IJ citation to the nursing home or acute and continuing care provider at or before the survey team exits the facility, except for EMTALA investigations.

CMS will evaluate the use of the IJ template for each IJ citation separately for nursing homes and acute and continuing care providers.

For nursing homes, CMS will calculate the proportion of IJ tags for which an IJ template is attached to recertification kits for each IJ tag cited during the fiscal year using the Long-Term Care Survey Process system. This could be an IJ tag cited on a recertification survey or on a complaint survey that was conducted with a recertification survey.

For acute and continuing care providers, CMS Locations will assess compliance with the requirement quarterly by determining if the IJ template is in ASPEN or iQIES for a sample of IJ tags cited during the fiscal year. Selected IJ tags will be reviewed from both recertification and complaint surveys. The following tables define the sample and selection process required for reporting.

Total Number of IJ Tags per State for which to Report Use of the IJ Template for All Acute and Continuing Care Providers

Total number of IJ tags in fiscal year per State	Total number of IJ tags for which to report use of the IJ Template per State
Less than 5 IJ tags in a State	Use all IJ tags
At least 5 but less than 32 IJ tags in a State	Select approximately 5 IJ tags
32 or more IJ tags in a State	Select approximately 10 IJ tags[c]

[a] For all Acute and Continuing Care providers combined, CMS Locations will report no more than approximately 10 IJ tags for any one State.
[b] Because CMS Locations will review tags quarterly, the targeted numbers here are approximate; see below for guidance on IJ tag selection.
[c] Because CMS Locations will review tags quarterly, the targeted numbers here are approximate; see below for guidance on IJ tag selection.

IJ Tag Selection Guidance for the Quarterly Review of IJ Tags per State for All Acute and Continuing Care Providers

Quarterly number of IJ tags per State	Quarterly selection of tags to review for reporting use of the IJ Template per State[a]
1 or 2	Review all IJ tags
3 to 7	Review the 1st and 3rd based on survey end dates for surveys conducted during that fiscal year quarter and available at the time of data collection.
8 or more	Review the 1st, 5th and last based on survey end dates for surveys conducted during that fiscal year quarter and available at the time of data collection.

[a] The selection of tags (i.e., 1st, 3rd, last) is based on the survey end date.

Scoring

This measure is scored as two separate measures: one for nursing homes and one for non-deemed acute and continuing care providers.

Met. A State Survey Agency achieves a score of Met if at least 80% of IJ templates are uploaded with their survey kits at the time of upload for IJ deficiencies identified during recertification surveys.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met and the FY24 measure value is 75% or greater.
- The FY23 score was Partially Met or Not Met; the FY24 measure value is at least 10 percentage points greater than the FY23 measure value; and the FY24 measure value is 60% or greater.
- The FY23 score was N/A and the FY24 measure value is 60% or greater.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has no IJ deficiencies cited in FY24.

A corrective action plan will not be required for this measure in FY24.

Evaluation

For nursing homes, CMS will review Long-Term Care Survey Process data for use of the IJ template for IJ tags cited on recertification surveys and on complaint surveys conducted with recertification surveys. CMS will identify all IJ tags available in the Long-Term Care Survey Process data and the number of those tags for which an IJ template was completed.

CMS Location staff will identify if an IJ template was provided for IJ tags cited for acute and continuing care providers.

See Appendix 3. Use of the IJ Template (S3) for further details.

References

State Operations Manual, Appendix Q

CMS Memo QSO-19-09-ALL

S4. Intakes Overdue for Investigation[3]

Threshold Criterion

The number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation is reduced by 35% or more by September 30, 2024, so that complaints/FRIs are addressed in a timely manner per the State Operations Manual and the Mission and Priority Document. This measure is inclusive of complaints and FRIs triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels. CMS will calculate this measure for the time period starting October 1, 2023 and ending September 30, 2024. CMS will continue to explore opportunities to provide greater context for this threshold for States that do not have a significant survey backlog. CMS will provide each State Survey Agencies with details on which complaints/FRIs are overdue for investigation.

CMS will assess this separately for nursing homes and acute and continuing care providers. Acute and continuing care providers include the following deemed and non-deemed provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

Scoring

This measure is scored as two separate measures: one for nursing homes and one for non-deemed acute and continuing care providers.

Met. A State Survey Agency achieves a score of Met if the number of intakes overdue for investigation is reduced by 35% or more in FY24.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met and at least a 30% reduction is achieved in FY24.
- The FY23 score was Partially Met or Not Met; the FY24 reduction is at least 10 percentage points greater than the FY23 reduction; and at least a 20% reduction is achieved in FY24.
- The FY23 score was N/A and at least a 20% reduction is achieved in FY24.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency receives a score of N/A (not applicable) if the number of intakes overdue for investigation at the start of the year is less than 5 and the number at the end of the year is less than 10. However, CMS will assess a State on all intakes prioritized as IJ, regardless of how many there were in FY24.

For the nursing home measure, a corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met. For the acute and continuing care provider measure, a corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met for providers for which recertification surveys are prioritized Tier 1 work

[3] S4. Intakes Overdue for Investigation is an established measure from the Pending Overdue Workload Project established to address State Agencies work that that is overdue as a result of the COVID-19 pandemic If the Pending Overdue Workload Project revises measure thresholds for FY24, this measure threshold will be revised to reflect those changes.

(home health agencies, hospice, and intermediate care facilities for individuals with intellectual disabilities). CMS will continue to score States on all applicable acute and continuing care providers, but the corrective action plan will be relevant for only Tier 1 work.

Evaluation

iQIES data will be used to calculate this measure for ambulatory surgical centers, hospices, and home health agencies. ASPEN data will be used to calculate this measure for all other provider types. CMS will identify the number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation on October 1, 2023, and the same measure on September 30, 2024. CMS will calculate the percentage difference between the number identified on October 1, 2023 and the number identified on September 30, 2024.

Reference

CMS Memo QSO-22-02-ALL

S5. EMTALA prioritized as IJ and Non-IJ High conducted within the required time period

Threshold Criteria

This performance measure evaluates the timeliness of EMTALA investigation initiation for complaints prioritized as Immediate Jeopardy (IJ) and non-IJ high. EMTALA complaints prioritized as IJ must be started within two business days of CMS Location approval. EMTALA investigations prioritized as non-IJ high investigations must be started within 45 calendar days of CMS Location approval.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) the percentage of EMTALA investigations prioritized as IJ started within the required time period is 95% or greater and (2) the percentage of EMTALA investigations prioritized as non-IJ high started within the required time period is 95% or greater.

Partially Met. A State Survey Agency achieves a score of Partially Met if (1) either sub-measure value is less than 95% and (2) both sub-measure values are 75% or more.

Not Met. A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has no IJ EMTALA complaints and 5 or fewer non-IJ high EMTALA complaints in FY24.

A corrective action plan must be submitted if the FY24 score for the sub-measure EMTALA investigations prioritized as IJ started within the required time period is Not Met.

Evaluation

To calculate the percentage of EMTALA complaints prioritized as IJ that were started within the required time period, the count of EMTALA complaints prioritized as IJ started within two business days of CMS Location approval is divided by the total number EMTALA complaints prioritized as IJ.

To calculate the percentage of EMTALA complaints prioritized as non-IJ high that were started within the required time period, the count of EMTALA complaints prioritized as non-IJ high started within 45 calendar days of CMS Location approval is divided by the total number EMTALA complaints prioritized as non-IJ high.

References

QSO-19-14-Hospitals, CAHs

State Operations Manual, Chapter 5, sections 5070, 5075, 5400

State Operations Manual, Appendix V

FY23 Mission & Priority Document

S6. Intakes prioritized as IJ started within the required time period

Threshold Criteria

This performance measure evaluates the timeliness of investigation initiation for intakes prioritized as IJ) for the following providers: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes.[4]

For nursing homes and non-deemed acute and continuing care providers, CMS will calculate the percentage of investigations initiated within the required time period of intakes prioritized as IJ.

For deemed acute and continuing care providers, CMS will calculate the percentage of investigations initiated within the required time period of receipt of CMS Location authorization of intakes prioritized as IJ.

Scoring

There will be three separate scores for this measure: (1) one score for nursing homes, (2) one score for non-deemed acute and continuing care providers and (3) one score for deemed acute and continuing care providers.

Met. A State Survey Agency achieves a score of Met if the percentage of IJ investigations started within the required time period is 80% or greater.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met and the FY24 measure value is at least 77%.
- The FY23 score was Partially Met or Not Met; the FY24 measure value is at least 5 percentage points greater than in FY23; and the FY24 measure value is 70% or greater.
- The FY23 score was N/A and the FY24 measure value is 75% or greater.

Not Met. A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency is assigned a score of N/A if there are no intakes prioritized as IJ in FY24.

A corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met.

Evaluation

Chapter 5 guidance revisions pertaining to the number of days between intake and survey of intakes prioritized as IJ go into effect on October 1, 2023; therefore, this measure will be calculated using the new Chapter 5 guidance (Revision 211).

To calculate the percentage of nursing home intakes prioritized as IJ that were started within the required time period, the count of IJ intakes started within the required time period is divided by the total number of nursing home intakes prioritized as IJ. For complaints, the required time period is

[4] SPSS FY24 measures will be calculated during the transition period from QIES to iQIES. Measures will be calculated for providers that have migrated to iQIES.

defined as three business days from the intake start date to the investigation start date. For facility-reported incidents, the required time period is defined as three business days if there is inadequate resident protection and seven business days if there is potentially adequate resident protection. Inadequate resident protection is defined as *Investigate within X Days* equal to three working days; potentially adequate resident protection is defined as *Investigate within X Days* equal to seven working days. If *Investigate within X Days* is equal to missing, it will be assumed that *Investigate within X Days* is equal to seven working days.

To calculate the percentage of intakes prioritized as IJ that were started within the required time period for non-deemed acute and continuing providers, the count of IJ intakes started within two business days of intake receipt is divided by the total number of intakes prioritized as IJ among non-deemed acute and continuing providers.

To calculate the percentage of intakes prioritized as IJ that were started within the required time period for deemed acute and continuing providers, the count of IJ intakes started within two business days of receipt of CMS Location authorization is divided by the total number of intakes prioritized as IJ among deemed acute and continuing providers.

References

State Operations Manual, Chapter 5, sections 5075, 5310.2A

S7. Off-Hour Surveys for Nursing Homes

Threshold Criteria

(1) At least 10% of nursing home health recertification surveys conducted in the fiscal year must begin during off-hours. Off-hours are currently defined in the SOM as weekends (Saturday or Sunday), State and Federal holidays, early-morning (before 8:00 am), or evenings (after 6:00 pm). These surveys must be completed on consecutive days.

(2) At least 50% of the required number of "off-hour" surveys must be started on the weekends (Saturday or Sunday). CMS will use *Expected Off-hour Survey* count instead of the actual number of off-hour surveys conducted to calculate this measure. *Expected Off-hour Survey* is defined as 10% of all surveys conducted within the fiscal year.

(3) At least 80% of off-hour weekend (Saturday or Sunday) surveys must be conducted among facilities with potential staffing issues. Facilities with potential staffing issues are identified in the Provider Ratings file that CMS provides to States on a monthly basis. A weekend survey can be included in this sub-measure if the facility had a Staffing Alert of "Low Weekend Staffing" and/or "High # of Days with No RN" on the Provider Ratings file in the three months prior to the survey.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) the percentage of nursing home health recertification surveys started during off-hours makes up at least 10% or more of all health recertification surveys; (2) at least 50% of off-hour surveys are started on the weekends; and (3) at least 80% of weekend surveys are conducted among facilities with potential staffing issues.

Partially Met. A State Survey Agency achieves a score of Partially Met if (1) the percentage of nursing home health recertification surveys started during off-hours makes up at least 8% or more of all health recertification surveys; (2) at least 40% of off-hours surveys are started on the weekend; and (3) at least 70% of weekend surveys are conducted among facilities with potential staffing issues.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either Met or Partially Met.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it conducted 5 or fewer health recertification surveys in FY24.

A corrective action plan must be submitted if the FY24 score is Not Met.

Evaluation

This measure includes three sub-measures. The first sub-measure assesses the percentage of surveys that were started during off-hours and is calculated as follows:

A) Identify the number of nursing home health recertification surveys that were conducted within the fiscal year.

B) From surveys identified in (A), identify the number that were started on Saturday, Sunday, a federal or state holiday, before 8:00 am, or after 6:00 pm.

C) Divide the count in (B) by the count in (A) and express this as a percentage.

$$\frac{B}{A}$$

The second sub-measure assesses the percentage of off-hour surveys that were started on the weekend and is calculated as follows:

D) Identify the number of expected off-hour surveys. This number is calculated by multiplying the number of surveys identified above in A by 10%.

Expected number of surveys conducted during off-hours =

E) Identify the number of surveys that were started on Saturday or Sunday.

F) Divide the count in (E) by the count in (D) and express this as a percentage.

$$\frac{E}{D}$$

The third sub-measure assesses the percentage of off-hour weekend surveys that were conducted among nursing homes with potential staffing issues and is calculated as follows:

G) Identify the number of off-hour weekend surveys that were conducted among facilities with potential staffing issues. A facility can be included in this count if they had a Staffing Alert of "Low Weekend Staffing" or "High # of Days with No RN" on a Provider Ratings file in the three months prior to the weekend survey. For example, if a facility had a Staffing Alert on the April 2024 Provider Ratings file and a weekend survey of that provider was conducted on July 15, 2024, that facility would be included in the count of off-hour weekend surveys conducted among facilities with potential staffing issues.

H) Divide the count in (G) by the count in (E) and express this as a percentage.

$$\frac{G}{E}$$

References

State Operations Manual, Chapter 7 Section 7207.2.2

QSO 19-02-NH

FY23 Mission & Priority Document

42 C.F.R. §488.318

S8. Frequency of Nursing Home Recertification Surveys

Threshold Criteria

Tier 1 State Survey Agency survey activities must be scheduled and conducted in accordance with the priority tier structure provided in the Mission and Priority Document. Recertification health surveys of nursing homes are included in Tier 1 requirements. The requirement states that State Survey Agencies must conduct a recertification health survey no later than 15.9 months after the last day of the previous recertification health survey for all nursing homes and that the statewide average time interval between consecutive recertification health surveys must be 12.9 months or less.

State Survey Agencies are still resolving overdue health recertification surveys as a result of the public health emergency. Taking this into consideration, this measure will assess whether State Survey Agencies conducted recertification surveys within the 15.9-month time interval; however, this measure will not assess the statewide average time interval between consecutive recertification health surveys requirement for this fiscal year.

Scoring

Met. A State achieves a score of Met if 100% of all active nursing homes are surveyed at least every 15.9 months.

Partially Met. A State achieves a score of Partially Met if at least 70% of all active nursing homes are surveyed at least every 15.9 months.

Not Met. A State achieves a score of Not Met if it does not meet the requirements for either Met or Partially Met.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has 5 or fewer active nursing homes in FY24.

A corrective action plan must be submitted if the FY24 score is Not Met.

Evaluation

The percentage of active nursing homes that have been surveyed within the required maximum interval between surveys is calculated as follows:

A) Identify the number of active nursing homes. An active nursing home is defined as having an original participation date 15.9 months before the end of the fiscal year and either no termination date or a termination date after the end of the fiscal year. This count is defined as the denominator.

B) From the active nursing homes identified in (A), identify the number of nursing homes that were surveyed in the 15.9-month time period prior to the end of the fiscal year.

C) From the nursing homes identified in (B), identify the number where the time between the most recent survey and the previous survey is greater than 15.9 months.

D) Subtract (C) from (B), divide the difference by A, and express as a percentage.

$$\frac{(B) - (C)}{A}$$

References

FY23 Mission & Priority Document

Section 1819(g)(3)(A)(iii) and 1919(g)(2)(A)(iii) of the Act

42 C.F.R. §488.308

S9. Frequency of Tier 1 Acute and Continuing Care Recertification Surveys

Threshold Criteria

Tier 1 State Survey Agency survey activities must be scheduled and conducted in accordance with the priority tier structure provided in the Mission and Priority Document. Recertification health surveys of non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities are included in Tier 1 requirements.

Non-deemed home health agencies must be surveyed every 36.9 months. Hospices must be surveyed every 36.9 months. Intermediate care facilities for individuals with intellectual disabilities must be surveyed every 15.9 months with a statewide average time interval between consecutive recertification health surveys of 12.9 months or less.

State Survey Agencies are still resolving overdue health recertification surveys as a result of the public health emergency. Taking this into consideration, this measure will not assess the intermediate care facilities for individuals with intellectual disabilities statewide average time interval between consecutive recertification health surveys requirement for this fiscal year.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) 100% of active non-deemed home health agencies were surveyed at least every 36.9 months; (2) 100% of active hospices were surveyed at least every 36.9 months; and (3) 100% of active intermediate care facilities for individuals with intellectual disabilities were surveyed at least every 15.9 months.

Partially Met. A State Survey Agency achieves a score of Partially Met if (1) any of the three Tier 1 survey requirements sub-measures fall below 100% and (2) none of the three Tier 1 survey requirement sub-measures fall below 50%.

Not Met. A State achieves a score of Not Met if it does not meet the requirements for either Met or Partially Met.

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has a combined total of 5 or fewer non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities.

A corrective action plan must be submitted if the FY24 score is Not Met.

Evaluation

See Appendix 4. Frequency of Tier 1 ACC Recertification Surveys (S9)

References

FY23 Mission & Priority Document

Home Health Agencies – Section 1891(c)(2)(A) of the Act; 42 C.F.R. §488.710

Hospices – 42 C.F.R. §488.1110

Intermediate Care Facilities for Individuals with Intellectual Disabilities – 42 CFR §§ 442.15, 442.109

Q1. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys

Threshold Criteria

For FY24, CMS will combine data from the Federal Monitoring Surveys for Health (Focus Concern Surveys and Federal Comparative Surveys) to calculate State performance. The two components of this measure were measures Q1 and Q2 in FY23. The rationale for combining these data is based on the small number of concern areas and tags reviewed for each. Specifically, there are a larger number of focus areas reviewed during Focus Concerns Surveys compared with the number of tags reviewed during Federal Comparative Surveys. To address this, 70 percent of States' scores will be based on the Focus Concern Survey data and the remaining 30 percent will be based on the Federal Comparative Survey data.

The Focus Concern Surveys ensures that State Survey Agency nursing home compliance, recertification, and revisit surveys are satisfactorily conducted, by effectively achieving the desired outcomes of the survey using the Federal standards, protocols, forms, methods, and procedures specified by CMS. A set of national concerns are chosen that include both a regulatory reference and a set of F-Tags. CMS Locations have the option of identifying additional concerns and any CMS State Operations Group Survey team could identify additional concerns if the situation warranted it. The SPSS measure focused on the national concern areas only.

The Federal Comparative Survey identifies deficiencies cited from all comparative surveys that the CMS Locations identified, whether State Survey Agencies identified the same or similar citation, at what severity/scope levels the deficiencies were cited by the CMS Location and the State Survey Agency; and whether the State Survey Agency should have found the deficiency or deficiencies.

State Survey Agencies will receive a Focused Concern Survey score that combines results for all national concern areas and a Federal Comparative Survey score that assesses whether deficiencies of severity and scope at level D or higher were cited by the State Survey Agency at the same or a higher severity level than was cited on the federal comparative survey. The Focused Concern Survey score will be weighted at 70 percent and the Federal Comparative Survey score will be weighted at 30 percent. The weighted scores will be summed to calculate an overall Federal Monitoring Survey score. If either the Focused Concern Survey score or the Federal Comparative Survey score is N/A, the other score will be weighted at 100 percent to calculate the overall Federal Monitoring Survey score. A State Survey Agency meets this measure if it achieves a score of 75% or higher.

Scoring

Met. A State Survey Agency achieves a score of Met if the overall FMS score is 75% or greater.

Partially Met. A State Survey Agency achieves a score of Partially Met if the overall FMS score is less than 75 percent but at least 65 percent.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency receives a score of N/A if there were two or fewer focused concerns investigated for the State in FY24 and there were fewer than 3 deficiencies reviewed of level D or higher in the FY24 comparative survey process for the State in FY24

A corrective action plan must be submitted if the FY24 score is Not Met.

Evaluation

See Appendix 5. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys (Q1)

Reference

CMS Memo QSO-22-09-ALL

Admin info 21-07-ALL Guidance for Federal Monitoring Surveys

Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act

42 C.F.R. §488.318

Q2. Nursing Home Tags Downgraded/Removed by IDR or IIDR and Unresolved IDRs/IIDRs

Threshold Criteria

A State Survey Agency shall have fewer than 40% of tags that are reviewed during an IDR or IIDR downgraded or removed as a result of the investigation during the fiscal year. This includes all types of deficiency tags identified during recertification or complaint surveys. Tags identified during Federal Monitoring Surveys and initial certification surveys are excluded. In addition, the proportion of surveys where an IDR or IIDR remains in the "requested" status and is beyond the 60-day period for completion may not exceed 5% of all surveys where an IDR or IIDR was requested between FY22 and FY24. This measure includes two sub-measures that must be met to meet the overall measure. The two sub-measures are:

Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR. Citation tags that underwent an IDR or IIDR process and were downgraded or removed may not exceed 40% of all tags that underwent an IDR or IIDR process in the current fiscal year.

Percent of Surveys with Unresolved IDR-IIDRs. Surveys with unresolved IDRs or IIDRs may not exceed 5% of all surveys conducted with requested IDRs or IIDRs between FY22 and FY24.

This measure will be calculated for nursing homes only.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) 40% or fewer tags are downgraded or removed as a result of the IDR/IIDR process and (2) no more than 5% of surveys with requested IDRs/IIDRs between FY22 and FY24 remain unresolved.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met; the FY24 sub-measure 1 value is no greater than 50%; and the FY24 sub-measure 2 value is no greater than 10%.
- The FY23 score was Not Met, Partially Met, or N/A; at least one of the FY24 sub-measure values meets the FY24 Met thresholds; and the FY24 sub-measure 1 value is no greater than 50% and the FY24 sub-measure 2 value is no greater than 10%.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State Survey Agency can achieve a score of N/A (not applicable) if the first sub-measure had fewer than 5 tags reviewed, and the second sub-measure had fewer than 5 surveys with requested IDR/IIDRs.

A corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met.

Evaluation

CMS will construct this measure using data available from QIES and ASPEN. To calculate this measure, two sub-measures will be calculated. If the sub-measure thresholds are met, the overall measure will be met.

The sub-measure **Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR** will be calculated by dividing the count of tags cited on the CMS-2567 across recertification and complaint surveys that were downgraded in severity and scope or removed as a result of an IDR or IIDR divided by the count of tags cited on the CMS-2567 for which an IDR or IIDR was completed. Only tags from surveys with a survey exit date in the fiscal year will be evaluated, regardless of IDR/IIDR completion date. An IDR/IIDR that has been requested but with no decision made regarding the IDR/IIDR by the end of the fiscal year will be excluded from the calculation. In cases where a State had fewer than 5 tags reviewed by IDR or IIDR during the fiscal year, that State will not receive a score for this sub-measure.

The sub-measure **Percent of Surveys with Unresolved IDR-IIDRs** will be calculated by dividing the number of recertification and complaint surveys submitted for IDR/IIDR review that have a status of "requested," and where the time period between the IDR/IIDR requested date and the date of data extraction is more than 60 days by the number of recertification and complaint surveys that were submitted for IDR/IIDR review. If the requested date is missing, 21 days following the survey exit date is used as a proxy for the requested date. If the number of days between the IDR/IIDR requested date and the date of data extraction is less than 60 days by the end of the fiscal year, the survey will be excluded from the calculation. Surveys with requested IDRs or IIDRs between FY22 and FY24 will be evaluated.

Reference

State Operations Manual Chapter 7, Sections 7212, 7213

Q3. Data Submission

Threshold Criteria

This performance measure evaluates (1) nursing home surveys that have not been uploaded and (2) nursing home surveys that have been uploaded without accompanying CMS-2567 text. This measure includes two sub-measures.

Percent of Missing Surveys. Surveys that have not been uploaded to CASPER may not exceed 5% of all surveys conducted between FY22 and FY24.

Percent of Surveys Missing CMS-2567 Text. Surveys with missing CMS-2567 text may not exceed 1% of all surveys conducted between FY22 and FY24.

This measure will be calculated for nursing homes only.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) the percentage of surveys conducted between FY22 and FY24 that have not been uploaded to QIES does not exceed 5% and (2) the percentage of surveys with missing CMS-2567 text conducted between FY22 and FY24 does not exceed 1%.

Partially Met. A State Survey Agency achieves a score of Partially Met if (1) the sub-measure 1 value is 10% or less and (2) the sub-measure 2 value is 2% or less.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

A corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met.

Evaluation

CMS will construct this measure using data available from QIES and ASPEN. To calculate this measure, two sub-measures will be calculated. If both sub-measure thresholds are met, the overall measure will be met.

The sub-measure Percent of Missing Surveys will be calculated by dividing the count of surveys conducted between FY22 and FY24 not uploaded to QIES by the count of surveys conducted between FY22 and FY24.

The sub-measure Percent of Surveys Missing CMS-2567 Text will be calculated by dividing the count of surveys uploaded with missing CMS-2567 text conducted between FY22 and FY24 by the count of uploaded surveys conducted between FY22 and FY24.

Reference

State Operations Manual Chapter 8, Section 8000C

N1. Timeliness of Revisits

Threshold Criterion

This performance measure evaluates whether a State Survey Agency conducted timely revisits for the following providers: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes. This performance measure only evaluates revisits of non-deemed providers. For nursing homes, onsite revisits should be conducted no more than 60 days after the survey exit date for those surveys citing deficiencies at a severity and scope of F with substandard quality of care[5] or higher. For non-deemed acute and continuing providers, onsite revisits should be conducted no more than 45 days after the survey exit date for those surveys citing condition-level deficiencies. Because data on the acceptance or receipt of facility plans of correction is not always accurately documented, this measure will not require that a State Survey Agency received or accepted a plan of correction. For all providers, this measure is focused on only Health surveys.

Scoring

This measure will be scored as two separate measures: one for nursing homes and one for acute and continuing care providers.

Met. A State Survey Agency achieves a score of Met if at least 70% of revisits are conducted within the required time period.

Partially Met. A State Survey Agency achieves a score of Partially Met if one of the following conditions are met:

- The FY23 score was Met and the FY24 measure value is 65% or greater.
- The FY23 score was Partially Met or Not Met; the FY24 measure value is at least 2 percentage points greater than in FY23; and the FY24 measure value is 60% or greater.
- The FY23 measure value was N/A and the FY24 measure value is 60% or greater.

Not Met. A State Survey Agency achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score.

N/A. A State receives a score of N/A (not applicable) if it had fewer than 10 surveys requiring a revisit in FY24.

A corrective action plan must be submitted if the FY24 score is Not Met or both the FY23 and FY24 scores were Partially Met.

Evaluation

CMS will construct this measure using data available from QIES and iQIES data via SAS Viya. For nursing homes, the count of onsite revisit surveys occurring within 60 days of survey exit will be divided by the count of recertification and complaint surveys with citations at F with substandard quality of care or higher to calculate the proportion of onsite revisits that occurred within the required time period. To calculate the proportion of revisits that occurred within the required time period for acute and continuing care providers, the count of onsite revisit surveys occurring within 45 days of survey exit for non-deemed providers will be divided by the count of recertification and complaint surveys of non-

[5] The following nursing home tags indicate substandard quality of care if the tag is cited at F level scope and severity: 550, 558, 559, 561, 565, 584, 600, 602, 603, 604, 605, 606, 607, 608, 609, 610, 675, 676, 677, 678, 679, 680, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 742, 743, 744, 745, 757, 758, 759, 760, 850, and 883.

deemed acute and continuing care providers requiring onsite revisit due to condition-level noncompliance.

See Appendix 7. Timeliness of Revisits (N1) for additional measure details.

Reference

State Operations Manual Chapter 3, Section 3012

State Operations Manual Chapter 5, Section 5110

State Operations Manual Chapter 7, Section 7317

Appendix 1. Special Focus Facilities for Nursing Homes (S1)

Data Source(s)

Survey and Certification Group Letter: S&C 17-20, Current SFF facilities lists, and QIES.

Method of Calculation

An active SFF must have one recertification health survey at least every six months starting at the time of selection into the SFF program. Once a facility has been selected for the SFF program, the State Survey Agency must conduct a recertification health survey within six months of that selection date but with an interval of no more than 15.9 months from the last recertification survey conducted before being selected as an SFF. A reasonable degree of unpredictability in these surveys must be maintained.

For the purposes of the State Performance Standards, States must complete one recertification survey at least every six months per each SFF slot. The number of slots is determined by the number of SFFs assigned to each State as designated in policy memorandum S&C-17-20. For example, if a State Survey Agency has five SFF slots, that State Survey Agency must complete 10 recertification surveys for its SFFs during the fiscal year with each facility being surveyed at least once every six months. Similarly, if a State Survey Agency has one SFF slot, that State would complete two recertification surveys conducted on that SFF in a given fiscal year, with each survey conducted not less than once every six months.

When a SFF is removed either through termination or graduation, the State Survey Agency must select another facility for that SFF slot within 21 calendar days as a replacement, so all slots are filled. For terminations, the State Survey Agency must select another facility for that SFF slot within 21 days calendar from the effective date of termination. For graduations, the State Survey Agency must select another facility for that SFF slot within 21 calendar days of the date of the letter the State Survey Agency sent to the graduating SFF of its removal from the SFF program.

For example, if facility A graduates on March 1st and is replaced within two weeks by facility B whose last standard survey was January 10th, then facility B should have a standard survey no later than September 1st to meet both the requirements of the SFF program and the SPSS. In this example, a SFF selection was made within 21 days of the graduation of the previous SFF and the recertification survey was conducted within six months of the selection date. If the selection of a replacement SFF had occurred after 21 days, the State Survey Agency would not meet this performance measure. Similarly, if the survey was not completed until October, it would not meet the SPSS measure because the survey did not occur within six months of selection to the SFF slot.

Appendix 2. Timeliness of Upload of Recertification Surveys (S2)

Data Source(s)

QIES

Method of Calculation

To calculate this measure, the average number of days between survey exit date and survey upload date must be less than or equal to 70 days for recertification surveys for the following provider types: community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, outpatient physical therapy/speech language pathology providers, psychiatric residential treatment facilities and rural health centers. This measure evaluates upload of recertification surveys conducted during this fiscal year of non-deemed providers only. Surveys with a condition-level deficiency are excluded.

Calculating Recertification Survey Average Upload Days

1. Calculate the number of days between survey exit date and Certification Transaction date for all recertification health surveys uploaded within the fiscal year (*Upload Days*). Sum all *Upload Days*.
2. Calculate the number of recertification surveys uploaded within the fiscal year (*Uploaded Surveys*).
3. Divide the Sum of all *Upload Days* by *Uploaded Surveys*.

This measure will be scored as two separate measures: one for nursing homes and one for all acute and continuing care providers.

Appendix 3. Use of the IJ Template (S3)

Data Source(s)

- Long-term Care Survey Process Data, ASPEN, Immediate Jeopardy Templates

Method of Calculation

Nursing Homes

For nursing homes, CMS will identify use of the IJ template directly in the long-term care survey process data for recertification surveys and complaint surveys conducted in tandem with recertification surveys. To calculate the proportion of IJ tags cited on nursing home surveys, CMS will identify the total number of IJ tags cited in the long-term care process data and the total number of those tags for which an IJ template was provided using information available in the long-term survey process data. The percentage with an IJ template provided is the number for which an IJ template was provided divided by the total number of IJ tags cited.

Acute and Continuing Care Providers

CMS Location staff will provide data on the use of the IJ template for acute and continuing care providers (ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities). Using the reporting template provided, CMS Locations will report on up to 10 IJ tags across all provider types cited during the fiscal year as summarized in the following table. The CMS Location will select the IJ tags to review for this measure.

Total Number of IJ Tags per State for which to Report Use of the IJ Template for All Acute and Continuing Care Providers

Total Number of IJ Tags in Fiscal Year per State	Total Number of Tags for which to Report use of the IJ Template per State[a]
Less than 5 IJ tags in a State	All IJ tags
At least 5 but less than 30 IJ tags in a State	5
30 or more IJ tags in a State	10

[a] For all Acute and Continuing Care providers combined. Hence, Locations will report only a maximum of 10 IJ tags for any one State.

CMS Locations will submit a reporting template quarterly unless the Location has already provided its complete data for the fiscal year. For example, if by the second quarter of a fiscal year, 30 or more IJ tags are cited in a particular State and the Location has already reported on the use of the IJ template for 10 tags, then the Location no longer has to report on the use of the IJ template for that State. CMS Locations will report IJ template results for acute and continuing care providers on the schedule provided in the General Instructions section above.

The percentage of acute and continuing care providers with an IJ template provided is the number for which an IJ template was provided divided by the total number of IJ tags cited from the sample reported by the CMS Location during the fiscal year.

Note: State Survey Agencies are required to attach the IJ template to the survey package when uploading to ASPEN Central Office/ASPEN Regional Office (ACO/ARO) for each instance of Immediate Jeopardy. For more information on the procedures for attaching documents, see the ACO Procedures Guide (https://qtso.cms.gov/system/files/qtso/ACO_PG_11.7.0.2_FINAL.pdf) and admin info 21-08-ALL.

In ASPEN, States should attach the IJ template under the Citation Manager Screen of the corresponding survey by using the "Attachment button." For consistency, the IJ template should be labeled "IJ Template-AlphaNumericTag-YearMonthDay" where AlphaNumericTag is the tag cited for the IJ deficiency and YearMonthDay is the exit date of the survey. For example, for a nursing home survey for which an IJ deficiency for infection control (F880) is identified on a survey ending on June 26, 2021, the IJ template should be named IJ Template-F880-2021June26 and attached to the survey.

If the State is using iQIES to upload surveys, please use the following steps:

1. Select Survey & Certification
2. Select Search
3. Search for the Provider or Survey to which you want to add the IJ Template
4. Select the survey under Recent Surveys by clicking on the Survey ID
5. Under Basic Information, select Attachments
6. Click on Select File to open the File Manager on your computer
7. Choose the IJ template file
8. Click on open to save
9. Please use the same filename labeling convention as noted above

Appendix 4. Frequency of Tier 1 ACC Recertification Surveys (S9)

Data Source(s)

QIES and iQIES

Method of Calculation

This measure includes three sub-measures that require calculation. The first sub-measure assesses the percentage of active home health agencies that have been surveyed within the required maximum interval between surveys and is calculated as follows:

A) Identify the number of home health agencies that were active from 36.9 months prior to the end of the fiscal year to the end of the fiscal year. To be included in this count, the home health agency must have an original participation date before the beginning of the time period and either no termination date or a termination date after the end of the fiscal year. This count is defined as the denominator.

B) From the active home health agencies identified in (A), identify the number that were surveyed within that 36.9-month time period.

C) From the home health agencies identified in (B), identify the number where the time between the most recent survey and the previous survey is greater than 36.9 months.

D) Subtract C from B, divide the difference by A, and express as a percentage.

$$\frac{(B) - (C)}{A}$$

The second sub-measure assesses the percentage of active hospices that have been surveyed within the required maximum interval between surveys and is calculated as follows:

E) Identify the number of hospices that were active from 36.9 months prior to the end of the fiscal year to the end of the fiscal year. To be included in this count, the hospice must have an original participation date before the beginning of the time period and either no termination date or a termination date after the end of the fiscal year. This count is defined as the denominator.

F) From the active hospices identified in (E), identify the number that were surveyed within that 36.9-month time period.

G) From the hospices identified in (F), identify the number where the time between the most recent survey and the previous survey is greater than 36.9 months.

H) Subtract G from F, divide the difference by E and express as a percentage.

$$\frac{(F) - (G)}{E}$$

The third sub-measure assesses the percentage of active intermediate care facility for individuals with intellectual disabilities (ICF/IID) that have been surveyed within the required maximum interval between surveys and is calculated as follows:

I) Identify the number of ICF/IIDs that were active from 15.9 months prior to the end of the fiscal year to the end of the fiscal year. To be included in this count, the ICF/IIDs must have an original participation date before the beginning of the time period and either no termination date or a termination date after the end of the fiscal year. This count is defined as the denominator.

J) From the active ICF/IIDs identified in (I), identify the number of ICF/IIDs that were surveyed within that 15.9-month time period.

K) From the ICF/IIDs identified in (J), calculate the number where the time between the most recent survey and the previous survey is greater than 15.9 months.

L) Subtract K from J, divide the difference by I, and express as a percentage.

$$\frac{(J) - (K)}{I}$$

Appendix 5. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys (Q1)

Data Source(s)

- Focused Concern Survey reports
- Federal Comparative Survey Data

Method of Calculation

Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys Calculation

For each concern area investigated:

A score of "Met" for that concern area will be given when the State Survey Agency properly identifies noncompliance and the associated harm level or the noncompliance that was missed by the State Survey Agency was "No actual harm with a potential for minimal harm" (level one).

A score of "Partially Met" for that concern area will be given when the State Survey Agency fails to identify noncompliance or misidentifies the level of harm for noncompliance for "No actual harm with a potential for more than minimal harm, but not immediate jeopardy" (level two). A score of "Partially Met" for that concern area will be given when the State Survey Agency identifies noncompliance but determines a level of harm that is not supported by the evidence available.

A score of "Not Met" for that concern area will be given when a State Survey Agency fails to identify noncompliance or fails to identify "Actual harm that is not immediate jeopardy" (level three), "immediate jeopardy" (level four), or Substandard Quality of Care (SQC).

- After receipt of the Focused Concern Survey report, the State Survey Agency will have 30 working days to appeal findings of "Not Met" or "Partially Met." These appeals will be addressed by the CMS Location that conducted the survey.

Calculating the overall FMS FCS score:

Tally points for each concern area investigated as follows.

- The State receives 2 points per "Met" score.
- The State receives 1 point per "Partially Met" score.
- The State receives 0 points per "Not Met" score.

To calculate the State Survey Agency's Focused Concern Survey score, create a numerator and denominator as follows.

Numerator: Add all the points assigned to "Met," "Not Met," and "Partially Met" national concern areas across all focus concern surveys

Denominator: Multiply the total number of national concern areas examined across all focus concern surveys by 2

The Focused Concern Survey score is the numerator divided by the denominator.

For example, if the total number of focus concern areas investigated across all Focused Concern Surveys was 10, then the total number of possible points that State could earn would be 20 (10 focus concern areas multiplied by a maximum of 2 points each). If the State met 6 of 10 concern areas, partially met 3 of 10 concern areas, and did not meet 1 of 10 concern areas, its total points earned would be 15 (6 "Mets" earns 12 points, 3 "Partially Mets" earns 3 points, and one 1 "Not Met" earns 0 points). The State's overall score would be 0.75 because 15 divided by 20 equals 0.75.

Assessment of Deficiency Identification using Federal Comparative Surveys Calculation

Citation Accuracy Chart

CMS Location, Federal Comparative Survey citations			Numerator Points		
Tag		Denominator Points	State Survey Agency cites similar tag at same or higher S/S	State Survey Agency cites similar tag at lower S/S	State Survey Agency does not cite similar tag SHF=yes
Immediate Jeopardy with substandard quality of care	JKL, sqc	12	12	6	0
Immediate Jeopardy without substandard quality of care	JKL, non-sqc	10	10	5	0
Actual Harm with substandard quality of care	HI, sqc	8	8	4	0
Actual Harm without substandard quality of care	GHI, non-sqc	4	4	3	0
Potential Harm with substandard quality of care	F, sqc	2	2	1	0
Potential Harm without substandard quality of care	DEF, non-sqc	1	1	0.5	0

Note: SHF= "Should have found"; S/S = severity and scope, sqc = substandard quality of care

The Federal Comparative Survey report identifies the deficiencies cited from comparative health surveys that the CMS Locations identified, whether State Survey Agencies identified the same or similar citation, at what severity/scope levels the deficiencies were cited by the CMS Location and the State Survey Agency; and whether the State Survey Agency should have found the deficiency or deficiencies.[6] For each deficiency at severity and scope of D or greater, based on what was written in the Federal Comparative Survey analysis report regarding how the State Survey Agency cited the same findings, the Citation Accuracy Chart is used to determine how many points are assigned to the numerator and denominator. If a tag identified during a federal comparative survey is changed or downgraded through the independent informal dispute resolution process, the revised tag and severity and scope will be used. If a tag cited during a Federal Comparative Survey is removed through the independent informal dispute resolution process, this tag will be excluded from scoring.

[6] Similar findings mean that both the Federal and State survey findings included similar issues around the same topic areas, such as falls, pressure ulcers, infection control, and so on. For example, both the State Survey Agency and CMS Location may cite F689. However, the findings would not be similar if the CMS Location identified only failure to prevent elopements and the State Survey Agency identified only failure to prevent falls.

Once points are determined for the numerator and denominator associated with each deficiency, all numerator points are summed, and all denominator points are summed. The overall score is calculated by dividing the denominator into the numerator.

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

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

Federal Comparative Survey Score = (Numerator/Denominator)

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

- The State Survey Agency did not cite a tag and the CMS Location determined the State Survey Agency should not have found the deficiency (Should Have Found (SHF) = No)
- The State Survey Agency did not cite a tag and the CMS Location was unable to determine if the deficiency should have been cited by the State Survey Agency (SHF=unable to determine)
- The State Survey Agency did not cite a tag and the CMS Location did not indicate whether the deficiency should have been cited by the State Survey Agency (SHF=missing)
- The State Survey Agency cited the same tag or a similar tag to the one cited by the CMS Location, but the State Survey Agency cited the tag at a lower severity and scope than that of the CMS Location and the CMS Location was unable to determine if the State Survey understated the severity and scope level (UnderStatement=unable to determine)
- The State Survey Agency cited the same tag or a similar tag to the one cited by the CMS Location, but the State Survey Agency cited the tag at a lower severity and scope than that of the CMS Location and the CMS Location did not indicate if the State Survey understated the severity and scope level (UnderStatement=missing)

Calculating the overall measure score

To calculate the overall measure score, multiply the Focused Concern Survey score by 0.7 and the Federal Comparative Survey score by 0.3. Sum the resulting values from both calculations together and multiply this value by 100.

For example, if the Focused Concern Survey score was 0.75 and the Federal Comparative Survey score was 0.50, the following steps would be taken to calculate the overall Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys score:

1. Multiply 0.75 by 0.7 resulting in a value of 0.525.
2. Multiply 0.50 by 0.3 resulting in a value of 0.15.
3. Sum 0.525 and 0.15 together resulting in a value of 0.675.
4. Multiply 0.675 by 100 resulting in an overall score of 67.5%

If either the Focused Concern Survey score or the Federal Comparative Survey score is N/A, the other score will be weighted at 100 percent to calculate the overall Federal Monitoring Survey score. If both scores are N/A then the overall measure score is also N/A.

Appendix 6. Timeliness of Revisits (N1)

Data Source(s)

- QIES and iQIES

Method of Calculation

Nursing Homes

To calculate this measure, the count of surveys requiring onsite revisit that received an onsite revisit within 60 days of survey exit (numerator) is divided by the count of surveys requiring onsite revisit (denominator).

The count of surveys requiring onsite revisits (denominator) is calculated by identifying all initial recertification and complaint surveys with survey exit dates within the fiscal year that resulted in a citation at F severity and scope with substandard quality of care or higher.[7] From this set of recertification or complaint surveys, surveys that meet any of the following conditions are excluded:

- an IDR/IIDR has been completed and all tags at F severity and scope with substandard quality of care or higher were removed or downgraded to less than F severity and scope with substandard quality of care
- a federal comparative survey is conducted for the same facility within 60 days of the survey exit
- the only identified citations of F with substandard quality of care or higher were past noncompliance
- Surveys that require a revisit, but have less than 60 days of data run out from the date of extraction and no evidence of a revisit

After survey exclusions are made, the remaining surveys constitute the count of surveys requiring onsite revisits (denominator).

Any survey identified as being in the denominator of this measure that has a corresponding revisit within 60 days of the survey exit date is included in the numerator of this measure. The total number of surveys with an onsite revisit and a revisit start date within 60 days of the initial survey exit date constitute the count of surveys requiring onsite revisit that received an onsite revisit within 60 days of survey exit (numerator).

The count of surveys requiring onsite revisits with a revisit within 60 days of survey exit (numerator) is divided by the count of surveys requiring onsite revisit (denominator). This value is multiplied by 100 to calculate the percentage of revisits that occurred within 60 days.

Using the table below as an example, ten surveys are conducted in the fiscal year and are included in the denominator. Of the ten surveys, eight surveys had revisits within the 60-day time period and are included in the numerator. Survey 2 is excluded from the numerator because the days between the survey exit date and the survey revisit start date were greater than 60 days. Survey 3 was excluded

[7] The following nursing home tags indicate substandard quality of care if the tag is cited at F level scope and severity: 550, 558, 559, 561, 565, 584, 600, 602, 603, 604, 605, 606, 607, 608, 609, 610, 675, 676, 677, 678, 679, 680, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 742, 743, 744, 745, 757, 758, 759, 760, 850, and 883.

because a revisit has not been conducted. Eight revisits divided by ten initial surveys results in 80% of timely revisits.

Nursing Home Table Example

Survey	Initial Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2024	3/15/2024	31
2	4/2/2024	7/3/2024	92
3	3/19/2024	.	.
4	11/5/2023	12/17/2023	42
5	7/22/2024	9/1/2024	41
6	9/25/2024	11/16/2024	52
7	1/12/2024	2/1/2024	20
8	5/28/2024	6/4/2024	7
9	2/14/2024	4/7/2024	52
10	10/2/2023	11/2/2023	31

This measure includes cases even when the plan of correction dates are missing. Historically, State Survey Agencies conduct revisits for a large proportion of surveys with missing data in these fields. CMS does not have enough information to accurately exclude cases when a plan of correction is delayed or not sent by a provider.

States with fewer than 10 surveys in the denominator are excluded from this measure.

Acute and Continuing Care Providers

To calculate this measure, the count of surveys requiring onsite revisits that received an onsite revisit within the 45-day time period (numerator) is divided by the count of surveys requiring onsite revisit (denominator).

The count of surveys requiring onsite revisit (denominator) is calculated by identifying all initial recertification and complaint surveys of non-deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities with survey exit dates within the fiscal year that resulted in a condition-level citation. Any survey identified in the denominator of this measure that has a corresponding revisit within 45 days of the survey exit data is included in the numerator of this measure. The count of these surveys (numerator) is divided by the count of surveys requiring onsite revisit (denominator). This value is multiplied by 100 to calculate the percentage of revisits that occurred within 45 days.

Using the table below as an example, ten surveys are conducted in the fiscal year and are included in the denominator. Of the ten surveys, six surveys had revisits within 45 days of the survey exit date and are included in the numerator. Survey 2, 6, 9 are excluded from the numerator because the number of days between the survey exit date and the revisit start date was greater than 45 days. Survey 3 was excluded because a revisit has not been conducted. Six revisits divided by ten initial surveys results in 60% of timely revisits.

ACC Table Example

Survey	Initial Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2024	3/15/2024	31
2	4/2/2024	7/3/2024	92
3	3/19/2024	.	.
4	11/5/2023	12/17/2023	42
5	7/22/2024	9/1/2024	41
6	9/25/2024	11/16/2024	52
7	1/12/2024	2/1/2024	20
8	5/28/2024	6/4/2024	7
9	2/14/2024	4/7/2024	52
10	10/2/2023	11/2/2023	31

This measure includes cases even when plan of correction dates are missing. Historically, State Survey Agencies conduct revisits for a large proportion of surveys with missing data in these fields. CMS does not have enough information to accurately exclude cases when a plan of correction is delayed or not sent by a provider.

States with fewer than 10 surveys in the denominator are excluded from this measure.

Appendix 7. SPSS Measure Data Sources, Specifications, and Reports for Measure Monitoring

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S1. Surveys of Nursing Home Special Focus Facilities (SFF)	Survey and Certification Group Letter: S&C 17-20, Current SFF facilities lists, and QIES	**Special Focus Facilities surveyed every six months sub-measure:** 1. Identify the number of special focus facility slots in the state and identify the special focus facilities that filled those slots during the fiscal year. 2. For each special focus facility, verify the following: a. no more than six months elapsed between each survey that occurred within the fiscal year, and b. no more than six months elapsed between the first standard survey that occurred within the fiscal year and survey previous to that survey, and c. no more than six months elapsed between the last standard survey that occurred within the fiscal year and the end of the fiscal year. **Special Focus Facilities slots filled within 21 calendar days sub-measure:** 1. Identify any special focus facilities that graduated or were terminated during the fiscal year. 2. For each special focus facility that graduated or was terminated, verify that another special focus facility was selected within 21 calendar days of graduation, the date of the letter the State Survey Agency sent to the graduating SFF of its removal from the SFF program, or termination, the termination effective date.	No reports available
S2. Timeliness of Upload of Recertification Surveys	QIES	**Nursing Home Timeliness of Upload of Recertification Surveys measure:** 1. Identify nursing home recertification surveys with a certification upload date within the fiscal year. 2. For recertification surveys identified in Step 1, calculate the number days between survey exit date and the certification upload date. 3. Sum all days between survey exit date and certification upload date for all recertification surveys.	1. QCOR – Nursing Homes – Frequency of Data Entry 2. QCOR – Hospitals – Frequency of Data Entry

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		4. Divide the day count calculated in Step 3 by the count of recertification surveys identified in Step 1 to calculate the nursing home recertification survey average upload days. **Acute and Continuing Care Provider Timeliness of Upload of Recertification Surveys measure:** 1. Identify recertification surveys of non-deemed community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, outpatient physical therapy/speech language pathology providers, psychiatric residential treatment facilities and rural health centers with a certification upload date within the fiscal year. 2. For recertification surveys identified in Step 1, calculate the number days between survey exit date and the certification upload date. 3. Sum all days between survey exit date and certification upload date for all recertification surveys. 4. Divide the day count calculated in Step 3 by the count of recertification surveys identified in Step 1 to calculate the acute and continuing care recertification survey average upload days.	
S3. Use of the IJ template	CMS Location submitted spreadsheet identifying whether Immediate Jeopardy Templates are attached to survey kits, and list of attachments from the Long-term Care Survey Process Data, iQIES and QIES	**Nursing Home – Use of the IJ Template measure:** 1. Identify the IJ tags cited during nursing home recertification surveys with survey exit dates within the fiscal year. Include any IJ tags cited on complaints that were investigated during recertification surveys that were conducted (denominator). 2. From the IJ tags identified in Step 1, identify the IJ tags where the IJ template was attached to the recertification kit (numerator). 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of Nursing home IJ tags where an IJ template was attached to the recertification survey. **Acute and Continuing Care – Use of the IJ Template measure:** 1. Identify the IJ tags that CMS Locations selected for IJ template review (denominator).	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		2. From the IJ tags identified in Step 1, identify the IJ tags where the IJ template was attached to the recertification kit (numerator). 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of Acute and Continuing Care IJ tags where an IJ template was attached to the survey.	
S4. Intakes Overdue for Investigation	ASPEN, iQIES, and QIES	**Nursing Homes Intakes Overdue for Investigation measure**: 1. Identify the number of nursing home complaints/FRIs that had been triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels but were overdue for investigation on October 1, 2023. 2. Identify the number of nursing home complaints/FRIs that had been triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels but were overdue for investigation on September 30, 2024. 3. Subtract the number of overdue intakes identified in Step 1 from the number of overdue intakes identified in Step 2. Divide the result by the number identified in Step 1 and multiply by 100 to calculate the percentage of overdue intake reduction. **Acute and Continuing Care Intakes Overdue for Investigation measure**: 1. Identify the number of ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics complaints that had been triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels but were overdue for investigation on October 1, 2023. 2. Identify the number of ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement	1. ACTS – Reports – Intakes without Scheduled Surveys 2. Acts – Reports – Complaint Incident Investigation Log

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics complaints that had been triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels but were overdue for investigation on September 30, 2024. 3. Subtract the number of overdue intakes identified in Step 1 from the number of overdue intakes identified in Step 2. Divide the result by the number identified in Step 1 and multiply by 100 to calculate the percentage of overdue intake reduction.	
S5. EMTALA prioritized as IJ and Non-IJ High conducted within the required time period	QIES – ACTS	**Percentage of EMTALA IJ Intakes started within 2 business days sub-measure:** 1. Identify all federal intakes with an EMTALA allegation prioritized as IJ that had a CMS investigation approval date within the fiscal year (denominator). 2. Calculate the number of business days between the CMS approval date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within two business days (numerator). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of EMTALA Intakes prioritized as IJ that were started within two business days. **Percentage of EMTALA non-IJ High Intakes started within 45 calendar days sub-measure:** 1. Identify all federal intakes with an EMTALA allegation prioritized as non-IJ that had a CMS investigation approval date within the fiscal year (denominator). 2. Calculate the number of calendar days between the CMS approval date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within 45 calendar days (numerator). 4. Divide the numerator identified in Step 1 by the denominator identified in Step 3 and multiply by 100 to calculate the percentage of EMTALA Intakes prioritized as non-IJ high that were started within 45 calendar days.	1. ACTS – Reports – Timeliness 2. ACTS – Reports – EMTALA – EMTALA Interval Report

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S6. Intakes prioritized as IJ started within the required time period	iQIES and QIES	**Nursing Home Intakes prioritized as IJ started within the required time period measure:** 1. Identify Nursing Home federal intakes prioritized as IJ with a received start date within the fiscal year (denominator). 2. Calculate the number of business days between the received start date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of complaint intakes that were started within three business days. 4. From the intakes identified in Step 1, identify the number of facility-reported incidents that were started within seven business days. 5. Sum the number of complaints and facility-reported incidents identified in Steps 3 and 4 (numerator). 6. Divide the numerator identified in Step 5 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of nursing home intakes prioritized as IJ started within the required time period. **Non-deemed Acute and Continuing Care Intakes prioritized as IJ started within the required time period measure:** 1. Identify all non-deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities federal intakes prioritized as IJ with a received end date within the fiscal year (denominator). 2. Calculate the number of business days between the received end date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within two business days (numerator). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of non-deemed acute and continuing care intakes prioritized as IJ started within the required time period. **Deemed Acute and Continuing Care Intakes prioritized as IJ started within the required time period measure:** 1. Identify deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and	1. CASPER Reports – 0837D – Timeliness of Complaint/Incident Investigations -Non-Deemed 2. CASPER Reports – 0838D – Timeliness of Complaint/Incident Investigations – Nursing Homes 3. ACTS Reports – Non-Deemed Provider – Immediate Jeopardy Federal Complaints Investigation Timeframe 4. ACTS Report – Long Term Care: Non IJ High/Medium Federal Investigation Timeframe

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		intermediate care facilities for individuals with intellectual disabilities federal intakes prioritized as IJ with a received end date within the fiscal year 2. From the intakes identified in Step 1, include only those with a CMS Location approval date (denominator). 3. Calculate the number of business days between the CMS Location approval date and the investigation start date. 4. From the intakes identified in Step 2, identify the number of intakes that were started within two business days (numerator). 5. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of deemed acute and continuing care intakes prioritized as IJ started within the required time period.	
S7. Off-Hour Surveys for Nursing Homes	CMS provided monthly provider rating lists and QIES	**Percent of surveys started during off-hours sub-measure:** 1. Identify the number of nursing home health recertification surveys that were conducted within the fiscal year (denominator). 2. From the surveys identified in Step 1, identify the number that were started on Saturday, Sunday, a federal or state holiday, before 8:00 am, or after 6:00 pm. 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of percent of surveys conducted during off-hours. **Percent of off-hours surveys started during weekends sub-measure:** 1. Identify the number of nursing home health recertification surveys that were conducted within the fiscal year. 2. Multiply the count identified in Step 1 by 10% (denominator). 3. Identify the number of surveys that were started on weekends (numerator). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of percent of off-hour surveys started during weekends. It is possible for this percentage to be greater than 100%.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		Percent of off-hours weekend surveys conducted among facilities with potential staffing issues sub-measure: 1. Identify the number of surveys that were started on weekends (denominator). 2. From surveys identified in Step 1, identify the surveys conducted among facilities with potential staffing issues. A facility can be included in this count if they had a Staffing Alert of "Low Weekend Staffing" or "High # of Days with No RN" on a Provider Ratings file provided to the state within the three months prior to the weekend survey (numerator). 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of percent of off-hour weekend surveys started conducted among facilities with potential staffing issues.	
S8. Frequency of Nursing Home Recertification Surveys	QIES -Survey Common Table QIES – Provider Common Table	1. Identify all active nursing homes. Active nursing homes are those with an original participation date before June 1, 2023 and either no termination date or a termination date after the end of the fiscal year. 2. Exclude any federal facilities, such as Indian Health Service or military/veteran facilities. 3. Calculate the number of resulting active nursing homes (denominator). 4. From the active nursing homes identified in Step 3, identify the number of nursing homes that were surveyed in the 15.9-month time period prior to the end of the fiscal year. 5. From the nursing homes identified in Step 4, identify the number where the time between the most recent survey and the previous survey is greater than 15.9 months. 6. Subtract the number of nursing homes identified in Step 5 by the number of nursing homes identified in Step 4 (numerator). 7. Divide the numerator identified in Step 6 by the denominator in Step 2 and multiply by 100 to calculate the percentage of active nursing homes that have had a recertification survey every 15.9 months.	1. QCOR - Overdue Recertification Surveys 2. CASPER Reports - 0803D - Nursing Home Providers Not Surveyed 3. CASPER Reports - 0842D - Providers Not Surveyed 4. ACO Reports - Months Since Last Certification

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S9. Frequency of Tier 1 Acute and Continuing Care Recertification Surveys	iQIES and QIES	**Home Health Agency Recertification sub-measure:** 1. Identify active non-deemed home health agencies. Active non-deemed home health agencies are those that have a deeming status of either missing or non-deemed, have an original participation date before March 1, 2020, and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the active non-deemed home health agencies identified in Step 1, identify the number that were surveyed within the 36.9-month time period prior to the end of the fiscal year. 3. From the active non-deemed home health agencies identified in Step 2, identify the number where the time between the most recent survey and the previous survey is greater than 36.9 months. 4. Subtract the home health agencies identified in Step 3 from the home health agencies identified in Step 2 (numerator). 5. Divide the numerator identified in Step 4 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active non-deemed home health agencies that have had a recertification survey every 36.9 months. **Hospice Recertification Survey sub-measure:** 1. Identify active non-deemed hospice facilities. Active non-deemed hospice facilities are those that have a deeming status of either missing or non-deemed, have an original participation date before March 1, 2020, and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the active non-deemed hospice facilities identified in Step 1, identify the number that were surveyed within the 36.9-month time period prior to the end of the fiscal year. 3. From the active non-deemed hospice facilities identified in Step 2, identify the number where the time between the most recent survey and the previous survey is greater than 36.9 months. 4. Subtract the hospice facilities identified in Step 3 from the hospice facilities identified in Step 2 (numerator).	1. CASPER Reports - 0812D - HHA Providers Not Surveyed 2. CASPER Reports - 0822D - ICF/IID Providers Not Surveyed 3. CASPER Reports - 0842D - Providers Not Surveyed 4. ACO Reports - Months Since Last Certification

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		5. Divide the numerator identified in Step 4 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active non-deemed hospice facilities that have had a recertification survey every 36.9 months. **Intermediate Care Facilities for Individuals with Intellectual Disabilities Recertification Survey sub-measure:** 1. Identify active intermediate care facilities for individuals with intellectual disabilities. Active intermediate care facilities for individuals with intellectual disabilities that have an original participation date an original participation date before June 1, 2023 and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the intermediate care facilities for individuals with intellectual disabilities identified in Step 2, identify the number that were surveyed in the 15.9-month time period prior to the end of the fiscal year. 3. From the intermediate care facilities for individuals with intellectual disabilities identified in Step 2, identify the number where the time between the most recent survey and the previous survey is greater than 15.9 months. 4. Subtract the number of intermediate care facilities for individuals with intellectual disabilities identified in Step 3 by the number of intermediate care facilities for individuals with intellectual disabilities identified in Step 2 (numerator). 5. Divide the numerator identified in Step 4 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active intermediate care facilities for individuals with intellectual disabilities that have had a recertification survey every 15.9 months.	

Q1. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys	Focused Concern Survey Data and Federal Comparative Survey Data	**Focused Concern Survey Data** 1. Calculate the number of areas investigated across focused concern surveys. 2. Multiple the identified focus concern areas investigated by 2 (denominator). 3. Identify the number of focus concern areas investigated that were "Met." Multiply this number by 2. 4. Identify the number of focus concern areas investigated that were "Partially Met." Multiply this number by 1. 5. Identify the number of focus concern areas investigated that were "Not Met." Multiply this number by 0. 6. Sum the totals calculated in Steps 3, 4, and 5 (numerator). 7. Divide the numerator calculated in Step 6 by the denominator identified in Step 2 to calculate the Focused Concern Survey score. **Federal Comparative Survey Data** 1. Identify CMS Location citations at severity and scope of D or greater during Federal Comparative Surveys that occurred during the fiscal year. 2. Exclude any citations where the Federal Comparative Survey report has not been approved. 3. Exclude any citations removed due to an IDR or IIDR process. 4. If an IDR or IIDR process downgraded a citation, replace the original citation and severity and scope with the revised citation and severity and scope. 5. If the SA did not identify the same or similar citation identified by the CMS Location, exclude the citations if the Federal Comparative Survey report indicates that the SA should have not have found the citation (SHF=No), it could not be determined if the SA should have found the citation (SHF=Unable to determine), or if there is no information about whether the SA should have found the citation (SHF=missing). 6. If the SA cited the same or similar citation identified by the CMS Location, exclude the citation when the CMS Location cited at a higher severity and scope than the SA cited and the Federal Comparative Survey report indicates that it could not be determined if the SA under-cited the (UnderStatement=Unable to determine), or if there is no information	No reports available

about whether the SA sunder-cited the citation (UnderStatement=missing).

7. The remaining citations constitute the pool of citations used to calculate the measure.
8. Using the chart below, column "Denominator Points," calculates the number of points each citation receives based on the severity and scope cited by the CMS Location. Sum all the points together (denominator).
9. Using the chart below, columns "Numerator Points," calculate the number of points each citation receives based on the severity and scope cited by the SA in comparison to the CMS Location. Sum all the points together (numerator).

CMS Location, Federal Comparative Survey citations		Numerator Points		
Tag	**Denominator Points**	**State Survey Agency cites similar tag at same or higher S/S**	**State Survey Agency cites similar tag at lower S/S**	**State Survey Agency does not cite similar tag SHF=yes**
JKL, sqc	12	12	6	0
JKL, non-sqc	10	10	5	0
HI, sqc	8	8	4	0
GHI, non-sqc	4	4	3	0
F, sqc	2	2	1	0
DEF, non-sqc	1	1	0.5	0

10. Divide the numerator calculated in Step 9 by the denominator calculated in Step 8 to calculate the Federal Comparative Survey score.

Calculating the overall measure score

1. Multiply the Focused Concern Survey score by 0.7.
2. Multiple the Federal Comparative Survey score by 0.3.
3. Sum the values calculated in Step 1 and Step 2 together and multiply this value by 100.

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
Q2. Nursing Home Tags Downgraded/Removed by IDR or IIDR and Unresolved IDRs/IIDRs	ASPEN and QIES	**Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR sub-measure:** 1. Identify all citation tags from nursing home recertification and complaint surveys that underwent IDR/IIDR review. Include only citation tags from surveys with a survey exit date within the fiscal year. Exclude any tags from a CDC survey. Exclude any citation tag from surveys where the IDR/IIDR is in the "requested" status (denominator). 2. From the citation tags identified in Step 1, identify citation tags that were downgraded or removed as the result of an IDR/IIDR (numerator). 3. Divide the numerator calculated in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR. **Percent of Surveys with Unresolved IDR/IIDRs sub-measure:** 1. Identify all nursing home recertification and complaint surveys with survey exit dates in fiscal year 2022 through fiscal year 2024 that were submitted for IDR/IIDR review. Exclude any survey where the IDR/IIDR request was rescinded. Exclude any CDC survey. Exclude any survey where the IDR/IIDR requested date was within 60-days of the end of fiscal year 2024 (denominator). 2. From the surveys identified in Step 1, identify the surveys where the IDR/IIDR remains in the "requested" status (numerator). 3. Divide the numerator calculated in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percent of surveys with unresolved IDR/IIDRs.	1. ACO Reports – Enforcement Reports – Ancillary Reports – IDR/IIDR Report
Q3. Data Submission	ASPEN and QIES	**Percent of Missing Surveys sub-measure:** 1. Identify the number of recertification, complaint, and special surveys with survey exit dates in fiscal year 2022 through fiscal year 2024 that have not been uploaded to the national database (numerator). These are surveys that are in ASPEN but are not in the national database. 2. Identify the number of recertification, complaint, and special surveys with survey exit dates in fiscal year 2022 through fiscal year 2024 that have been uploaded to the national database. These are surveys that are in ASPEN and the national database.	1. State counts spreadsheet. This is provided monthly to states via Box.

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		3. Sum surveys identified Step 1 and Step 2 (denominator). 4. Divide the numerator calculated in Step 1 by the denominator identified in Step 3 and multiply by 100 to calculate the percentage of missing surveys. **Percent of Surveys Missing CMS-2567 Text sub-measure:** 1. Identify the number of recertification, complaint, and special surveys with survey exit dates in fiscal year 2022 through fiscal year 2024 that have been uploaded to the national database (denominator). 2. From the surveys identified in Step 1, identify those surveys that are indicated as missing CMS-2567 text from the Survey Errors Report provided via Box (numerator). 3. Divide the numerator calculated in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percent of surveys missing CMS-2567 text.	
N1. Timeliness of Revisits	ASPEN, iQIES and QIES	**Nursing Home Timeliness of Revisits measure:** 1. Identify all nursing home initial recertification and complaint surveys with a survey exit date in the fiscal year. 2. From surveys identified in Step 1, identify those surveys that require an onsite revisit. Onsite revisits are required if the initial survey identified citations at F severity and scope with substandard quality of care or higher. 3. From surveys identified in Step 2, exclude any survey where: a. an IDR/IIDR was completed and all citations at F severity and scope with substandard quality of care or higher were removed or reduced to below F with substandard quality of care, or b. a comparative survey was conducted at the same facility within 60 days of the survey exit date, or c. all citations at F severity and scope with substandard quality of care were past noncompliance, or d. the survey exit date is less than 60 days from date of data extraction and there is no evidence of a revisit. Remaining surveys after exclusions are those that require onsite revisit (denominator).	1. ACO – Tracking – Overdue Revisits

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
		4. From the surveys identified in Step 3, identify those surveys that had a revisit with a start date within 60 days of the survey exit of the initial survey (numerator). 5. Divide the numerator identified in Step 4 by the denominator identified in Step 3 and multiply by 100 to calculate the percentage of nursing home revisits conducted within the required time period. **Acute and Continuing Care Timeliness of Revisits measure:** 1. Identify all non-deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities initial recertification and complaint surveys with a survey exit date in the fiscal year. 2. From surveys identified in Step 1, identify those surveys that require an onsite revisit. Onsite revisits are required if the initial survey identified condition level citations (denominator). 3. From surveys identified in Step 2, identify the surveys that had a revisit start date within 45 days of the survey exit. 4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of non-deemed acute and continuing care revisits conducted within the required time period.	