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

Admin Info: 24-20-ALL

DATE: **August 1, 2024**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group
Director
Survey and Operations Group

SUBJECT: Fiscal Year 2023 (FY23) State Performance Standards System (SPSS) Findings

Memorandum Summary

- ***Results for CMS SPSS FY23 SPSS Measures*** that were calculated for FY23 are identified and summarized. For each measure, States received a score of Met, Partially Met, or Not Met. For each "Not Met" score received in FY23, States must develop a corrective action plan to address identified issues. CMS Locations monitor the implementation of corrective action plans to ensure States are making progress to improve performance.

Background

Every year, the Centers for Medicare & Medicaid Services (CMS) assesses each State Survey Agency's (SA's) performance relative to measures included in the State Performance Standards System (SPSS) program. Through this program and other oversight activities, CMS works with the SAs to ensure that the care provided across provider and supplier settings to patients and residents is of the highest quality.

CMS views Fiscal Year 2023 (FY23) SPSS findings in the context of flat SA funding levels since FY2015 despite considerable resource and workload challenges resulting from the COVID-19 pandemic and continuing after the end of the COVID-19 public health emergency on May 11, 2023. CMS does not take these challenges lightly and will continue to work with SAs towards ensuring the highest quality of care and safest health care environments for all beneficiaries.

Additionally, during the review of FY23 SPSS findings, CMS identified challenges with the SPSS measure Assessment of Deficiency Identification using Federal Comparative Surveys (Q2) due to changes in the measure from prior periods and the measurement process; consequently, CMS will not score this measure for FY23 and is working with SAs to clarify the measure for future SPSS periods.

FY23 SPSS results indicate an overall improvement in SA performance in survey and certification activities. Across all SAs, there were fewer instances of Not Met scores in FY23

compared to the previous fiscal year. Specifically, in FY22, across all SAs about 30% of scored instances were Not Met. In contrast, in FY23 across all SAs, 17.7% of scored instances were Not Met. In FY23, CMS introduced a new scoring category, Partially Met, to recognize SA performance that substantially improved or did not significantly worsen from established SPSS measure thresholds compared to the prior fiscal year. SAs received a Partially Met score in FY23 for 9.2% of total scored instances in recognition of improvement from FY22 or continued strong performance.

We remain heartened by the work of the States in their focus on SPSS and their diligence using and understanding the performance data to drive improvement through robust dialogue across the States and CMS Locations. States have addressed the issues identified in current and previous plans of correction.

The following provides an overview of FY23 SPSS findings. Supporting tables at the end of this document provide detailed findings by SA.[1]

FY 2023 SPSS Measures

The SPSS is aligned with CMS expectations for SA performance in accordance with the §1864 Agreement (referencing that Section of the Social Security Act) 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. In FY23, measurement for the SPSS focused on three domains: (1) Survey and Intake Process, (2) Survey and Intake Quality, and (3) Noncompliance Resolution. The measures in these three domains included:

Survey and Intake Process

S1. Surveys of Nursing Home Special Focus Facilities (SFF). CMS assessed 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 should not exceed an average of 70 calendar days.

S3. Use of the Immediate Jeopardy (IJ) Template. CMS will assess the mandatory use of the IJ template. 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. State Survey Agencies should reduce the number of complaints/FRIs overdue for investigation by at least 25% between October 1, 2022 and September 30, 2023.

[1] Includes 50 U.S. States, the District of Columbia, and Puerto Rico.

S5. Recertification Survey Completion Rate. The completion of past-due recertification surveys. State Survey Agencies should reduce the number of past-due recertification surveys by at least 50% between October 1, 2022 and September 30, 2023.

S6. Intakes prioritized as IJ started within the required time period. At least 80% of State Survey Agencies' investigations of IJ intakes should be started within the required time period.

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. This measure is not scored for FY23 but will return in a different form in the future.

Q3. Nursing Home Tags Downgraded/Removed by informal dispute review (IDR) or independent IDR (IIDR). This measure includes two submeasures: (1) 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; and (2) 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. This measure includes two submeasures: (1) Nursing home surveys that have not been uploaded to CASPER may not exceed five percent of all surveys conducted between FY2021 and FY2023; and (2) 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. States must conduct at least 70% of onsite revisits within the required timeframes.

Domain 1: Survey and Intake Process

There are six total measures in this domain. This domain included one nursing home-specific measure that assessed SA monitoring of Special Focus Facilities (SFFs) (S1) among the 49 SAs with at least one SFF. In FY23, 44 SAs met SPSS criteria for this measure which includes conducting a recertification survey once every six months and replacing a SFF with a new one if the previous facility is removed from the SFF list. The remaining 5 SAs partially met this measure.

The remaining five measures in this domain assessed SA survey and certification activities for all provider/supplier types (nursing homes and acute and continuing care [ACC] providers). These measures examined the timeliness of survey upload for Tier 1 standard recertification surveys, the use of the Immediate Jeopardy (IJ) template, intakes overdue for investigation, the recertification survey completion rate, and intakes prioritized as IJ started within the required time period. Overall State performance on these measures was as follows:

- Most SAs (41) successfully uploaded standard recertification surveys for nursing homes within the required average of 70 days. About half of SAs (25) met recertification survey upload requirements for Tier 1 ACC providers.[2] This measure will not be necessary in the future when CMS moves to a cloud-based information system for all provider and supplier types. This measure is important to ensure that information is available in the national data system to be reported publicly.
- CMS requires that when a surveyor identifies an IJ deficiency the surveyor provide the facility with an IJ template that summarizes the deficiency. Among the 48 SAs with at least one IJ cited for nursing homes in FY23, 38 provided the IJ template at least 80 percent of the time to nursing homes and uploaded it with their survey findings. Among the 36 SAs with at least one IJ cited for ACC providers, 25 provided the IJ template at least 80 percent of the time and uploaded it with their survey findings. This measure is important to ensure that providers understand the basis for the most serious non-compliance determinations.
- During the COVID-19 public health emergency, many SAs received a large volume of complaints for health care providers, resulting in unanticipated and unprecedented challenges with investigating these complaints. Since the public health emergency, serious complaints have continued to increase across provider and supplier settings while in the context of a flat budget. In FY23, in an effort to continue working into the backlog of the most serious complaints, CMS required that SAs reduce their overdue IJ intake investigations by 25 percent.
  - Among the 17 SAs with enough overdue nursing home IJ intakes to receive a score on this measure, most (14) reduced their total by at least 25%.
  - Among the 14 SAs with enough overdue ACC provider IJ intakes to receive a score on this measure, most (11) reduced their total by at least 25%.[3]
- CMS required SAs reduce the number of past-due recertification surveys by 50% in FY23.
  - Among the 34 SAs with enough past-due nursing home recertification surveys to receive a score on this measure, 20 reduced their total by 50% or more.
  - Among the 34 SAs with enough past-due Tier 1 ACC provider recertification surveys to receive a score on this measure, 24 reduced their total by 50% or more. Another 6 SAs achieved a score of Partially Met, signaling an improvement or continued strong performance from FY22 though not reaching the 50% reduction threshold.
- CMS requires that SAs start surveys for intakes prioritized as IJ within two days for most provider types. CMS measures this separately for nursing homes, non-deemed ACC providers, and deemed ACC providers and requires that at least 80% of IJ-prioritized intake surveys are started on time.
  - For nursing homes, 41 SAs began at least 80% of their surveys for IJ prioritized intakes on time.

[2] Tier 1 ACC providers include home health agencies, hospice, and intermediate care facilities for individuals with intellectual disabilities. Only 33 SAs had enough Tier 1 ACC surveys to qualify for this measure.
[3] This measure was scored 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.

- For non-deemed ACC providers, 29 SAs began at least 80% of their surveys for IJ prioritized intakes on time.

- For deemed ACC providers, 38 SAs began at least 80% of their surveys for IJ prioritized intakes on time.

Domain 2: Survey and Intake Quality

This domain included four nursing home measures on which CMS assessed SA performance: (1) a measure of State performance on identifying Federal focus concern areas; (2) a measure of State performance on Federal Comparative Surveys, (3) a measure of IDR/IIDR resolution and the extent to which Nursing Home deficiency tags were downgraded or removed by either the IDR or IIDR process, and (4) a measure on data submission, which assesses missing surveys and surveys missing CMS-2567 text.

Due to widespread challenges with the measure of State performance on Federal Comparative Surveys, CMS is not reporting those results as there are concerns about the validity of the measure and process beyond just an individual State's performance on the measure. In FY23, CMS had revised this measure to incorporate all lower-level deficiencies. CMS has convened a joint workgroup with States to more fully evaluate the scope and process for this measure and make recommendations for a FY25 measure as we believe this is an important aspect of performance to measure. As we are mid-way through FY24, we do not expect that changes will be made and implemented until FY25. State performance on other measures in this domain was as follows:

- CMS Locations conduct focus concern surveys each year to assess SA performance on identifying specific areas of concern in nursing homes identified in advance by CMS. Most SAs (46) met this measure in FY23, indicating a very high compliance across the nation on the part of States in investigating focus concern areas in nursing homes. Three SAs achieved a score of Partially Met.
- CMS assessed SAs for tags downgraded or removed in the IDR or IIDR process and unresolved IDRs and IIDRs. Among the 47 SAs with at least 5 deficiency tags reviewed by the IDR or IIDR process, 33 SAs achieved a score of Met and 13 SAs achieved a score of Partially Met.

- To measure data submission, CMS assessed SAs on the percent of surveys missing from the National Database and surveys with missing CMS-2567 text if they had at least 5 surveys in FY23. Nearly all SAs achieved high marks on this measure; 48 SAs achieved a score of Met and 2 achieved a score of Partially Met.

Domain 3: Noncompliance Resolution

This domain included one measure on which CMS assessed SA performance on onsite revisits conducted within the required timeframes for all provider/supplier types. CMS measured nursing home revisits separately from ACC revisits. To achieve a score of Met, CMS requires SAs to conduct 70% of revisits within 60 days for nursing homes and to conduct 70% of revisits within 45 days for ACC providers. Timely revisits are important to ensure that mandatory enforcement remedies are not inadvertently triggered unrelated to the provider's achieving compliance.

- Among the 47 SAs with at least 5 surveys requiring an onsite revisit for nursing homes, 33 SAs achieved a score of Met.
- Among the 39 SAs with at least 5 surveys requiring an onsite revisit for ACC providers, 10 achieved a score of Met and 7 earned a score of Partially Met.

Ongoing Communications on Quality and State Performance

CMS is committed to supporting all SAs in their efforts to ensure compliance with the health and safety standards at healthcare facilities that serve Medicare and Medicaid beneficiaries. In its oversight role, CMS reviews data on quality and State performance on an ongoing basis and is committed to sharing these data with States.

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: Please contact the SPSS team at SPSS_Team@cms.hhs.gov with any questions or concerns.

Effective Date: Immediately. This information should be communicated to all survey and certification staff, their managers and the State/CMS Location training coordinators within 30 days of this memorandum.

/s/

Karen L. Tritz
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David R. Wright
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cc: Survey and Operations Group

Table 1. Survey and Intake Process Domain SPSS Measures

State	S1 NH	S2 NH	S2 ACC	S3 NH	S3 ACC	S4 NH	S4 ACC	S5 NH	S5 ACC	S6 NH	S6 ACC Deemed	S6 ACC Non-deemed
Alabama	Met	Met	n.a.	Met	Met	Not Met	n.a.	Not Met	Met	Not Met	Met	n.a.
Alaska	n.a.	Met	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	Not Met	n.a.
Arizona	Met	Not Met	Met	Not Met	Not Met	n.a.	n.a.	n.a.	Met	Met	Not Met	Met
Arkansas	Partially Met	Met	Met	Partially Met	Not Met	n.a.	n.a.	n.a.	Met	Met	Met	Not Met
California	Met	Met	Met	Partially Met	Not Met	Met	Met	Not Met	Not Met	Met	Met	Met
Colorado	Met	Met	Not Met	Met	Met	n.a.	n.a.	Met	Met	Met	Met	Met
Connecticut	Met	Met	Partially Met	Met	Met	Met	Met	Not Met	Met	Met	Met	Met
Delaware	Met	Met	n.a.	Met	n.a.	n.a.	Met	Met	Met	Met	Not Met	n.a.
District of Columbia	n.a.	Not Met	Partially Met	n.a.	n.a.	n.a.	n.a.	n.a.	Met	Met	Met	Not Met
Florida	Met	Met	Met	Met	Met	Met	Met	Not Met	Partially Met	Met	Met	Met
Georgia	Met	Met	n.a.	Met	Met	Met	Met	Met	Partially Met	Met	Met	Met
Hawaii	Met	Not Met	Not Met	Not Met	n.a.	n.a.	n.a.	n.a.	Met	Not Met	Met	n.a.
Idaho	Met	Not Met	Met	Not Met	Met	n.a.	n.a.	Not Met	n.a.	Met	n.a.	n.a.
Illinois	Met	Met	Met	Met	Met	n.a.	n.a.	Met	n.a.	Met	Met	Met
Indiana	Met	Met	Met	Met	Partially Met	n.a.	n.a.	Met	Met	Met	Met	Met
Iowa	Met	Met	Met	Met	Met	Met	n.a.	Met	n.a.	Met	Met	Met
Kansas	Partially Met	Met	n.a.	Met	n.a.	Met	Met	Met	Met	Met	Not Met	Not Met
Kentucky	Met	Not Met	n.a.	Met	n.a.	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Louisiana	Met	Met	Met	Met	Met	n.a.	Met	n.a.	Met	Met	Met	Met
Maine	Met	Met	Met	Met	Met	n.a.	n.a.	Met	n.a.	Met	Met	Met

State	S1 NH	S2 NH	S2 ACC	S3 NH	S3 ACC	S4 NH	S4 ACC	S5 NH	S5 ACC	S6 NH	S6 ACC Deemed	S6 ACC Non-deemed
Maryland	Met	Partially Met	n.a.	Not Met	n.a.	n.a.	Met	Not Met	Met	Met	Met	Met
Massachusetts	Met	Met	n.a.	Met	Met	n.a.	n.a.	Met	Met	Met	Met	Met
Michigan	Met	Met	n.a.	Met	Met	n.a.	n.a.	Met	Met	Met	Not Met	Not Met
Minnesota	Met	Met	Partially Met	Met	Met	Met	Met	Met	Met	Not Met	Not Met	Not Met
Mississippi	Met	Met	Met	Met	Met	n.a.	Met	Met	Met	Met	Met	Not Met
Missouri	Met	Met	Met	Met	Met	Met	n.a.	Met	Met	Met	Met	Met
Montana	Met	Met	n.a.	Met	n.a.	n.a.	n.a.	n.a.	n.a.	Met	n.a.	n.a.
Nebraska	Met	Met	Met	Met	n.a.	n.a.	n.a.	Met	n.a.	Met	Met	Met
Nevada	Met	Met	Met	Partially Met	Not Met	n.a.	n.a.	Met	Partially Met	Met	Met	Met
New Hampshire	Met	Met	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	Met	n.a.	n.a.
New Jersey	Partially Met	Met	n.a.	Met	Met	Met	n.a.	Partially Met	n.a.	Not Met	Met	Met
New Mexico	Met	Met	Met	Partially Met	Met	n.a.	n.a.	n.a.	n.a.	Met	Met	n.a.
New York	Met	Met	Partially Met	Partially Met	Partially Met	Met	n.a.	Not Met	Partially Met	Met	Met	Met
North Carolina	Met	Met	Partially Met	Met	Met	n.a.	Not Met	Met	n.a.	Met	Not Met	Met
North Dakota	Met	Met	Met	Met	n.a.	n.a.	n.a.	n.a.	n.a.	Met	Met	n.a.
Ohio	Met	Met	Met	Met	Met	Met	n.a.	Partially Met	Partially Met	Met	Met	Met
Oklahoma	Partially Met	Partially Met	Met	Met	n.a.	Met	n.a.	Met	Met	Met	Met	Partially Met
Oregon	Met	Met	n.a.	Met	Not Met	n.a.	n.a.	Met	Met	Met	Met	Not Met
Pennsylvania	Partially Met	Met	Not Met	Met	Met	n.a.	n.a.	n.a.	Not Met	Met	Met	Met
Puerto Rico	n.a.	Not Met	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	Not Met	n.a.
Rhode Island	Met	Met	n.a.	Met	Met	n.a.	n.a.	n.a.	n.a.	Met	Met	Met

State	S1 NH	S2 NH	S2 ACC	S3 NH	S3 ACC	S4 NH	S4 ACC	S5 NH	S5 ACC	S6 NH	S6 ACC Deemed	S6 ACC Non-deemed
South Carolina	Met	Met	Met	Met	n.a.	n.a.	n.a.	Not Met	Met	Not Met	Met	Not Met
South Dakota	Met	Met	n.a.	Met	Met	n.a.	n.a.	Met	n.a.	Met	Met	Met
Tennessee	Met	Met	Met	Met	Met	Not Met	Not Met	Not Met	Partially Met	Not Met	Not Met	Not Met
Texas	Met	Met	Met	Met	Met	Met	Met	n.a.	Met	Met	Met	Met
Utah	Met	Met	Met	Met	Met	n.a.	n.a.	Not Met	n.a.	Not Met	Met	Met
Vermont	Met	Not Met	n.a.	Met	n.a.	n.a.	n.a.	n.a.	Met	Met	Met	Met
Virginia	Met	Not Met	Met	Met	Not Met	n.a.	n.a.	Not Met	Not Met	Not Met	Met	Met
Washington	Met	Met	n.a.	Met	Met	Met	n.a.	Met	Met	Met	Met	Met
West Virginia	Met	Partially Met	Met	Partially Met	Not Met	n.a.	n.a.	n.a.	n.a.	Met	Met	Met
Wisconsin	Met	Met	Met	Met	Met	n.a.	n.a.	n.a.	Met	Met	Met	Not Met
Wyoming	Met	Met	n.a.	Met	n.a.	n.a.	n.a.	n.a.	n.a.	Met	n.a.	n.a.

Note: The Fiscal Year 2023 measures each had a distinct shorthand naming convention. S1 refers to Surveys of Nursing Home Special Focus Facilities (SFF). S2 refers to Timeliness of upload into CASPER of Standard Surveys. S3 refers to Use of the IJ template. S4 refers to Intakes Overdue for Investigation. S5 refers to Recertification Survey Completion Rate. S6 refers to intakes prioritized as IJ with Survey Started within the Required Time Period (S6). A score of n.a. (or not applicable) is assigned to a State when there is not enough data to conduct the review for the fiscal year.
SPSS = State Performance Standards System, NH = Nursing Home, ACC = Acute and Continuing Care Providers

Table 2. Survey and Intake Quality SPSS Measures

State	Q1 NH	Q3 NH	Q4 NH
Alabama	Met	n.a.	Met
Alaska	Met	Met	Met
Arizona	Not Met	Met	Met
Arkansas	Met	Met	Met
California	Partially Met	Met	Partially Met
Colorado	Met	Partially Met	Met
Connecticut	Met	Partially Met	Met
Delaware	Met	n.a.	Not Met
District of Columbia	Met	n.a.	Not Met
Florida	Met	Met	Met
Georgia	Met	Met	Met
Hawaii	Met	Not Met	Met
Idaho	Met	Met	Met
Illinois	Met	Met	Met
Indiana	Met	Met	Met
Iowa	Met	Met	Met
Kansas	Met	Met	Met
Kentucky	Met	Met	Met
Louisiana	Met	Met	Met
Maine	Met	Met	Met
Maryland	Met	Met	Met
Massachusetts	Met	Met	Met
Michigan	Met	Met	Met
Minnesota	Met	Partially Met	Met
Mississippi	Met	n.a.	Met
Missouri	Met	Met	Met
Montana	Met	Partially Met	Met
Nebraska	Met	Partially Met	Met
Nevada	Not Met	Met	Met
New Hampshire	Met	Partially Met	Met
New Jersey	Met	Met	Met
New Mexico	Partially Met	Partially Met	Met
New York	Met	Met	Met
North Carolina	Met	Met	Met
North Dakota	Met	Met	Met
Ohio	Met	Met	Met
Oklahoma	Met	Met	Met
Oregon	Met	Partially Met	Met
Pennsylvania	Met	Met	Met

State	Q1 NH	Q3 NH	Q4 NH
Puerto Rico	n.a.	n.a.	Met
Rhode Island	Met	Met	Met
South Carolina	Met	Met	Met
South Dakota	Met	Partially Met	Met
Tennessee	Met	Partially Met	Met
Texas	Met	Met	Met
Utah	Met	Partially Met	Met
Vermont	Met	Partially Met	Met
Virginia	Partially Met	Met	Met
Washington	Met	Met	Met
West Virginia	Met	Partially Met	Partially Met
Wisconsin	Met	Met	Met
Wyoming	Met	Met	Met

Note: The Fiscal Year 2023 measures each had a distinct shorthand naming convention. Q1 refers to Conduct of Nursing Home Health Surveys in Accordance with Federal Standards. Q3 refers to Nursing Home Tags Downgraded/Removed by IDR or IIDR. Q4 refers to Data Submission.
A score of n.a. (or not applicable) is assigned to a State when there is not enough data to conduct the review for the fiscal year.
SPSS = State Performance Standards System, NH = Nursing Home, ACC = Acute and Continuing Care Providers

Table 3. Noncompliance Resolution SPSS Measure

State	N1 NH	N1 ACC
Alabama	Met	Met
Alaska	n.a.	n.a.
Arizona	Not Met	Not Met
Arkansas	Partially Met	Not Met
California	Met	Not Met
Colorado	Met	Partially Met
Connecticut	Not Met	Not Met
Delaware	n.a.	n.a.
District of Columbia	n.a.	n.a.
Florida	Met	Not Met
Georgia	Partially Met	Met
Hawaii	Not Met	n.a.
Idaho	Not Met	Not Met
Illinois	Met	Partially Met
Indiana	Met	Partially Met
Iowa	Met	Partially Met
Kansas	Met	Not Met
Kentucky	Not Met	n.a.
Louisiana	Met	Met
Maine	Met	n.a.
Maryland	Not Met	Not Met
Massachusetts	Met	Not Met
Michigan	Met	Not Met
Minnesota	Met	Not Met
Mississippi	Met	Met
Missouri	Met	Not Met
Montana	Met	Not Met
Nebraska	Met	Met
Nevada	Met	n.a.
New Hampshire	n.a.	n.a.
New Jersey	Met	Not Met
New Mexico	Partially Met	Not Met
New York	Not Met	Not Met
North Carolina	Met	Not Met
North Dakota	Met	Met
Ohio	Met	Met
Oklahoma	Not Met	Partially Met
Oregon	Met	Not Met

State	N1 NH	N1 ACC
Pennsylvania	Met	Not Met
Puerto Rico	n.a.	n.a.
Rhode Island	Met	n.a.
South Carolina	Met	Not Met
South Dakota	Met	Partially Met
Tennessee	Met	Met
Texas	Met	Not Met
Utah	Met	Not Met
Vermont	Not Met	n.a.
Virginia	Met	Partially Met
Washington	Met	Met
West Virginia	Not Met	n.a.
Wisconsin	Met	Met
Wyoming	Partially Met	n.a.

Note: The Fiscal Year 2023 measures each had a distinct shorthand naming convention. N1 refers to Timeliness of Revisits.
A score of n.a. (or not applicable) is assigned to a State when there is not enough data to conduct the review for the fiscal year.
SPSS = State Performance Standards System, NH = Nursing Home, ACC = Acute and Continuing Care Providers