DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality

Admin Info: 23-12-ALL

DATE: August 11, 2023

TO: State Survey Agency Directors

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

SUBJECT: ***REVISED***: Fiscal Year (FY) 2023 State Performance Standards System (SPSS) Guidance

Memo Revision Information:
Revisions to: *Admin Info: 22-08-ALL* ***Original release date:*** *September 20, 2022*

Memorandum Summary

- CMS is releasing revisions to the process used to oversee State Survey Agency performance for ensuring Medicare/Medicaid certified providers and suppliers are compliant with federal requirements to improve and protect the health and safety of Americans.

Background:
Every year, CMS conducts a formal assessment of each State Survey Agencies' performance relative to measures included in the SPSS program. CMS works with the State Survey Agencies to strengthen oversight so that the care provided in nursing homes and other acute and continuing care providers and suppliers is of the highest quality. *The FY 2023 SPSS guidance has been revised to include updates to the scoring approach and additional technical detail.*

The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve the health and safety of Americans such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents. The three domains of the SPSS for the 2023 fiscal year include:

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

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

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

Effective Date:
Immediately. Please communicate to all appropriate staff within 30 days.

/s/

Karen L. Tritz Director, Survey & Operations Group	David R. Wright Director, Quality, Safety & Oversight Group

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

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

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

Fiscal Year 2023

State Performance Standards

System Guidance

September 9, 2022

Revised July 2023

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Introduction

CMS actively evaluates the State Performance Standards System (SPSS) to improve its efficiency, consistency, and relevance in the assessment of State Survey Agency performance. The SPSS Fiscal Year 2023 guidance is meant to ensure State Survey Agencies are consistently monitoring compliance of health care facilities. The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve health and safety of Americans such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents.

A. Primary changes to the SPSS for Fiscal Year 2023

Previous SPSS guidance documents identified multiple domains of assessment such as Frequency, Quality, and Coordination of Provider Noncompliance. For this fiscal year, SPSS domains include the Survey and Intake Process, Survey and Intake Quality, and Noncompliance Resolution. A primary objective of identifying measures for this fiscal year was to include measures in the SPSS that CMS could construct from existing data sources. This data-driven approach will facilitate regular monitoring and reporting of SPSS measures on a quarterly basis during the fiscal year.

*Beginning in FY23, CMS is adding a new scoring category of **Partially Met** to acknowledge State performance that has improved substantially or not worsened significantly from established SPSS measure thresholds compared to the prior fiscal year. The scoring category of **Partially Met** will apply for all SPSS FY23 measures. How CMS will apply this new scoring category to each SPSS measure is detailed in Appendix 7.*

B. Ongoing Activities

Due to the changes to the SPSS, CMS will conduct ongoing monitoring and support activities and proactively assess what measures should be included in the SPSS for Fiscal Year 2024. CMS will continue to work with States to address their performance identified by the SPSS measures during this fiscal year. If you have questions or recommendations related to the SPSS, please contact SPSS_Team@cms.hhs.gov.

C. Fiscal Year 2023 SPSS Measures[1]

The Fiscal Year 2023 SPSS includes 11 measures across 3 domains. Eight measures are the same as those for Fiscal Year 2022. Measures labeled S6, Q4, and N1 are new.

Survey and Intake Process

- S1. Surveys of Nursing Home Special Focus Facilities (SFF)
  - CMS will assess the frequency of standard surveys conducted for SFFs and the addition of new facilities to the SFF list. State Survey Agencies must conduct a standard survey with each SFF at least once every six months and a new SFF must replace a removed facility within 21 days.
- S2. Timeliness of Upload of Recertification Surveys
  - The time from survey completion to successful data upload into the National Database for surveys uploaded this fiscal year. The average number of days should not exceed 70 calendar days. CMS will assess whether states uploaded recertification surveys within 70 days of survey exit on average. CMS will assess this measure for the following provider types: community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, outpatient physical therapy/speech language pathology providers, psychiatric residential treatment facilities, and rural health clinics.
- S3. Use of the Immediate Jeopardy (IJ) Template
  - CMS will assess the mandatory use of the IJ template by State Survey Agencies for ambulatory surgical centers, end-stage renal disease facilities, hospices, hospitals, intermediate care facilities for individuals with intellectual disabilities and nursing homes. State Survey Agencies should provide this template for at least 80% of all IJ deficiencies.
- S4. Intakes Overdue for Investigation
  - The number of complaints/facility-reported incidents (FRIs) entered that have been triaged for investigation and are overdue for investigation. Between October 1, 2022 and September 30, 2023, State Survey Agencies should reduce the number of complaints/FRIs overdue for investigation by at least 25%. CMS will assess this measure for the following provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

[1] SPSS FY 2023 measures will be calculated during the transition period from CASPER to iQIES. Measures will be calculated for providers that have migrated to iQIES.

- S5. Recertification Survey Completion Rate
  - The completion of past-due recertification surveys. Between October 1, 2022 and September 30, 2023, State Survey Agencies should reduce the number of past-due recertification surveys by at least 50%. CMS will assess this for Tier 1, Tier 2, and Tier 3 surveys for the following provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.
- S6. Intakes prioritized as IJ started within the required time period
  - Complaint surveys to investigate Immediate Jeopardy (IJ) Intakes should be started within the required time period per Chapter 5 guidance. CMS will assess this measure for the following provider types: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes.

Survey and Intake Quality

- Q1. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys
  - Nursing home health surveys are satisfactorily conducted based on a composite score of 80% or more.
- Q2. Assessment of Deficiency Identification using Federal Comparative Surveys
  - Nursing home health surveys are satisfactorily conducted based on a composite score of 90% or more.
- Q3. Nursing Home Tags Downgraded/Removed by informal dispute review (IDR) or independent IDR (IIDR)
  - This measure evaluates the number of tags that have been downgraded or removed via IDR/ IIDR and the number of surveys where an IDR/IIDR has been requested but has not been completed. This measure includes the following two sub-measures:
    - Tags cited on the CMS-2567 from surveys conducted in FY2023 for nursing homes are downgraded or removed due to IDR or IIDR 50% or less of the time.
    - Surveys with unresolved IDRs or IIDRs may not exceed five percent of all surveys with a requested IDR or IIDR conducted between FY2021 and FY2023.
- Q4. Data Submission
  - Nursing home surveys should be uploaded to CASPER and be free of errors. This measure evaluates nursing home surveys that have not been uploaded and nursing home surveys that have been uploaded without accompanying 2567 text. This measure includes two sub-measures:

    - Nursing home surveys that have not been uploaded to CASPER may not exceed five percent of all surveys conducted between FY2021 and *FY2023*.
    - Nursing homes surveys missing CMS-2567 text uploaded to CASPER may not exceed five percent of all surveys conducted between FY2021 and FY2023.

Noncompliance Resolution

- N1. Timeliness of Revisits

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

General Instructions

This year's SPSS Guidance provides instructions to CMS Locations and State Survey Agencies on how CMS will evaluate State Survey Agency performance. CMS will use available data to construct 10 of 11 SPSS measures and part of the remaining 11th measure. CMS will construct the IJ template measure from existing data for nursing homes and with data reported by CMS Location staff for acute and continuing care providers. CMS will provide an Excel template with instructions for CMS Location staff to complete this data collection quarterly.

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.

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

Timeline

The Fiscal Year (FY) 2023 SPSS evaluation period is October 1, 2022 through September 30, 2023 with milestone dates as follows:

Milestone Dates for SPSS FY 2023

Activity	Approximate Date
FY2023 SPSS Results Available for State Survey Agency review and Informal Requests for Reconsideration (IRR) begins	*January 15, 2024*
Deadline for State Survey Agencies to submit IRR	*February 2, 2024*
FY2023 SPSS Results Finalized	*February 29, 2024*
Corrective Action Plans Due from States	*March 15, 2024*

Corrective Action Plan

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

A corrective action plan should also consider previous years' corrective actions. For example, if a State 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's performance on that measure.

If performance was impacted by State law, regulation, or executive action during the fiscal year, the State Survey Agency should document how the State law, regulation, or executive action impacted their

performance on the measure in its corrective action plan. Any exclusions approved by CMS management 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 States' corrective action plans address all failures to meet performance measures and describe specific actions States plan to take to improve State performance. If a State has not met a performance measure in two or more consecutive years, the correction action plan must include an evaluation of the previous corrective action plan and explain why it did not result in adequate State performance improvement. CMS Locations will save final approved corrective action plans on a designated CMS SharePoint site.

Reconsideration

There is no formal appeal of findings relative to this Report of State Survey Agency Performance since the assessment is under the umbrella of the "Evaluation" Article (Article V) of the §1864 Agreement. However, where the State Survey Agency and CMS Location cannot come to a final agreement on key findings, the State Survey Agency may ask CMS for informal reconsideration. The request should be made in writing to its CMS Location and SPSS_Team@cms.hhs.gov. The request should be made within 14 calendar days of the date the State Survey Agency received the draft SPSS results report. Any potential request is relevant for only the final FY2023 SPSS results draft report which is anticipated to be available by late-December 2023.

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 to SPSS_Team@cms.hhs.gov.

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

Threshold Criteria

Each State Survey Agency shall conduct one standard survey of each designated Special Focus Facility (SFF) at least once every six months. For example, if the last standard survey's exit date is July 8, 2022 then the next standard survey's start date may be no later than January 7, 2023.

When one SFF is removed either through termination or graduation, then another SFF is selected within 21 calendar days as a replacement so all the SFF slots are filled. The selection date is considered the date State Survey Agencies 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

- If both threshold criteria are met, this measure is scored as “Met.”
- If either threshold criterion is not met, this measure is scored as “Not Met.”

Evaluation

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

References

- Survey and Certification Group Letter: S&C 17-20
- Survey and Certification Group Letter: S&C-14-20
- Special Focus Facilities Procedures Guide

S2. Timeliness of upload of Recertification Surveys[2]

Threshold Criterion

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

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

Scoring

- If the average upload days is less than or equal to 70 calendar days for data entry of recertification surveys, this measure is scored as “Met.”
- If the average upload days is greater than 70 calendar days for data entry for recertification surveys, this measure is scored as “Not Met.”
- This measure will be scored as two separate measures: one for nursing homes and one for all acute and continuing care providers.

Evaluation

See Appendix 2: Timeliness of upload of Recertification Surveys (S2)

References

- Article II (J) of the 1864 Agreement
- State Operations Manual, Chapter 7, Section 7410

[2] Complaint surveys are not included in this measure because they are automatically uploaded once the survey information has been entered and linked intakes are finalized.

S3. Use of the IJ template

Threshold Criterion

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

CMS will evaluate the use of the IJ template for each IJ citation separately for nursing homes and acute and continuing care providers.[3]

- For nursing homes, CMS will calculate the proportion of IJ tags for which an IJ template is attached to recertification kits for each IJ tag cited during the fiscal year using the Long-Term Care Survey Process system. This could be an IJ tag cited on a recertification survey or on a complaint survey that was conducted with a recertification survey.
- For acute and continuing care providers, CMS Locations will assess compliance with the requirement quarterly by determining if the IJ template is in ASPEN or iQIES for a sample of IJ tags cited during the fiscal year. The following tables define the sample and selection process required for reporting.

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

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

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

[3] S4. Intakes Overdue for Investigation is an established measure from the Pending Overdue Workload Project established to address State Agencies work that that is overdue as a result of the COVID-19 pandemic If the Pending Overdue Workload Project revises measure thresholds for FY2023, this measure threshold will be revised to reflect those changes.

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

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

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

Scoring

- There will be one score for nursing homes and one score for all acute and continuing care providers combined.
- If the percentage of IJ tags with a template provided is 80 percent or more for both nursing homes and all acute and continuing care providers combined, this measure is scored as "Met."
- If the percentage of IJ tags with a template provided is less than 80 percent for either nursing homes or acute and continuing care providers, this measure is scored as "Not Met."

Evaluation

For nursing homes, CMS will review long-term care survey process data for use of the IJ template for IJ tags cited on recertification surveys and on complaint surveys conducted with recertification surveys. CMS will identify all IJ tags available in the long-term care survey process data and the number of those tags for which an IJ template was completed.

CMS Location staff will identify if an IJ template was provided for IJ tags cited for acute and continuing care providers. An Excel spreadsheet will be used to document the use of the IJ template and will be provided to CMS Location staff. Data elements included in the spreadsheet are: provider number and provider type, survey event identifier, survey exit date, and whether the IJ template was provided on or before the survey exit date.

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

References

- State Operations Manual, Appendix Q
- CMS Memo QSO-19-09-ALL

S4. Intakes Overdue for Investigation[4]

Threshold Criterion

The number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation is reduced by 25% or more by September 30, 2023 so that complaints/FRIs are addressed in a timely manner per the State Operations Manual and the Mission and Priority Document. This measure is inclusive of complaints and FRIs triaged at the immediate jeopardy (IJ), non-IJ high, non-IJ medium, and non-IJ low levels. CMS will calculate this measure for the time period starting October 1, 2022 and ending September 30, 2023. CMS will continue to explore opportunities to provide greater context for this threshold for States that do not have a significant survey backlog. CMS will provide each State with details on which complaints/FRIs are overdue for investigation.

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

Scoring

- If the number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation is reduced by 25%, this measure is scored as “Met.”
- If the number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation is reduced by less than 25%, this measure is scored as “Not Met.”
- This measure will be scored as two separate measures: one for nursing homes and one for all acute and continuing care providers.

Evaluation

Using data from ASPEN or iQIES[5], CMS will identify the number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation on October 1, 2022 and the same measure on September 30, 2023. CMS will calculate the percentage difference between the number identified on October 1, 2022 and the number identified on September 30, 2023.

Reference

- CMS Memo QSO-22-02-ALL

[4] S4. Intakes Overdue for Investigation is an established measure from the Pending Overdue Workload Project established to address State Agencies work that that is overdue as a result of the COVID-19 pandemic If the Pending Overdue Workload Project revises measure thresholds for FY2023, this measure threshold will be revised to reflect those changes.

[5] Information for hospice, home health agencies and ambulatory surgical centers have migrated from ASPEN to iQIES.

S5. Recertification Survey Completion Rate[6]

Threshold Criterion

The number of past-due recertification surveys, for non-deemed providers, is reduced by 50% or more by September 30, 2023. CMS will calculate this measure for the time period starting October 1, 2022 and ending September 30, 2023 for non-deemed providers. CMS will provide States with details on which facilities have past-due recertification surveys.

CMS will assess this for Tier 1, Tier 2, and Tier 3 surveys as defined in the Mission and Priorities Document. CMS will assess this separately for nursing homes and acute and continuing care providers. Acute and continuing care providers include the following non-deemed provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

Scoring

- If the number of past-due recertification surveys is reduced by 50% or more, this measure is scored as "Met."
- If the number of past-due recertification surveys is reduced by less than 50%, this measure is scored as "Not Met."
- This measure will be scored as two separate measures: one for nursing homes and one for all acute and continuing care providers.

Evaluation

Using data from ASPEN and iQIES[7] CMS will compare the number of past-due recertification surveys on October 1, 2022 to the number of past-due recertification surveys on September 30, 2023. CMS will calculate the percentage difference between the number identified on October 1, 2022 and the number identified on September 30, 2023.

Reference

- CMS Memo QSO-22-02-ALL

[6] S5. Recertification Survey Completion Rate is an established measure from the Pending Overdue Workload Project established to address State Agencies work that that is overdue as a result of the COVID-19 pandemic. If the Pending Overdue Workload Project revises measure thresholds for FY2023, this measure threshold will be revised to reflect those changes.

[7] Information for hospice, home health agencies and ambulatory surgical centers have migrated from ASPEN to iQIES.

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

Threshold Criteria

This performance measure evaluates the timeliness of investigation initiation for intakes prioritized as Immediate Jeopardy (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.[8]

Due to revisions in Chapter 5 of the SOM, the calculation of this measure will depend on when Chapter 5 revisions are implemented. CMS released Chapter 5 revisions with memo QSO-22-19-NH on June 29, 2022. These revisions change the number of days to start *investigations of nursing home* intakes prioritized as IJ *from two days between received end and investigation start date to three days between received start date and investigation start date. These changes must be implemented by October 1, 2023, but a State Survey Agency can voluntarily choose to implement these changes prior to October 1, 2023.* Until Chapter 5 revisions are implemented *by the State Survey Agency*, CMS will *use the* current Chapter 5 guidance *(Revision 211)*. Once *a State Survey Agency has implemented the* Chapter 5 revisions *(Revision 212)*, CMS will evaluate State *Survey Agencies* using the new Chapter 5 guidance.

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

Scoring

- There will be three separate scores for this measure: (1) one score for nursing homes, (2) one score for non-deemed acute and continuing care providers and (3) one score for deemed acute and continuing care providers.
- For nursing homes and non-deemed acute and continuing care providers:
- If the percentage of investigations started within the required time period is at least *80* percent, the measure is scored as “Met.”
- If the percentage of investigations started within the required time period is less than *80* percent, the measure is scored as “Not Met.”
- For deemed acute and continuing care providers:

- If the percentage of investigations started within two business days of CMS Location authorization at least *80* percent, the measure is scored as “Met.”
  If the percentage of investigations started within two business days of CMS Location authorization is less than *80* percent, the measure is scored as “Not Met.”

[8] SPSS FY 2023 measures will be calculated during the transition period from CASPER to iQIES. Measures will be calculated for providers that have migrated to iQIES.

Evaluation

Chapter 5 guidance pertaining to the number of days between intake and survey of intakes prioritized as IJ was revised in FY2022. *The* effective date for these revisions *is October 1, 2023*. To calculate this measure, CMS will employ current Chapter 5 guidance for intakes with a received end date between the beginning of fiscal year 2023 through the date *the State Survey Agency implements* Chapter 5 revisions. CMS will employ revised Chapter 5 guidance for intakes with a received start date *on or after the State Survey Agency's Chapter 5 implementation date.*

To calculate the percentage of nursing home intakes prioritized as IJ that were started within the required time period, the count of IJ intakes started within the required time period is divided by the total number of nursing home intakes prioritized as IJ. The required time period is two business days if Chapter 5 revisions have not been implemented. For complaints, if Chapter 5 revisions have been implemented, the required time period is defined as three business days. For facility-reported incidents, if Chapter 5 revisions have been implemented, the required time period is defined as three business days if there is inadequate resident protection and seven business days if there is potentially adequate resident protection. Because there is not an available data element to assess adequate resident protection, seven business days will be used to assess if facility-reported incidents prioritized IJs were started within the required time period.

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

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

References

- State Operations Manual, Chapter 5, section 5075

Q1. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys

Threshold Criteria

State Survey Agency nursing home surveyor performance of the health survey is evaluated by Federal Monitoring Survey (FMS) Focus Concern Surveys (FCS), which ensures that State Survey Agency nursing home compliance, recertification, and revisit surveys are satisfactorily conducted, by effectively achieving the desired outcomes of the survey using the Federal standards, protocols, forms, methods, and procedures specified by CMS. A set of national concerns are chosen that include both a regulatory reference and a set of F-Tags. CMS Locations have the option of identifying additional concerns and any SOG Survey team could identify additional concerns if the situation warranted it. This SPSS measure is specific to only the national concern areas.

A State Survey Agency will receive an overall FMS FCS score that combines results for all national concern areas and a score for each national concern area investigated in the fiscal year. This measure is considered met if the State Survey Agency meets or exceeds the scoring threshold for the overall FMS FCS score.

- The overall FMS FCS score is a composite measure of all current fiscal year national concern areas investigated on all focus concern surveys. A State Survey Agency meets this measure if it achieves a score of 80 percent or higher based on the scoring algorithm described below.
- Individual FMS FCS scores are also constructed separately for each national focus concern area. While a score is constructed for each concern area, a State is not assessed on each individual concern area score for this measure.

Scoring

- If the overall FMS FCS score is 80 percent or higher, this measure is scored as “Met.”
- If the overall FMS FCS score is less than 80 percent, this measure is scored as “Not Met.”

Evaluation

For each concern area investigated:

- A score of “Met” will be given when the State properly identifies noncompliance and the associated harm level or the noncompliance that was missed by the State was “No actual harm with a potential for minimal harm” (level one).
- A score of “Partially Met” will be given when the State fails to identify noncompliance or misidentifies the level of harm for noncompliance for “No actual harm with a potential for more than minimal harm, but not immediate jeopardy” (level two). A score of “Partially Met” will be given when the State Survey Agency identifies noncompliance but determines a level of harm that is not supported by the evidence available.
- A score of “Not Met” will be given when a State fails to identify noncompliance or fails to identify “Actual harm that is not immediate jeopardy” (level three), “immediate jeopardy” (level four), or Substandard Quality of Care (SQC).

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

Calculating points for each concern area investigated:

- Tally points for each concern area investigated as follows.
  - The State receives 2 points per "Met" score.
  - The State receives 1 point per "Partially Met" score.
  - The State receives 0 points per "Not Met" score.
- For example, if an FMS FCS includes the investigation of three focus concern areas and the first two areas are "Met" and the third area is "Partially Met," the State receives 5 total points out of 6 for that FCS.

Calculating the overall FMS FCS score:

To calculate the State's overall FCS score, create a numerator and denominator as follows.

- Numerator: Add all the points assigned to "Met," "Not Met," and "Partially Met" national concern areas across all focus concern surveys
- Denominator: Multiply the total number of national concern areas examined across all focus concern surveys by 2
- The overall score is the numerator divided by the denominator multiplied by 100.
- For example, if the total number of focus concern areas investigated across all FCS surveys was 10, then the total number of possible points that State could earn would be 20 (10 focus concern areas multiplied by a maximum of 2 points each). If the State met 6 of 10 concern areas, partially met 3 of 10 concern areas, and did not meet 1 of 10 concern areas, its total points earned would be 15 (6 "Mets" earns 12 points, 3 "Partially Mets" earns 3 points, and one 1 "Not Met" earns 0 points). The State's overall score would be 75 percent because 15 divided by 20 equals 0.75.

Reference

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

Q2. Assessment of Deficiency Identification using Federal Comparative Surveys

Threshold Criterion

This threshold criterion evaluates the State Survey Agency's identification of onsite findings of noncompliance as measured by federal comparative survey results. For 90 percent or more of the deficiencies cited on the federal comparative surveys 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 severity level.

Scoring

- If the percentage agreement rate is 90 percent or higher (without rounding up), this measure is scored as "Met."
- If the percentage agreement rate is less than 90 percent, this measure is scored as "Not Met."

Evaluation

See Appendix 4: Assessment of Deficiency Identification using Federal Comparative Surveys (Q2)

References

- Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act
- 42 C.F.R. §488.318

Q3. Nursing Home Tags Downgraded/Removed by IDR or IIDR

Threshold Criterion

A State Survey Agency shall have fewer than 50% of tags that are reviewed during an IDR or IIDR downgraded or removed as a result of the investigation. This includes all types of deficiency tags identified during recertification or complaint surveys. Tags identified during Federal Monitoring Surveys and initial certification surveys are excluded. In addition, the proportion of surveys where an IDR or IIDR remains in the "requested" status and is beyond the 60-day time period for completion may not exceed five percent of all surveys where an IDR or IIDR was requested *between FY2021 and FY2023*. This measure includes two sub-measures that must be met to meet the overall measure. The two sub-measures are:

- **Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR**. Citation tags that underwent an IDR or IIDR process and were downgraded or removed may not exceed 50% of all tags that underwent an IDR or IIDR process.
- **Percent of Surveys with Unresolved IDR-IIDRs**. Surveys with unresolved IDRs or IIDRs may not exceed five percent of all surveys conducted with requested IDRs or IIDRs.

This measure will be calculated for nursing homes only.

Scoring

- If both sub-measure threshold criteria are met, this measure is scored as "Met."
- If either of the two sub-measure threshold criteria are not met, this measure is scored as "Not Met."

Evaluation

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

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

- The sub-measure **Percent of Surveys with Unresolved IDR-IIDRs** will be calculated by dividing the number of recertification and complaint surveys submitted for IDR/IIDR review that have a status of "requested," and *where the time period between the IDR/ IIDR requested date and the date of data extraction is more than 60 days* by the number of recertification and complaint surveys that were submitted for IDR/IIDR review. *If the requested date is missing, 21 days following the survey exit date is used to a proxy for the requested date. If the number of days between the IDR/IIDR requested date and the date of data extraction is less than 60 days, the survey will be excluded from the calculation.* Surveys with requested IDRs or IIDRs between FY2021 and FY2023 will be evaluated.

Reference

- State Operations Manual Chapter 7, Sections 7212, 7213

Q4. Data Submission

Threshold Criteria

This performance measure evaluates nursing home surveys that have not been uploaded and nursing home surveys that have been uploaded without accompanying 2567 text. This measure includes two sub-measures that must be met to meet the overall measure. The two sub-measures are:

- **Percent of Missing Surveys.** Surveys that have not been uploaded to CASPER may not exceed five percent of all surveys conducted between FY2021 and FY2023.
- **Percent of Surveys Missing CMS-2567 Text.** Surveys with missing CMS-2567 text may not exceed five percent of all surveys conducted between FY2021 and FY2023.

This measure will be calculated for nursing homes only.

Scoring

- If both sub-measure threshold criteria are met, this measure is scored as "Met."
- If either of the two sub-measure threshold criteria are not met, this measure is scored as "Not Met."

Evaluation

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

- The sub-measure Percent of Missing Surveys will be calculated by dividing the count of surveys conducted between FY2021 and FY2023 not uploaded to CASPER by the count of surveys conducted between FY2021 and FY2023.
- The sub-measure Percent of Surveys Missing CMS-2567 Text will be calculated by dividing the count of surveys uploaded with missing CMS-2567 text conducted between FY2021 and FY2023 by the count of uploaded surveys conducted between FY2021 and FY2023.

Reference

- State Operations Manual Chapter 8, Section 8000C

N1. Timeliness of Revisits *(Revised July 2023)*

Threshold Criterion

This performance measure evaluates whether a State Survey Agency conducted timely revisits for the following providers: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes. For nursing homes, onsite revisits should be conducted no more than 60 days after the survey exit date for those surveys citing deficiencies at a scope and severity of F with substandard quality of care[9] or higher. For non-deemed acute and continuing providers, onsite revisits should be conducted no more than 45 days after the survey exit date for those surveys citing condition-level deficiencies. For deemed acute and continuing providers, onsite revisits should be conducted no more than 45 days after a provider/supplier termination notification has been sent for surveys citing condition-level deficiencies. Provider termination notification dates are largely missing from QIES and iQIES; therefore, substitute method calculations will be employed when provider termination notification dates are missing. When the termination notification date is not missing, that date will be used to assess the 45-day time period. When the termination notification date is missing, the statement of deficiency date will be used to calculate the 45-day time period. When both the provider notification date and the statement of deficiency date are missing the survey exit date plus 10 days will be used to assess the 45-day time period. Because data on the acceptance or receipt of facility plans of correction is not always accurately documented, this measure will not require that a State Survey Agency received or accepted a plan of correction. For all providers, this measure is focused on only Health surveys.

Scoring

- This measure will be scored as two separate measures: one for nursing homes and one for acute and continuing care providers.
- For nursing homes, if 70 percent or more of revisits are conducted within specified timeframes, this measure is scored as “Met.” Any state with less than 10 surveys requiring revisit during the fiscal year are excluded from this measure.
- For ACC providers, if 70 percent or more of revisits are conducted within specified timeframes, this measure is scored as “Met.” Any state with less than 10 surveys requiring revisit during the fiscal year are excluded from this measure.

Evaluation

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

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

non-deemed providers and the count of onsite revisit surveys occurring within 45 days of provider notification of termination of deemed providers with be summed together and divided by the count of recertification and complaint surveys of 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, Section 5110
- State Operations Manual Chapter 7, Section 7317

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

Data Source(s)

- List of identified special focus facilities (SFFs), ACO/AEM, provider certification files, and State Survey Agency feedback on standard survey data related to facilities on the candidate list.

Method of Calculation

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

- For the purposes of the State Performance Standards, States must complete one standard survey at least every six months per each SFF slot. The number of slots is determined by the number of SFFs assigned to each State as designated in policy memorandum S&C-17-20. For example, if a State has five SFF slots, that State must complete 10 standard surveys for its SFFs during the fiscal year with each facility being surveyed at least once every six months. Similarly, if a State has one SFF slot, that State would complete two standard surveys conducted on that SFF in a given fiscal year, with each survey conducted not less than once every six months.
- When one SFF is removed either through termination or graduation, the State Survey Agency must select another facility for that SFF slot within 21 days as a replacement, so all slots are filled. For terminations, the State Survey Agency must select another facility for that SFF slot within 21 days from the effective date of termination. For graduations, the State Survey Agency must select another facility for that SFF slot within 21 days of the date of the letter the State Survey Agency sent to the graduating SFF of its removal from the SFF program.
- For example, if facility A graduates on March 1st and is replaced within two weeks by facility B whose last standard survey was January 10th, then facility B should have a standard survey no later than September 1st to meet both the requirements of the SFF program and the State Performance Standards. In this example, the standard survey was conducted within six months of the selection date and within 15.9 months of the last annual survey and therefore would meet the requirement. If the survey was not completed until October, it would not meet the performance measure because the survey did not occur within six months of selection to the SFF slot. If the selection of a replacement SFF occurs after 21 days, the State Survey Agency would not meet the performance measure.

Appendix 2: Timeliness of upload of Recertification Surveys (S2)

Data Source(s)

- CASPER

Method of Calculation

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

Calculating Recertification Survey Average Upload Days

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

Average Days = Sum of Upload Days/Uploaded Surveys

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

Appendix 3: Use of the IJ Template (S3)

Data Source(s)

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

Method of Calculation

Nursing Homes

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

Acute and Continuing Care Providers

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

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

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

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

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

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

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

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

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

- Select Survey & Certification
- Select Search
- Search for the Provider or Survey to which you want to add the IJ Template
- Select the survey under Recent Surveys by clicking on the Survey ID
- Under Basic Information, select Attachments
- Click on Select File to open the File Manager on your computer
- Choose the IJ template file
- Click on open to save

Please use the same filename labeling convention as noted above

Appendix 4: Assessment of Deficiency Identification using Federal Comparative Surveys (Q2)

Data Source(s)

- Federal Comparative Survey Data

Method of Calculation

Citation Accuracy Chart

CMS Location, Federal Comparative Survey citations / State Survey Agency	Denominator Points	Numerator Points		
		State Survey Agency cites similar tag at same or higher S/S	State Survey Agency cites similar tag at lower S/S	State Survey Agency does not cite similar tag SHF=yes
Immediate Jeopardy with substandard quality of care	15	15	7.5	0
Immediate Jeopardy without substandard quality of care	12	12	6	0
Actual Harm with substandard quality of care	9	9	4.5	0
Actual Harm without substandard quality of care	6	6	3	0
Potential Harm with substandard quality of care	3	3	1.5	0
Potential Harm without substandard quality of care	1	1	0.5	0

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

The FMS comparative survey report identifies all the deficiencies cited from all comparative surveys that the CMS Locations identified, whether State Survey Agencies identified the same or similar citation, at what severity/scope levels the deficiencies were cited by the CMS Location and the State Survey Agency; and whether the State Survey Agency should have found the deficiency or deficiencies. For each such deficiency, based on what was written in the FMS analysis report regarding how the State Survey Agency cited the same findings, the Citation Accuracy Chart is used to determine how many points are assigned to the numerator and denominator. This measure only considers cases when the State Agency is deemed accountable for the CMS Location reviewers.

Once points are determined for the numerator and denominator associated with each deficiency, all numerator points are summed and all denominator points are summed. The overall score is calculated by dividing the denominator into the numerator and multiplying the result by 100%.

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

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

Score = (Numerator/Denominator) ×100

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

- The State Survey Agency does not cite any tags and CMS Location determined the State Survey Agency should not have found the deficiency (Should Have Found (SHF) =No)
- The CMS Location was unable to determine if the deficiency should have been cited by State Survey Agency (SHF=unable to determine)
- The CMS Location was unable to determine if State Survey Agency understated the severity level (understatement=unable to determine)

For tags cited a “D,” the State Survey Agency had to cite the same findings at an “D" or higher to be scored as having cited at the same or higher severity

Points in numerator columns indicate priority order; that is, the first column that fits the situation indicates the number of points to be assigned.

This analysis is done for each deficiency cited by the CMS Location at no actual harm with potential for more than minimal harm (D and higher) for all health and LSC deficiencies. After adding up the numerator and denominator over all the deficiencies included in the analysis, calculate a percentage.

Lower Severity includes deficiencies the State Survey Agency cited at severity levels 1, 2 or 3 that are at a severity level less than what the CMS Location cited and deficiencies that were not cited at all.

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.

Appendix 5: Timeliness of Revisits (N1) *(Revised July 2023)*

Data Source(s)

- QIES
- iQIES

Method of Calculation

Nursing Homes

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

The count of surveys requiring onsite revisits (denominator) is calculated by identifying all initial recertification and complaint surveys with survey exit dates within the fiscal year that resulted in a citation at F scope and severity with substandard quality of care[10] or higher. From this set of recertification or complaint surveys, surveys that meet any of the following conditions are excluded:

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

After excluding surveys that meet at least one of the above three criteria, the total number of remaining surveys make up the count of surveys requiring onsite revisits (denominator).

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

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

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

Nursing Home Table Example

Survey	Initial Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2023	3/15/2023	31
2	4/2/2023	7/3/2023	92
3	3/19/2023	--	--
4	11/5/2022	12/17/2022	42
5	7/22/2023	9/1/2023	41
6	9/25/2023	11/16/2023	52
7	1/12/2023	2/1/2023	20
8	5/28/2023	6/4/2023	7
9	2/14/2023	4/7/2023	52
10	10/2/2022	11/2/2022	31

Dashes indicate missing data.

Using the table above as an example, ten surveys are conducted in the fiscal year and are included in the denominator. Of the ten surveys, eight surveys had revisits within the 60-day time period and are included in the numerator. Survey 2 is excluded from the numerator because the days between the survey exit date and the survey revisit start date was greater than 60 days. Survey 3 was excluded because a revisit has not been conducted. Eight revisits divided by ten initial surveys results in 80% of timely revisits.

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

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

Acute and Continuing Care Providers

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

The count of surveys requiring onsite revisit (denominator) is calculated by identifying all initial recertification and complaint surveys of ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities with survey exit dates within the fiscal year that resulted in a condition-level citation.

Any survey identified as being in the denominator of this measure that has a corresponding revisit in the required 45-day time period is included in the numerator of this measure. For non-deemed acute and continuing care providers, the count of surveys requiring revisit that had a revisit within 45 days of the

survey exit are included in the numerator. For deemed acute and continuing care providers, the count of surveys requiring revisit that had a revisit within 45 days of the termination notification date are included in the numerator. Because provider termination notification dates are largely missing from QIES and iQIES additional methods were required to calculate the number of days between provider termination notification and revisit. When the provider termination notification date is not missing, that date will be used to assess the 45-day time period. When the termination notification date is missing, the statement of deficiency date will be used to calculate the 45-day time period. When both the provider notification date and the statement of deficiency date are missing the survey exit date plus 10 days will be used to assess the 45-day time period.

Onsite revisits conducted within the 45-day time period for both deemed and non-deemed acute and continuing care providers are summed to calculate the numerator.

The count of these surveys (numerator) is divided by the count of surveys requiring onsite revisit (denominator). This value is multiplied by 100 to calculate the percentage of revisits that occurred within 45 days.

ACC Table Example

Survey	45-Day Time Period Start Date[11]	Revisit Start Date	Days between 45-Day Time Period Start Date and Revisit Survey Start
1	2/12/2023	3/15/2023	31
2	4/2/2023	7/3/2023	92
3	3/19/2023	--	--
4	11/5/2022	12/17/2022	42
5	7/22/2023	9/1/2023	41
6	9/25/2023	11/16/2023	52
7	1/12/2023	2/1/2023	20
8	5/28/2023	6/4/2023	7
9	2/14/2023	4/7/2023	52
10	10/2/2022	11/2/2022	31

Dashes indicate missing data.

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

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

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

[11] For non-deemed providers, the 45-day start date is the initial survey exit date. For deemed providers, the 45-day start date is the provider/supplier termination notification date.

Appendix 6. Rounding Issues

Numbers should be rounded to the nearest **tenth** (one decimal point); however, rounding will not be used to determine whether a State Survey Agency met or did not meet a threshold criterion.

S1. Rounding is not relevant as this measure is required to be 100% to meet the threshold.

S2 through S6. Rounding is not allowed in determining whether the State Survey Agency met or did not meet the threshold criterion for these measures.

Q1 through Q3. Rounding is not allowed in determining whether the State Survey Agency met or did not meet the threshold criterion for these measures.

N1. Rounding is not allowed in determining whether the State Survey Agency met or did not meet the threshold criterion for these measures.

Appendix 7. State Performance Standards System Scoring Categories *(Added July 2023)*

The goal of the SPSS is to ensure the highest quality of care is being provided to individuals who are served by nursing homes and other acute and continuing care providers through monitoring of State Survey Agency performance as enumerated in the State Operations Manual and the Mission and Priorities Document. CMS understands that State Survey Agencies encounter many challenges on a day-to-day basis related to staffing concerns, an abundance of complaints, and budget pressures. To that end, CMS is adding the Partially Met scoring category to recognize State Survey Agencies that make progress from year to year and encourage continued progress towards established SPSS measure thresholds.

What's changed?

In Fiscal Year 2022 (FY22), CMS scored individual measures of State Survey Agency performance for SPSS measures as either **Met** or **Not Met** based on pre-defined thresholds for each measure. Beginning in FY23, CMS is adding a new scoring category of **Partially Met** to acknowledge State performance that has improved substantially or not worsened significantly from established SPSS measure thresholds compared to the prior fiscal year. The scoring category of **Partially Met** will apply for all SPSS FY23 measures.

A summary of how CMS will assign scores to each measure, including the new **Partially Met** category, and a detailed description of how States can achieve specific scoring categories for each measure are provided below. If you have questions about the addition of this new category or how it will be applied, please submit them to your CMS Location lead and the SPSS team at spss_team@cms.hhs.gov.

CMS understands that State Survey Agencies may have questions about this new scoring category and we encourage you to regularly discuss SPSS measures with your designated CMS Location points of contact. Please contact the SPSS team if you are unsure of your CMS point of contact.

What are the SPSS FY23 Scoring Categories?

The following summarizes the revised SPSS FY23 scoring categories. Details on how CMS will implement these new scoring categories for each FY23 measure are included in Table 1.

1. **Met.** A State achieves a score of **Met** for a specific measure if the end of fiscal year value of that measure meets or exceeds the threshold identified in the FY23 SPSS Guidance.
2. **Partially Met.** A State achieves a score of **Partially Met** for a specific measure if one of the following conditions are met:
    - The measure was **Met** in FY22 and the FY23 measure value is **slightly below** the established FY23 threshold.
    - The measure was **Not Met** in FY22 and the FY23 measure value demonstrates substantial progress from FY22.

- The measure was **Not applicable** (N/A) in FY22 and the FY23 measure value is equal to or better than the threshold set for Partially Met (Table 1).
- The measure was **not included** in FY22 SPSS and the FY23 measure value at is at or above the Partially Met threshold (Table 1).

3. **Not Met.** A State achieves a score of **Not Met** for a specific measure if the end of fiscal year value of the measure does not meet the threshold identified in the FY23 Guidance or does not meet the conditions necessary to qualify as a **Partially Met**.
4. **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. How this category applies for each measure in FY23 is noted in Table 1.

When does a State Survey Agency need to develop a Corrective Action Plan?

For FY23, a State Survey Agency is required to submit a corrective action plan if any FY23 SPSS measure achieves a score of **Not Met**. For SPSS measures that pertain to survey recertification or the investigation of intakes, CMS will only consider Tier 1 work as relevant for the submission of a corrective action plan. The measures for which this is relevant are identified in Table 1.

Beginning in FY24, a State Survey Agency is required to submit a corrective action plan for a SPSS measure if the State achieves a score of **Not Met** for that measure in that fiscal year or if the State has achieved two consecutive scores of **Partially Met** for the same SPSS measure. The FY24 SPSS Guidance will include information identifying which measures qualify under this new consecutive Partially Met rule.

Table 1. SPSS FY23 Measure Scoring Category Details

Measure	Met/Partially Met/Not Met
S1. Surveys of Nursing Home Special Focus Facilities (SFF) *(This measure is constructed only for Nursing Homes.)*	**Met.** A State achieves a score of Met if (1) it conducts a standard survey for each SFF in its State at least once every six months and (2) SFFs that are removed—due to either termination or graduation from the program—from the list are replaced within 21 calendar days. **Partially Met.** A State achieves a score of Partially Met if it meets the requirements for at least one of the two sub-components that make up this measure. **Not Met.** A State achieves a score of Not Met if it does not meet the requirements for either sub-component of this measure. **N/A.** A State receives a score of N/A (not applicable) if it has no SFF slots allocated to it. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.
S2. Timeliness of Upload of Recertification Surveys *(CMS will construct one measure for nursing homes and one measure for acute and continuing care providers. A State will receive one score for each measure. This measure does not apply for provider surveys uploaded automatically to iQIES.)*	**Met.** A State achieves a score of Met if the average number of days to upload recertification surveys is 70 calendar days or less. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and the value of S2 in FY23 is at least 10 days less than its FY22 score, with the exception that all States must meet a threshold of less than 100 days; (2) FY22 score was Met and the value of S2 in FY23 is no greater than 73; or (3) FY22 average number of days to upload was 80 days or less and its FY23 value is smaller than the FY22 value. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A if the number of recertification surveys conducted in FY23 is less than 5. **Corrective Action Plan.** For the nursing home sub-measure, a State must submit a corrective action in FY23 if it achieves a score of Not Met. For the acute and continuing care provider sub-measure, a State must submit a corrective action plan in FY23 if it achieves a score of Not Met for providers for which recertification surveys are prioritized as Tier 1 work (home health agencies, hospice, and intermediate care facilities for individuals with intellectual disabilities). CMS will continue to score States on all applicable acute and continuing care providers, but the corrective action plan will be relevant for only Tier 1 work. CMS will provide a detailed breakdown of their scores to States.

Measure	Met/Partially Met/Not Met
S3. Use of the Immediate Jeopardy (IJ) Template *(CMS will construct one measure for nursing homes and one measure for acute and continuing care providers. A State will receive one score for each measure.)*	**Met.** A State achieves a score of Met if at least 80% of IJ templates are uploaded with their survey kits at the time of upload for IJ deficiencies identified in recertification surveys. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and the value of S3 in FY23 is at least 10 percentage points greater than its FY22 value, with the exception that all States must meet a threshold of no less than 60% (including States that were N/A in FY22) or (2) FY22 score was Met and the value of S3 in FY23 is no less than 75%. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A (not applicable) if it has no IJ deficiencies cited in FY23. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.
S4. Intakes Overdue for Investigation *(CMS will construct one measure for nursing homes and one measure for acute and continuing care providers. A State will receive one score for each measure.)*	**Met.** A State achieves a score of Met if the number of intakes overdue for investigation is reduced by 25% or more in FY23. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and the value of S4 in FY23 is at least 10 percentage points less than its FY22 value, with the exception that all States must meet a threshold of no less than a 10% reduction (including States that were N/A in FY22); (2) FY22 score was Met and the State achieves at least a 22% reduction in FY23; or (3) FY22 reduction was 15% or greater and the FY23 percent reduction is greater than in FY22. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A (not applicable) if the number of non-IJ intakes overdue for investigation at the start of the year is less than 5 and the number at the end of the year is less than 10. **Corrective Action Plan.** All States will be assessed on all intakes prioritized as IJ. For the nursing home sub-measure, a State must submit a corrective action plan in FY23 if it achieves a score of Not Met for all intakes prioritized as IJ. For the acute and continuing care (ACC) provider sub-measure, a State must submit a corrective action plan if it achieves a score of Not Met for ACC providers with a Tier 1 priority for IJ intakes: ASC (deemed), CORFs, CMHCs, ESRD, FQHCs, RHCs, HHAs, Hospice, Hospitals, ICF-IID, OPT-SLPs portable x-ray, and PRTFs. CMS will continue to score States on all applicable acute and continuing care providers, but the corrective action plan will be relevant for only Tier 1 work. CMS will provide a detailed breakdown of their scores to States.

Measure	Met/Partially Met/Not Met
S5. Recertification Survey Completion Rate *(CMS will construct one measure for nursing homes and one measure for acute and continuing care providers. A State will receive one score for each measure.)*	**Met.** A State achieves a score of Met if the number of past due recertification surveys is reduced by 50% or more in FY23. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and the value of S5 in FY23 is at least 10 percentage points less than its FY22 value, with the exception that all States must meet a threshold of no less than a 25% reduction (including States that were N/A in FY22; (2) FY22 score was Met and the State achieves at least a 47% reduction in FY23; or (3) FY22 reduction was 40% or greater and the FY23 percent reduction is greater than in FY22. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A (not applicable) if the number of past due recertification surveys at the start of the year is less than 5 and the number at the end of the year is less than 10. **Corrective Action Plan.** For the nursing home sub-measure, a State must submit a corrective action plan in FY23 if they achieve a score of Not Met. For the acute and continuing care provider sub-measure, a State must submit a corrective action plan in FY23 if it achieves a score of Not Met for providers for which recertification surveys are prioritized as Tier 1 work (home health agencies, hospice, and intermediate care facilities for individuals with intellectual disabilities). CMS will continue to score States on all applicable acute and continuing care providers, but the corrective action plan will be relevant for only Tier 1 work. CMS will provide a detailed breakdown of their scores to States.
S6. Intakes prioritized as IJ started within the required time period *(CMS will construct one measure for nursing homes, one measure for non-deemed acute and continuing care providers, and one measure for deemed acute and continuing care providers. A State will receive one score for each measure.)*	**Met.** A State achieves a score of Met if the value of S6 is 80% or greater. **Partially Met.** A State achieves a score of Partially Met if the value of S6 is at least 75% but less than 80%. **Not Met.** A State achieves a score of Not Met if the value for S6 is less than 75%. **N/A.** A State is assigned a score of N/A if there are no intakes prioritized as IJ in FY23. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.

Measure	Met/Partially Met/Not Met
Q1. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys *(This measure is constructed only for Nursing Homes.)*	**Met.** A State achieves a score of Met if the value for Q1 is 80% or greater. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and its FY23 value is at least 10 percentage points higher than in FY22, (2) FY22 score was Met and its FY23 value is no lower than 77%, or (3) FY22 value was 70% or greater and its FY23 value is greater than in FY22. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A if there were two or fewer focused concerns investigated for that State in FY23. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.
Q2. Assessment of Deficiency Identification using Federal Comparative Surveys *(This measure is constructed only for Nursing Homes.)*	**Met.** A State achieves a score of Met if the value for Q2 is 90% or greater. **Partially Met.** A State achieves a score of Partially Met if its (1) FY22 score was Not Met and its FY23 value is at least 5 percentage points higher than its FY22 value; (2) FY22 score was N/A and the FY23 value for Q2 is at least 70%; (3) FY22 score was Met and its FY23 value is no lower than 87%; or (4) FY22 value was 85% or greater and its FY23 value is greater than in FY22. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A (not applicable) if it had fewer than 3 deficiencies reviewed of level D or higher in the FY23 comparative survey process. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.
Q3. Nursing Home Tags Downgraded/Removed by informal dispute review (IDR) or independent IDR (IIDR) *Sub-measure 1: Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR* *Sub-measure 2: Percent of Surveys with Unresolved IDR-IIDRs* *(This measure is constructed only for Nursing Homes)*	**Met.** A State receives a score of Met if the value of sub-measure 1 is 50% or less and the value of sub-measure 2 is 5% or less. **Partially Met.** A State receives a score of Partially Met if (1) the value of at least one sub-measure is equal to or lower than the established threshold to be considered Met or (2) both sub-measures' values are greater than the Met thresholds but the first sub-measure value is no greater than 60% and the second sub-measure value is no greater than 10% in FY23. **Not Met.** A State achieves a score of Not Met if it does not meet the criteria for either a Met or Partially Met score. **N/A.** A State receives a score of N/A (not applicable) if both sub-measures had fewer than 5 tags reviewed. If only one sub-measure has fewer than 5 tags, a State receives a score based on the sub-measure with at least 5 surveys or tags. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.

Measure	Met/Partially Met/Not Met
Q4. Data Submission *Sub-measure 1: Percent of Missing Surveys* *Sub-measure 2: Percent of Surveys Missing CMS-2567 Text* *(This measure is constructed only for Nursing Homes)*	**Met.** A State achieves a score of Met if the value for each Q4 sub-measure is 5% or less. **Partially Met.** A State can achieve a score of Partially Met if the value for each sub-measure is 10% or less. **Not Met.** A State achieves a score of Not Met if the value for either sub-measure is greater than 10%. **N/A.** A State receives a score of N/A (not applicable) if it had fewer than 5 surveys conducted in FY23. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.
N1. Timeliness of Revisits *(CMS will construct one measure for nursing homes and one measure for acute and continuing care providers. A State will receive one score for each measure.)*	**Met.** A State achieves a score of Met if the value for N1 is 70% or greater. **Partially Met.** A State achieves a score of Partially Met if the value for N1 is at least 60% but less than 70%. **Not Met.** A State achieves a score of Not Met if the value of N1 is less than 60%. **N/A.** A State receives a score of N/A (not applicable) if it had fewer than 5 surveys that required a revisit in FY23. **Corrective Action Plan.** A State must submit a corrective action plan for this measure in FY23 if it achieves a score of Not Met.