

13

SNF QUALITY REPORTING PROGRAM

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NOTE: Unless otherwise noted, PDF is the recommended output format for the reports described herein. Excel and CSV output formats may result in a report that is not visually aesthetic.

GENERAL INFORMATION

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) reports are requested on the **CASPER Reports** page (Figure 13-1).

Figure 13-1. CASPER Reports Page – SNF Quality Reporting Program Category



1. Select the SNF Quality Reporting Program link from the *Report Categories* frame on the left. A list of the SNF QRP reports you may request displays in the right-hand frame.

NOTE: Only those report categories to which you have access are listed in the *Report Categories* frame.

2. Select the desired underlined report name link from the right-hand frame. One or more **CASPER Reports Submit** pages are presented providing criteria options with which you specify the information to include in your report. These options may differ for each report.

3. Choose the desired criteria and select the **Submit** or **Next** button.

NOTE: SNF Quality Reporting Program reports access detailed information and may require a significant amount of time to process. Once you submit your report request(s), you may consider exiting the CASPER Reporting application, and viewing the completed report(s) at a later time.

4. Refer to Section 2, Functionality, of the CASPER Reporting User's Guide for assistance in viewing, printing, saving and exporting the reports you request.

NOTE: SNF Quality Reporting Program reports are automatically purged after 60 days.

SNF FACILITY-LEVEL QUALITY MEASURE REPORT

The SNF Facility-Level Quality Measure Report provides facility-level quality measure values for a select 12-month period. SNF quality measure values are compiled from the following sources:

- MDS 3.0 assessment data
- Medicare Fee-For-Service (FFS) claims and Eligibility Files

The **CASPER Reports Submit** criteria page (Figure 13-2) for the SNF Facility-Level Quality Measure Report presents *Begin Date* and *End Date* criteria options.

Figure 13-2. SNF Facility-Level Quality Measure Report CASPER Reports Submit Page.

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: SNF Facility-Level Quality Measure Report

Begin Date (mm/dd/yyyy): 01/01/2017
End Date (mm/dd/yyyy): 12/31/2017

Template Folder: My Favorite Reports
Template Name: SNF Facility-Level Quality Measure Report

Submit Save & Submit Back Save

Begin Date and *End Date* values define the date range of the measure calculations to select for the report. A drop-down list provides the end dates of the calendar quarters for which pressure ulcer measure calculations are available. The default value is the end date of the most recently calculated quarter. You may select a different quarter end date from the list. *Begin Date* is a read-only field that displays the first day of the 12-month period ending with the specified *End Date*.

The SNF QRP Facility-Level Quality Measure Report (Figure 13-3) presents the following:

- Facility ID (for MDS 3.0 assessment-based measures only)
- CMS Certification Number (CCN)
- Facility Name
- City/State
- Report Period: The beginning and ending reporting year dates corresponding to the user-selected *End Date* criterion.
 - N/A indicates the user-selected *End Date* is prior to the date noted in the 1st Quarter End Date Available column of Table 13-A.
 - Medicare Fee-For-Service data for the potentially preventable readmission measure are reported for a two-year period.

- Data was calculated on
 - For MDS 3.0 assessment data, this is the date the data were calculated for the 12-month period indicated in the Report Period field.
 - For Medicare FFS claims data, this is the date the data were loaded into the QIES national database.
- Comparison Group Period: The date range used to calculate national rates for comparison with facility rates during the report period. National rates are based upon stays within this date range. These dates correspond to the Report Period dates. Displayed for non-Medicare Fee-For-Service Claims measures only.
- Report Run Date: The date the report was run.
- Report Version Number: The version of the reporting system software used to produce the report.

Table 13-A. Quality Measure Dates

Measure name	Source	Earliest Date Data Available	1st Quarter End Date Available	1st Reporting Year Available
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)	Asmt	10/1/2016	9/30/2017	10/01/2016 - 09/30/2017
Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	Asmt	10/1/2016	9/30/2017	10/01/2016 - 09/30/2017
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	Asmt	10/1/2016	9/30/2017	10/01/2016 - 09/30/2017
Medicare Spending per Beneficiary (MSPB) – Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program	Claims	1/1/2016	9/30/2017	01/01/2016 - 12/31/2016
Potentially Preventable 30-Day Post-Discharge Readmission Measure for the Skilled Nursing Facility Quality Reporting Program	Claims	1/1/2015	9/30/2017	01/01/2015 - 12/31/2016
Discharge to Community–Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program	Claims	1/1/2016	9/30/2017	01/01/2016 - 12/31/2016

The main body of the report provides the following information for the measure(s) indicated:

- MDS 3.0 pressure ulcer measure (Page 1):
 - Table Legend
 - Note: Dashes represent a value that could not be computed. Dashes display in the Facility Observed Percent and Facility Risk-Adjusted Percent columns when the denominator is zero.
 - N/A = Not Available – Indicates no result value exists for the measure(s) for the requested period.
 - Source: Minimum Data Set 3.0 (MDS 3.0)
 - Measure Name
 - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
 - CMS Measure ID: The unique identification number assigned by CMS to each measure.
 - Numerator: The number of stays in the SNF that triggered the measure during the report period.
 - Denominator: The total number of qualified stays in the SNF that did not meet the exclusion criteria during the report period.
 - Facility Observed Percent: The percentage of residents who could have the QM and actually triggered it. It is computed by dividing the numerator by the denominator.
 - Facility Risk-Adjusted Percent: A computed rate whereby resident characteristics and the national average observed rate are applied to the Facility Observed Percent.
 - Comparison Group: National Average: The nationwide average of the measure for the Comparison Group Period. SNFs can compare their facility performance to the national average.
- MDS 3.0 outcomes/processes performed measures (Page 2):
 - Table Legend
 - Note: Dashes represent a value that could not be computed. Dashes display in the Facility Percent column when the denominator is zero.
 - N/A = Not Available – Indicates no result value exists for the measure(s) for the requested period.
 - Source: Minimum Data Set 3.0 (MDS 3.0)
 - Measure Name
 - Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
 - CMS Measure ID: The unique identification number assigned by CMS to each measure.
 - Numerator: The number of stays in the SNF that triggered the measure during the report period.
 - Denominator: The total number of qualified stays in the SNF that did not meet the exclusion criteria during the report period.
 - Facility Percent: The percentage of residents who could have the QM and actually triggered it, and is computed by dividing the numerator by the denominator.
 - Comparison Group: National Average: The nationwide average of the measure for the Comparison Group Period. SNF can compare their facility performance to the national average.
- Medicare FFS claims Medicare spending measure (Page 3):
 - Table Legend:
 - [a]: The treatment period is the time during which the resident receives care services from the attributed SNF, and includes Part A, Part B, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.
 - [b]: The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.
 - Note: Dashes represent a value that could not be computed. Dashes occur in the Average Spending Per Episode and MSPB Amount-Average Risk-Adjusted Spending columns when the Number of Eligible Episodes is zero.
 - N/A = Not Available – Indicates no result value exists for the measure(s) for the requested period.
 - Note: Claims-based measures do not have CASPER Resident-Level Quality Measure reports.
 - Source: Medicare Fee-For-Service Claims and Eligibility Files
 - Measure Name
 - Medicare Spending Per Beneficiary (MSPB) - Post-Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program
 - Comparison Group: Measure values and calculations are provided for the SNF and, as a comparison, all SNFs in the nation.
 - CMS Measure ID: The unique identification number assigned by CMS to each measure.

- o Number of Eligible Episodes: Total number of episodes that did not meet the exclusion criteria are provided for the SNF and, as a comparison, all SNFs in the nation.
- o Average Spending Per Episode
 - Spending During Treatment Period: Average spending per episode during the treatment period - non-risk-adjusted. The treatment period starts at the day of admission and ends at discharge. Claims for the provider as well as Part B and DMEPOS are included.
 - Spending During Associated Services Period: Average spending over the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending - non-risk-adjusted.
 - Total Spending During Episode: Average spending over the time during which the resident received care services from the SNF - non-risk-adjusted.
- o MSPB Amount
 - Average Risk-Adjusted Spending: Average spending per episode during the treatment period plus average spending per episode during the associated services period.
 - National Median: Average risk-adjusted episode spending across all episodes for all SNFs.
- o MSPB Score: The ratio of the provider's MSPB Amount to the episode-weighted median MSPB Amount across all SNF providers.
- Medicare FFS claims readmission measure (Page 4):
 - o Table Legend:
 - Note: Dashes represent a value that could not be computed. Dashes occur in the Crude Readmission Rate, Risk Standardized Readmission Rate, and Comparative Performance Category columns when the Number of Eligible Stays is zero.
 - N/A = Not Available – Indicates no result value exists for the measure(s) for the requested period.
 - Note: Claims-based measures do not have CASPER Resident-Level Quality Measure reports.
 - o Source: Medicare Fee-For-Service Claims
 - o Measure Name
 - Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program
 - o CMS Measure ID: The unique identification number assigned by CMS to each measure.
 - o Number of Readmissions: The number of residents with an unplanned readmission event in the 30-day post-discharge period.

- o Number of Eligible Stays: The total number of stays in the SNF that did not meet the exclusion criteria.
- o Observed Readmission Rate: The number of unplanned readmissions following discharge in the SNF divided by number of eligible stays in the SNF.
- o Risk Standardized Readmission Rate (RSRR): A risk adjustment of the Crude Readmission Rate that accounts for resident characteristics and a statistical estimate of the SNF effect beyond resident mix.
- o National Observed Readmission Rate: The number of unplanned readmissions following discharge in the nation divided by number of eligible stays in the nation.
- o Comparative Performance Category: A comparison of the performance of the SNF to the national benchmark depicted as one of the following:
 - Better than the National Rate
 - No Different from the National Rate
 - Worse than the National Rate
- Medicare FFS claims discharge to the community measure (Page 5):
 - o Table Legend:
 - Note: Dashes represent a value that could not be computed. Dashes occur in the Observed Discharge to Community Rate, Risk Standardized Discharge to Community Rate, and Comparative Performance Category columns when the Number of Eligible Stays is zero.
 - N/A = Not Available – Indicates no result value exists for the measure(s) for the requested period.
 - Note: Claims-based measures do not have CASPER Resident-Level Quality Measure reports.
 - o Source: Medicare Fee-For-Service Claims
 - o Measure Name
 - Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program
 - o CMS Measure ID: The unique identification number assigned by CMS to each measure.
 - o Number of Discharges to Community: The number of residents discharged to the community.
 - o Number of Eligible Stays: The total number of stays in the SNF that did not meet the exclusion criteria.
 - o Observed Discharge to Community Rate: The number of discharges to the community from the SNF divided by number of eligible stays in the SNF.

- o Risk Standardized Discharge to Community Rate: A risk adjustment of the Observed Discharge to Community Rate that accounts for resident characteristics and a statistical estimate of the SNF effect beyond resident mix.
- o National Observed Discharge to Community Rate: The number of discharges to the community in the nation divided by number of eligible stays in the nation.
- o Comparative Performance Category: A comparison of the performance of the SNF to the national benchmark depicted as one of the following:
 - Better than the National Rate
 - No Different from the National Rate
 - Worse than the National Rate

Figure 13-3. SNF QRP Facility-Level Quality Measure Report ¹

Measure Name	CMS Measure ID	Numerator	Denominator	Facility Observed Percent	Facility Risk-Adjusted Percent	Comparison Group: National Average
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)	S002.01	4	135	3.0%	7.2%	1.8%

[1]: National observed mean is .0122654.

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

¹ Fictitious, sample data are depicted.

The report records are sorted by State Code, CCN, Resident Last Name, Resident First Name ascending, Discharge Date, and Admission Date descending.

NOTE: The SNF QRP Facility-Level Quality Measure Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

SNF PROVIDER THRESHOLD REPORT

The SNF Provider Threshold Report details the status of the measures required for the Annual Payment Update (APU) by fiscal year of the APU.

CMS considers a SNF to have complied with data submission requirements for a program year if the SNF completes 100 percent of the required data elements on at least 80 percent of the MDS assessments submitted for that program year on measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Social Security Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Social Security Act. Assessments must have 100 percent of the required data elements needed to calculate the measures and standardized resident assessment data elements that apply to that program year on at least 80 percent of all required assessments. Failure to submit the required quality data may result in a two-percentage point reduction in the SNFs annual payment update.

NOTE: Only assessments submitted for residents with complete SNF Medicare Part A stays are evaluated. Residents with incomplete stays are those with an unplanned discharge, a discharge to an acute, psychiatric, or long-term hospital, a SNF PPS Part A stay less than 3 days, or death.

The criteria selection page (Figure 13-4) for the SNF Provider Threshold Report presents *Fiscal Year (FY)* options.

Figure 13-4. CASPER Reports Submit Page – SNF Provider Threshold Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: SNF Provider Threshold Report

Fiscal Year (FY): 2021

Template Folder: My Favorite Reports

Template Name: SNF Provider Threshold Report

Submit Back

Save & Submit Save

The *Fiscal Year (FY)* drop-down list contains the current APU fiscal year for which measure data collection has begun and one prior APU fiscal year. Select the desired fiscal year.


The SNF QRP Provider Threshold Report (Figure 13-5) details the following for the specified fiscal year:

- CCN
- Facility Name
- Facility City
- State

- Resident Assessment Measures:
 - Target Percentage for Assessments Meeting Data Completion Threshold: 80%
 - Definitions:
 - Resident Assessments Meeting Data Completion Threshold: Number of Resident Assessments with 100 percent of the Resident Assessment data element items for this measure for the time period.
 - Percentage of Resident Assessments Meeting Data Completion Threshold: Total number of Resident Assessments Meeting Data Completion Threshold divided by the Number of Successfully Submitted Resident Assessments, multiplied by 100 and rounded to the next highest whole number for the time period.
 - Successfully Submitted: A new Resident Assessment, or new Resident Assessments, that meet the data criteria for uploaded files and are found “valid” and accepted by the QIES national data warehouse.
 - *: A symbol used to denote an intentionally empty field. For example, there will never be a date under the “Data Submission Deadline” column for the Year row as no “Yearly” deadline exists for the measure.
 - Measure Short Names:
 - Pressure Ulcer
 - Application of Falls
 - Application of Functional Assessment/Care Plan
 - DRR
 - Pressure Ulcer/Injury
 - Functional Status Outcome: Discharge Self-Care Score
 - Functional Status Outcome: Discharge Mobility Score
 - Functional Status Outcome: Change in Self-Care Score
 - Functional Status Outcome: Change in Mobility Score
 - Totals by Year and Quarter
 - Time Period
 - Data Collection Start Date
 - Data Collection End Date
 - Data Submission Deadline (approximately 4.5 months after the end of the quarter)
 - Percentage of Resident Assessments Meeting Data Completion Threshold
 - Number of Successfully Submitted Resident Assessments
 - Number of Resident Assessments Meeting Data Completion Threshold
 - Totals by Month
 - Month

- Percentage of Resident Assessments Meeting Data Completion Threshold
- Number of Successfully Submitted Resident Assessments
- Number of Resident Assessments Meeting Data Completion Threshold

Figure 13-5. SNF QRP Provider Threshold Report – Page 1 Excerpt¹

		CASPER Report FY 2020 SNF QRP Provider Threshold Report		Run Date: 12/31/2019 Page 1 of 9		
CCN: Facility Name: Facility City: State:						
Resident Assessment Measures: Target Percentage for Resident Assessments Meeting Data Completion Threshold: 80%						
Definitions: Resident Assessments Meeting Data Completion Threshold: Number of Resident Assessments with 100 percent of the Resident Assessment data element items for this measure for the time period. Percentage of Resident Assessments Meeting Data Completion Threshold: Total number of Resident Assessments Meeting Data Completion Threshold divided by the Number of Successfully Submitted Resident Assessments, multiplied by 100 and rounded to the next highest whole number for the time period. Successfully Submitted: A new Resident Assessment, or new Resident Assessments, that meet the data criteria for uploaded files and are found "valid" and accepted by the QIES national data warehouse. *: A symbol used to denote an intentionally empty field. For example, there will never be a date under the "Data Submission Deadline" column for the Year row, as no "Yearly" deadline exists for the measure.						
Pressure Ulcer Totals by Year and Quarter:						
Time Period	Data Collection Start Date	Data Collection End Date	Data Submission Deadline	Percentage of Resident Assessments Meeting Data Completion Threshold	Number of Successfully Submitted Resident Assessments	Number of Resident Assessments Meeting Data Completion Threshold
CY 18 Q1	01/01/2018	03/31/2018	08/15/2018	56%	967	540
CY 18 Q2	04/01/2018	06/30/2018	11/15/2018	60%	1070	640
CY 18 Q3	07/01/2018	09/30/2018	02/15/2019	55%	1086	594
CY 18 Q4	10/01/2018	12/31/2018	05/15/2019	51%	1628	819
Year	01/01/2018	12/31/2018	*	55%	4751	2593
Totals by Month:						
Month	Percentage of Resident Assessments Meeting Data Completion Threshold	Number of Successfully Submitted Resident Assessments	Number of Resident Assessments Meeting Data Completion Threshold			
CY 18 January	65%	368	238			
CY 18 February	56%	283	156			
CY 18 March	47%	316	146			
CY 18 April	61%	326	197			
CY 18 May	64%	374	236			
CY 18 June	56%	370	207			
CY 18 July	56%	352	195			
CY 18 August	59%	394	229			
CY 18 September	50%	340	170			
CY 18 October	47%	581	268			
CY 18 November	56%	549	303			
CY 18 December	50%	498	248			
This report may contain privacy protected data and should not be released to the public. Any alteration to this report is strictly prohibited.						

¹ Fictitious, sample data are depicted.

NOTE: The SNF QRP Provider Threshold Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

SNF RESIDENT-LEVEL QUALITY MEASURE REPORT

The SNF Resident-Level Quality Measure Report identifies each resident with assessment records identifying a qualifying MDS 3.0 Medicare Part A Stay (SNF Stay) used to calculate the facility-level quality measure values for a select 12-month period. The report displays each resident's name and indicates how/if the resident's assessment affected the SNF's quality measures.

NOTE: The SNF Resident-Level Quality Measure Report only provides resident-level information for the quality measures associated with MDS 3.0 assessment records and does not provide resident-level information for the Medicare FFS quality measures.

The **CASPER Reports Submit** criteria page (Figure 13-6) for the SNF Resident-Level Quality Measure Report presents *Begin Date* and *End Date* criteria options.

Figure 13-6. SNF Resident-Level Quality Measure Report CASPER Reports Submit Page

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: SNF Resident-Level Quality Measure Report

Begin Date (mm/dd/yyyy): 01/01/2017

End Date (mm/dd/yyyy): 12/31/2017

Template Folder: My Favorite Reports

Template Name: SNF Resident-Level Quality Measure Report

Submit Save & Submit Back Save

Begin Date and *End Date* values define the date range of the measure calculations to select for the report. A drop-down list provides the end dates of the calendar quarters for which pressure ulcer measure calculations are available. The default value is the end date of the most recently calculated quarter. You may select a different quarter end date from the list. *Begin Date* is a read-only field that displays the first day of the 12-month period ending with the specified *End Date*.

The SNF QRP Resident-Level Quality Measure Report (Figure 13-7) presents the following:

- Facility ID
- CMS Certification Number (CCN)
- Facility Name
- City/State
- Report Period

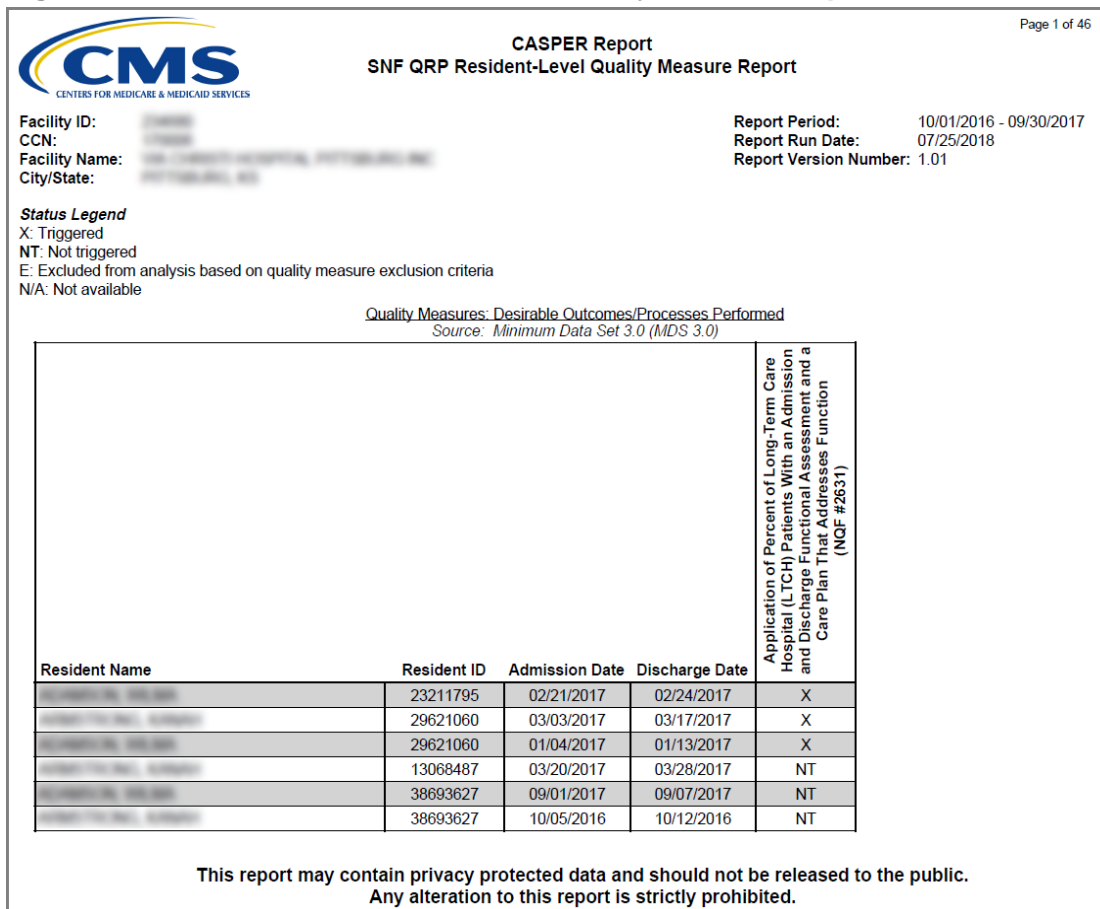
- Report Run Date
- Report Version Number

The remainder of the report provides the following information and measure status at the resident level for the measure(s) indicated:

- Quality Measures: Desirable Outcomes/Processes Performed:
 - o Status Legend:
 - X: Triggered
 - **NT**: Not triggered
 - E: Excluded from analysis based on quality measure exclusion criteria
 - N/A = Not Available
 - o Source: Minimum Data Set 3.0 (MDS 3.0)
 - o Resident Name
 - o Resident ID: The unique ID assigned to the resident in the national database.
 - o Admission Date: The A2400B (Start of most recent Medicare stay) date from the Medicare Part A Admission record.
 - o Discharge Date: The A2400C (End of most recent Medicare stay) date from the Medicare Part A Discharge record.
 - o Quality Measure Name
 - Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
- Quality Measures: Undesirable Outcomes/Processes Not Performed:
 - o Status Legend:
 - **X**: Triggered
 - NT: Not triggered
 - E: Excluded from analysis based on quality measure exclusion criteria
 - N/A = Not Available
 - o Source: Minimum Data Set 3.0 (MDS 3.0)
 - o Resident Name
 - o Resident ID: The unique ID assigned to the resident in the national database.
 - o Admission Date: The A2400B (Start of most recent Medicare stay) date from the Medicare Part A Admission record.
 - o Discharge Date: The A2400C (End of most recent Medicare stay) date from the Medicare Part A Discharge record.

- o Quality Measure Name
 - Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
 - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

Figure 13-7. SNF QRP Resident-Level Quality Measure Report ¹



¹ Fictitious, sample data are depicted.

The report records are sorted by State Code, CCN, Resident Last Name, Resident First Name ascending, Discharge Date, and Admission Date descending.

NOTE: The SNF QRP Resident-Level Quality Measure Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

SNF REVIEW AND CORRECT REPORT

The SNF Review and Correct Report allows SNF providers to review their quality measure (QM) data to identify if any corrections or changes are necessary prior to the quarter's data submission deadline, which is 4.5 months after the end of the quarter.

NOTE: Correction periods for each quarter end as follows:
Q1 (1/1-3/31) – August 15
Q2 (4/1-6/30) – November 15
Q3 (7/1-9/30) – February 15
Q4 (10/1-12/31) – May 15

The SNF Review and Correct Report provides a breakdown, by measure and by quarter, of the provider's QM results for four rolling quarters. The report also identifies the open/closed status of each quarter's data correction period as of the report run date.

NOTE: Quality Measure calculations are performed weekly and on the first day of each quarter.

The **CASPER Reports Submit** criteria page (Figure 13-8) for the SNF Review and Correct Report presents *Begin Date*, *End Date*, *Quality Measures*, and *Include Resident-Level Data* criteria options.

Figure 13-8. SNF Review and Correct Report CASPER Reports Submit Page

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: SNF Review and Correct Report

Begin Date: Q2 2018
End Date: Q1 2019

*Quality Measures:
Select All
Pressure Ulcers
Application of Falls
Application of Functional Assessment/Care Plan
DRR
Pressure Ulcer/Injury
Discharge Self-Care Score
Discharge Mobility Score
Change in Self-Care Score
Change in Mobility Score
 Include Resident-Level Data

* To select multiple items, hold down the Ctrl key and click the desired items

Template Folder: My Favorite Reports
Template Name: SNF Review and Correct Report

Submit Back
Save & Submit Save

Begin Date and *End Date* values define the date range of the QM calculations to select for the report. A drop-down list associated with the *End Date* field provides the calendar quarters for which calculated quality measure data is available. The default value is the most recently completed calculated quarter. You may select a different quarter from the list. *Begin Date* is a read-only field that displays the first quarter of the 4-quarter period ending with the specified *End Date*.

NOTE: Only qualifying patient stays with a discharge record containing a Discharge Date between the Begin Date and End Date are included in the QM calculations for the report.

The *Quality Measures* list box presents the measures that are available for the period associated with the selected *End Date*. All measures are selected by default. Alternately you may select only those measures of interest. Press and hold the Ctrl and/or Shift keys on the keyboard as you click to select/highlight multiple measures. If all measures are no longer selected, use the **Select All** button to reselect all measures if necessary. You must select at least one measure.

NOTE: For the Q4 2018 End Date and prior, the following measures are reported:

- Pressure Ulcer (Short Stay)
- Application of Falls
- Application of Functional Assessment/Care Plan

For the Q1 2019 End Date and forward, the following measures are reported:

- Pressure Ulcer (Short Stay)*
- Application of Falls
- Application of Functional Assessment/Care Plan
- DRR
- Pressure Ulcer/Injury
- Discharge Self-Care Score
- Discharge Mobility Score
- Change in Self-Care Score
- Change in Mobility Score.

* Effective with the Q4 2019 End Date and forward, the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)' measure (NQF #0678) CMS ID S002.01 will no longer be reported.

The *Include Resident-Level Data* checkbox, when selected, adds criteria options to the **CASPER Reports Submit** criteria page (Figure 13-9) for the inclusion of resident-level information in the report output.

The resident-level data criteria options presented are *Generate Resident-Level Data CSV*, *Status*, *Reporting Quarter*, *Data Correction Status*, *Primary Sort By*, and *Reverse Default Sort Order*.

Figure 13-9. SNF Review and Correct Report CASPER Reports Submit Page with Resident-Level Criteria

The screenshot shows the 'CASPER Reports Submit' interface for the 'SNF Review and Correct Report'. At the top, there are navigation links and a menu bar with options like 'Logout', 'Folders', 'MyLibrary', 'Reports', 'Queue', 'Options', 'Maint', and 'Home'. The main content area is titled 'Report: SNF Review and Correct Report' and contains several sections:

- Begin Date:** Q2 2018
- End Date:** Q1 2019
- *Quality Measures:** A list of measures including Pressure Ulcers, Application of Falls, Application of Functional Assessment/Care Plan DRR, Pressure Ulcer/Injury, Discharge Self-Care Score, Discharge Mobility Score, Change in Self-Care Score, and Change in Mobility Score. A 'Select All' button is present. Below the list are checkboxes for 'Include Resident-Level Data' (checked) and 'Generate Resident-Level Data CSV' (unchecked).
- *Status:** A list of status options: Triggered, Not Triggered, Excluded, and Dash.
- *Reporting Quarter:** A list of quarters: Q1 2019, Q4 2018, Q3 2018, and Q2 2018.
- Data Correction Status:** Radio buttons for 'Both' (selected), 'Open', and 'Closed'.
- Primary Sort By:** A dropdown menu set to 'Discharge Date' and a checkbox for 'Reverse Default Sort Order'.

At the bottom, there are fields for 'Template Folder' (My Favorite Reports) and 'Template Name' (SNF Review and Correct Report), along with 'Submit', 'Save & Submit', 'Back', and 'Save' buttons. A note at the bottom states: '* To select multiple items, hold down the Ctrl key and click the desired items'.

Select the *Generate Resident-Level CSV* checkbox to create a separate resident-level data CSV file that is placed in *My Inbox* on the **CASPER Folders** page.

Status options include *Triggered*, *Not Triggered*, *Excluded*, and *Dash*. All are selected by default. Press and hold the Ctrl key on the keyboard as you click to select/highlight only the status option(s) of interest. You must select at least one status.

The *Reporting Quarter* list box presents the quarters for which measure data are available for the specified *End Date*. Press and hold the Ctrl key on the keyboard as you click to select/highlight only the reporting quarter option(s) of interest. You must select at least one reporting quarter.

Data Correction Status options include *Both* (the default), *Open*, and *Closed* radio buttons.

Primary Sort By drop-down options include *Discharge Date* (the default), *Admission Date*, *Last Name/First Name*, and *Status or Score*. You may select only one primary sort-by option.

The default sort order for the patient-level measure results is as follows:

- Discharge Date (newest to oldest)
- Admission Date (newest to oldest)
- Lastname, Firstname (A to Z)
- Status (1-4) OR Score
 - 1 – Triggered
 - 2 – Not Triggered
 - 3 – Excluded
 - 4 – Dash
- Score (1-4)
 - 1 – Lowest (largest negative number first)
 - 2 – Highest Number
 - 3 – Excluded
 - 4 – Dash
- Resident ID (smallest to largest)

The *Reverse Default Sort Order* checkbox, when selected, reverses the order of each of the sort elements as follows:

- Discharge Date (oldest to newest)
- Admission Date (oldest to newest)
- Lastname, Firstname (Z to A)
- Status (4-1) OR Score
 - 1 – Triggered
 - 2 – Not Triggered
 - 3 – Excluded
 - 4 – Dash
- Score (4-1)
 - 1 – Lowest (largest negative number last)
 - 2 – Highest Number
 - 3 – Excluded
 - 4 – Dash
- Resident ID (largest to smallest)

The header of the SNF Review and Correct Report (Figure 13-10) presents the following for each selected measure:

- Facility ID
- CMS Certification Number (CCN)
- Facility Name
- City/State
- Requested Quarter End Date
- Report Release Date
- Report Run Date
- Data Calculation Date
- Report Version Number

For the selected measures that are available for the period, the following information is provided:

- MDS 3.0 Quality Measure Name
- Table Legend (one or more of the following, as appropriate):
 - Dash (-): Data not available or not applicable
 - X: Triggered
 - NT: Not Triggered
 - E: Excluded from analysis based on quality measure exclusion criteria
 - Note: Triggered if the resident had an observed discharge self-care score that met or exceeded the expected discharge self-care score [Discharge Self-Care Score measure only]
 - Note: Triggered if the resident had an observed discharge mobility score that met or exceeded the expected discharge mobility score [Discharge Mobility Score measure only]
 - Note: This measure is risk-adjusted; only observed data are available at this time [Discharge Self-Care Score and Discharge Mobility Score measures only]
 - *: Observed Change in Self-Care Score = (Observed Discharge Self-Care Score - Observed Admission Self-Care Score) [Change in Self-Care Score measure only]
 - *: Observed Change in Mobility Score = (Observed Discharge Mobility Score - Observed Admission Mobility Score) [Change in Mobility Score measure only]

The *Facility-Level Data* section of the report details facility-level results of each selected measure that is available for the period as follows:

- Reporting Quarter: The quarter and calendar year for which the data were collected
- CMS ID: The identifier assigned to a measure by CMS

- Start Date: Beginning date of the reporting quarter
- End Date: Ending date of the reporting quarter
- Data Correction Deadline: The date after which the data for the reporting quarter are frozen

NOTE: Corrections of the data for a reporting quarter made after the Data Correction Deadline will not affect QM results.

- Data Correction Period as of Report Run Date:
 - Open = As of the Report Run Date, the data correction deadline of the reporting quarter is either today or in the future; data may still be corrected
 - Closed = As of the Report Run Date, the data correction deadline is in the past; data can no longer be corrected and affect the QM results
- Number of Eligible SNF Stays [Change in Self-Care and Mobility Score measures only]
- Average Observed Discharge Self-Care Score [Discharge Self-Care Score measure only]
- Average Observed Discharge Mobility Score [Discharge Mobility Score measure only]
- Number of SNF Stays that Triggered the Quality Measure
- Number of SNF Stays Included in the Denominator
- Facility Percent
- Your SNF's Observed Performance Rate
- Your SNF's Average Observed Change in Self-Care Score [Change in Self-Care Score measure only]
- Your SNF's Average Observed Change in Mobility Score [Change in Mobility Score measure only]

When selected, a *Resident-Level Data* section of the report immediately follows the *Facility-Level Data* section for each selected measure and presents the following for the related resident records:

- Reporting Quarter
- Resident Name (Last, First)
- Resident ID
- Admission Date
- Discharge Date
- Data Correction Deadline
- Data Correction Period as of Report Run Date
- Observed Discharge Self-Care Score [Discharge Self-Care Score measure only]

- Observed Discharge Mobility Score [Discharge Mobility Score measure only]
- Observed Change in Self-Care Score [Change in Self-Care Score measure only]
- Observed Change in Mobility Score [Change in Mobility Score measure only]
- Status

NOTE: The SNF Review and Correct Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 13-10. SNF Review and Correct Report ¹

CMS		CASPER Report		SNF QRP Review and Correct Report		Page 1 of 290		
Facility ID:		Requested Quarter End Date:	Q3 2019					
CCN:		Report Release Date:	01/01/2021					
Facility Name:		Report Run Date:	01/01/2021					
City/State:		Data Calculation Date:	01/30/2019					
		Report Version Number:	2.0					
MDS 3.0 Quality Measure: Pressure Ulcers								
Table Legend								
Dash (-): Data not available or not applicable								
X: Triggered								
NT: Not Triggered								
E: Excluded from analysis based on quality measure exclusion criteria								
Facility-Level Data								
Reporting Quarter	CMS ID	Start Date	End Date	Data Correction Deadline	Data Correction Period as of Report Run Date	Number of SNF Stays that Triggered the Quality Measure	Number of SNF Stays Included in the Denominator	Facility Percent
Q3 2019	S002.1	07/01/2019	09/30/2019	02/15/2020	Closed	-	-	-
Q2 2019	S002.1	04/01/2019	06/30/2019	11/15/2019	Closed	40	487	8.2%
Q1 2019	S002.1	01/01/2019	03/31/2019	08/15/2019	Closed	2	6	33.3%
Q4 2018	S002.1	10/01/2018	12/31/2018	05/15/2019	Closed	-	-	-
Cumulative	-	10/01/2018	09/30/2019	-	-	42	493	8.5%
Resident-Level Data								
Reporting Quarter	Resident Name	Resident ID	Admission Date	Discharge Date	Data Correction Deadline	Data Correction Period as of Report Run Date	Status	
Q3 2019		44744496	05/01/2019	07/08/2019	02/15/2020	Closed	E	
Q3 2019		44740147	06/30/2019	07/07/2019	02/15/2020	Closed	NT	
Q3 2019		44744483	03/30/2019	07/07/2019	02/15/2020	Closed	E	
Q3 2019		44744485	03/30/2019	07/07/2019	02/15/2020	Closed	X	
Q3 2019		44744484	03/30/2019	07/07/2019	02/15/2020	Closed	E	
Q3 2019		44744095	03/30/2019	07/07/2019	02/15/2020	Closed	NT	
This report may contain privacy protected data and should not be released to the public. Any alteration to this report is strictly prohibited.								

¹ Fictitious, sample data are depicted.

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