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Center for Clinical Standards and Quality

Admin Info: 25-03-ALL

DATE: October 23, 2024

TO: State Survey Agency Directors

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

SUBJECT: Fiscal Year (FY) 2025 State Performance Standards System (SPSS) Guidance

Memorandum Summary

CMS is releasing the Fiscal Year 2025 guidance for the State Performance Standards System (SPSS), the process used to oversee State Survey Agency performance for ensuring Medicare/Medicaid certified providers and suppliers are compliant with federal requirements to improve and protect the health and safety of Americans.

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

Discussion:
The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve the health and safety of Americans such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents. The three domains of the SPSS for the 2025 fiscal year include:

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

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

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

Effective Date:
October 1, 2024. 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

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Fiscal Year 2025

State Performance Standards

System Guidance

October 22, 2024

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Introduction

CMS actively evaluates the State Performance Standards System (SPSS) to improve its efficiency, consistency, and relevance in the assessment of State Survey Agency performance. The SPSS is aligned with CMS expectations for State Survey Agency performance in accordance with the §1864 Agreement and all related regulations and policies intended to protect and improve health and safety of Americans, such as the State Operations Manual, the Mission and Priority Document, survey procedure guides, and other relevant documents. The SPSS Fiscal Year 2025 (FY25) guidance is meant to ensure State Survey Agencies are consistently monitoring compliance of health care facilities.

A. Primary changes to the SPSS for Fiscal Year 2025

The Fiscal Year 2025 (FY25) SPSS measures are organized by the following three domains: Survey and Intake Process, Survey and Intake Quality, and Noncompliance Resolution. In FY25, CMS is retiring two measures from the previous fiscal year including the data submission measure and measures on the timeliness of upload of recertification surveys. CMS has discontinued these measures because iQIES implementation will enable seamless survey uploads. CMS has added a new measure to the Survey and Intake Quality domain: Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated. CMS has also reintroduced an updated version of the measure Assessment of Deficiency Identification using Federal Comparative Surveys.

B. Ongoing Activities

CMS will monitor survey and certification guidance to ensure FY25 measures remain in alignment with current guidance. In conducting oversight activities, CMS will continue to provide ongoing monitoring and support and will proactively identify priorities and measures to consider for the Fiscal Year 2026 (FY26) SPSS. CMS will also continue to work with State Survey Agencies to address their performance as assessed by the SPSS measures during this fiscal year. If you have questions or feedback related to the SPSS, please contact us via email at SPSS_Team@cms.hhs.gov.

C. Fiscal Year 2025 SPSS Measures[1]

The FY25 SPSS includes 13 measures across the three domains: Survey and Intake Process (measures S1-S8); Survey and Intake Quality (measures Q1-Q4); and Noncompliance Resolution (measure N1). The following list summarizes each FY25 SPSS measure by domain.

Survey and Intake Process

- S1. Surveys of Nursing Home Special Focus Facilities (SFF)
  - CMS will assess the frequency of recertification surveys conducted for SFFs and the addition of new facilities to the SFF list. State Survey Agencies must conduct a recertification survey with each SFF at least once every 186 calendar days and select a new SFF within 21 calendar days of the graduation[2] or termination of a facility from the SFF Program.
- S2. Use of the Immediate Jeopardy (IJ) Template – *previously S3*

[1] SPSS FY25 measures will be calculated for all providers during the transition period from QIES to iQIES.

[2] 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.

  - CMS will assess the mandatory use of the IJ template by State Survey Agencies. CMS will assess this measure for ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals, intermediate care facilities for individuals with intellectual disabilities, and nursing homes.

- S3. Immediate Jeopardy (IJ) Intakes Overdue for Investigation – *previously S4*
  - CMS will assess the number of IJ complaints/facility-reported incidents entered that have been triaged for investigation and are overdue for investigation. Between October 1, 2024, and September 30, 2025, State Survey Agencies should reduce the number of IJ complaints/facility reported incidents overdue for investigation by at least 35%. CMS will assess this measure for the following provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, nursing homes, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

- S4. EMTALA complaints prioritized as IJ and Non-IJ High conducted within the State Operations Manual (SOM) timeframe – *previously S5*
  - CMS will assess whether IJ EMTALA complaint investigations are started within the required two business days of CMS Location approval and non-IJ high EMTALA complaint investigations are started within 45 calendar days of CMS Location approval.

- S5. Intakes prioritized as Immediate Jeopardy (IJ) started within the required time period – *previously S6*
  - CMS will assess whether IJ intake surveys are started within the required time period per Chapter 5 guidance of the SOM. CMS will assess this measure for the following provider types: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes.

- S6. Off-Hour Surveys for Nursing Homes – *previously S7*
  - CMS will assess whether the appropriate proportion of nursing home health recertification surveys are started during off-hours, on weekends, and at facilities with potential staffing issues.

- S7. Frequency of Nursing Home Recertification Surveys – *previously S8*
  - CMS will assess whether nursing home recertification health surveys are conducted within the maximum time interval of 15.9 months.

- S8. Frequency of Tier 1 Acute and Continuing Care (ACC) Provider Recertification Surveys – *previously S9*
  - CMS will assess whether Tier 1 recertification surveys are conducted within the maximum time intervals for ACC providers. Tier 1 includes recertification health surveys for non-deemed home health agencies, non-deemed hospices, and intermediate care facilities for individuals with intellectual disabilities.

Survey and Intake Quality

- Q1. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys
  - CMS will assess whether State Survey Agency nursing home compliance, recertification, and revisits are being conducted in compliance with Federal standards, protocols, forms, methods, and procedures specified by CMS using the Federal Monitoring Survey (FMS) Focus Concern Surveys (FCS) results.
- Q2. Assessment of Deficiency Identification using Federal Comparative Surveys *(updated and reintroduced in FY25)*
  - CMS will assess if State Survey Agency citations are similar to findings by CMS Location findings on Federal comparative surveys.
- Q3. Nursing Home Tags Downgraded/Removed by Informal Dispute Resolution (IDR) or Independent IDR (IIDR) and Unresolved IDRs/IIDRs
  - CMS will assess the 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.
- Q4. Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated *(new measure in FY25)*
  - CMS will assess the frequency and type of nursing home deficiencies and the completion of mandatory or triggered tasks on recertification surveys. This measure combines six measures into a composite score: (1) Number of Deficiencies per 1,000 Beds, (2) Percentage of Deficiency-Free Surveys, (3) Percentage of Surveys Identifying G, H or I Scope and Severity, (4) Percentage of Surveys Identifying J, K or L Scope and Severity, (5) Percentage of Surveys where 1 or more Mandatory Tasks Not Investigated, and (6) Percentage of Surveys where 1 or more Triggered Tasks Not Investigated.

Noncompliance Resolution

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

General Instructions

This year's SPSS Guidance provides instructions to CMS Locations and State Survey Agencies on how CMS will evaluate State Survey Agency performance. CMS will use available data to construct 12 of 13 SPSS measures and part of the remaining 13th measure. CMS will construct the IJ template measure from existing data for nursing homes and with data reported by CMS Location staff for acute and continuing care providers. SPSS FY25 measures will be calculated during the transition period from QIES to iQIES. Measures will be calculated for providers that have migrated to iQIES.

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

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

Timeline

The FY25 SPSS evaluation period is October 1, 2024, through September 30, 2025, with milestone dates as follows:

Milestone Dates for SPSS FY25

Activity	Approximate Date
FY25 SPSS Results available for State Survey Agency review and Informal Requests for Reconsideration (IRR) begins	January 16, 2026
Deadline for State Survey Agencies to submit IRR	February 6, 2026
FY25 SPSS Results Finalized	February 27, 2026
Corrective Action Plans Due from States	March 13, 2026

SPSS Scoring

CMS will score State Survey Agency performance on SPSS measures as Met, Partially Met, and Not Met. The Partially Met scoring category was added in FY23 to recognize State Survey Agencies that make progress from year to year and to encourage continued progress towards established SPSS measure thresholds. In FY25, CMS is adding a new Requires Research scoring category specifically for the new Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated measure (Q4). A summary of how CMS will assign scores to each State Survey Agency, including the Partially Met category, and a detailed description of how State Survey Agencies can achieve specific scoring categories for each SPSS measure are provided below.

- **Met.** A State Survey Agency can achieve a score of Met for a FY25 SPSS measure if the end of fiscal year value of that measure meets or exceeds the threshold identified in the FY25 SPSS Guidance.
- **Partially Met.** A State Survey Agency can achieve a score of Partially Met for a FY25 SPSS measure if:
  - that measure in FY24 was Met and the FY25 measure value is slightly below the established FY24 threshold; or
  - that measure in FY24 was Not Met or Partially Met and the FY25 measure value demonstrates substantial progress from FY24; or
  - that measure in FY24 was scored as not applicable (N/A) and the FY25 measure value is at or above the Partially Met threshold established for that measure for FY25; or
  - that measure was not included in the FY24 SPSS but the FY25 measure value is at or above the Partially Met threshold established for that measure for FY25.
- **Not Met.** A State Survey Agency achieves a score of Not Met for a FY25 SPSS measure if the FY25 measure value does not meet the Met threshold identified in the FY25 Guidance and does not meet the conditions necessary to qualify as Partially Met.
- **Requires Research.** CMS classifies a state as Requires Research if the FY25 *Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated (Q4)* measure composite is less than the required threshold. This scoring classification is only used for this one measure and not others.
- **N/A (Not applicable).** There are some circumstances under which CMS will not score a SPSS measure, primarily based on a small number of applicable cases for any specific measure.

Corrective Action Plan

For some measures scored as "Not Met" at the end of the fiscal year, the State Survey Agency will develop and implement an action plan that will address identified problems. The State Survey Agency corrective action plan must contain an action plan for each applicable measure that is scored as "Not Met." A State Survey Agency must also submit an action plan if it received a score of Partially Met on the same measure in both FY24 and FY25. The CMS Location will review and follow-up to ensure that the State Survey Agency is progressing toward making corrections. In some instances, a State Survey Agency

may not be expected to fully improve their performance on a measure due to the timing of the final report for a given fiscal year.

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

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

CMS Locations are required to monitor the implementation of State Survey Agency corrective action plans on a quarterly basis. CMS Locations must ensure that State Survey Agencies' corrective action plans address all failures to meet performance measures and describe specific actions State Survey Agencies plan to take to improve State performance. If a State Survey Agency has not met a performance measure in two or more consecutive years, the corrective 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 in a designated State specific CMS BOX location.

Informal Reconsideration Request

There is no formal appeal of findings relative to this Report of State Survey Agency Performance since the assessment is under the umbrella of the "Evaluation" Article (Article V) of the §1864 Agreement. However, State Survey Agencies may ask CMS for informal reconsideration. CMS will provide instructions for submitting reconsideration requests to State Survey Agencies when FY25 SPSS Results are made available for State Survey Agency review. State Survey Agencies will have 15 business days from receipt of FY25 SPSS Results to submit an Informal Reconsideration Request.

Contacts

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

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

Threshold Criteria

Each State Survey Agency shall conduct one standard recertification survey of each designated Special Focus Facility (SFF) at least once every 186 calendar days. For example, if the last recertification survey's exit date is October 9, 2024, then the next recertification survey's start date may be no later than April 13, 2025.

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

Scoring

Met. A State Survey Agency achieves a score of Met if (1) it conducts a standard recertification survey for each SFF in its State at least once every 186 calendar days and (2) SFFs that are removed from the list, due to either termination or graduation from the program, are replaced within 21 calendar days.

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

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

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

If this measure is Not Met in FY25 or was Partially Met in both FY24 and FY25, a Corrective Action Plan is required.

Evaluation

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

References

CMS Memo QSO-23-01-NH

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

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

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

S2. 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 when notifying the facility of the IJ and before exiting.

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

For nursing homes, CMS will calculate the proportion of IJ tags for which an IJ template is attached to recertification kits for each IJ tag cited during the fiscal year using the long-term care survey process application data. This could be an IJ tag cited on a recertification survey or on a complaint survey that was conducted with a recertification survey. IJ templates should be attached in the long-term care survey process application during the survey. State Survey Agencies have up to 70 calendar days from the survey exit date to upload the IJ Template.

For acute and continuing care providers, CMS Locations will assess compliance with the requirement quarterly for a sample of IJ tags by determining if the IJ template has been attached to the survey and uploaded in ASPEN within 70 calendar days of the survey exit date. iQIES does not require 'uploading;' however, for FY25, IJ templates attached in iQIES within 70 calendar days of the survey exit will be assessed to meet the requirement. Selected IJ tags will be reviewed from both recertification and complaint surveys. The following tables define the sample and selection process required for reporting.

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

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

[a] For all Acute and Continuing Care providers combined, CMS Locations are not required to report more than 10 IJ tags for any one State, but may do so at their discretion.

[b] Because CMS Locations will review tags quarterly, the targeted numbers here are approximate; see below for guidance on IJ tag selection.

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

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

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

Scoring

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

Met. A State Survey Agency achieves a score of Met if at least 80% of IJ templates are attached or attached and uploaded within 70 calendar days of the survey exit date for identified IJ deficiencies.

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

- The FY24 score was Met and the FY25 measure value is 75% or greater.
- The FY24 score was Partially Met or Not Met; the FY25 measure value is at least 10 percentage points greater than the FY24 measure value; and the FY25 measure value is 60% or greater.
- The FY24 score was N/A and the FY25 measure value is 60% or greater.

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

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has no IJ deficiencies cited in FY25.

A corrective action plan is not required for this measure in FY25.

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 attached in the LTCSP and uploaded within 70 calendar days of the survey exit.

For acute and continuing care providers, CMS Location staff will identify if an IJ template was attached to the survey in iQIES or attached to the survey and uploaded in ASPEN within 70 calendar days of the survey exit date for IJ tags cited.

See Appendix 2. Use of the IJ Template (S2) for further details.

References

State Operations Manual, Appendix Q

CMS Memo QSO-19-09-ALL

S3. Immediate Jeopardy (IJ) Intakes Overdue for Investigation[3]

Threshold Criterion

The number of immediate jeopardy (IJ) complaints/facility reported incidents entered that have been triaged for investigation and are overdue for investigation is reduced by 35% or more by September 30, 2025, so that complaints/facility reported incidents are addressed in a timely manner per the State Operations Manual and the Mission and Priority Document. CMS will calculate this measure in two ways: (1) for IJ nursing home complaints and facility reported incidents for the time period starting October 1, 2024 and ending September 30, 2025, and (2) for IJ intakes for Tier 1 acute and continuing care provider complaints for the time period starting October 1, 2024 and ending September 30, 2025. 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 assess this separately for nursing homes and acute and continuing care providers. Acute and continuing care providers include the following deemed and non-deemed provider types: ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics.

Scoring

This measure is scored as two separate measures: one for nursing homes and one for acute and continuing care providers. For both these measures, a State Survey Agency is only scored based on IJ complaints and facility reported incidents.[4]

Met. A State Survey Agency achieves a score of Met if the number of intakes overdue for investigation is reduced by 35% or more in FY25.

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

- The FY24 score was Met and at least a 30% reduction is achieved in FY25.
- The FY24 score was Partially Met or Not Met; the FY25 reduction is at least 10 percentage points greater than the FY24 reduction; and at least a 20% reduction is achieved in FY25.
- The FY24 score was N/A and at least a 20% reduction is achieved in FY25.

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

N/A. A State Survey Agency receives a score of N/A (not applicable) if the number of intakes overdue for investigation at the start of the year is less than 5 and the number at the end of the year is less than 10.

A State Survey Agency must submit a corrective action plan for the nursing home measure if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met. For the acute and continuing care

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[3] S3. 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 FY25, this measure threshold will be revised to reflect those changes.

[4] Facility reported incidents are only applicable for nursing homes.

(ACC) provider measure, a State must submit a corrective action plan if it achieves a score of Not Met in FY25 or both the FY24 and FY25 scores were Partially Met for ACC providers with a Tier 1 priority for IJ intakes: ASC, CORFs, CMHCs, ESRD, FQHCs, RHCs, HHAs, Hospice, Hospitals, ICF-IID, OPT-SLPs portable x-ray, and PRTFs.

Evaluation

We will use either iQIES or ASPEN data to calculate this measure depending on where these data are located. At the start of FY25, data for ambulatory surgical centers, hospices, and home health agencies are in iQIES and other providers are in ASPEN. CMS will identify the number of IJ complaints/facility reported incidents entered that have been triaged for investigation and are overdue for investigation on October 1, 2024, and the same measure on September 30, 2025. CMS will calculate the percentage difference between the number identified on October 1, 2024 and the number identified on September 30, 2025.

Reference

CMS Memo QSO-22-02-ALL

S4. EMTALA prioritized as IJ and Non-IJ High conducted within the required time period

Threshold Criteria

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

Scoring

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

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

- The FY24 score was Met and the FY25 measure values for both sub-measures are at least 90%.
- The FY24 score was Partially Met or Not Met; the FY25 sub-measure values that fell below 95% in FY24 are at least 2 percentage points greater than in FY24; and the FY25 measure values for both sub-measures are 75% or greater.
- The FY24 score was N/A and the FY25 measure values for both sub-measures are 75% or greater.
- The FY25 value is at least 50% and less than 75%, and 80% or more of the State Survey Agency's late cases for EMTALA investigation were late by only 1 day.

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

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has no IJ EMTALA complaints and 5 or fewer non-IJ high EMTALA complaints in FY25.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

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

To calculate the percentage of EMTALA complaints prioritized as non-IJ high that were started within the required time period, the count of EMTALA complaints prioritized as non-IJ high started within 45

calendar days of CMS Location approval is divided by the total number of EMTALA complaints prioritized as non-IJ high.

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

References

QSO-19-14-Hospitals, CAHs

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

State Operations Manual, Appendix V

FY24 Mission & Priority Document

S5. Intakes prioritized as IJ started within the required time period

Threshold Criteria

This performance measure evaluates the timeliness of survey initiation for intakes prioritized as IJ for the following providers: ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, and nursing homes. For nursing homes and non-deemed acute and continuing care providers, CMS will calculate the percentage of surveys initiated within the required time period of intakes prioritized as IJ. For deemed acute and continuing care providers, CMS will calculate the percentage of surveys initiated within the required time period of receipt of CMS Location approval of intakes prioritized as IJ.

Scoring

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

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

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

- The FY24 score was Met and the FY25 measure value is at least 77%.
- The FY24 score was Partially Met or Not Met; the FY25 measure value is at least 5 percentage points greater than in FY24; and the FY25 measure value is 70% or greater.
- The FY24 score was N/A and the FY25 measure value is 75% or greater.
- The FY25 value is at least 50% and less than 70%, and 80% or more of the State Survey Agency’s late surveys for IJ-prioritized intakes were late by only 1 day.

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

N/A. A State Survey Agency is assigned a score of N/A if there are no intakes prioritized as IJ in FY25.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

To calculate the percentage of nursing home intakes prioritized as IJ that were started within the required time period, the count of IJ intakes started within the required time period is divided by the total number of nursing home intakes prioritized as IJ. For complaints, the required time period is defined as three business days from the intake start date to the survey start date. For facility-reported incidents, the required time period is defined as three business days if there is inadequate resident protection and seven business days if there is potentially adequate resident protection. The data element *Investigate within X Days* is used to assess whether facility-reported incidents need to be started within three business days or seven business days. If *Investigate within X Days is* equal to three business days, the facility-reported incident is required to be started within three business days. If *Investigate within X Days* is equal to seven business days, the facility-reported incident is required to be

started within seven business days. If *Investigate within X Days* is equal to missing, it will be assumed that *Investigate within X Days* is equal to seven business days.

To calculate the percentage of non-deemed acute and continuing care 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 intakes prioritized as IJ among non-deemed acute and continuing providers. The required time period is defined as two business days from the intake received end date to the survey start date.

To calculate the percentage of deemed acute and continuing care 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 intakes prioritized as IJ among deemed acute and continuing providers authorized by CMS Locations. The required time period is defined as two business days of receipt of CMS Location approval to the survey start date.

References

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

S6. Off-Hour Surveys for Nursing Homes

Threshold Criteria

(1) At least 10% of nursing home health recertification surveys conducted in the fiscal year must begin during off-hours. Off-hours surveys are currently defined as those that start on weekends (Saturday or Sunday), Federal holidays, early morning (before 8:00am), or evenings (after 6:00pm).[5] These surveys must be completed on consecutive days.

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

(3) At least 80% of off-hour weekend (Saturday or Sunday) surveys must be conducted among facilities with potential staffing issues. Facilities with potential staffing issues are identified in the Provider Ratings file that CMS provides to States on a monthly basis. A weekend survey can be included in this sub-measure if the facility had a Staffing Alert of "Low Weekend Staffing" and/or "High # of Days with No RN" on the Provider Ratings file in the three months prior to the survey. CMS will use *Expected Off-hour Weekend Survey* count instead of the actual number of off-hour weekend surveys conducted to calculate this measure. *Expected Off-hour Weekend Surveys* is defined as 5% of all recertification surveys conducted within the fiscal year.

Scoring

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

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

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

N/A. A State Survey Agency receives a score of N/A (not applicable) if it conducted 3 or fewer health recertification surveys in FY25.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

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

[5] The definition of off-hours is subject to change by CMS. If the definition of off-hours is updated, this measure will be evaluated using the new definition from that point forward.

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

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

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

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

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

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

$$\text{Number of Expected Off Hours Surveys} = A * 0.10$$

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

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

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

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

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

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

$$\text{Number of Expected Off Hours Weekend Surveys} = A * 0.05$$

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

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

References

State Operations Manual, Chapter 7 Section 7207.2.2

QSO 19-02-NH

FY23 Mission & Priority Document

42 C.F.R. §488.318

S7. Frequency of Nursing Home Recertification Surveys

Threshold Criteria

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

State Survey Agencies are still resolving overdue health recertification surveys as a result of the COVID-19 public health emergency. Taking this into consideration, this measure will assess whether State Survey Agencies conducted recertification surveys within the 15.9-month time interval; however, this measure will not assess the statewide average time interval between consecutive recertification health surveys requirement for this fiscal year.

Scoring

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

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

- At least 70% of all active nursing homes are surveyed at least every 15.9 months
- The FY25 measure value is 10 percentage points greater than the FY24 measure value and the FY25 measure value is at least 50%.

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

N/A. A State Survey Agency receives a score of N/A (not applicable) if it has 5 or fewer active nursing homes in FY25.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

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

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

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

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

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

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

References

FY24 Mission & Priority Document

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

42 C.F.R. §488.308

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

Threshold Criteria

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

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

State Survey Agencies are still resolving overdue health recertification surveys as a result of the COVID-19 public health emergency. Taking this into consideration, this measure will assess if HHAs have had a recertification survey in the 36.9 months before the end of the fiscal year and if Hospices have had a recertification survey in the 36.9 months before the end of the fiscal year. This measure will also exclude the intermediate care facilities for individuals with intellectual disabilities statewide average time interval between consecutive recertification health surveys requirement for this fiscal year.

Scoring

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

Partially Met. A State Survey Agency achieves a score of Partially Met if (1) any of the three Tier 1 survey requirements sub-measures fall below 100%; (2) none of the three Tier 1 survey requirement sub-measures fall below 50%; and (3) none of the three FY25 Tier 1 survey sub-measure values fall more than 15 percentage points below the FY24 sub-measure values.

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

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

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

See Appendix 3. Frequency of Tier 1 ACC Recertification Surveys (S8)

References

FY24 Mission & Priority Document

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

Hospices – 42 C.F.R. §488.1110

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

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

Threshold Criteria

Focus Concern Surveys (FCSs) ensure that State Survey Agency nursing home recertification, complaint, 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; however, the SPSS measure focuses on national concern areas only.

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 85 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

Met. A State Survey Agency achieves a score of Met if its overall FMS FCS score is 85 percent or higher.

Partially Met. To achieve a score of Partially Met, a State must achieve a score of at least 70 percent in FY25 and at least one of the following conditions must be met: (1) FY24 score was Not Met and its FY25 value is at least 10 percentage points higher than in FY24, (2) FY24 score was Met and its FY25 value is no lower than 78 percent, or (3) FY24 score was N/A or Partially Met and its FY25 value is at least 70 percent.

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

N/A. A State Survey Agency receives a score of N/A if there were two or fewer focused concerns investigated for the State in FY25 across all focus concern surveys.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

See Appendix 4. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys (Q1)

Reference

CMS Memo QSO-22-09-ALL

Admin info 24-12-NH Guidance for Federal Monitoring Surveys

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

42 C.F.R. §488.318

Q2. 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 during health recertification surveys as measured by federal comparative survey results. For 80 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 scope and severity level.

Scoring

For SPSS FY25, CMS is implementing a hybrid scoring approach that acknowledges State Survey Agencies' efforts to conduct the highest quality surveys possible. The primary method of scoring will be a tag-based method but a State Survey Agency's final SPSS score will also consider survey-level scores. Appendix 5 includes details on how CMS will score State Survey Agencies under the tag-based and survey-level methods. CMS will score this measure as Met, Partially Met, or Not Met in the following way for FY25:

Met. The State Survey Agency achieves a score of Met if (1) the tag-based score is 80 percent or higher or (2) at least 75 percent of all comparative surveys are scored as Met.

Partially Met. The State Survey Agency achieves a score of Partially Met if (1) the tag-based score is 60 percent or more but less than 80 percent or (2) 60 percent or more but less than 75 percent of all comparative surveys are scored as Met or Partially Met.

Not Met. The State Survey Agency achieves a score of Not Met if (1) the tag-based score is less than 60 percent and (2) less than 60 percent of all comparative surveys are scored as Met or Partially Met.

N/A. The State Survey Agency receives a score of N/A if there are no federal comparative surveys in FY25.

Evaluation

See Appendix 5: 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 and Unresolved IDRs/IIDRs

Threshold Criteria

A State Survey Agency shall have fewer than 40% of tags that are reviewed during an IDR or IIDR downgraded or removed as a result of the investigation during the fiscal year. This includes all deficiency tags identified during initial recertification or complaint surveys; revisit tags are excluded. Tags identified during Federal Monitoring Surveys and initial certification surveys are excluded. In addition, the proportion of surveys where an IDR or IIDR remains in the "requested" status and is beyond the 60-day period for completion may not exceed 5% of all surveys where an IDR or IIDR was requested between FY23 and FY25. 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 and/or IIDR process and were downgraded or removed may not exceed 40% of all tags that underwent an IDR or IIDR process in the current fiscal year.

Percent of Surveys with Unresolved IDR-IIDRs. Surveys with unresolved IDRs or IIDRs may not exceed 5% of all surveys conducted with requested IDRs or IIDRs between FY23 and FY25.

This measure will be calculated for nursing homes only.

Scoring

Met. A State Survey Agency achieves a score of Met if (1) 40% or fewer tags are downgraded or removed as a result of the IDR/IIDR process and (2) no more than 5% of surveys with requested IDRs/IIDRs between FY23 and FY25 remain unresolved.

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

- The FY24 score was Met; the FY25 sub-measure 1 value is no greater than 50%; and the FY25 sub-measure 2 value is no greater than 10%.
- The FY24 score was Not Met, Partially Met, or N/A; at least one of the FY25 sub-measure values meets the FY25 Met thresholds; and the FY25 sub-measure 1 value is no greater than 50% and the FY25 sub-measure 2 value is no greater than 10%.

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

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

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

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

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

The sub-measure Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR will be calculated by dividing the count of tags cited on the CMS-2567 across recertification and complaint surveys that were downgraded in severity and scope or removed as a result of an IDR or IIDR (numerator) by the count of tags cited on the CMS-2567 for which an IDR or IIDR was completed (denominator). Only tags from surveys with a survey exit date in the fiscal year will be evaluated, regardless of IDR/IIDR completion date. An IDR/IIDR that has been requested but with no decision made regarding the IDR/IIDR by the end of the fiscal year will be excluded from the calculation. In cases where a State had fewer than 5 tags reviewed by IDR or IIDR during the fiscal year, that State will not receive a score for this sub-measure. Revisit survey tags are excluded from this 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 where the IDR/IIDR status is "requested" and there were over 60 days between the IDR/IIDR requested date and the end of fiscal year 2025 by the number of recertification and complaint surveys that were submitted for IDR/IIDR review. If the requested date is missing, 21 days following the survey exit date is used as a proxy for the requested date. If the number of days between the IDR/IIDR requested date and the last day of FY25 is less than 60 days by the end of the fiscal year, the survey will be excluded from the calculation. Only surveys with survey exit dates between FY23 and FY25 with requested IDRs or IIDRs will be evaluated.

Reference

State Operations Manual Chapter 7, Sections 7212, 7213

Q4. Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated

Threshold Criteria

CMS is committed to working with State Survey Agencies to ensure that nursing home health recertification surveys are high quality and identify appropriate deficiencies that reflect nursing home quality of care, and that surveyors cite deficiencies at the appropriate level of scope and severity and complete mandatory or triggered survey tasks during nursing home surveys. To assess the frequency and type of nursing home deficiencies and the completion of mandatory or triggered tasks on health recertification surveys, CMS will construct a measure that combines six measures into one composite score.[6] This composite measure aims to gauge State Survey Agency performance but is not an attempt to establish deficiency or investigation quotas. By using information across all health recertification surveys across a fiscal year for a State Survey Agency and combining six different measures into one composite measure, CMS seeks to understand broader performance of the State Survey Agency and not impose quotas or limits. In addition, lower scores on this composite measure would not necessarily indicate that a State Survey Agency is encountering challenges in its work because the measure itself is context free. The six measures that make up this composite include:

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

Different from other SPSS measures, CMS will assign each State a classification of “Requires Research” or N/A based on the composite score for this measure rather than a score of Met, Not Met, or Partially Met. CMS will not require States to address this measure in corrective action plans. Instead, after the end of the fiscal year, CMS will require a State classified as Requires Research to review its data and to explore with CMS potential underlying reasons for a lower composite score and, if necessary, strategies to improve its performance on these measures in the future. And, for example, after conducting research the State Survey Agency and CMS might identify previously unknown data issues that contributed to a lower than expected score on this composite measure. CMS will request that each State Survey Agency that is assigned a Requires Research classification discuss its findings with its CMS Location no later than 60 days after the FY25 score is final. State Survey Agencies are not required to examine potential reasons for a lower composite score until after the FY25 score is final. CMS and SAs will work collaboratively to review data and explore reasons for potential low composite scores. Appendix 6 includes some illustrative examples of how State Survey Agencies might examine measures.

Scoring

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

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

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[6] Further detail on how each of these measures are calculated is included in Appendix 6.

Evaluation

This measure is a composite score using six different measures. For each of the six measures, CMS will assign full credit, partial credit, or no credit based on each measure's end of FY25 value with scoring thresholds determined in July of the previous fiscal year based on the distribution of each measure across all States and territories.

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

Each measure can account for a maximum of 25 points. To construct the composite score, CMS will sum the number of points assigned to each measure. The following tables summarize how CMS will assign points to each measure based on predetermined thresholds for FY25.

FY25 Percentile (pctl) Thresholds and Scoring for Measures where Higher Values Receive Lower Scores

Measure	Full Credit	Upper Bound	Partial Upper Bound	Lower Bound	Partial Lower Bound
% of Deficiency-Free Surveys	Below 80th pctl [9.4%]	At or above the 90th pctl [12.6%]	Between 80th and 90th pctl [9.4%-12.6%]	Not Applicable	Not Applicable
% of Surveys where 1 + Mandatory Tasks Not Investigated	Below 90th pctl [3%]	At or above the 95th pctl [4%]	Between 90th and 95th pctl [3%-4%]	Not Applicable	Not Applicable
% of Surveys where 1 + Triggered Tasks Not Investigated	Below 90th pctl [8.3%]	At or above the 95th pctl [10.9%]	Between 90th and 95th pctl [8.3%-10.9%]	Not Applicable	Not Applicable
Points Earned if value in this portion of distribution	**25**	**0**	**12.5**	**Not Applicable**	**Not Applicable**

Note: To qualify for the Full Credit, Partial Lower Bound, and Partial Upper Bound zone, a State Survey Agency must have a measure value that is higher than the lower end of the threshold and lower than the upper end of the threshold. For example, for the measure "% of Deficiency-Free Surveys," a State Survey Agency with a value of 12.4% qualifies for the Partial Upper Bound zone because 12.4% is larger than the lower end (9.4%) and smaller than the upper end (12.6%).

FY25 Percentile (pctl) Thresholds and Scoring for Measures where Lower Values Receive Lower Scores

Measure	Full Credit	Lower Bound	Partial Lower Bound	Upper Bound	Partial Upper Bound
Number of Deficiencies per 1,000 Beds	Between 20th and 90th pctl [54.3-101.2]	At or below the 10th pctl [47.2]	Between 10th and 20th pctl [47.2-54.3]	At or above the 95th pctl [167.5]	Between 90th and 95th pctl [139.8-167.5]
% of Surveys Identifying G, H or I Scope and Severity	Between 20th and 90th pctl [4.3%-24.4%]	At or below the 10th pctl [2.3%]	Between 10th and 20th pctl [2.3%-4.3%]	At or above the 95th pctl [28.2%]	Between 90th and 95th pctl [24.4%-28.2%]

Measure	Full Credit	Lower Bound	Partial Lower Bound	Upper Bound	Partial Upper Bound
% of Surveys Identifying J, K or L Scope and Severity	Between 20th and 90th pctl [2.8%-10.9%]	At or below the 10th pctl [2.0%]	Between 10th and 20th pctl [2.0%-2.8%]	At or above the 95th pctl [19.3%]	Between 90th and 95th pctl [10.9%-19.3%]
Points Earned if value in this portion of distribution	**25**	**0**	**12.5**	**20**	**22.5**

Note: To qualify for the Full Credit, Partial Lower Bound, and Partial Upper Bound zone, a State Survey Agency must have a measure value that is higher than the lower end of the threshold and lower than the upper end of the threshold. For example, for the measure "Number of Deficiencies per 1,000 Beds," a State Survey Agency with a value of 55.4 qualifies for the Full Credit zone because 55.4 is larger than the lower end (54.3) and smaller than the upper end (101.2).

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

Example Scenarios

	Example Scenario 1		Example Scenario 2	
Measure	Measure Value	Points Earned	Measure Value	Points Earned
# of Deficiencies / 1,000 Beds	48.6	12.5	60.1	25
% of Deficiency-Free Surveys	11.3%	12.5	5.5%	25
% of Surveys Identifying G, H or I Scope and Severity	11.1%	25	7.5%	25
% of Surveys Identifying J, K or L Scope and Severity	9.5%	25	6.2%	25
% of Surveys where 1 or more Mandatory Tasks Not Investigated	1.1%	25	1.2%	25
% of Surveys where 1 or more Triggered Tasks Not Investigated	9.7%	12.5	2.0%	25
Total Points Earned		112.5		150
Research Required?		Yes		No

N1. Timeliness of Onsite Revisits

Threshold Criterion

This performance measure evaluates whether a State Survey Agency conducted timely revisits for the following non-deemed providers: home health agencies, hospices, intermediate care facilities for individuals with intellectual disabilities, and nursing homes. For nursing homes, onsite revisits should be conducted no more than 60 days after the survey exit date for those surveys citing deficiencies at a severity and scope of F with substandard quality of care[7] or higher. For non-deemed acute and continuing providers, onsite revisits should be conducted no more than 45 days after the survey exit date for those surveys citing condition-level deficiencies. Because data on the acceptance or receipt of facility plans of correction is not always accurately documented, this measure will not require that a State Survey Agency received or accepted a plan of correction. For all providers, this measure is focused on health surveys only.

Scoring

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

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

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

- The FY24 score was Met and the FY25 measure value is 65% or greater.
- The FY24 score was Partially Met or Not Met; the FY25 measure value is at least 2 percentage points greater than in FY24; and the FY25 measure value is 60% or greater.
- The FY24 measure value was N/A and the FY25 measure value is 60% or greater.
- The FY25 value is no less than 50% but 80% or more of the State Survey Agency's late revisit surveys were late by 3 or fewer days.

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

N/A. A State receives a score of N/A (not applicable) if it had fewer than 10 surveys requiring a revisit in FY25.

A corrective action plan must be submitted if the FY25 score is Not Met or both the FY24 and FY25 scores were Partially Met.

Evaluation

CMS will construct this measure using data available from QIES and iQIES data. For nursing homes, the count of onsite revisit surveys occurring within 60 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

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

providers, the count of onsite revisit surveys occurring within 45 days of survey exit for non-deemed providers will be divided by the count of recertification and complaint surveys of non-deemed acute and continuing care providers requiring onsite revisit due to condition-level noncompliance.

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

Reference

State Operations Manual Chapter 3, Section 3012

State Operations Manual Chapter 5, Section 5110

State Operations Manual Chapter 7, Section 7317

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

Data Source(s)

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

Method of Calculation

An active SFF must have one standard recertification health survey at least every 186 calendar days 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 recertification health survey within 186 calendar days of the selection date but with an interval of no more than 15.9 months from the last standard recertification survey exit date conducted before being selected as an SFF. Following the first standard recertification survey as an SFF, there can be no more than 186 calendar days between the standard recertification survey exit date (this does not include the survey exit date of any associated revisits) and the next standard recertification start date. For example, if the last recertification survey's exit date is October 20, 2024, then the next recertification survey's start date may be no later than April 20, 2025. A reasonable degree of unpredictability in these surveys must be maintained.

For the purposes of the State Performance Standards, State Survey Agencies must conduct one standard recertification survey at least every 186 calendar days per each SFF slot. The number of slots is determined by the number of SFFs assigned to each State as designated in policy memorandum S&C-17-20. For example, if a State Survey Agency has five SFF slots, that State Survey Agency must complete 10 standard recertification surveys for its SFFs during the fiscal year with each facility being surveyed at least once every 186 calendar days. Similarly, if a State Survey Agency has one SFF slot, that State would complete two standard recertification surveys conducted on that SFF in a given fiscal year, with each survey conducted not less than once every 186 calendar days.

When a SFF is removed either through termination or graduation, the State Survey Agency must select another facility for that SFF slot within 21 calendar days as a replacement, so all slots are filled. For terminations, the State Survey Agency must select another facility for that SFF slot within 21 calendar days from the effective date of termination. For graduations, the State Survey Agency must select another facility for that SFF slot within 21 calendar days of the date of the 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 on March 19th by facility B whose last standard survey exit date was January 10th, then a standard survey should begin at facility B no later than September 21st to meet both requirements of the SFF program including (1) a standard recertification health survey must be conducted within 186 calendar days of the selection date and (2) there can be an interval of no more than 15.9 months from the last standard recertification survey exit date conducted before being selected as an SFF. In this example, a SFF selection was made within 21 days of the graduation of the previous SFF, the recertification survey was started within 186 calendar days of the selection date, and the interval between the last standard recertification survey exit date conducted before being selected as an SFF and the first standard recertification survey as an SFF was less than 15.9 months. If the selection of a replacement SFF had occurred after 21 days, the State Survey Agency would not meet this performance measure. Similarly, if the standard survey in this example was not started until September 22nd or later, it would not meet the SPSS measure because the survey did not start within 186 calendar days of selection to the SFF slot.

Appendix 2. Use of the IJ Template (S2)

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. IJ templates should be attached in the long-term care survey process application during the survey. State Survey Agencies have up to 70 calendar days from the survey exit date to upload the IJ Template. To calculate the proportion of IJ tags cited on nursing home surveys, CMS will identify the total number of IJ tags cited in the long-term care process data and the total number of those tags for which an IJ template was provided using information available in the long-term survey process data. The percentage with an IJ template provided is the number for which an IJ template was provided divided by the total number of IJ tags cited.

Acute and Continuing Care Providers

CMS Location staff will provide data on the use of the IJ template for acute and continuing care providers (ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities). Using the reporting template provided, CMS Locations will report on up to 10 IJ tags across all provider types cited during the fiscal year as summarized in the following table. The CMS Location will select the IJ tags to review for this measure. For each IJ tag selected, CMS Locations will assess compliance with the requirement quarterly by determining if the IJ template has been attached to the survey and uploaded in ASPEN within 70 calendar days of the survey exit date. iQIES does not require 'uploading;' however, for FY2025, IJ templates attached in iQIES within 70 calendar days of the survey exit will be assessed to meet the requirement.

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, CMS Locations are not required to report more than 10 IJ tags for any one State, but may do so at their discretion.

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

Locations will report IJ template results for acute and continuing care providers on the schedule provided in the General Instructions section above.

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

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

In ASPEN, States should attach the IJ template under the Citation Manager Screen of the corresponding survey by using the "Attachment button." For consistency, the IJ template should be labeled "IJ Template-AlphaNumericTag-YearMonthDay" where AlphaNumericTag is the tag cited for the IJ deficiency and YearMonthDay is the exit date of the survey. For example, for a nursing home survey for which an IJ deficiency for infection control (F880) is identified on a survey ending on June 26, 2025, the IJ template should be named IJ Template-F880-2025June26 and attached to the survey.

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

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

Appendix 3. Frequency of Tier 1 ACC Recertification Surveys (S8)

Data Source(s)

QIES and iQIES

Method of Calculation

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

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

B) From the active home health agencies identified in (A), identify the number that were surveyed within the 36.9-months prior to the end of the fiscal year.

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

% Recertified within the maximum time interval = (B ÷ A) * 100

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

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

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

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

% Recertified within the maximum time interval = (E ÷ D) * 100

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

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

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

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

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

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

Appendix 4. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys (Q1)

Data Source(s)

Focused Concern Survey (FCS) reports

Method of Calculation

During focused concern surveys, Federal surveyors independently investigate nationally identified concern areas within 60 calendar days following a State Survey Agency standard or complaint survey exit date. Following each focused concern survey, the Federal surveyor completes a focused concern survey report and provides ratings of “Met,” “Partially Met,” or “Not Met” for each of the concern areas investigated.

Score	Score Definition	Points
Met	Met SA properly identifies noncompliance and harm Level SA missed noncompliance at Level 1	2
Partially Met	SA fails to identify noncompliance at Level 2 SA failed to provide evidence to support the Level of harm cited	1
Not Met	SA failed to identify noncompliance at: SQC, Level 3 for all tags, Level 4 for all tags	0

Following completion of all FCSs, an overall FCS score is calculated by summing points across all focused concern areas investigated during the fiscal year (numerator). This number is then divided by the total number of points that a state survey agency could have received if they had Met all the focused concern areas investigated (denominator).

Using the table below as an example, three FCSs are conducted with a total of 9 focus concern areas investigated in the fiscal year. Each concern area can receive a maximum of 2 points; therefore, the denominator is equal to 18 total points. Of the nine concern areas, eight were "Met," one was "Partially Met," and one was "Not Met" resulting in a numerator of 15. The State’s overall score would be 83.%.3% because 15 divided by 18 equals 0.83 and 0.83 multiplied by 100 equals 83.3%

Focused Concern Survey	Identified Concern Area	Score	Numerator Points	Denominator Points
Focused Concern Survey A	Nurse Staffing	Met	2	2
Focused Concern Survey A	Unnecessary Psychotropic Medication	Met	2	2
Focused Concern Survey A	Facility-Initiated Discharge	Met	2	2
Focused Concern Survey B	Nurse Staffing	Partially Met	1	2
Focused Concern Survey B	Unnecessary Psychotropic Medication	Met	2	2
Focused Concern Survey B	Facility-Initiated Discharge	Met	2	2
Focused Concern Survey C	Nurse Staffing	Not Met	0	2

Focused Concern Survey	Identified Concern Area	Score	Numerator Points	Denominator Points
Focused Concern Survey C	Unnecessary Psychotropic Medication	Met	2	2
Focused Concern Survey C	Facility-Initiated Discharge	Met	2	2
Total			**15**	**18**

Appendix 5: Assessment of Deficiency Identification using Federal Comparative Surveys (Q2)

Data Source(s)

Federal Comparative Survey Data

Method of Calculation

The Federal Comparative Survey report identifies the deficiencies cited on comparative health surveys that the CMS Locations conducted, 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.[8]

For each State Survey Agency, CMS will construct an overall deficiency tag-based score and a separate score for each comparative survey. The State Survey Agency level FY25 score is based primarily on the tag-based score; the survey-level score may supplement the final FY25 score. Each of these scores will consider only nursing home F-tags of level D and above cited by the CMS Location uniquely or nursing home F-tags cited by both the State Survey Agency and CMS Locations. The tags cited uniquely by CMS Locations that are indicated as "Should Have Found = Yes" will be included in the analysis; any deficiencies cited uniquely by CMS Locations indicated otherwise are excluded. Any tags cited uniquely by State Survey Agencies are not considered in these scores.

Tag-Based Calculation

For each tag cited at scope and severity of D or greater, based on what was written in the Federal Comparative Survey analysis report regarding how the State Survey Agency cited the same findings, CMS will use the Citation Accuracy Chart to determine how many points are assigned to the numerator and denominator of the State Survey Agency FY25 measure. If a tag identified during a federal comparative survey is changed or downgraded through the independent informal dispute resolution process, the revised tag and severity and scope will be used. If a tag cited during a Federal Comparative Survey is removed through the independent informal dispute resolution process, this tag will be excluded from scoring.

Citation Accuracy Chart

CMS Location, Federal Comparative Survey Tag	Denominator Points	Numerator Points		
		State Survey Agency cites similar tag at same or higher S/S	State Survey Agency cites similar tag at lower S/S	State Survey Agency does not cite similar tag SHF=yes
Immediate Jeopardy (J, K, or L tags)	3	3	1.5	0
Actual Harm (G, H, or I tags)	2	2	1	0

[8] 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.

CMS Location, Federal Comparative Survey Tag	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
Potential Harm (D, E, or F tags)	1	1	0.5	0

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

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

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

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

Federal Comparative Survey Score = (Numerator ÷ Denominator) * 100

Survey Level Calculation

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

The survey-level score includes two components (1) the value of the numerator points divided by denominator points (i.e., a tag-based score) and (2) whether or not the CMS Location determined the SA missed an Immediate Jeopardy deficiency either by under citation of a tag cited by both the State Survey Agency and the CMS Location or if the CMS Location determined that the State Survey Agency should have found a deficiency uniquely cited by the CMS Location. CMS will determine the survey-level score of Met, Partially Met, or Not Met as follows:

- The State Survey Agency achieves a score of Met on a survey if (1) the tag-based score for that survey is 80 percent or higher and (2) the CMS Location did not determine that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey.
- The State Survey Agency achieves a score of Partially Met on a survey if (1) the tag-based score for that survey is 60 percent or more but less than 80 percent and (2) the CMS Location did not determine that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey.
- The State Survey Agency achieves a score of Not Met on a survey if (1) the tag-based score for that survey is less than 60 percent or (2) the CMS Location determines that the State Survey Agency understated or did not cite an Immediate Jeopardy deficiency on that survey.

Exclusions from both the Tag-Based and Survey Level Calculations

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

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

Appendix 6. Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated (Q4)

Data Source(s)

QIES and LTCSP

Method of Calculation

CMS will calculate all six measures that make up this composite measure for all active nursing homes during FY25. Active nursing homes either have no termination date or a termination date after the end of the fiscal year. The following details how CMS will construct each measure.

Number of Deficiencies per 1,000 Beds

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

A) The numerator is the count of deficiencies identified during all recertification surveys at active nursing homes with an exit date during FY25.

B) The denominator is the count of beds at active nursing homes with a recertification survey exit date during FY25.

Number of Deficiencies per 1,000 Beds = (A÷B) x 1,000

The next five measures all use the same denominator:

C) All recertification surveys completed at active nursing homes with an exit date during FY25

Percentage of Deficiency-Free Surveys

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

D) The numerator is the count of deficiency-free recertification surveys at active nursing homes with an exit date during FY25.

Percentage of Deficiency-Free Surveys = (D÷C) x 100

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

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

E) The numerator is the count of recertification surveys at active nursing homes with an exit date in FY25 that cited one or more deficiencies with a scope and severity score of G, H, or I.

% of Surveys Identifying G, H or I Scope and Severity = (E÷C) x 100

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

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

F) The numerator is the count of recertification surveys at active nursing homes with an exit date in FY25 that cited one or more deficiencies with a scope and severity score of J, K or L.

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

% of Surveys where 1 or more Mandatory Tasks Not Investigated

This measure consists of a numerator (G) and a denominator (C).[9]

G) The numerator is the count of recertification surveys at active nursing homes with an exit date during FY25 on which one or more Mandatory Tasks was not investigated.

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

Percent of Surveys where 1 or more Triggered Tasks Not Investigated

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

H) The numerator is the count of recertification surveys at active nursing homes with an exit date during FY25 on which one or more tasks that triggered (other than Resident Assessment) were not investigated.

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

[9] Three mandatory tasks Resident Council Meeting, Dining Observation, and Medication Storage are eligible for temporary discretion and excluded from this measure.

Illustrative Examples of Analyses Might Conduct

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

- To examine a high value for the percentage of surveys that were deficiency-free, a State Survey Agency may consider examining if facilities without deficiencies are located in similar geographic proximity to each other, if surveyors on these survey teams are newer to their Agency, if facilities without deficiencies cited also had no deficiencies in previous years or were highly rated on Nursing Home compare, or if survey teams at these facilities completed an anticipated number of mandatory and triggered tasks during the surveys, among other potential analyses.
- To study a high value for the percentage of surveys where one or more mandatory task was not investigated, a State Survey Agency may consider examining if surveyors missed many or just a few mandatory tasks across surveys in question, if the types of mandatory tasks missed were similar or varied across surveys, if surveyors require additional training on the long term care survey process and need for examining mandatory tasks, or if surveys with one or more missed mandatory tasks were located in a specific area of their state or conducted by a subset of survey teams, among other potential analyses. The State Survey Agency may also consider situations where surveyors might have bundled mandatory tasks and cite them on a CMS-2567 but did not clear them in the LTCSP software as being conducted.
- To investigate a low value for the percentage of surveys with at least one J, K, or L deficiency, a State Survey Agency may consider examining if there were G, H, or I level deficiencies that might have been considered higher severity, if a large proportion of previous J, K, or L deficiencies were removed after the informal dispute resolution (IDR) process or independent IDR process, or if the level of J, K, or L deficiencies has changed over time, among other potential analyses.

Appendix 7. Timeliness of Onsite Revisits (N1)

Data Source(s)

QIES and iQIES

Method of Calculation

Nursing Homes

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

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

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

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

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

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

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

[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.

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

Nursing Home Table Example

Survey	Initial Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2025	3/15/2025	31
2	4/2/2025	7/3/2025	92
3	3/19/2025	.	.
4	11/5/2024	12/17/2024	42
5	7/22/2025	9/1/2025	41
6	9/25/2025	11/16/2025	52
7	1/12/2025	2/1/2025	20
8	5/28/2025	6/4/2025	7
9	2/14/2025	4/7/2025	52
10	10/2/2024	11/2/2024	31

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

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

Acute and Continuing Care Providers

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

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

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

ACC Table Example

Survey	Initial Survey Exit Date	Revisit Start Date	Days between Survey Exit and Revisit Survey Start
1	2/12/2025	3/15/2025	31
2	4/2/2025	7/3/2025	92
3	3/19/2025	.	.
4	11/5/2024	12/17/2024	42
5	7/22/2025	9/1/2025	41
6	9/25/2025	11/16/2025	52
7	1/12/2025	2/1/2025	20
8	5/28/2025	6/4/2025	7
9	2/14/2025	4/7/2025	52
10	10/2/2024	11/2/2024	31

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

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

Appendix 8. SPSS Measure Data Sources, Specifications, and Reports for Measure Monitoring

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S1. Surveys of Nursing Home Special Focus Facilities (SFF)	Survey and Certification Group Letter: S&C 17-20, Current SFF facilities lists, and QIES iQIES once it is available for nursing homes	**Special Focus Facilities surveyed every 186 calendar days sub-measure:** 1. Identify the number of special focus facility slots in the state and identify the special focus facilities that filled those slots during the fiscal year. 2. For each special focus facility, verify the following: a. no more than 186 calendar days elapsed between the survey exit date of each standard survey and the start date of the following standard survey that occurred within the fiscal year, and b. no more than 186 calendar days elapsed between the start date of the first standard survey that occurred within the fiscal year and survey exit date of the previous standard survey, and c. no more than 186 calendar days elapsed between the last standard survey exit date that occurred within the fiscal year and the end of the fiscal year. **Special Focus Facilities slots filled within 21 calendar days sub-measure:** 1. Identify any special focus facilities that graduated or were terminated during the fiscal year. 2. For each special focus facility that graduated or was terminated, verify that another special focus facility was selected within 21 calendar days of the date of the letter the State Survey Agency sent to the graduating SFF notifying it of its removal from the SFF program, or the termination effective date.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S2. Use of the IJ template	CMS Location submitted spreadsheet identifying whether Immediate Jeopardy Templates are attached to survey kits for acute and continuing care providers, and list of attachments from the Long-term Care Survey Process Data, iQIES and QIES for nursing homes	**Nursing Home – Use of the IJ Template measure:** 1. Identify the IJ tags cited during nursing home recertification surveys with survey exit dates within the fiscal year. Include any IJ tags cited on complaints that were investigated during recertification surveys that were conducted (denominator). 2. From the IJ tags identified in Step 1, identify the IJ tags where the IJ Template was attached in the long-term care survey process application and uploaded within 70 calendar days of the survey exit date (numerator). 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of Nursing home IJ tags where an IJ template was attached in the long-term care survey process application and uploaded within 70 calendar days of the survey exit date. **Acute and Continuing Care – Use of the IJ Template measure:** 1. Identify the IJ tags that CMS Locations selected for IJ template review (denominator). 2. From the IJ tags identified in Step 1, identify the IJ tags where the IJ template was attached to the survey in iQIES or attached to the survey and uploaded in ASPEN within 70 calendar days of the survey exit date (numerator). 3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of Acute and Continuing Care IJ tags where an IJ template was attached to the survey in iQIES or attached to the survey and uploaded in ASPEN within 70 calendar days of the survey exit date.	No reports available

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S3. Immediate Jeopardy (IJ) Intakes Overdue for Investigation	ASPEN, iQIES, and QIES	**Nursing Homes Intakes Overdue for Investigation measure**: 1. Identify the number of nursing home complaints/facility reported incidents that had been triaged at the immediate jeopardy (IJ) level but were overdue for investigation on October 1, 2024. 2. Identify the number of nursing home complaints/facility reported incidents that had been triaged at the immediate jeopardy (IJ) level but were overdue for investigation on September 30, 2025. 3. Subtract the number of overdue intakes identified in Step 1 from the number of overdue intakes identified in Step 2. Divide the result by the number identified in Step 1 and multiply by 100 to calculate the percentage of overdue intake reduction. **Acute and Continuing Care Intakes Overdue for Investigation measure**: 1. Identify the number of ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics complaints that had been triaged at the immediate jeopardy (IJ) level but were overdue for investigation on October 1, 2024. 2. Identify the number of ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, federally qualified health centers, home health agencies, hospices, hospitals (all types), intermediate care facilities for individuals with intellectual disabilities, organ procurement organizations, outpatient physical therapy/speech language pathology providers, portable x-ray providers, psychiatric residential treatment facilities, and rural health clinics complaints that had been triaged at the immediate jeopardy (IJ) level but were overdue for investigation on September 30, 2025. 3. Subtract the number of overdue intakes identified in Step 1 from the number of overdue intakes identified in Step 2. Divide the result by the number identified in Step 1 and multiply by 100 to calculate the percentage of overdue intake reduction.	1. ACTS – Reports – Intakes without Scheduled Surveys 2. Acts – Reports – Complaint Incident Investigation Log

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S4. EMTALA prioritized as IJ and Non-IJ High conducted within the required time period	QIES – ACTS	Both sub-measures exclude pregnancy-related EMTALA complaints **Percentage of EMTALA IJ Intakes started within 2 business days sub-measure:** 1. Identify all federal intakes with an EMTALA allegation prioritized as IJ that had a CMS investigation approval date within the fiscal year. Exclude any intakes where an associated EMTALA allegation was pregnancy-related including allegations indicated as a "labor emergency" or "other obstetric emergency." This is the denominator. 2. Calculate the number of business days between the CMS approval date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within two business days (numerator). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of EMTALA Intakes prioritized as IJ that were started within two business days. **Percentage of EMTALA non-IJ High Intakes started within 45 calendar days sub-measure:** 1. Identify all federal intakes with an EMTALA allegation prioritized as non-IJ that had a CMS investigation approval date within the fiscal year. Exclude any intakes where an associated EMTALA allegation was pregnancy-related including allegations indicated as a "labor emergency" or "other obstetric emergency." This is the denominator. 2. Calculate the number of calendar days between the CMS approval date and the investigation start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within 45 calendar days (numerator). 4. Divide the numerator identified in Step 1 by the denominator identified in Step 3 and multiply by 100 to calculate the percentage of EMTALA Intakes prioritized as non-IJ high that were started within 45 calendar days.	1. ACTS – Reports – Timeliness 2. ACTS – Reports – EMTALA – EMTALA Interval Report

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S5. Intakes prioritized as IJ started within the required time period	iQIES and QIES	**Nursing Home Intakes prioritized as IJ started within the required time period measure:** 1. Identify Nursing Home federal intakes prioritized as IJ with a received start date within the fiscal year (denominator). 2. Calculate the number of business days between the received start date and the survey start date. 3. From the intakes identified in Step 1, identify the number of facility-reported incidents that were started within the required number of days. a. Facility reported incidents with inadequate resident protection are required to be started within three business days of received start date. b. Facility reported incidents with adequate resident protection are required to be started within seven business days of received start date. 4. Sum the number of complaints and facility-reported incidents identified in Step 3 (numerator). 5. Divide the numerator identified in Step 4 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of nursing home intakes prioritized as IJ started within the required time period. **Non-deemed Acute and Continuing Care Intakes prioritized as IJ started within the required time period measure:** 1. Identify all non-deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities federal intakes prioritized as IJ with a received end date within the fiscal year (denominator). 2. Calculate the number of business days between the received end date and the survey start date. 3. From the intakes identified in Step 1, identify the number of intakes that were started within two business days (numerator). 4. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of non-deemed acute and continuing care intakes prioritized as IJ started within the required time period. **Deemed Acute and Continuing Care Intakes prioritized as IJ started within the required time period measure:** 1. Identify deemed ambulatory surgical centers, end-stage renal disease facilities, home health agencies, hospices, hospitals (all types), and intermediate care facilities for individuals with intellectual disabilities federal intakes prioritized as IJ with a received end date within the fiscal year. 2. From the intakes identified in Step 1, include only those with a CMS Location approval date (denominator). 3. Calculate the number of business days between the CMS Location approval date and the survey start date. 4. From the intakes identified in Step 2, identify the number of intakes that were started within two business days (numerator). 5. Divide the numerator identified in Step 3 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of deemed acute and continuing care intakes prioritized as IJ started within the required time period.	1. CASPER Reports – 0837D – Timeliness of Complaint/ Incident Investigations - Non-Deemed 2. CASPER Reports – 0838D – Timeliness of Complaint/ Incident Investigations – Nursing Homes 3. ACTS Reports – Non-Deemed Provider – Immediate Jeopardy Federal Complaints Investigation Timeframe 4. ACTS Report – Long Term Care: Non IJ High/ Medium Federal Investigation Timeframe

<table>
<tr><th>SPSS Measure</th><th>Data Sources</th><th>Measure Specifications</th><th>Measure Monitoring Reports</th></tr>
<tr><td>S6. Off-Hour Surveys for Nursing Homes</td><td>CMS provided monthly provider rating lists and QIES</td><td>Percent of surveys started during off-hours sub-measure:
1. Identify the number of nursing home health recertification surveys that were conducted within the fiscal year (denominator).
2. From the surveys identified in Step 1, identify the number that were started on Saturday, Sunday, a federal holiday, before 8:00 am, or after 6:00 pm.
3. Divide the numerator identified in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percentage of surveys conducted during off-hours.
Percent of off-hours surveys started during weekends sub-measure:
1. Identify the number of nursing home health recertification surveys that were conducted within the fiscal year.
2. Multiply the count identified in Step 1 by 10% (denominator).
3. Identify the number of surveys that were started on weekends (numerator).
4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of off-hour surveys started during weekends. It is possible for this percentage to be greater than 100%.
Percent of off-hours weekend surveys conducted among facilities with potential staffing issues sub-measure:
1. Identify the number of nursing home health recertification surveys that were conducted within the fiscal year.
2. Multiply the count identified in Step 1 by 5% (denominator).
3. From surveys identified in Step 2, identify the surveys conducted among facilities with potential staffing issues. A facility can be included in this count if they had a Staffing Alert of “Low Weekend Staffing” or “High # of Days with No RN” on a Provider Ratings file provided to the state within the three months prior to the weekend survey (numerator).
4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of off-hour weekend surveys conducted among facilities with potential staffing issues.</td><td>No reports available</td></tr>
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SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S7. Frequency of Nursing Home Recertification Surveys	QIES -Survey Common Table QIES – Provider Common Table iQIES once it is available for nursing homes	1. Identify all active nursing homes. Active nursing homes are those with an original participation date before June 1, 2024 and either no termination date or a termination date after the end of the fiscal year. 2. Exclude any federal facilities, such as Indian Health Service or military/veteran facilities. 3. Calculate the number of resulting active nursing homes (denominator). 4. From the active nursing homes identified in Step 3, identify the number of nursing homes with completed recertifications surveys in the 15.9-month time period prior to the end of the fiscal year. 5. From the nursing homes identified in Step 4, identify the number where the time between the most recent recertification survey and the previous recertification survey is greater than 15.9 months. 6. Subtract the number of nursing homes identified in Step 5 by the number of nursing homes identified in Step 4 (numerator). 7. Divide the numerator identified in Step 6 by the denominator in Step 2 and multiply by 100 to calculate the percentage of active nursing homes that have had a recertification survey every 15.9 months.	1. QCOR - Overdue Recertification Surveys 2. CASPER Reports - 0803D - Nursing Home Providers Not Surveyed 3. CASPER Reports - 0842D - Providers Not Surveyed 4. ACO Reports - Months Since Last Certification

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
S8. Frequency of Tier 1 Acute and Continuing Care Recertification Surveys	iQIES and QIES	**Home Health Agency Recertification sub-measure:** 1. Identify active non-deemed home health agencies. Active non-deemed home health agencies are those that have a deeming status of either missing or non-deemed, have an original participation date before September 1, 2022, and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the active non-deemed home health agencies identified in Step 1, identify the number that were surveyed within the 36.9-month time period prior to the end of the fiscal year. 3. Divide the numerator identified in Step 2 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active non-deemed home health agencies that have had a recertification survey within 36.9 months. **Hospice Recertification Survey sub-measure:** 1. Identify active non-deemed hospice facilities. Active non-deemed hospice facilities are those that have a deeming status of either missing or non-deemed, have an original participation date before September 1, 2022, and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the active non-deemed hospice facilities identified in Step 1, identify the number that were surveyed within the 36.9-month time period prior to the end of the fiscal year. 3. Divide the numerator identified in Step 2 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active non-deemed hospice facilities that have had a recertification survey within 36.9 months. **Intermediate Care Facilities for Individuals with Intellectual Disabilities Recertification Survey sub-measure:** 1. Identify active intermediate care facilities for individuals with intellectual disabilities. Active intermediate care facilities for individuals with intellectual disabilities that have an original participation date before June 1, 2024 and either no termination date or a termination date after the end of the fiscal year (denominator). 2. From the intermediate care facilities for individuals with intellectual disabilities identified in Step 2, identify the number that were surveyed in the 15.9-month time period prior to the end of the fiscal year. 3. From the intermediate care facilities for individuals with intellectual disabilities identified in Step 2, identify the number where the time between the most recent survey and the previous survey is greater than 15.9 months. 4. Subtract the number of intermediate care facilities for individuals with intellectual disabilities identified in Step 3 by the number of intermediate care facilities for individuals with intellectual disabilities identified in Step 2 (numerator). 5. Divide the numerator identified in Step 4 by the denominator in Step 1 and multiply by 100 to calculate the percentage of active intermediate care facilities for individuals with intellectual disabilities that have had a recertification survey every 15.9 months.	1. CASPER Reports - 0812D - HHA Providers Not Surveyed 2. CASPER Reports - 0822D - ICF/IID Providers Not Surveyed 3. CASPER Reports - 0842D - Providers Not Surveyed 4. ACO Reports - Months Since Last Certification

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
Q1. Assessment of Survey Practice in Accordance with Federal Standards using Focused Concern Surveys	Focused Concern Survey Data	1. Calculate the number of areas investigated across focused concern surveys. 2. Multiply the identified focus concern areas investigated by 2 (denominator). 3. Identify the number of focus concern areas investigated that were "Met." Multiply this number by 2. 4. Identify the number of focus concern areas investigated that were "Partially Met." Multiply this number by 1. 5. Identify the number of focus concern areas investigated that were "Not Met." Multiply this number by 0. 6. Sum the totals calculated in Steps 3, 4, and 5 (numerator). 7. Divide the numerator calculated in Step 6 by the denominator identified in Step 2 and multiply the result by 100 to calculate the Focused Concern Survey score.	No reports available
Q2. Assessment of Survey Practice and Deficiency Identification using Federal Monitoring Surveys	Federal Comparative Survey Data	1. Identify all nursing home F-tags eligible for this measure from comparative survey data. 2. Construct a state-level tag-based score using the scoring rubric identified in the Citation Accuracy Chart on pages 41 and 42. 3. Construct a survey-level tag-based score using the scoring rubric identified in the Citation Accuracy Chart. 4. Assign a score of Met, Partially Met, or Not Met for each comparative survey using the instructions in Appendix 5. 5. Assign a score of Met, Partially Met, or Not Met at the State Survey Agency level for FY25 using the scoring rules on page 26 under the description of measure Q2.	Federal Comparative Survey Data

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
Q3. Nursing Home Tags Downgraded/Removed by IDR or IIDR and Unresolved IDRs/IIDRs	ASPEN and QIES; iQIES once it is available for nursing homes	**Percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR sub-measure:** 1. Identify all citation tags from nursing home recertification and complaint surveys that underwent IDR/IIDR review. Include only citation tags from surveys with a survey exit date within the fiscal year. Exclude any tags from a CDC survey. Exclude any citation tag from surveys where the IDR/IIDR is in the "requested" status (denominator). 2. From the citation tags identified in Step 1, identify citation tags that were downgraded or removed as the result of an IDR/IIDR (numerator). 3. Divide the numerator calculated in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percent of Nursing Home Tags Downgraded or Removed by IDR or IIDR. **Percent of Surveys with Unresolved IDR/IIDRs sub-measure:** 1. Identify all nursing home recertification and complaint surveys with survey exit dates in fiscal year 2023 through fiscal year 2025 that were submitted for IDR/IIDR review. Exclude any survey where the IDR/IIDR request was rescinded. Exclude any CDC survey. Exclude any survey where the IDR/IIDR requested date was within 60-days of the end of fiscal year 2025 (denominator). 2. From the surveys identified in Step 1, identify the surveys where the IDR/IIDR remains in the "requested" status (numerator). 3. Divide the numerator calculated in Step 2 by the denominator identified in Step 1 and multiply by 100 to calculate the percent of surveys with unresolved IDR/IIDRs.	1. ACO Reports – Enforcement Reports – Ancillary Reports – IDR/IIDR Report
Q4. Nursing Home Recertification Survey Deficiency Citation and Tasks Investigated	QIES and LTCSP; iQIES once it is available for nursing homes	1. Calculate the number of recertification survey deficiencies per 1,000 beds among nursing homes with a recertification survey exit date during FY25. 2. Calculate the percentage of deficiency free nursing home recertification surveys in FY25. 3. Calculate the percentage of nursing home recertification surveys identifying G, H or I scope and severity in FY25. 4. Calculate the percentage of nursing home recertification surveys identifying J, K or L scope and severity in FY25. 5. Calculate the percentage of nursing home recertification surveys on which one or more Mandatory Tasks was not investigated in FY25. 6. Calculate the percentage of nursing home recertification surveys on which one or more Triggered Tasks (other than Resident Assessment) was not investigated in FY25. 7. From the values calculated in steps 1-6, identify the associated number of points for each measure using the tables on pages 30 and 31 under the description of measure Q4. 8. Add the number of points identified in step 7.	1. ASPEN Reports - Deficiency Free Surveys report 2. QCOR - Deficiency Count Report (provides deficiency counts) 3. QCOR - Survey Activity Report (provides survey counts) 4. ASPEN Reports - Severity/Scope Summary

SPSS Measure	Data Sources	Measure Specifications	Measure Monitoring Reports
N1. Timeliness of Onsite Revisits	ASPEN, iQIES and QIES	**Nursing Home Timeliness of Onsite Revisits measure:** 1. Identify all nursing home initial recertification and complaint surveys with a survey exit date in the fiscal year. 2. From surveys identified in Step 1, identify those surveys that require an onsite revisit. Onsite revisits are required if the initial survey identified citations at F severity and scope with substandard quality of care or higher. 3. From surveys identified in Step 2, exclude any survey where: a. an IDR/IIDR was completed and all citations at F severity and scope with substandard quality of care or higher were removed or reduced to below F with substandard quality of care, or b. a comparative survey was conducted at the same facility within 60 days of the survey exit date, or c. all citations at F severity and scope with substandard quality of care were past noncompliance, or d. the survey exit date is less than 60 days from date of data extraction and there is no evidence of a revisit. Remaining surveys after exclusions are those that require onsite revisit (denominator). 4. From the surveys identified in Step 3, identify those surveys that had a revisit with a start date within 60 days of the survey exit of the initial survey (numerator). 5. Divide the numerator identified in Step 4 by the denominator identified in Step 3 and multiply by 100 to calculate the percentage of nursing home revisits conducted within the required time period. **Acute and Continuing Care Timeliness of Onsite Revisits measure:** 1. Identify all non-deemed home health agencies, hospices, and intermediate care facilities for individuals with intellectual disabilities initial recertification and complaint surveys with a survey exit date in the fiscal year. 2. From surveys identified in Step 1, identify those surveys that require an onsite revisit. Onsite revisits are required if the initial survey identified condition level citations (denominator). 3. From surveys identified in Step 2, identify the surveys that had a revisit start date within 45 days of the survey exit. 4. Divide the numerator identified in Step 3 by the denominator identified in Step 2 and multiply by 100 to calculate the percentage of non-deemed acute and continuing care revisits conducted within the required time period.	1. ACO – Tracking – Overdue Revisits