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

Admin Info: 26-02-ALL

DATE: January 13, 2026

TO: State Survey Agency Directors

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

SUBJECT: Fiscal Year 2026 (FY26) State Performance Standards System (SPSS) Guidance

Memorandum Summary

- ***SPSS Annual Assessment.*** State Survey Agencies (SAs) conduct survey and certification work for Medicare/Medicaid-certified providers and suppliers on behalf of CMS. CMS annually reviews each SA's performance effectiveness. Most SPSS measures carry over from year to year to track SA progress toward meeting Federal requirements. CMS removes measures that are no longer needed as SAs improve.
- ***FY26 SPSS Guidance.*** CMS is issuing updated guidance for the process used to oversee SA performance for ensuring Medicare/Medicaid-certified providers and suppliers meet Federal requirements to protect Americans' health and safety. The updated guidance accounts for impacts of the federal government shutdown that occurred from October 1, 2025 through November 12, 2025.

Background:
CMS works with the SAs to strengthen oversight so that care provided in nursing homes and other acute and continuing care providers and suppliers is of the highest quality. CMS works closely with states through ongoing discussions, case reviews, and analysis of interim performance, and CMS formally assesses each SA's performance relative to SPSS program measures.

CMS recognizes the challenges SAs face with provider and supplier migration from the legacy data system to the Internet Quality Improvement and Evaluation System (iQIES). CMS will closely monitor effects of provider migrations to iQIES to ensure SPSS measures are calculated accurately.

CMS is adjusting the evaluation of several FY26 SPSS measures in recognition of the Federal government shutdown that occurred from October 1, 2025 through November 12, 2025. Measures directly impacted by shutdown guidance (refer to QSO-26-01-ALL Revised) limiting SAs' ability to conduct certain survey and certification work will have an exception applied commensurate with the approximate time period affected, approximately 20% of the FY. These exceptions will only be applied FY26 and will not carry over into future years.

Discussion:
The SPSS is aligned with CMS expectations for SA performance in accordance with the Social Security Act §1864 Agreement and all related statutes, regulations, and policies intended to improve and protect the health and safety of those accessing care by CMS-certified providers, 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 FY26 include:

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

Process:
CMS provides progress reports, data, and support on SPSS measures to SAs throughout the fiscal year. After the end of the fiscal year, CMS releases final SPSS results to SAs. SAs must submit a corrective action plan addressing each SPSS measure scored Not Met or Partially Met for the second consecutive year. CMS Locations monitor SAs progress with corrections.

On behalf of CMS, we truly appreciate states' efforts to improve the health, safety, and quality of life of all who access care in CMS-certified providers.

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

Effective Date:
October 1, 2025. Please communicate to all appropriate staff within 30 days.

/s/

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Director, Survey & Operations Group

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

Fiscal Year 2026

State Performance Standards

System Guidance

January 13, 2026

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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 Social Security Act §1864 Agreement and all related statutes, 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 SPSS guidance is meant to ensure State Survey Agencies are consistently monitoring compliance of health care providers.

A. Primary changes to the SPSS for Fiscal Year 2026

The SPSS measures are organized by the following three domains: Survey and Intake Process, Survey and Intake Quality, and Noncompliance Resolution. CMS is retiring three measures from the previous fiscal year due to State Survey Agency improvements and greater focus on highest priority survey and certification work. The retired measures include: immediate jeopardy (IJ) template use, IJ intakes overdue for investigation, and focused concern surveys. CMS discontinued focused concern surveys in FY25. Nearly all State Survey Agencies eliminated or nearly eliminated backlogs of overdue IJ intakes as of FY25, making this measure irrelevant to most. At the end of FY24, 88.5% of State Survey Agencies had fewer than two overdue nursing home IJ intakes, and 88.5% of SAs had fewer than two overdue acute and continuing care provider IJ intakes. State Survey Agencies have also demonstrated high performance on IJ template use. In FY24, over 90% of State Survey Agencies SAs met the expectation of completing IJ templates for 80% of nursing home IJ tags, and over 80% of SAs met this expectation for acute and continuing care provider IJ tags.

CMS is evaluating FY26 SPSS in the context of unchanged State Survey Agency funding levels since FY15, despite continued resource and workload challenges in the last five years. The FY26 SPSS measure set focuses primarily on ensuring State Survey Agencies are completing survey and certification work that is statutorily mandated and related to serious quality concerns.

For measures continued from FY25, changes to scoring thresholds are flagged in red font and marked with an asterisk throughout this memo. To account for the impacts to survey and certification activities resulting from the Federal government shutdown that occurred from October 1, 2025 through November 12, 2025, CMS is adjusting the evaluation of several FY26 SPSS measures to ensure fairness to State Survey Agencies. CMS approximates that 20% of FY26 was impacted by the shutdown when considering the length of the shutdown plus the time needed to resume full, normal operations after the shutdown ended. This approximation informs reductions in thresholds for several measures. Exceptions are noted in a box at the beginning of each measure section and in Appendix 7.

B. Ongoing Activities

CMS will monitor survey and certification guidance to ensure measures remain aligned with current guidance. Throughout FY26, CMS anticipates and welcomes SA feedback regarding operational impacts of the government shutdown to SPSS measures. In conducting oversight activities, CMS will continue to provide ongoing monitoring and support to State Survey Agencies to address their performance as assessed by the SPSS measures during this fiscal year. CMS will also proactively identify priorities and measures to consider for the Fiscal Year 2027 (FY27) SPSS. If you have questions or feedback related to the SPSS, please contact us via email at SPSS_Team@cms.hhs.gov.

C. Fiscal Year 2026 SPSS Measures

The SPSS includes nine measures across three domains: Survey and Intake Process (measures S1-S8); Survey and Intake Quality (measures Q1-Q4); and Noncompliance Resolution (measure N1). The following list summarizes each SPSS measure by domain.[1] Specific shutdown exceptions are included upfront in each measure section, applicable measure appendices and in Appendix 7.

Survey and Intake Process

- S1. Nursing Home Special Focus Facilities (SFFs)
  - CMS will assess the frequency of recertification surveys conducted for SFFs and the timely addition of new facilities to the SFF list.
- S4. EMTALA complaints prioritized as IJ and Non-IJ High with surveys started timely
  - CMS will assess whether IJ and non-IJ high EMTALA complaint investigations are started within the required time period per SOM Chapter 5 guidance.
- S5. Intakes prioritized as IJ with surveys started timely
  - CMS will assess whether IJ intake surveys are started within the required time period per SOM Chapter 5 guidance. CMS will assess this measure for the following provider types, both deemed and non-deemed: 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.
- S6. Nursing Home Off-Hour Surveys
  - CMS will assess whether the appropriate proportion of nursing home health-recertification surveys are started during off-hours, on weekends, and at facilities with potential staffing issues per SOM Chapter 7 guidance.
- S7. Frequency of Nursing Home Recertification Surveys
  - CMS will assess whether nursing home health-recertification surveys are conducted within the maximum time interval.
- S8. Frequency of Tier 1 Acute and Continuing Care (ACC) Provider Recertification Surveys
  - CMS will assess whether Tier 1 health-recertification surveys are conducted within the maximum time intervals for non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities as these providers have statutorily-mandated survey frequencies.

Survey and Intake Quality

- Q2. Assessment of Deficiency Identification using Federal Comparative Surveys
  - CMS will assess if State Survey Agency citations are similar to findings by CMS Location findings on Federal comparative surveys.
- Q3. Nursing Home Tags Downgraded/Removed by Informal Dispute Resolution (IDR) or Independent IDR (IIDR) and Unresolved IDRs/IIDRs
  - CMS will assess the percentage of tags that have been downgraded or removed via IDR/IIDR and the percentage of surveys where an IDR/IIDR has been requested but has not been completed.

[1] Beginning in FY26, measure codes (e.g., S5) will remain consistent from year to year.

- Q4. Nursing Home Recertification Survey Composite
  - CMS will assess the frequency and type of nursing home deficiencies and the completion of mandatory or triggered tasks on recertification surveys. This measure combines six sub-measures into a composite score: (1) Number of Deficiencies per 1,000 Beds, (2) Percentage of Deficiency-Free Surveys, (3) Percentage of Surveys Identifying G, H, or I Scope and Severity, (4) Percentage of Surveys Identifying J, K, or L Scope and Severity, (5) Percentage of Surveys where 1 or more Mandatory Tasks Not Investigated, and (6) Percentage of Surveys where 1 or more Triggered Tasks Not Investigated.

Noncompliance Resolution

- N1. Onsite Revisit Timeliness
  - 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 calendar days after the survey exit date for those surveys citing deficiencies at a scope and severity 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 calendar days after the survey exit date for those surveys citing condition-level deficiencies. CMS will assess this measure for the following provider types: home health agencies, hospices, 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 all SPSS measures. Measures will be calculated for providers that have migrated to the Internet Quality Improvement and Evaluation System (iQIES), including nursing homes, home health agencies, hospices, and ambulatory surgical centers. For all other providers, measures will be calculated using QIES.

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 Nursing Home 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. Refer to each measure section and Appendix 7 for CMS-approved SPSS exceptions that account for the impact of the Federal government shutdown. 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 to prevent the State Survey Agency from meeting the measure.

Timeline

The FY26 SPSS evaluation period is October 1, 2025, through September 30, 2026, with milestone dates as follows:

Milestone Dates for SPSS FY26

Activity	Approximate Date
FY26 SPSS Preliminary Results available for State Survey Agency review and Informal Requests for Reconsideration (IRR) begins	January 15, 2027
Deadline for State Survey Agencies to submit IRR	February 5, 2027
FY26 SPSS Results finalized	February 26, 2027
Corrective Action Plans due from States	March 12, 2027

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. In FY25, CMS added a new "Requires Research" scoring category specifically for the Nursing Home Recertification Survey Composite measure (Q4). A summary of how CMS will assign scores to each State Survey Agency 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 FY26 SPSS measure if the end of fiscal year value of that measure meets or exceeds the threshold identified in the FY26 SPSS Guidance.

- **Partially Met.** A State Survey Agency can achieve a score of Partially Met for a FY26 SPSS measure if:

  - that measure in FY25 was Met and the FY26 measure value is slightly below the established FY26 threshold; or

  - that measure in FY25 was Not Met or Partially Met and the FY26 measure value demonstrates substantial progress from FY25; or

  - that measure in FY25 was scored as not applicable (N/A) and the FY26 measure value is at or above the Partially Met threshold established for that measure for FY26.

- **Not Met.** A State Survey Agency achieves a score of Not Met for a FY26 SPSS measure if the FY26 measure value does not meet the Met threshold identified in the FY26 Guidance and does not meet the conditions necessary to qualify as Partially Met.

- **Requires Research.** CMS classifies a State as Requires Research if the FY26 *Nursing Home Recertification Composite (Q4)* measure value is less than the required threshold. This scoring classification is only used for this one measure and not others.

- **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 all measures scored as Not Met at the end of the fiscal year, the State Survey Agency will develop and implement an action plan that will address identified problems. The State Survey Agency corrective action plan must contain an action plan for each applicable measure that is scored as Not Met. A State Survey Agency must also submit an action plan if it received a score of Partially Met on the same measure in both the previous fiscal year and current fiscal year. The CMS Location will review and follow-up to ensure the State Survey Agency is progressing toward making corrections. In some instances, a State Survey Agency may not be expected to fully improve 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 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 performance. If a State Survey Agency has not met a performance measure in two or more consecutive years, the corrective action plan must include an evaluation of the previous corrective action plan and explain why it did not result in adequate performance improvement. CMS Locations will save final approved corrective action plans in a designated State-specific, shared collaboration location.

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, State Survey Agencies may ask CMS for informal reconsideration. CMS expects State Survey Agencies to correct data entry errors before submitting a reconsideration request. States may submit a reconsideration request at any time throughout the fiscal year. The final deadline for State Survey Agencies to submit an Informal Reconsideration Request will be 15 business days after CMS provides the FY26 SPSS Preliminary Results.

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. Nursing Home Special Focus Facilities (SFF)

Exceptions to account for Federal government shutdown

State Agencies will have until March 31, 2026 to survey Special Focus Facilities that were due to be surveyed during the first quarter of FY26 (October 1, 2025 – December 31, 2025).

CMS will not evaluate the 21-calendar day replacement timeframe for Special Focus Facilities that were eligible to graduate between September 15, 2025 and November 15, 2025.

Threshold Criteria

Each State Survey Agency shall conduct one standard health-recertification survey of each designated Special Focus Facility (SFF) at least once every 186 calendar days. For example, if the last recertification survey's exit date is October 9, 2025, then the next recertification survey's start date may be no later than April 13, 2026. 186 calendar days is roughly equal to six months, but accounts for the fact that some calendar months are longer than others.

When one SFF is removed either through termination or graduation, 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 recertification survey for each SFF in its State at least once every 186 calendar days and
(2) SFFs that are removed from the list, due to either termination or graduation from the program, 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 measure.

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 FY26 or was Partially Met in both FY25 and FY26, a Corrective Action Plan is required.

Evaluation

See Appendix 1. Nursing Home Special Focus Facilities (S1)

References

Social Security Act Sections 1819(f)(8) and 1919(f)(10)

QSO-23-01-NH

S&C 17-20-NH

S&C-14-20-NH

S&C-10-32-NH

S4. EMTALA complaints prioritized as IJ and Non-IJ High with surveys started timely

Exceptions to account for Federal government shutdown

For EMTALA complaints prioritized as IJ or non-IJ high received between October 1, 2025 and November 12, 2025, the survey must be started within 2 business days (for IJ EMTALA complaints) or 45 calendar days (for non-IJ high EMTALA complaints) of the **intake received end date** (rather than CMS RO approval date).

Threshold Criteria

This performance measure evaluates the timeliness of EMTALA investigation initiation for complaints prioritized as Immediate Jeopardy (IJ) and non-IJ high, excluding any EMTALA complaints for pregnancy-related issues. 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 one of the following conditions is met:

- The FY25 score was Met and the FY26 values for both sub-measures are at least 90%.
- The FY25 score was Partially Met or Not Met; the FY26 sub-measure values that fell below 95% in FY25 are at least 2 percentage points greater than in FY25; and the FY26 values for both sub-measures are 75% or greater.
- The FY25 score was N/A and the FY26 values for both sub-measures are 75% or greater.
- Both FY26 sub-measure values are at least 75% and all late surveys for IJ-prioritized and non-IJ high prioritized EMTALA investigations were late by only 1 day.*

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 and no non-IJ high EMTALA complaints in FY26.*

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

The percentage of EMTALA complaints prioritized as IJ that were started timely is calculated as follows:

A) Identify the total number of EMTALA complaints prioritized as IJ in the fiscal year.

B) From (A), count the number of EMTALA complaints prioritized as IJ with the survey started within two business days of CMS Location approval.

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

% of EMTALA complaints prioritized as IJ with survey started timely = (B ÷A) × 100

The percentage of EMTALA complaints prioritized as non-IJ high that were started timely is calculated as follows:

D) Identify the total number of EMTALA complaints prioritized as non-IJ high in the fiscal year.

E) From (D), count the number of EMTALA complaints prioritized as non-IJ high with the survey started within 45 calendar days of CMS Location approval.

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

% of EMTALA complaints prioritized as non-IJ high with survey started timely = (E ÷D) × 100

EMTALA complaints that include a pregnancy-related allegation, including allegations identified as "labor emergency" or "other obstetric emergency" will be excluded from this measure.

Beginning FY26, the CMS extension date field in ACTS for EMTALA surveys will no longer be factored into the calculation for this measure.*

References

QSO-19-14-Hospitals, CAHs

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

State Operations Manual, Appendix V

QSOG Mission & Priority Document Webpage

S5. Intakes prioritized as IJ with surveys started timely

Exceptions to account for Federal government shutdown

For deemed ACC intakes prioritized as IJ received between October 1, 2025 and November 12, 2025, the survey must be started within 2 business days of the **intake received end date for providers in ASPEN** (rather than CMS RO approval date). Deemed ACC intakes for providers in iQIES will, as usual, be evaluated using the CMS RO approval date.

Threshold Criteria

This performance measure evaluates the timeliness of survey 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. For nursing homes and non-deemed acute and continuing care providers, CMS will calculate the percentage of surveys initiated within the required time period of intakes prioritized as IJ. For deemed acute and continuing care providers, CMS will calculate the percentage of surveys initiated within the required time period of receipt of CMS Location approval 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 surveys started within the required time period is 90% or greater.*

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

- The FY25 score was Met and the FY26 measure value is at least 85%.*
- The FY25 score was Partially Met or Not Met; the FY26 measure value is at least 5 percentage points greater than in FY25; and the FY26 measure value is 80% or greater.*
- The FY25 score was N/A and the FY26 measure value is 80% or greater.*
- The FY26 value is at least 80%, and all of the State Survey Agency's late surveys for IJ-prioritized intakes were late by only 1 day.*

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 is assigned a score of N/A if there are no intakes prioritized as IJ in FY26.

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

The percentage of intakes prioritized as IJ with the survey started timely is calculated separately for nursing homes, non-deemed acute and continuing care providers, and deemed acute and continuing care providers:

A) Identify the total number of intakes prioritized as IJ in the fiscal year among nursing homes, non-deemed acute and continuing care providers, or deemed acute and continuing care providers.

B) From (A), count the number of intakes prioritized as IJ with the survey started timely, as defined for nursing homes, non-deemed acute and continuing care providers, or deemed acute and continuing care providers.

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

$$\% \text{ of intakes prioritized as IJ with survey started timely} = (B \div A) \times 100$$

For nursing home complaints and facility-reported incidents with inadequate resident protection, the required time period is defined as three business days from the intake received start date to the survey start date. For facility-reported incidents with potentially adequate resident protection, the required time period is defined as seven business days from the intake received start date to the survey start date. If the nursing home complaint or facility-reported incident is initially received after 5:00pm local time or on a weekend or Federal holiday, then the intake start date is considered the next business day for measure evaluation purposes.

For non-deemed acute and continuing care providers, the required time period is defined as two business days from the intake received end date to the survey start date.

For deemed acute and continuing care providers, the required time period is defined as two business days of receipt of CMS Location approval to the survey start date.

References

State Operations Manual, Chapter 5, sections 5070, 5075, 5310.2A

S6. Nursing Home Off-Hour Surveys

Exceptions to account for Federal government shutdown

CMS is reducing FY26 Met and Partially Met thresholds for all three sub-measures under S6. Refer to the scoring section below and Appendix 7 for details.

Threshold Criteria

(1) At least 8% (reduced from previous 10% requirement) of nursing home health-recertification surveys conducted in the fiscal year must begin during off-hours. Off-hour surveys are currently defined as those that start on weekends (Saturday or Sunday), Federal holidays, early morning (before 8:00am), or evenings (after 6:00pm).[2] These surveys must be completed on consecutive days.

(2) At least 40% (reduced from previous 50% requirement) 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 Surveys* is defined as 10% of all recertification surveys conducted within the fiscal year.

(3) At least 70% (reduced from previous 80% requirement) 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 monthly. 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. CMS will use *Expected Off-hour Weekend Survey* count instead of the actual number of off-hour weekend surveys conducted to calculate this measure. *Expected Off-hour Weekend Surveys* is defined as 5% of all recertification surveys conducted within the fiscal year.[3]

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 8% (reduced from previous 10% requirement) or more of all health recertification surveys,
(2) at least 40% (reduced from previous 50% requirement) of off-hour surveys are started on the weekends, and

[2] The definition of off hours is subject to change by CMS. If the definition of off hours is updated, this measure will be evaluated using the new definition from that point forward. Although State Operations Manual Chapter 7 section 7207.2.2 recognizes State holidays as off hours, this measure (and all other SPSS measures) will not account for State-specific holidays in scoring to ensure consistency in performance evaluation.
[3] QSO 19-02-NH requires that States conduct 100% of off-hour weekend surveys at facilities with potential staffing issues. The SPSS threshold for this sub-measure is 70% to account for challenges States may face in meeting this requirement.

(3) at least 70% (reduced from previous 80% requirement) 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 6% (reduced from previous 8% requirement) or more of all health recertification surveys,
(2) at least 30% (reduced from previous 40% requirement) of off-hour surveys are started on the weekend, and
(3) at least 60% (reduced from previous 70% requirement) 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 three or fewer health-recertification surveys in FY26.

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

This measure includes three sub-measures. The first sub-measure assesses the percentage of recertification 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 holiday, before 8:00 am local time, or after 6:00 pm local time.

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

$$\% \text{ of Surveys Started During Off Hours} = (B \div A) \times 100$$

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%.

$$\text{Number of Expected Off-Hour Surveys} = A \times 0.10$$

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.

$$\% \text{ of Off-Hour Surveys Started on Weekends} = (E \div D) \times 100$$

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 2026 Provider Ratings file and a weekend survey of that provider was conducted on July 18, 2026, that facility would be included in the count of off-hour weekend surveys conducted among facilities with potential staffing issues.

H) Identify the number of expected off-hour weekend surveys. This number is calculated by multiplying the number of surveys identified above in A by 5%.

$$\text{Number of Expected Off-Hour Weekend Surveys} = A \times 0.05$$

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

$$\%\text{ of Off-Hour Weekend Surveys at Facilities with Potential Staffing Issues} = (G \div H) \times 100$$

References

State Operations Manual, Chapter 7 Section 7207.2.2

QSO 19-02-NH

QSOG Mission & Priority Document Webpage

S7. Frequency of Nursing Home Recertification Surveys

Exceptions to account for Federal government shutdown

CMS is reducing the FY26 Met and Partially Met thresholds for S7. Refer to the scoring section below and Appendix 7 for details.

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. Nursing home health-recertification surveys are included in Tier 1 requirements. The requirement states that State Survey Agencies must conduct a health-recertification survey no later than 15.9 months after the last day of the previous health-recertification he 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 COVID-19 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 Survey Agency achieves a score of Met if 80% (reduced from previous 100% requirement) of all active nursing homes are surveyed at least every 15.9 months.

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

- At least 60% (reduced from previous 70% requirement) of all active nursing homes are surveyed at least every 15.9 months.
- The FY26 measure value is 10 percentage points greater than the FY25 measure value, and the FY26 measure value is at least 40% (reduced from previous 50% requirement).

Not Met. A State Survey Agency 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 no active nursing homes in FY26.*

In previous years, CMS assigned a score of **Not Met-On Track** to State Survey Agencies that surveyed a significant proportion of nursing homes in the 15.9 months prior to the end of fiscal year but otherwise would have received a score of Not Met. Throughout FY26, CMS will monitor trends in performance across all State Survey Agencies to evaluate if and how Not Met-On Track may be used as a score for FY26 SPSS.

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met or Not Met-On Track. Additionally, if the State Survey Agency scores Not Met-On Track after receiving a score of Partially Met or Met in the previous fiscal year, they must submit a corrective action plan.

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.

$$\% \text{ Recertified within the maximum time interval} = [\ (B - C) \div A\ ] \times 100$$

Note: Recertification surveys must have at least 0.50 onsite hours to be counted in the evaluation of this measure.

References

QSOG Mission & Priority Document Webpage

Social Security Act Sections 1819(g)(3)(A)(iii) and 1919(g)(2)(A)(iii)

42 CFR §488.308

S8. Frequency of Tier 1 Acute and Continuing Care Recertification Surveys

Exceptions to account for Federal government shutdown

CMS is reducing the FY26 Met and Partially Met thresholds for S8. Refer to the scoring section below and Appendix 7 for details.

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 and 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 COVID-19 public health emergency and the constrained Survey and Certification funding levels. Taking this into consideration, this measure will exclude the intermediate care facilities for individuals with intellectual disabilities statewide average time interval between consecutive recertification health surveys requirement for this fiscal year. Additionally, this measure will only assess if non-deemed hospices and non-deemed home health agencies have had a health recertification survey within 36.9 months of the end of fiscal year and will not evaluate the interval between consecutive recertification surveys for this fiscal year.

Scoring

Met. A State Survey Agency achieves a score of Met if:

(1) 80% (reduced from previous 100% requirement) of active non-deemed home health agencies were surveyed within 36.9 months of the end of the fiscal year,
(2) 80% (reduced from previous 100% requirement) of active hospices were surveyed within 36.9 months of the end of fiscal year, and
(3) 80% (reduced from previous 100% requirement) 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 80% (reduced from previous 100% requirement) and
(2) none of the three Tier 1 survey requirement sub-measures fall below 40% (reduced from previous 50% requirement).

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 no 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 FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

See Appendix 2. Frequency of Tier 1 ACC Recertification Surveys (S8)

References

QSOG Mission & Priority Document Webpage

Home Health Agencies – Social Security Act Section 1891(c)(2)(A); 42 CFR §488.710

Hospices – 42 CFR §488.1110

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

Q2. Assessment of Deficiency Identification using Federal Comparative Surveys

No exception for Federal government shutdown. Available data will be used.

Threshold Criterion

This threshold criterion evaluates the State Survey Agency's identification of onsite findings of noncompliance during nursing home health-recertification and complaint surveys as measured by Federal comparative survey results. For 80 percent or more of the deficiencies cited on the Federal comparative surveys with a scope and severity at potential for more than minimal harm or higher, the State Survey Agency must cite the same findings on its survey at the same or higher scope and severity level.

Scoring

CMS is continuing a hybrid scoring approach that acknowledges State Survey Agencies' efforts to conduct the highest quality surveys possible. A State Survey Agency's final SPSS score will consider both a tag-based score and a survey-level score. Appendix 3 includes details on how CMS will score State Survey Agencies under the tag-based and survey-level methods.

Met. The State Survey Agency achieves a score of Met if:

(1) the tag-based score is 80 percent or higher or
(2) at least 75 percent of all comparative surveys are scored as Met.

Partially Met. The State Survey Agency achieves a score of Partially Met if:

(1) the tag-based score is 60 percent or more, but less than 80 percent, or
(2) 60 percent or more of all comparative surveys are scored as Met or Partially Met.

Not Met. The State Survey Agency achieves a score of Not Met if:

(1) the tag-based score is less than 60 percent and
(2) less than 60 percent of all comparative surveys are scored as Met or Partially Met.

N/A. The State Survey Agency receives a score of N/A if there are no Federal comparative surveys in FY26 or if all Federal comparative surveys are excluded from scoring of the measure in FY26.

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

See Appendix 3: Assessment of Deficiency Identification using Federal Comparative Surveys (Q2)

References

Social Security Act Sections 1819(g)(3)(A) and 1919(g)(3)(A)

42 CFR §488.318

Q3. Nursing Home Tags Downgraded/Removed by IDR or IIDR and Unresolved IDRs/IIDRs

No exception for Federal government shutdown. Available data will be used.

Threshold Criteria

Downgrade or removal of a nursing home tag through IDR or IIDR may indicate a State Survey Agency did not provide sufficient supporting evidence for the scope and severity of a deficiency or the existence of noncompliance. When large proportions of tags reviewed by IDR or IIDR are downgraded or removed, it reflects a survey quality concern State Survey Agencies must address, or it may also indicate a systemic problem with the IDR or IIDR processes. To that end, 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 deficiency tags identified during nursing home health-recertification or complaint surveys. Tags identified during Federal Monitoring Surveys, initial certification surveys, and revisit 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 FY24 and FY26. This measure includes two sub-measures that must be met to meet the overall measure:

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

2. **Percent of Surveys with Unresolved IDRs/IIDRs**. Surveys with unresolved IDRs or IIDRs may not exceed 5% of all surveys conducted with requested IDRs or IIDRs between FY24 and FY26.

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 FY24 and FY26 remain unresolved.

Partially Met. A State Survey Agency achieves a score of Partially Met if:

- The FY25 score was Met; the FY26 first sub-measure value is no greater than 50%; and the FY26 second sub-measure value is no greater than 10%, or
- The FY25 score was Not Met, Partially Met, or N/A; at least one of the FY26 sub-measure values meets the FY26 Met thresholds; and the FY26 first sub-measure value is no greater than 50%; and the FY26 second sub-measure 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 receives a score of N/A on the first sub-measure if it had fewer than five tags reviewed by IDR/IIDR and on the second sub-measure if it had 0 surveys with requested IDRs/IIDRs.*

If a State Survey Agency has an N/A value for either sub-measure, CMS will score this measure using the value of the non-missing sub-measure.

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

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

For the sub-measure Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR, 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 five tags reviewed by IDR or IIDR during the fiscal year, that State will not receive a score for this sub-measure. Tags identified during Federal Monitoring Surveys, initial certification surveys, and revisit surveys are excluded. After applying these evaluation and exclusion criteria, the percentage of nursing home tags downgraded or removed by IDR or IIDR is calculated as follows:

A) Identify the number of tags cited on the CMS-2567 across health-recertification and complaint surveys for which an IDR or IIDR were completed.

B) From (A), count the number of tags cited on the CMS-2567 that were downgraded in scope and severity or removed as a result of an IDR or IIDR.

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

Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR = $(B \div A) \times 100$

For the sub-measure Percent of Surveys with Unresolved IDR/IIDRs, IDRs/IIDRs are considered unresolved when the status is "requested" and there were over 60 days between the IDR/IIDR requested date and the end of FY26. 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 last day of FY26 is less than 60 days by the end of the fiscal year, the survey will be excluded from the calculation. Only surveys with survey exit dates between FY24 and FY26 with requested IDRs or IIDRs will be evaluated. Federal Monitoring Surveys, initial certification surveys, and revisit surveys are excluded. After applying these evaluation and exclusion criteria, the percentage of surveys with unresolved IDRs or IIDRs is calculated as follows:

D) Identify the number of health-recertification and complaint surveys with exit dates between FY24 and FY26 that were submitted for IDR/IIDR review.

E) From (D) identify the number of surveys where the IDR/IIDR status is “requested” and there were over 60 days between the IDR/IIDR requested date and the end of FY26.

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

$$\text{Percent of Surveys with Unresolved IDR/IIDRs} = (E \div D) \times 100$$

Reference

42 CFR §488.331 and §488.431

State Operations Manual Chapter 7, Sections 7212, 7213

Q4. Nursing Home Recertification Survey Composite

No exception for Federal government shutdown. Available data will be used.

Threshold Criteria

CMS is committed to working with State Survey Agencies to ensure nursing home health-recertification surveys are high quality, identify appropriate deficiencies, and that surveyors cite deficiencies at the appropriate scope and severity and complete mandatory and triggered survey tasks. To assess the frequency and type of nursing home deficiencies and the completion of mandatory and triggered tasks on health recertification surveys, this measure combines six sub-measures into one composite score. This composite measure aims to gauge State Survey Agency performance but is not an attempt to establish deficiency or investigation quotas. In addition, lower scores on this composite measure would not necessarily indicate that a State Survey Agency is encountering challenges in its work. The six sub-measures include:

- Number of Deficiencies per 1,000 Beds
- Percentage of Deficiency-Free Surveys
- Percentage of Surveys Identifying G, H, or I Scope and Severity
- Percentage of Surveys Identifying J, K, or L Scope and Severity
- Percentage of Surveys where 1 or more Mandatory Tasks Not Investigated
- Percentage of Surveys where 1 or more Triggered Tasks Not Investigated

Different from other SPSS measures, CMS will assign each State a classification of Requires Research or N/A based on the composite score for this measure rather than a score of Met, Not Met, or Partially Met. CMS will not require States to address this measure in corrective action plans. Instead, after the end of the fiscal year, CMS will require a State classified as Requires Research to review its data and to explore with CMS potential underlying reasons for a lower composite score and, if necessary, strategies to improve its performance on these measures in the future. For example, after conducting research, the State Survey Agency and CMS might identify previously unknown data issues that contributed to a lower than expected score on this composite measure. CMS will require that each State Survey Agency assigned a Requires Research classification discuss its findings with its CMS Location no later than 60 days after the FY26 score is final. State Survey Agencies are not required to examine potential reasons for a lower composite score until after the FY26 score is final. CMS and SAs will work collaboratively to review data and explore reasons for potential low composite scores. Appendix 4 includes some illustrative examples of how State Survey Agencies might examine measures.

Classification

Requires Research. A State Survey Agency achieves a composite score of less than 120 points.

N/A. A State Survey Agency achieves a composite score of 120 points or more.

Evaluation

This measure is a composite score using six different measures. For each of the six measures, CMS will assign full credit, partial credit, or no credit based on each measure's end of FY26 value with scoring thresholds determined in July of the previous fiscal year based on the distribution of each measure across all States and territories.

CMS will use either iQIES or long-term care survey process data (LTCSP) to construct the six measures that make up the composite. CMS will use iQIES data to construct the Number of Deficiencies per 1,000 Beds; the Percentage of Deficiency-Free Surveys; the Percentage of Surveys Identifying G, H, or I Scope and Severity; and the Percentage of Surveys Identifying J, K, or L Scope and Severity. CMS will use LTCSP data to construct the Percentage of Surveys where 1 or more Mandatory Tasks Not Investigated and the Percentage of Surveys where 1 or more Triggered Tasks Not Investigated.

Each measure can account for a maximum of 25 points. To construct the composite score, CMS will sum the number of points assigned to each measure. The following tables summarize how CMS will assign points to each measure based on predetermined thresholds for FY26.

FY26 Percentile (pctl) Thresholds and Scoring for Measures where Higher Values Receive Lower Scores

Measure	Full Credit	Upper Bound	Partial Upper Bound	Lower Bound	Partial Lower Bound
% of Deficiency-Free Surveys	Below 80th pctl [7.0%]	At or above the 90th pctl [9.7%]	Between 80th and 90th pctl [7.0%-9.7%]	Not Applicable	Not Applicable
% of Surveys where 1 + Mandatory Tasks Not Investigated	Below 90th pctl [3.6%]	At or above the 95th pctl [4.8%]	Between 90th and 95th pctl [3.6%-4.8%]	Not Applicable	Not Applicable
% of Surveys where 1 + Triggered Tasks Not Investigated	Below 90th pctl [7.1%]	At or above the 95th pctl [9.7%]	Between 90th and 95th pctl [7.1%-9.7%]	Not Applicable	Not Applicable
Points Earned if value in this portion of distribution	**25**	**0**	**12.5**	**Not Applicable**	**Not Applicable**

Note: To qualify for the Full Credit, Partial Lower Bound, and Partial Upper Bound zone, a State Survey Agency must have a measure value that is higher than the lower end of the threshold and lower than the upper end of the threshold. For example, for the measure "% of Deficiency-Free Surveys," a State Survey Agency with a value of 9.1% qualifies for the Partial Upper Bound zone because 9.1% is larger than the lower end (7.0%) and smaller than the upper end (9.7%).

FY26 Percentile (pctl) Thresholds and Scoring for Measures where Lower Values Receive Lower Scores

Measure	Full Credit	Lower Bound	Partial Lower Bound	Upper Bound	Partial Upper Bound
Number of Deficiencies per 1,000 Beds	Between 20th and 90th pctl [51.4-130.6]	At or below the 10th pctl [48.2]	Between 10th and 20th pctl [48.2-51.4]	At or above the 95th pctl [152.5]	Between 90th and 95th pctl [130.6-152.5]

Measure	Full Credit	Lower Bound	Partial Lower Bound	Upper Bound	Partial Upper Bound
% of Surveys Identifying G, H or I Scope and Severity	Between 20th and 90th pctl [5.1%-23.7%]	At or below the 10th pctl [3.0%]	Between 10th and 20th pctl [3.0%-5.1%]	At or above the 95th pctl [25.9%]	Between 90th and 95th pctl [23.7%-25.9%]
% of Surveys Identifying J, K or L Scope and Severity	Between 20th and 90th pctl [2.2%-12.3%]	At or below the 10th pctl [1.7%]	Between 10th and 20th pctl [1.7%-2.2%]	At or above the 95th pctl [17.7%]	Between 90th and 95th pctl [12.3%-17.7%]
Points Earned if value in this portion of distribution	**25**	**0**	**12.5**	**20**	**22.5**

Note: To qualify for the Full Credit, Partial Lower Bound, and Partial Upper Bound zone, a State Survey Agency must have a measure value that is higher than the lower end of the threshold and lower than the upper end of the threshold. For example, for the measure "Number of Deficiencies per 1,000 Beds," a State Survey Agency with a value of 55.4 qualifies for the Full Credit zone because 55.4 is larger than the lower end (51.4) and smaller than the upper end (130.6).

States that conduct fewer than 20 nursing home recertification surveys in FY26 will earn 12.5 points for a given measure when they otherwise would have earned zero points. This adjustment ensures fairness for States with small numbers of nursing homes.

The following table provides two example scenarios for this composite measure.

Example Scenarios

Measure	Example Scenario 1 Measure Value	Example Scenario 1 Points Earned	Example Scenario 2 Measure Value	Example Scenario 2 Points Earned
# of Deficiencies / 1,000 Beds	48.6	12.5	60.1	25
% of Deficiency-Free Surveys	8.9%	12.5	5.5%	25
% of Surveys Identifying G, H, or I Scope and Severity	11.1%	25	7.5%	25
% of Surveys Identifying J, K, or L Scope and Severity	9.5%	25	6.2%	25
% of Surveys where 1 or more Mandatory Tasks Not Investigated	1.1%	25	1.2%	25
% of Surveys where 1 or more Triggered Tasks Not Investigated	9.3%	12.5	2.0%	25
Total Points Earned		112.5		150
Research Required?		Yes		No

See Appendix 4: Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated (Q4) for additional measure details.

Reference

LTCSP Procedure Guide

N1. Onsite Revisit Timeliness

Exceptions to account for Federal government shutdown

Originating nursing home health-surveys with an exit date during the shutdown citing deficiencies at scope and severity of F with substandard quality of care, and no deficiencies cited at scope and severity G or higher, will be excluded from the measure evaluation.

Originating home health agency surveys with an exit date during the shutdown citing condition-level deficiencies without immediate jeopardy will be excluded from the measure evaluation.

Threshold Criterion

This performance measure evaluates whether a State Survey Agency conducted timely onsite revisits for the following non-deemed providers: home health agencies, hospices, intermediate care facilities for individuals with intellectual disabilities, and nursing homes. For nursing homes, onsite revisits should be conducted no more than 60 calendar days after the survey exit date for those surveys citing deficiencies at scope and severity of F with substandard quality of care[4] or higher. For non-deemed acute and continuing providers, onsite revisits should be conducted no more than 45 calendar days after the survey exit date for those surveys citing condition-level deficiencies.[5] 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 health surveys only.

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 onsite 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 is met:

- The FY25 score was Met and the FY26 measure value is 65% or greater.
- The FY25 score was Partially Met or Not Met; the FY26 measure value is at least 2 percentage points greater than in FY25; and the FY26 measure value is 60% or greater.
- The FY25 measure value was N/A and the FY26 measure value is 60% or greater.
- The FY26 value is no less than 50% but 80% or more of the State Survey Agency's late revisit surveys were late by 3 or fewer calendar days.

[4] The following nursing home tags indicate substandard quality of care if the tag is cited at scope and severity of F: 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.

[5] Note that facilities with unremoved IJ deficiencies are placed on a 23-calendar day termination track, per State Operations Manual Chapter 3 section 3010B.

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 five surveys requiring an onsite revisit in FY26.*

A corrective action plan must be submitted if the FY26 score is Not Met or both the FY25 and FY26 scores were Partially Met.

Evaluation

CMS will construct this measure using data available from QIES and iQIES data. For nursing homes, the count of onsite revisit surveys occurring within 60 calendar days of survey exit will be divided by the count of recertification and complaint surveys with citations at scope and severity of 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 calendar days of survey exit for non-deemed providers will be divided by the count of recertification and complaint surveys of non-deemed acute and continuing care providers requiring onsite revisit due to condition-level noncompliance.

See Appendix 5. Timeliness of Revisits (N1) for additional measure details.

Reference

State Operations Manual Chapter 3, Section 3012

State Operations Manual Chapter 5, Sections 5110.3-5110.4

State Operations Manual Chapter 7, Section 7317.2

Appendix 1. Nursing Home Special Focus Facilities (S1)

Exceptions to account for Federal government shutdown

State Agencies will have until March 31, 2026 to survey Special Focus Facilities that were due to be surveyed during the first quarter of FY26 (October 1, 2025 – December 31, 2025).

CMS will not evaluate the 21-calendar day replacement timeframe for Special Focus Facilities that were eligible to graduate between September 15, 2025 and November 15, 2025.

Data Source(s)

S&C 17-20-NH, Current SFF facilities lists, and iQIES.

Method of Calculation

An active SFF must have one standard health-recertification survey at least every 186 calendar days, starting at the time of selection into the SFF program. Once a facility has been selected, the State Survey Agency must conduct a standard recertification survey within 186 calendar days of the selection date but with an interval of no more than 15.9 months from the last standard recertification survey exit date conducted before being selected as an SFF. Following the first standard recertification survey as an SFF, there can be no more than 186 calendar days between the standard recertification survey exit date (this does not include the survey exit date of any associated revisits) and the next standard recertification start date. For example, if the last recertification survey's exit date is October 20, 2025, then the next recertification survey's start date may be no later than April 24, 2026. A reasonable degree of unpredictability in these surveys must be maintained.

For the purposes of the State Performance Standards, State Survey Agencies must conduct one standard recertification survey at least every 186 calendar days per 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-NH. For example, if a State Survey Agency has five SFF slots, it must complete ten standard recertification surveys for its SFFs during the fiscal year with each facility being surveyed at least once every 186 calendar days. Similarly, if a State Survey Agency has one SFF slot, that State would complete two standard recertification surveys conducted on that SFF in a given fiscal year, with each survey conducted at least once every 186 calendar days.

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 calendar days 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 graduation letter the State Survey Agency sent to the removed SFF. CMS expects State Survey Agencies to send graduation letters as soon as possible but no later than five business days after the SFF has returned to substantial compliance, meets graduation criteria, and the State Survey Agency receives the CMS Location's approval for the SFF graduation.*

For example, if facility A graduates on March 1st and is replaced on March 19th by facility B, whose last standard survey exit date was January 10th, then a standard survey should begin at facility B no later

than September 21st to meet both requirements of the SFF program including (1) a standard recertification health survey must be conducted within 186 calendar days of the selection date and (2) there can be an interval of no more than 15.9 months from the last standard recertification survey exit date conducted before being selected as an SFF. In this example, a SFF selection was made within 21 days of the graduation of the previous SFF. The recertification survey was started within 186 calendar days of the selection date, and the interval between the last standard recertification survey exit date conducted before being selected as an SFF and the first standard recertification survey as an SFF was less than 15.9 months. 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 standard survey in this example was not started until September 22nd or later, it would not meet the SPSS measure because the survey did not start within 186 calendar days of selection to the SFF slot.

Appendix 2. Frequency of Tier 1 Acute and Continuing Care (ACC) Recertification Surveys (S8)

Exceptions to account for Federal government shutdown

CMS is reducing the FY26 Met and Partially Met thresholds for S8. Refer to the scoring section and Appendix 7 for details.

Data Source(s)

QIES and iQIES

Method of Calculation

This measure includes three sub-measures. The first sub-measure assesses the percentage of active, non-deemed home health agencies that have been surveyed within the required time period and is calculated as follows:

A) Identify the number of non-deemed 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 36.9-month 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 the 36.9 months prior to the end of the fiscal year.

C) Divide B by A and express as a percentage.

$$\% \text{ Recertified within the maximum time interval} = (B \div A) \times 100$$

The second sub-measure assesses the percentage of active, non-deemed hospices that have been surveyed within the required time period and is calculated as follows:

D) Identify the number of non-deemed 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.

E) From the active hospices identified in (D), identify the number that were surveyed within the 36.9 months prior to the end of the fiscal year.

F) Divide E by D and express as a percentage.

$$\% \text{ Recertified within the maximum time interval} = (E \div D) \times 100$$

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

G) Identify the number of ICFs/IID 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 ICFs/IID 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.

H) From the active ICFs/IID identified in (G), identify the number of ICFs/IID that were surveyed within the 15.9months prior to the end of the fiscal year.

I) From the ICFs/IID identified in (H), identify the number of ICFs/IID where the time between the most recent survey and the previous survey is greater than 15.9 months.

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

$$\% \text{ Recertified within the maximum time interval} = [\ (H - I) \div G\ ] \times 100$$

Note: Recertification surveys must have at least 0.50 onsite hours to be counted in the evaluation of each sub-measure.

Appendix 3: Assessment of Deficiency Identification using Federal Comparative Surveys (Q2)

No exception for Federal government shutdown. Available data will be used.

Data Source(s)

Federal Comparative Survey Data

Method of Calculation

The Federal Comparative Survey report identifies deficiencies cited on comparative health surveys that CMS Locations conducted, whether State Survey Agencies identified the same or similar citations, at what scope and severity 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 State Survey Agency, CMS will construct an overall deficiency tag-based score and a separate score for each comparative survey. Scores on individual comparative surveys determine each State Survey Agency's overall survey-level score. The final FY26 SPSS score considers both the overall tag-based score and overall survey-level score. Each of these scores will consider only nursing home F-tags of severity level 2 and above cited by the CMS Location uniquely or nursing home F-tags cited by both the State Survey Agency and CMS Locations. The tags cited uniquely by CMS Locations that are indicated as "Should Have Found = Yes" will be included in the analysis; any deficiencies cited uniquely by CMS Locations indicated otherwise are excluded. Any tags cited uniquely by State Survey Agencies are not considered in these scores.

Tag-Based Calculation

For each tag cited at scope and severity 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, CMS will use the Citation Accuracy Chart to determine how many points are assigned to the numerator and denominator of the State Survey Agency FY26 measure. If a tag identified during a Federal comparative survey is changed or downgraded through either the informal dispute resolution and/or independent informal dispute resolution processes, the revised tag and scope and severity will be used. If a tag cited during a Federal Comparative Survey is removed through the informal dispute resolution and/or independent informal dispute resolution processes, 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.

Citation Accuracy Chart

CMS Location, Federal Comparative Survey Tag	Denominator Points	Numerator Points State Survey Agency cites similar tag at same or higher S/S	Numerator Points State Survey Agency cites similar tag at lower S/S	Numerator Points State Survey Agency does not cite similar tag SHF=yes
Immediate Jeopardy (J, K, or L tags)	3	3	1.5	0
Actual Harm (G, H, or I tags)	2	2	1	0
No Actual Harm with Potential for More Than Minimal Harm (D, E, or F tags)	1	1	0.5	0

Note: SHF = "Should have found;" S/S = scope and severity

After CMS determines all points for the numerator and denominator, all numerator points are summed, and all denominator points are summed. The overall tag-based score is calculated by dividing the total denominator points into the total numerator points.

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

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

Federal Comparative Survey Tag-Based Score = (Numerator ÷ Denominator) × 100

Survey-Level Calculation

The survey-level calculation uses the same approach to assigning points to tags as the tag-based method. The primary difference between the two methods is that each State Survey Agency receives a score of Met, Partially Met, or Not Met for each comparative survey. CMS will use the Citation Accuracy Chart to determine a tag-based score for each comparative survey, identifying total numerator and total denominator points for that survey alone. Individual survey level scores may only supplement the final score for a State Survey Agency and do not make up the primary component of this measure.

The survey-level score includes two components when at least one tag is evaluated for a survey:

(1) the value of the numerator points divided by denominator points (i.e., a tag-based score) and
(2) whether or not the CMS Location determined the SA missed an Immediate Jeopardy deficiency either by under citation of a tag cited by both the State Survey Agency and the CMS Location or if the CMS Location determined that the State Survey Agency should have found an Immediate Jeopardy deficiency uniquely cited by the CMS Location.

The State Survey Agency achieves a score of Met on a survey if:

(1) the tag-based score for that survey is 80 percent or higher and the CMS Location did not determine that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey or
(2) the CMS Location and State Survey Agency did not cite any deficiencies on that survey or

(3) all deficiencies cited by the CMS Location on that survey qualified for exclusion from the measure calculation and the State Survey Agency did not uniquely cite any deficiencies on that survey

The State Survey Agency achieves a score of Partially Met on a survey if:

(1) the tag-based score for that survey is 60 percent or more but less than 80 percent and
(2) the CMS Location did not determine that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey.

The State Survey Agency achieves a score of Not Met on a survey if:

(1) the tag-based score for that survey is less than 60 percent or
(2) the CMS Location determines that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey.

Exclusions from both the Tag-Based and Survey Level Calculations

The following circumstances are excluded from the numerator and denominator for both the deficiency tag-based and survey-level calculations and, thus, excluded from scoring for this measure:

- 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 scope and severity than that of the CMS Location and the CMS Location was unable to determine if the State Survey Agency understated the scope and severity (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 scope and severity than that of the CMS Location and the CMS Location did not indicate if the State Survey Agency understated the scope and severity (UnderStatement=missing)
- Tags cited uniquely by State Survey Agencies

Appendix 4. Nursing Home Recertification Survey Composite (Q4)

No exception for Federal government shutdown. Available data will be used.

Data Source(s)

iQIES and LTCSP

Method of Calculation

CMS will calculate all six measures that make up this composite measure for all active nursing homes during FY26. Active nursing homes either have no termination date or a termination date after the end of the fiscal year. The following details how CMS will construct each measure.

Number of Deficiencies per 1,000 Beds

This measure consists of a numerator (A) and a denominator (B).

A) The numerator is the count of deficiencies identified during all recertification surveys at active nursing homes with an exit date during FY26.

B) The denominator is the count of beds at active nursing homes with a recertification survey exit date during FY26.

$$\text{Number of Deficiencies per 1,000 Beds} = (A \div B) \times 1{,}000$$

The next four measures all use the same denominator:

C) All recertification surveys completed at active nursing homes with an exit date during FY26

Percentage of Deficiency-Free Surveys

This measure consists of a numerator (D) and a denominator (C).

D) The numerator is the count of deficiency-free recertification surveys at active nursing homes with an exit date during FY26.

$$\text{Percentage of Deficiency-Free Surveys} = (D \div C) \times 100$$

% of Surveys Identifying G, H or I Scope and Severity

This measure consists of a numerator (E) and a denominator (C).

E) The numerator is the count of recertification surveys at active nursing homes with an exit date in FY26 that cited one or more deficiencies with a scope and severity score of G, H, or I.

$$\text{\% of Surveys Identifying G, H or I Scope and Severity} = (E \div C) \times 10$$

% of Surveys Identifying J, K or L Scope and Severity

This measure consists of a numerator (F) and a denominator (C).

F) The numerator is the count of recertification surveys at active nursing homes with an exit date in FY26 that cited one or more deficiencies with a scope and severity score of J, K, or L.

% of Surveys Identifying J, K or L Scope and Severity = (F÷C) x 100

% of Surveys where 1 or more Mandatory Tasks Not Investigated

This measure consists of a numerator (G) and a denominator (C).[7]

G) The numerator is the count of recertification surveys at active nursing homes with an exit date during FY26 on which one or more Mandatory Tasks was not investigated.

% of Surveys where 1 or more Mandatory Tasks Not Investigated = (G÷C) x 100

Percent of Surveys where 1 or more Triggered Tasks Not Investigated

This measure consists of a numerator (H) and a denominator (I).

H) The numerator is the count of recertification surveys at active nursing homes with an exit date during FY26 on which one or more tasks that triggered (other than Resident Assessment) were not investigated.
I) The denominator is all recertification surveys with triggered tasks at active nursing homes with an exit date during FY26.

% of Surveys where 1 or more Triggered Tasks Not Investigated = (H÷I) x 100

Illustrative Examples of Analyses State Survey Agencies Might Conduct

State Survey Agencies classified as Requires Research at the end of the fiscal year may examine several different types of data or conduct different types of analyses to satisfy the requirement of examining their outcomes in advance of a meeting with their CMS Location. While not prescriptive, the following are some examples of the types of analyses that State Survey Agencies might consider:

- To examine a high value for the percentage of surveys that were deficiency-free, a State Survey Agency may consider examining if: facilities without deficiencies are located in similar geographic proximity to each other; surveyors on these survey teams are newer to their Agency; facilities without deficiencies cited also had no deficiencies in previous years or were highly rated on Nursing Home Care Compare; or survey teams at these facilities completed an anticipated number of mandatory and triggered tasks during the surveys, among other potential analyses.
- To study a high value for the percentage of surveys where one or more mandatory task was not investigated, a State Survey Agency may consider examining if: surveyors missed many

[7] Three mandatory tasks: Resident Council Meeting, Dining Observation, and Medication Storage, are eligible for temporary discretion or triggered and excluded from this measure. See QSO-22-02-ALL.

or just a few mandatory tasks across surveys in question; the types of mandatory tasks missed were similar or varied across surveys; surveyors require additional training on the long term care survey process and the need for examining mandatory tasks; or surveys with one or more missed mandatory tasks were located in a specific area of the State or conducted by a subset of survey teams, among other potential analyses. The State Survey Agency may also consider situations where surveyors might have bundled mandatory tasks and cited them on a CMS-2567 but did not clear them in the LTCSP software as being conducted.

- To investigate a low value for the percentage of surveys with at least one J, K, or L deficiency, a State Survey Agency may consider examining if: there were G, H, or I deficiencies that might have been considered higher severity; a large proportion of previous J, K, or L deficiencies were removed after the informal dispute resolution (IDR) process or independent IDR process; or the level of J, K, or L deficiencies has changed over time, among other potential analyses.

Appendix 5. Onsite Revisit Timeliness (N1)

Exceptions to account for Federal government shutdown

Originating nursing home health-surveys with an exit date during the shutdown citing deficiencies at scope and severity of F with substandard quality of care, and no deficiencies cited at scope and severity G or higher, will be excluded from the measure evaluation.

Originating home health agency surveys with an exit date during the shutdown citing condition-level deficiencies without immediate jeopardy will be excluded from the measure evaluation.

Data Source(s)

QIES and iQIES

Method of Calculation

Nursing Homes

The count of surveys requiring onsite revisits is the number of all originating health surveys with survey exit dates within the fiscal year that resulted in a citation at scope and severity of F with substandard quality of care or higher.[8] From this set of health surveys, surveys that meet any of the following conditions are excluded:

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

After survey exclusions are made, this measure consists of a denominator (A) and a numerator (B).

A) Identify the count of surveys requiring onsite revisits
B) From (A), count the number of surveys with an onsite revisit and a revisit start date within 60 calendar days of the originating survey exit date. To be considered onsite, the revisit survey must have at least 0.50 onsite hours.

[8] The following nursing home tags indicate substandard quality of care if the tag is cited at scope and severity of F : 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.

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

$$\text{Percentage of revisits that occurred within 60 calendar days} = (B \div A) \times 100$$

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 onsite revisits within the 60-calendar-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 calendar days. Survey 3 was excluded because a revisit has not been conducted. Eight revisits divided by ten originating surveys results in 80% of timely revisits.

Nursing Home Table Example

Survey	Originating Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2026	3/15/2026	31
2	4/2/2026	7/3/2026	92
3	3/19/2026	.	.
4	11/5/2025	12/17/2025	42
5	7/22/2026	9/1/2026	41
6	9/25/2026	11/16/2026	52
7	1/12/2026	2/1/2026	20
8	5/28/2026	6/4/2026	7
9	2/14/2026	4/7/2026	52
10	10/2/2025	11/2/2025	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 five surveys in the denominator are excluded from this measure.

Acute and Continuing Care Providers

The count of surveys requiring onsite revisit is the number of all originating health surveys of non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities with survey exit dates within the fiscal year that resulted in a condition-level citation. From this set of health surveys, surveys that meet any of the following conditions are excluded:

- Originating home health agency surveys with an exit date during the shutdown citing condition-level deficiencies without immediate jeopardy

This measure consists of a denominator (A) and a numerator (B).

A) Identify the count of surveys requiring onsite revisits among non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities
B) From (A), count the number of surveys with an onsite revisit and a revisit start date within 45 calendar days of the originating survey exit date. To be considered onsite, the revisit survey must have at least 0.50 onsite hours.
C) Divide the count in (B) by the count in (A) and express this as a percentage.

$$\text{Percentage of revisits that occurred within 45 calendar days} = (B \div A) \times 100$$

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 onsite revisits within 45 calendar days of the survey

exit date and are included in the numerator. Surveys 2, 6, and 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 calendar days. Survey 3 was excluded because a revisit has not been conducted. Six revisits divided by ten originating surveys results in 60% of timely revisits.

ACC Table Example

Survey	Originating Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2026	3/15/2026	31
2	4/2/2026	7/3/2026	92
3	3/19/2026	.	.
4	11/5/2025	12/17/2025	42
5	7/22/2026	9/1/2026	41
6	9/25/2026	11/16/2026	52
7	1/12/2026	2/1/2026	20
8	5/28/2026	6/4/2026	7
9	2/14/2026	4/7/2026	52
10	10/2/2025	11/2/2025	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 five surveys in the denominator are excluded from this measure.

Appendix 6. SPSS Measure Data Sources, Specifications, and Reports for Measure Monitoring

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S1. Nursing Home Special Focus Facilities (SFF)	S&C 17-20-NH, Current SFF facilities lists, and iQIES	**Special Focus Facilities surveyed every 186 calendar days 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 186 calendar days elapsed between the survey exit date of each standard survey and the start date of the following standard survey that occurred within the fiscal year, and b. no more than 186 calendar days elapsed between the start date of the first standard survey that occurred within the fiscal year and survey exit date of the previous standard survey, and c. no more than 186 calendar days elapsed between the last standard survey exit date 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 the date of the letter the State Survey Agency sent to the graduating SFF notifying it of its removal from the SFF program, or the termination effective date.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S4. EMTALA complaints prioritized as IJ and Non-IJ High with survey started timely	QIES – ACTS	Both sub-measures exclude pregnancy-related EMTALA complaints. Beginning FY26, the CMS extension date field in ACTS for EMTALA surveys will no longer be factored into the calculation for this measure.* **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. Exclude any intakes where an associated EMTALA allegation was pregnancy-related including allegations indicated as a "labor emergency" or "other obstetric emergency." This is the 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. Exclude any intakes where an associated EMTALA allegation was pregnancy-related including allegations indicated as a "labor emergency" or "other obstetric emergency." This is the 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 3. CASPER 0625D—EMTALA Timeliness

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S5. Intakes prioritized as IJ with survey started timely	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 survey start date. If the nursing home complaint or facility-reported incident is initially received after 5:00pm local time or on a weekend or Federal holiday, then the received start date is considered the next business day. 3. From the intakes identified in Step 1, identify the number of facility-reported incidents that were started within the required number of days. a. Facility reported incidents with inadequate resident protection are required to be started within three business days of received start date. b. Facility reported incidents with adequate resident protection are required to be started within seven business days of received start date. 4. Sum the number of complaints and facility-reported incidents identified in Step 3 (numerator). 5. Divide the numerator identified in Step 4 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 survey start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within two business days (numerator).	1. ACTS Reports – Non-Deemed Provider – Immediate Jeopardy Federal Complaints Investigation Timeframe 2. iQIES ACC Dashboard->Intakes Tab->Detailed Complaint/Incident Data Table

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S5. Intakes prioritized as IJ with survey started timely (continued)	iQIES and QIES (continued)	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 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 survey 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.	

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S6. Nursing Home Off-Hour Surveys	CMS provided monthly provider rating lists and iQIES	**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 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 surveys conducted during off-hours. **Percent of off-hour 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 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 off-hour surveys started during weekends. It is possible for this percentage to be greater than 100%. **Percent of off-hour weekend surveys conducted among facilities with potential staffing issues 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 5% (denominator). 3. From surveys identified in Step 2, identify the surveys conducted among facilities with potential staffing issues. A facility can be included in this count if it 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). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of off-hour weekend surveys conducted among facilities with potential staffing issues.	1. iQIES NH Dashboard->Surveys Tab->Calculated Statistic: % Off-Hour Surveys per Applied Filters

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S7. Frequency of Nursing Home Recertification Surveys	iQIES	1. Identify all active nursing homes. Active nursing homes are those with an original participation date before June 1, 2025 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, Department of Defense (military,) or Veterans Administration 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 with completed recertifications surveys 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 recertification survey and the previous recertification 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. iQIES NH Dashboard->Recertifications Tab->Certifications Due by Facility Report

S8. 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, which are those that have a deeming status of either missing or non-deemed, have an original participation date before September 1, 2023, 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. Divide the numerator identified in Step 2 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 within 36.9 months. **Hospice Recertification Survey sub-measure:** 1. Identify active non-deemed hospice providers, which are those that have a deeming status of either missing or non-deemed, have an original participation date before September 1, 2023, and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the active non-deemed hospice providers 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. Divide the numerator identified in Step 2 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active non-deemed hospice providers that have had a recertification survey within 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, which are those that have an original participation date before June 1, 2025 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.	1. CASPER Reports - 0822D - ICF/IID Providers Not Surveyed 2. CASPER Reports - 0842D - Providers Not Surveyed 3. ACO Reports - Months Since Last Certification 4. iQIES ACC Dashboard->Provider Last Completed Survey Tab->Active Non-Deemed Providers by State and Years Since Last Completed Survey Details

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S8. Frequency of Tier 1 Acute and Continuing Care Recertification Surveys (continued)	iQIES and QIES (continued)	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.	
Q2. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys	Federal Comparative Survey Data	1. Identify all nursing home F-tags eligible for this measure from comparative survey data. 2. Construct a State-level tag-based score using the scoring rubric identified in the Citation Accuracy Chart in Appendix 3. 3. Construct a survey-level tag-based score using the scoring rubric identified in the Citation Accuracy Chart. 4. Assign a score of Met, Partially Met, or Not Met for each comparative survey using the instructions in Appendix 3. 5. Assign a score of Met, Partially Met, or Not Met at the State Survey Agency level for FY26 using the scoring rules on page 19 under the description of measure Q2.	Federal Comparative Survey State Agency Reports

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
Q3. Nursing Home Tags Downgraded/Removed by IDR or IIDR and Unresolved IDRs/IIDRs	iQIES	**Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR sub-measure:** 1. Identify all citation tags from nursing home health-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 Federal Monitoring Surveys, initial certification surveys, or revisit surveys. 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 health-recertification and complaint surveys with survey exit dates in FY24 through FY26 that were submitted for IDR/IIDR review. Exclude any survey where the IDR/IIDR request was rescinded. Exclude any Federal Monitoring Surveys, initial certification surveys, or revisit surveys. Exclude any survey where the IDR/IIDR requested date was within 60-days of the end of FY26 (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.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
Q4. Nursing Home Recertification Survey Composite	iQIES and LTCSP	1. Calculate the number of recertification survey deficiencies per 1,000 beds among nursing homes with a recertification survey exit date during FY26. 2. Calculate the percentage of deficiency free nursing home recertification surveys in FY26. 3. Calculate the percentage of nursing home recertification surveys identifying G, H, or I scope and severity in FY26. 4. Calculate the percentage of nursing home recertification surveys identifying J, K, or L scope and severity in FY26. 5. Calculate the percentage of nursing home recertification surveys on which one or more Mandatory Tasks was not investigated in FY26. 6. Calculate the percentage of nursing home recertification surveys on which one or more Triggered Tasks (other than Resident Assessment) was not investigated in FY26. 7. From the values calculated in steps 1-6, identify the associated number of points for each measure using the tables on pages 23 and 24 under the description of measure Q4. 8. Add the number of points identified in step 7.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
N1. Onsite Revisit Timeliness	iQIES and QIES	**Nursing Home Timeliness of Onsite Revisits measure:** 1. Identify all nursing home originating health-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 originating survey identified citations at scope and severity of F 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 scope and severity of F 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 calendar days of the survey exit date, or c. all citations at scope and severity of F with substandard quality of care or higher were past noncompliance, or d. the survey exit date is less than 60 calendar 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). 4. From the surveys identified in Step 3, identify those surveys that had a revisit with a start date within 60 calendar days of the survey exit of the originating 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.	1. ACO – Tracking – Overdue Revisits (for ICF-IIDs) No reports available for NHs, HHAs, or Hospices

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
N1. Onsite Revisit Timeliness (continued)	iQIES and QIES (continued)	**Acute and Continuing Care Timeliness of Onsite Revisits measure:** 1. Identify all non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities originating 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 originating survey identified condition-level citations (denominator). 3. From surveys identified in Step 2, identify the surveys that had a revisit start date within 45 calendar days of the originating 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.	

Appendix 7. SPSS Measure Exceptions to Account for Federal Government Shutdown

The table below describes the impacts of the government shutdown on each FY26 SPSS measure and the CMS-approved exceptions to mitigate those impacts. Adjustments are not necessary for all measures.

Measure Code	FY26 Measure	Shutdown Impact	SPSS Exceptions
S1a	NH SFFs Sub-Measure 1: Standard Surveys	Recertification surveys paused during shutdown	For SFFs due to be surveyed October 1-December 31, 2025 (first quarter), CMS extends the survey due date to March 31, 2026. The 186-day survey interval will reset on the date the SA completes the survey (not March 31).
S1b	NH SFFs Sub-Measure 2: Replacement Selection Timeframe	Graduations paused during shutdown	CMS will exclude SFFs that were eligible for graduation September 15-November 15, 2025 and will not evaluate the 21-calendar day replacement timeframe. *Note*: SPSS would not begin measuring the 186-day survey interval for replacement SFFs until the date of selection.
S4	EMTALA complaints prioritized as IJ and Non-IJ High with surveys started timely (ACC – Hospitals)	Complaints prioritized as IJ or NIJH continued to be investigated during shutdown CMS approval not required to start these surveys during the shutdown	For EMTALA complaints prioritized as IJ or non-IJ high received October 1-November 12, 2025, the survey must be started within 2 business days (for IJ EMTALA complaints) or 45 calendar days (for non-IJ high EMTALA complaints) of the i**ntake received end date** (rather than CMS RO approval date).
S5	Intakes prioritized as IJ with surveys started timely (NH and ACC)	Complaints and FRIs prioritized as IJ continued to be investigated during the shutdown CMS approval was not required to start surveys for deemed ACC providers in ASPEN but was required for deemed ACC providers in iQIES	For deemed ACC intakes prioritized as IJ received October 1-November 12, 2025, the survey must be started within 2 business days of the **intake received end date for providers in ASPEN** (rather than CMS RO approval date). Deemed ACC intakes for providers in iQIES will, as usual, be evaluated for timeliness of survey start using the CMS RO approval date.

Measure Code	FY26 Measure	Shutdown Impact	SPSS Exceptions
S6a	NH Off-Hour Surveys Sub-Measure 1: Total Requirement	Recertification surveys paused during shutdown	CMS will reduce Met and Partially Met thresholds for all sub-measures under this measure: • Met score: At least 8% of NH recertification surveys must begin during off-hours (reduced from previous 10% requirement) • Partially Met score: At least 6% of NH recertification surveys must begin during off-hours (reduced from previous 8% requirement)
S6b	NH Off-Hour Surveys Sub-Measure 2: Weekend Requirement	Recertification surveys paused during shutdown	• Met score: At least 40% of the required number of off-hours surveys must begin on weekends (reduced from previous 50% requirement) • Partially Met score: At least 30% of the required number of off-hours surveys must begin on weekends (reduced from previous 40% requirement)
S6c	NH Off-Hour Surveys Sub-Measure 3: Potential Staffing Issues Weekend Requirement	Recertification surveys paused during shutdown	• Met score: At least 65% of the required number of weekend surveys must be conducted among facilities with potential staffing issues (reduced from previous 80% requirement) • Partially Met score: At least 55% of the required number of weekend surveys must be conducted among facilities with potential staffing issues (reduced from previous 70% requirement)

S7	Frequency of NH Recertification Surveys	Recertification surveys paused during shutdown	CMS will reduce Met and Partially Met thresholds for this measure:
			• Met score: 80% of all active nursing homes are surveyed at least every 15.9 months (reduced from previous 100% requirement)
			• Partially Met score: if one of the following conditions are met:
			  ○ At least 55% of all active nursing home were surveyed at least every 15.9 months (reduced from previous 70% requirement)
			  ○ The FY26 measure value is 10 percentage points greater than the FY25 measure value, and the FY26 measure value is at least 40% (reduced from previous 50% requirement)

Measure Code	FY26 Measure	Shutdown Impact	SPSS Exceptions
S8	Frequency of Tier 1 ACC Recertification Surveys	ICF-IID surveys continued as usual (Medicaid-only facilities) Hospice surveys continued as usual (SAs received CAA funds) HHA surveys paused during shutdown	CMS will reduce Met and Partially Met thresholds for this measure: • Met score if: ○ 80% of active non-deemed HHAs were surveyed within 36.9 months of the end of the fiscal year (reduced from previous 100% requirement); ○ 80% of active non-deemed hospices were surveyed within 36.9 months of the end of fiscal year, and (reduced from previous 100% requirement); and ○ 80% of active ICFs/IID were surveyed at least every 15.9 months (reduced from previous 100% requirement) • Partially Met score if: ○ Any of the three Tier 1 survey requirements sub-measures fall below 80% (reduced from previous 100% requirement) and ○ none of the three Tier 1 survey requirement sub-measures fall below 40% (reduced from previous 50% requirement)
Q2	Assessment of Deficiency Identification using Federal Health Comparative Surveys (NH)	Comparative surveys not conducted during shutdown	None: available data will be used for FY26.
Q3a	NH IDRs/IIDRs Sub-Measure 1: Nursing Home Tags Downgraded/Removed by IDR or IIDR	Not conducted unless there would be an immediate adverse action	None: available data will be used for FY26.
Q3b	NH IDRs/IIDRs Sub-Measure 2: Unresolved IDRs/IIDRs		None: unresolved IDRs/IIDRs are still expected to be completed by the end of FY26.
Q4	NH Recertification Survey Composite	Recertification surveys paused during shutdown	None: available data will be used for FY26.

Measure Code	FY26 Measure	Shutdown Impact	SPSS Exceptions
N1	Onsite Revisit Timeliness (NH and ACC)	The only authorized and excepted revisits are those necessary to: (1) ensure that IJ or actual patient/resident harm has been addressed; (2) to prevent termination of Medicare participation within 45 days of the termination date; or (3) prevent mandatory denial of payment for new admissions within 15 days of imposition.	CMS will exclude NH surveys conducted during the shutdown that cited s/s of F-SQC (and nothing higher) from the denominator. CMS will evaluate revisit timeliness for NH surveys citing s/s of G or higher S/S as normal. For non-deemed HHAs, CMS will only evaluate revisit timeliness for surveys identifying Condition-level deficiencies **and** IJ during the shutdown. CMS will evaluate revisit timeliness for ICF-IIDs and hospices as normal.