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

Admin Info: 22-06-ALL

DATE: **March 10, 2022**

TO: State Survey Agency Directors

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

SUBJECT: Fiscal Year (FY) 2022 State Performance Standards System (SPSS) Guidance

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' (SAs') performance relative to measures included in the SPSS program. CMS works with the SAs 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.

This year's SPSS guidance is informed by several factors, such as the ongoing public health emergency, the resulting backlog of recertification and complaint surveys, and a desire 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 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 2022 fiscal year include:

- Standard and Complaint Survey Process
- COVID Infection Control Surveys
- Quality of the Survey Process

A fundamental change in the SPSS for this fiscal year compared to previous years is a focus on measures that CMS can construct with available data. CMS is committed to making the SPSS as objective and consistent as possible to ensure State Survey Agencies are assessed consistently throughout the fiscal

year. To that end, CMS will also release interim SPSS results each quarter to provide State Survey Agencies and CMS Locations the information needed to assess State performance as often as possible and make improvements as soon as possible.

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

cc: Survey and Certification CMS Location Management

Fiscal Year 2022

State Performance Standards

System Guidance

February 24, 2022

Table of Contents

Introduction

CMS actively evaluates the State Performance Standards System (SPSS) to improve its efficiency, consistency, and relevance in the assessment of State Survey Agency (SA) performance. This year's SPSS guidance is informed by several factors, such as the ongoing public health emergency, the resulting backlog of recertification and complaint surveys, and a desire 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 the 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 2022

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 Standard and Complaint Survey Process, COVID Infection Control Surveys, and the Quality of the Survey Process. 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.

B. Ongoing Activities

Due to the changes to the SPSS and the continuing public health emergency, CMS will conduct ongoing monitoring and support activities and proactively assess what measures should be included in the SPSS for Fiscal Year 2023. CMS will continue to work with States to address their performance identified by the SPSS measures used during this fiscal year. If you have questions or recommendations related to the SPSS, please contact **SPSS_Team@cms.hhs.gov**.

C. Fiscal Year 2022 SPSS Measures

The Fiscal Year 2022 SPSS includes 9 measures across 3 domains. Several measures are the same as those in previous guidance and others reflect focus areas related to the public health emergency. Measures labeled S4, S5, and Q3 and the acute and continuing care component of S2 are new.

Standard and Complaint Survey Process

- S1. Surveys of Nursing Home Special Focus Facilities (SFF)
  - The frequency of standard surveys conducted for SFFs and the addition of new facilities to the SFF list. SAs 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 Standard 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 this measure for 10 different provider types.
- S3. Use of the Immediate Jeopardy (IJ) Template
  - CMS will assess the mandatory use of the IJ template by SAs for nursing homes, home health agencies, hospices, hospitals, ESRD, ICF/IID, and ASCs. SAs should provide this template for at least 70% 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 November 30, 2021 and September 30, 2022, SAs should reduce the number of complaints/FRIs overdue for investigation by at least 60%. CMS will assess this measure for 14 different provider types.
- S5. Recertification Survey Completion Rate
  - The completion of past-due standard recertification surveys. Between November 30, 2021 and September 30, 2022, SAs should reduce the number of past-due standard recertification surveys by at least 50%. CMS will assess this for Tier 1, Tier 2, and Tier 3 surveys.

COVID Infection Control Surveys

- C1. Conduct of COVID focused infection surveys in nursing homes
  - SAs are required to conduct a COVID infection control survey for at least 20% of nursing homes.

Quality of the Survey Process

- Q1. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards
  - If nursing home health surveys are satisfactorily conducted based on a composite score of 80% or more.
- Q2. Identification of Health, LSC, and Emergency Preparedness on Surveys
  - If 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)
  - If tags cited on the CMS-2567 for nursing homes were downgraded or removed due to IDR or IIDR. Less than 50% of these tags should be downgraded or removed.

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 almost all (8 of 9) measures except for the measure pertaining to the use of the IJ template. 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 Location staff to complete this data collection quarterly.

CMS will calculate measures according to the specifications for each measure and collect these data quarterly to facilitate review by CMS Locations and State Survey Agencies. 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. CMS Locations will forward interim and final results to their State Survey Agencies. If State Survey Agencies have questions about the interim reports or disagree with the information in the interim reports, they should discuss concerns with their CMS Location.

There are no exceptions as to how each measure is scored unless CMS management 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 and prevented the State Survey Agency from meeting the measure.

Timeline

The Fiscal Year (FY) 2022 SPSS evaluation period is October 1, 2021 through September 30, 2022 with milestone dates as follows:

Milestone Dates for SPSS FY 2022

Activity	Date
CMS Locations submit first and second quarter IJ template results for ACC providers	April 12, 2022
Second quarter FY2022 SPSS Interim Results Available	April 30, 2022
CMS Locations submit third quarter IJ template results for ACC providers	July 12, 2022
Third quarter FY2022 SPSS Interim Results Available	July 31, 2022
CMS Locations submit fourth quarter IJ template results for ACC providers	October 12, 2022
Fourth Quarter FY2022 SPSS Interim Results Available	October 30, 2022
Draft FY2022 SPSS Results Available for State Survey Agency review	December 30, 2022
State Survey Agencies send comments on the draft results to CMS Locations	January 16, 2023
FY2022 SPSS Results Finalized	January 31, 2023

Note: CMS will calculate scores for the use of the IJ template for nursing homes.

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. The inclusion of interim quarterly findings for this fiscal year is meant to facilitate State's ability to make corrections during a 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 specifically 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, describe specific actions that States plan to take, and are designed to promote improved survey performance. If a State has not met any 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 lead to adequate survey performance. The CMS Location 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 FY2022 SPSS results draft report which is anticipated to be available by mid-December 2022 as all other reports are considered interim findings and not final.

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.

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. For terminations, it would be 21 calendar days from the effective date of termination. For graduations, it would be the date of the letter the State Survey Agency sent to the graduating SFF informing it of its removal from the SFF program.

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 Standard Surveys

Threshold Criterion

This performance measure evaluates the timeliness of standard survey uploads for the following providers: hospitals (all types), hospices, outpatient physical therapy/speech language pathology providers, rural health clinics, End-Stage Renal Disease (ESRD) facilities, comprehensive outpatient rehabilitation facilities, community mental health centers, nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and psychiatric residential treatment facilities. The measure is focused on non-deemed providers only and health surveys only.[1]

For each provider type, CMS will calculate the average number of days between survey exit date and survey upload date across all standard 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 there are no recertifications surveys conducted in this 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 standard surveys, this Measure is scored as "Met."
- If the average upload days is greater than 70 calendar days for data entry for standard 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 Standard Survey Upload (S2)

References

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

[1] CMS will not assess this for ASC or HHA providers due to the transfer of surveys for these providers to IQIES in fiscal year 2022.

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 exit interview, except for EMTALA investigations.

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

- For nursing homes, CMS will calculate the proportion of IJ tags for which an IJ template is provided for each IJ tag cited during the fiscal year using Long-Term Care Survey Process data.

- 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.

CMS Locations will report on the use of the IJ template for the following acute and continuing care providers: ambulatory surgery centers (ASCs), home health agencies (HHAs), hospices, hospitals, ESRD facilities, and ICF/IID. CMS Locations will select IJ tags relevant to both the first and second quarter for their initial data collection due on July 12, 2022. For the first six months of fiscal year 2022, select the number of IJ tags for review for the first quarter first and then, separately, for the second quarter.

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[1]
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[2]
32 or more IJ tags in a State	Select approximately 10 IJ tags[2]

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

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

Quarterly Number of IJ Tags per State	Quarterly Selection of Tags to Review for Reporting use of the IJ Template per State[1]
1 or 2	Review all IJ tags
3 to 7	Review the 1st and 3rd based on survey end dates for surveys conducting 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 conducting during that fiscal year quarter and available at the time of data collection.

[1] The selection of tags (i.e. 1st, 3rd, last) is based on the survey end date. CMS Locations will select IJ tags relevant to both the first and second quarter for their initial data collection due on July 12, 2022.

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 70 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 70 percent for either nursing homes or acute and continuing care providers, this measure is scored as "Not Met."

Evaluation

CMS Location staff will identify that an IJ template is 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 to be included in the spreadsheet are: provider number and provider type, survey event identifier, survey exit date, and whether the IJ template was provided.

For nursing homes, CMS will review long-term care survey process data for use of the IJ template for IJ tags cited on standard surveys and on complaint surveys conducted in tandem with standard 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 used.

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

References

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

S4. Intakes Overdue for Investigation

Threshold Criterion

The number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation is reduced by 60% or more by September 30, 2022 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 November 30, 2021 and ending September 30, 2022. 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 ASCs, HHAs, hospitals (all types), federally qualified health centers, hospices, rural health clinics, end-stage renal disease (ESRD) facilities, comprehensive outpatient rehabilitation facilities, community mental health centers, nursing homes, ICF-IID, outpatient physical therapy/speech language pathology providers, portable x-ray providers, and psychiatric residential treatment facilities. CMS will assess this for deemed and non-deemed providers.

Scoring

- If the number of complaints/FRIs entered that been triaged for investigation and are overdue for investigation is reduced by 60% or more for each provider type, this measure is scored as "Met."
- If the number of complaints/FRIs entered that been triaged for investigation and are overdue for investigation is reduced by less than 60% for all provider types, 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[2], CMS will identify the number of complaints/FRIs entered that have been triaged for investigation and are overdue for investigation on November 30, 2021 and the same measure on September 30, 2022. For each provider type, CMS will calculate the percentage difference between the number identified on November 30, 2021 and the number identified on September 30, 2022.

Reference

- CMS Memo QSO-22-02-ALL

[2] Information for home health agencies has migrated from ASPEN to iQIES and information for ASCs will migrate to iQIES from ASPEN during this fiscal year.

S5. Recertification Survey Completion Rate

Threshold Criterion

The number of past-due standard recertification surveys, for non-deemed providers, is reduced by 50% or more by September 30, 2022. CMS will calculate this measure for the time period starting November 30, 2021 and ending September 30, 2022 for non-deemed providers. CMS will provide States with details on which facilities have past-due standard 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 for ASCs, HHAs, hospitals (all types), hospices, rural health clinics, end-stage renal disease (ESRD) facilities, comprehensive outpatient rehabilitation facilities, community mental health centers, nursing homes, ICF-IID, outpatient physical therapy/speech language pathology providers, portable x-ray providers, and psychiatric residential treatment facilities.

Scoring

If the number of past-due standard recertification surveys is reduced by 50% or more for each of provider type, this measure is scored as "Met."

If the number of past-due standard recertification surveys is reduced by less than 50% for any of the provider types, 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[3], CMS will compare the number of past-due standard recertification surveys on November 30, 2021 to the number of past-due standard recertification surveys on September 30, 2022. For each provider type, CMS will calculate the percentage difference between the number identified on November 30, 2021 and the number identified on September 30, 2022.

Reference

CMS Memo QSO-22-02-ALL

[3] Information for home health agencies has migrated from ASPEN to iQIES and information for ASCs will migrate to iQIES from ASPEN during this fiscal year.

C1. Conduct COVID focused infection surveys in Nursing Homes

Threshold Criterion

A State Survey Agency must conduct a focused infection control (FIC) survey with at least 20% of active nursing homes in its State during this fiscal year. In order to be included in the required 20%, these FIC surveys must be stand-alone surveys or conducted with a complaint survey. FIC surveys conducted with a recertification survey do not count toward meeting this measure. Additionally, FIC surveys conducted in Fiscal Year 2022 triggered by meeting the following criteria may count toward meeting the State's 20% requirement: (1) multiple weeks with new COVID-19 cases; (2) low staffing; (3) selection as a Special Focus Facility per Section 1819(f)(8)(B) of the Social Security Act; (4) concerns related to conducting outbreak testing per CMS requirements; or (5) allegations or complaints which pose a risk for harm or Immediate Jeopardy to the health or safety of residents which are related to certain areas, such as abuse or quality of care (e.g., pressure ulcers, weight loss, depression, and decline in functioning).

Scoring

If the 20% threshold criterion is met, this Measure is scored as "Met."

If the threshold criterion is not met, this Measure is scored as "Not Met."

Evaluation

The numerator for this measure will be calculated based on the number of focused infection control surveys uploaded to the National Repository through ASPEN. The denominator is the total number of active nursing home providers during Fiscal Year 2022. The numerator and denominator will exclude all FIC surveys conducted by CMS Locations. If more than one FIC survey was conducted for a facility and at least one of those surveys was conducted by a State Agency, that survey will be included in the numerator and denominator of this measure.

References

- CMS memo QSO-20-31
- CMS memo QSO-22-02- ALL

Q1. Conduct of Nursing Home Health Surveys in Accordance with Federal Standards

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 ensure 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 this 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 more based on the scoring algorithm described below.
- The FMS FCS score for each national concern area is constructed separately for each national focus concern area. While a score is constructed for each concern area, a State is not assessed on each concern area separately.

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.

Scoring

For each survey, 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 a 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.

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” concern areas across all focus concern surveys
- Denominator: Multiply the total number of instances examined across all concern areas by 2
- The overall score is the numerator divided by the denominator multiplied by 100.
- For example, if across all focused concern surveys the total number of instances investigated across all concern areas was 10, then the total number of possible points that State could earn would be 20 (10 instances multiplied by a maximum of 2 points each). If the State met 6 of 10 instances, partially met 3 of 10 instances, and did not meet 1 of 10 instances, its total points earned would be 15 (the 6 “Met” multiplied by 2 plus the 3 “Partially Met” multiplied by 1). The State’s overall score would be 75 percent because 15 divided by 20 equals 0.75.

To calculate a score for any one specific focus concern area, create a numerator and denominator as follows.

- Numerator: Add all the points assigned to “Met,” “Not Met,” and “Partially Met” instances for that specific concern area across all focus concern surveys
- Denominator: Multiply the total number of instances examined for that concern area by 2
- The overall score is the numerator divided by the denominator multiplied by 100.

- For example, if across all focused concern surveys the total number of instances investigated for a specific concern area was 6, then the total number of possible points that State could earn would be 12 (6 instances multiplied by a maximum of 2 points each). If the State met 3 of 6 instances, partially met 2 of 6 instances, and did not meet 1 of 6 instances, its total points earned would be 8 (the 3 “Met” multiplied by 2 plus the 2 “Partially Met” multiplied by 1). The State’s overall score would be 67 percent because 8 divided by 12 equals 0.667.

Reference

Admin info 21-07-ALL for FY2021 Guidance for Federal Monitoring Surveys

Q2. Identification of Health, LSC, and EP Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results

Threshold Criteria

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 immediate jeopardy or actual harm levels or that resulted in SQC for health surveys, the State Survey Agency must cite the same findings on its survey at the same or higher severity level. This measure only considers cases when the State Agency is deemed accountable for the CMS Location reviewers.

Note

For SQC at an F, the State Survey Agency had to cite the same findings at an F or higher.

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: Identification of Health, LSC and Emergency Preparedness (EP) Deficiencies on Nursing Home 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 health or LSC recertification or complaint surveys. Tags identified during Federal Monitoring Surveys and initial recertification surveys are excluded.

Scoring

If fewer than 50% of the tags reviewed during an IDR or IIDR are downgraded or removed, this Measure is scored as “Met.”

If 50% or more of the tags reviewed during an IDR or IIDR are downgraded or removed, this Measure is scored as “Not Met.”

Evaluation

This measure is the count of tags cited on the CMS-2567 across standard 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. CMS will construct this measure using data available from the National database. 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. To qualify for this measure, a State must have had at least 5 tags reviewed by IDR or IIDR during the fiscal year.

Reference

State Operations Manual Chapter 7, Sections 7212, 7213

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

Data Source(s)

List of identified 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 each six months from 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. 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 each six months per SFF slot. Slots are 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 the 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 occurred in more than six months from 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 Standard Survey Upload (S2)

Data Source(s)

National Survey Database

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: hospitals (all types), hospices, outpatient physical therapy/speech language pathology providers, rural health clinics, End-Stage Renal Disease (ESRD) facilities, comprehensive outpatient rehabilitation facilities, community mental health centers, nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and psychiatric residential treatment facilities. Surveys with a condition-level deficiency are excluded. The measure is focused on non-deemed providers and for standards surveys conducted during this fiscal year. For interim SPSS results reporting quarterly, this measure will use the last day of the fiscal year quarter to assess timeliness of surveys completed in this fiscal year but not yet uploaded to the National Survey Database. For example, if a survey was completed on September 15 but not yet uploaded as of September 30, the number of days to upload for that survey as of September 30 will be considered 15 days for the first quarter interim measure.

Calculating Standard/Recertification Survey Average Upload Days

1. Calculate the number of days between Survey 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*.

$$\text{Average Days} = \frac{\text{Sum of Upload Days}}{\text{Uploaded Surveys}}$$

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

Nursing Homes

For nursing homes, CMS will identify use of the IJ template directly in the long-term care survey process data for standard surveys and complaint surveys conducted in tandem with standard 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 proportion 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 (ASCs, HHAs, hospices, hospitals, ESRD facilities, and ICF/IID). 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 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. Identification of Health, LSC, and Emergency Preparedness (EP) Deficiencies on Surveys (Q2)

1. Data Source(s)

Federal Monitoring Survey Data

2. Method

Citation Accuracy Chart

CMS Location Federal Comparative Survey citations	Points in Denominator	Points in numerator: SA cites similar findings at same or different tag; same or higher severity	Points in numerator: SA cites similar findings at same or different tag; lower severity which was appropriate at time of its survey	Points in numerator: SA cites similar findings at same or different tag; lower severity that should have cited at same or higher severity level or SQC	Points in numerator: SA cites same tag, no similar findings	Points in numerator: SA does not cite tag at all SHF = yes
IJ/SQC	15	15	15	7.5	7.5	0
IJ/no SQC	12	12	12	6	6	0
AH/SQC	9	9	9	4.5	4.5	0
AH/no SQC	6	6	6	3	3	0
F SQC	3	3	3	1.5	1.5	0

SA = State Survey Agency; SQC = substandard quality of care; SHF = "should have found;" IJ = immediate jeopardy; AH = actual harm

The FMS comparative survey report identifies all the deficiencies cited from health and LSC comparative surveys that the CMS Locations identified at IJ, actual harm and/or SQC; 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 above table 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 percent agreement rate 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

Percentage Agreement Rate = $(Numerator/Denominator)$ ×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=un able to determine)

For “F” SQC, the State Survey Agency had to cite the same findings at an “F" 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 an IJ or Actual harm level for health and LSC deficiencies and for any health deficiencies that are cited at an F S/S level that is SQC. 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. 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 S5. Rounding is not allowed in determining whether the State Survey Agency met or did not meet the threshold criterion for these measures.

C1. Rounding is not allowed in determining whether the State Survey Agency met or did not meet the threshold criterion.

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.