**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**

*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 (QM) Report (Figure 13-3) presents the following:

- Facility ID
- CMS Certification Number (CCN)
- Facility Name
- City/State
- Requested Report End Date: The user-selected End Date criterion, which corresponds to the ending reporting year date.

  - N/A indicates the user-selected End Date is prior to the date noted in the 1st Quarter End Date Available column of Table 53-A.
  - Medicare Fee-For-Service data for the potentially preventable readmission measure are reported for a two-year period.
- **Report Run Date:** The date the report was produced.
- **Data Calculation Date**
  - For MDS 3.0 assessment data, this is the date the data were calculated for the 12-month period ending corresponding with the Requested Report End Date.
  - For Medicare FFS claims data, this is the date the data were loaded into the QIES national database.
- **Report Version Number:** The version of the reporting system software used to produce the report.

### Table 53-A. Quality Measure Dates

<table>
<thead>
<tr>
<th>Measure name [Short name]</th>
<th>Source</th>
<th>Earliest Date Data Available</th>
<th>1st Quarter End Date Available</th>
<th>1st Reporting Year Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) [Application of Falls (NQF #0674)]</td>
<td>Asmt</td>
<td>10/1/2016</td>
<td>9/30/2017</td>
<td>10/1/2016 - 9/30/2017</td>
</tr>
<tr>
<td>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 Functional Assessment/Care Plan (NQF #2631)]</td>
<td>Asmt</td>
<td>10/1/2016</td>
<td>9/30/2017</td>
<td>10/1/2016 - 9/30/2017</td>
</tr>
<tr>
<td>Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) [Functional Status Outcome: Discharge Self-Care Score (NQF #2635)]</td>
<td>Asmt</td>
<td>10/1/2018</td>
<td>9/30/2019</td>
<td>10/1/2018 - 9/30/2019</td>
</tr>
<tr>
<td>Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) [Functional Status Outcome: Discharge Mobility Score (NQF #2636)]</td>
<td>Asmt</td>
<td>10/1/2018</td>
<td>9/30/2019</td>
<td>10/1/2018 - 9/30/2019</td>
</tr>
<tr>
<td>Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) [Functional Status Outcome: Change in Self-Care (NQF #2633)]</td>
<td>Asmt</td>
<td>10/1/2018</td>
<td>9/30/2019</td>
<td>10/1/2018 - 9/30/2019</td>
</tr>
<tr>
<td>Measure name [Short name]</td>
<td>Source</td>
<td>Earliest Date Data Available</td>
<td>1st Quarter Reporting Year Available</td>
<td>1st Reporting Year Available</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------</td>
<td>-----------------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) [Functional Status Outcome: change in Mobility (NQF #2634)]</td>
<td>Asmt</td>
<td>10/1/2018</td>
<td>9/30/2019</td>
<td>10/1/2018 - 9/30/2019</td>
</tr>
<tr>
<td>Drug Regimen Review Conducted With Follow-Up for Identified Issues -Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) [DRR]</td>
<td>Asmt</td>
<td>10/1/2018</td>
<td>9/30/2019</td>
<td>10/1/2018 - 9/30/2019</td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary (MSPB) – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) [MSPB]</td>
<td>Claims</td>
<td>1/1/2016</td>
<td>9/30/2017</td>
<td>1/1/2016 - 12/31/2016</td>
</tr>
<tr>
<td>Potentially Preventable 30-Day Post-Discharge Readmission Measure for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) [PPR]</td>
<td>Claims</td>
<td>1/1/2015</td>
<td>9/30/2017</td>
<td>1/1/2015 - 12/31/2016</td>
</tr>
<tr>
<td>Discharge to Community–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) [DTC]</td>
<td>Claims</td>
<td>1/1/2016</td>
<td>9/30/2017</td>
<td>1/1/2016 - 12/31/2016</td>
</tr>
</tbody>
</table>

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

- **Source:** Minimum Data Set 3.0 (MDS 3.0)
  - Table Legend
    - Dash (-): Data not available or not applicable
  - Measure Name (Short name):
    - **Pressure Ulcer/Injury**
  - Report Period: The reporting period corresponding to the user-selected End Date (Requested Report End Date). For example, if the Requested Report End Date is 09/30/2019, the Report Period is 10/01/2018 – 09/30/2019.
  - CMS ID: The unique identifier assigned by CMS to each measure.
- **CMS ID Discharge Dates**: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.
- **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.
- **National Average**: The nationwide average of the measure to which facility performance may be compared.

- **Measure Name (Short name)**:
  - Application of Falls (NQF #0674)
  - Application of Functional Assessment/Care Plan (NQF #2631)
  - DRR

- **Report Period**: The reporting period corresponding to the user-selected End Date (Requested Report End Date). For example, if the Requested Report End Date is 09/30/2019, the Report Period is 10/01/2018 – 09/30/2019.

- **CMS ID**: The unique identifier assigned by CMS to each measure.

- **CMS ID Discharge Dates**: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.

- **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. It is computed by dividing the numerator by the denominator.

- **National Average**: The nationwide average of the measure to which facility performance may be compared.
o Measure Name (Short name):
  - **Functional Status Outcome: Discharge Self-Care Score (NQF #2635)**
  - **Functional Status Outcome: Discharge Mobility Score (NQF #2636)**

o Report Period: The reporting period corresponding to the user-selected End Date (Requested Report End Date). For example, if the Requested Report End Date is 09/30/2019, the Report Period is 10/01/2018 – 09/30/2019.

o CMS ID: The unique identifier assigned by CMS to each measure.

o CMS ID Discharge Dates: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.

o Average Observed Discharge Score: The average score on discharge of the quality measure for the facility.

o Average Expected Discharge Score: Computed using a mathematical model that accounts for patient or resident characteristics for the average discharge score.

o Numerator: The number of stays in the SNF that triggered the measure during the report period.

o Denominator: The total number of qualified stays in the SNF that did not meet the exclusion criteria during the report period.

o Facility Percent: The percentage of residents who could have the QM and actually triggered it. It is computed by dividing the numerator by the denominator.

o National Average: The nationwide average of the measure to which facility performance may be compared.

o Measure Name (Short name):
  - **Functional Status Outcome: Change in Self-Care (NQF #2633)**
  - **Functional Status Outcome: Change in Mobility (NQF #2634)**

o Report Period: The reporting period corresponding to the user-selected End Date (Requested Report End Date). For example, if the Requested Report End Date is 09/30/2019, the Report Period is 10/01/2018 – 09/30/2019.

o CMS ID: The unique identifier assigned by CMS to each measure.

o CMS ID Discharge Dates: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.
o Denominator: The total number of qualified stays in the SNF that did not meet the exclusion criteria during the report period.

o Average Observed Admission Score: The average score on admission of the quality measure for the facility.

o Average Observed Discharge Score: The average score on discharge of the quality measure for the facility.

o Average Observed Change: The average observed change (discharge minus admission) in score for the facility.

o Average Risk-Adjusted Change. Computed using a mathematical model that accounts for patient or resident characteristics for the average change in score.

o National Average: The nationwide average of the measure to which facility performance may be compared.

- Source: Medicare Fee-For-Service Claims
  
  o Table Legend
    ▪ Dash (-): Data not available or not applicable
    ▪ [a]: (Lower Limit, Upper Limit)
    ▪ [b]: 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.
    ▪ [c]: 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.

  o Measure Name (Short name):
    ▪ PPR

  o Report Period: The reporting period corresponding to the user-selected End Date (Requested Report End Date). Beginning with a user selected End Date of 9/30/2020 the claims period of 10/01/2017-09/30/2019 is reported. A user-selected End Date prior to 9/30/2020 reports the claims period of 10/10/2016 – 09/30/2018. The user-selected End Date of 09/30/2021 will report the claims period of 10/01/2018 – 09/30/2020.

  o CMS ID: The unique identifier assigned by CMS to each measure.

  o CMS ID Discharge Dates: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.

  o Number of Readmissions: The number of residents with an unplanned readmission event in the 30-day post-discharge period.
- **Number of Eligible Stays**: The total number of stays in the SNF that did not meet the exclusion criteria.

- **Observed Readmission Rate**: The number of unplanned readmissions following discharge in the SNF divided by number of eligible stays in the SNF.

- **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.

- **95% Confidence Interval**: 95% confidence interval for the Risk-Standardized Readmission Rate.

- **National Observed Readmission Rate**: The number of unplanned readmissions following discharge in the nation divided by number of eligible stays in the nation.

- **Comparative Performance Category**:
  - Better than the National Rate
  - No Different from the National Rate
  - Worse than the National Rate

- **Measure Name (Short name)**:
  - **DTC**

- **Report Period**: The reporting period corresponding to the user-selected End Date (Requested Report End Date). Beginning with a user selected End Date of 9/30/2020 the claims period of 10/01/2017-09/30/2019 is reported. A user-selected End Date prior to 9/30/2020 reports the claims period of 10/10/2016 – 09/30/2018. The user-selected End Date of 09/30/2021 will report the claims period of 10/01/2018 – 09/30/2020.

- **CMS ID**: The unique identifier assigned by CMS to each measure.

- **CMS ID Discharge Dates**: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.

- **Number of Discharges to Community**: The number of residents discharged to the community.

- **Number of Eligible Stays**: The total number of stays in the SNF that did not meet the exclusion criteria.

- **Observed Discharge to Community Rate**: The number of discharges to the community from the SNF divided by number of eligible stays in the SNF.
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.

95% Confidence Interval: 95% confidence interval for the Risk-Standardized Discharge to Community Rate.

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.

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

Measure Name (Short name):
- MSPB (Your Facility)
- MSPB (National)

Report Period: The reporting period corresponding to the user-selected End Date (Requested Report End Date). Beginning with a user selected End Date of 9/30/2020 the claims period of 10/01/2017-09/30/2019 is reported. A user-selected End Date prior to 9/30/2020 reports the claims period of 10/1/2016 – 09/30/2018. The user-selected End Date of 09/30/2021 will report the claims period of 10/01/2018 – 09/30/2020.

CMS ID: The unique identifier assigned by CMS to each measure.

CMS ID Discharge Dates: The range of valid discharge dates for the Report Period and measure. These dates take into consideration the measure availability dates.

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.

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.

  - **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.

  - **MSPB Score**: The ratio of the provider’s MSPB Amount to the
episode-weighted median MSPB Amount across all SNF providers.

- **Measure Name (Short name):**
  - **SNF HAI**

  - **Report Period**: The reporting period corresponding to the user-
selected End Date (Requested Report End Date). Beginning with a
user selected End Date of 9/30/2021 the claims period of 10/01/2019-
09/30/2020 is reported.

  - **CMS ID**: The unique identifier assigned by CMS to each measure.

  - **CMS ID Discharge Dates**: The range of valid discharge dates for the
Report Period and measure. These dates take into consideration the
measure availability dates.

  - **Number of Eligible Stays**: The total number of stays in the SNF that
did not meet the exclusion criteria.

  - **Observed HAI Rate**: The number of healthcare-associated infections
requiring hospitalization in the SNF divided by number of eligible stays
in the SNF.

  - **Number of HAIs**: The number of healthcare-associated infections
requiring hospitalization that occurred in the SNF.

  - **Risk-Standardized HAI Rate**: A risk adjustment of the Healthcare-
Associated Infections Requiring Hospitalization Rate that accounts for
resident characteristics and a statistical estimate of the SNF effect
beyond resident mix.

  - **95% Confidence Interval**: 95% confidence interval for the Risk-
Standardized HAI Rate.

  - **Observed National Average**: The number of healthcare-associated
infections requiring hospitalization in the nation divided by number of
eligible stays in the nation.
- Facility 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

**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.

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

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Report Period</th>
<th>CMS ID</th>
<th>CMS ID Exchange Dates</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Observed Percent</th>
<th>Facility Risk-Adjusted Percent</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer Injury</td>
<td>01/01/2021 - 06/30/2022</td>
<td>0333.62</td>
<td>01/01/2021 - 06/30/2022</td>
<td>2</td>
<td>69</td>
<td>3.7%</td>
<td>3.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Application of Falls (NSF 136.74)</td>
<td>01/01/2021 - 06/30/2022</td>
<td>0333.62</td>
<td>01/01/2021 - 06/30/2022</td>
<td>0</td>
<td>66</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Application of Furniture Assessment (Core Audit Plan (NSF 282.1))</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5031.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>66</td>
<td>66</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.7%</td>
</tr>
<tr>
<td>Functional Status Outcome: Discharge Self-Care Scale (RDR 477.0L)</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5022.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>26.9</td>
<td>32.4</td>
<td>9.0%</td>
<td>9.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Functional Status Outcome: Incontinence Scale (RDR 477.0L)</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5022.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>14.9</td>
<td>23.4</td>
<td>9.6%</td>
<td>9.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>CMB</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5022.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>63</td>
<td>63</td>
<td>98.1%</td>
<td>98.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Functional Status Outcome: Change in Self-Care (RDR 285.0L)</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5022.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>47</td>
<td>22.7</td>
<td>39.6%</td>
<td>3.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Functional Status Outcome: Change in Incontinence (RDR 285.0L)</td>
<td>01/01/2021 - 06/30/2022</td>
<td>5022.63</td>
<td>01/01/2021 - 06/30/2022</td>
<td>47</td>
<td>31.6</td>
<td>45.9%</td>
<td>14.3%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

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.
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 meets or exceeds two separate data completion thresholds:

1. 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.

2. Submits 100% for the required data for measures submitted using the Center for Disease Control and Prevention, beginning with Fiscal Year 2023 and for all subsequent payment updates.

Failure to submit the required quality data may result in a two-percentage point reduction in the SNFs annual payment update.

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

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 (CMS Certification Number)
• Facility Name
• Facility City
• State
• Data Collection Start Date
• Data Collection End Date
• # of MDS 3.0 Assessments Submitted
• # of MDS 3.0 Assessments Submitted Complete
• % of MDS 3.0 Assessments Submitted Complete

o When appropriate, a footnote (*) details the following for the % of MDS 3.0 Assessments Submitted Complete value:

FY 2024 SNF QRP Annual Payment Update (APU) Determination Table is limited to the data elements that are used for determining SNF QRP compliance and are included in the APU submission threshold. There are additional data elements used to risk adjust the quality measures used in the SNF QRP. It should be noted that failure to submit all data elements used to calculate and risk adjust a quality measure can affect the quality measure calculations that are displayed on the Compare website.

• SNF Definitions

o # of MDS 3.0 Assessments Submitted: The total number of PPS 5-Day and PPS discharge assessments with a target date within the quarter and submitted to CMS by the data submission deadline for the Data Collection Start Date and Data Collection End Date identified on the report. This is the denominator. The data collection timeframes and submission deadlines are posted on the Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information page. See: [www.cms.hhs.gov](http://www.cms.hhs.gov) > Medicare > Skilled Nursing Facility Quality Reporting Program [under the Quality Initiatives/Patient Assessment Instruments heading] > Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information > select the SNF QRP Table for Reporting Assessment-Based Quality Measures for the FY APU pdf at the bottom of the page for the RY of the report.

o # of MDS 3.0 Assessments Submitted Complete: The number of PPS 5-Day and PPS Discharge assessments identified in the denominator that do not contain dashes (-) for any of the required data elements used to determine APU Compliance for the SNF QRP for the applicable fiscal year. This is the numerator.

o % of MDS 3.0 Assessments Submitted Complete: Divide the numerator (# of PPS 5-Day and PPS Discharge assessments Submitted Complete) by the denominator (# of PPS 5-Day and PPS Discharge assessments Submitted) to calculate the SNF’s percent of
complete assessments. SNFs with a percentage under 80% are determined to be non-compliant with the SNF QRP.

COVID-19 HCP displays data collected by the CDC from the National Healthcare Safety Network (NHSN) and that has been reported to CMS, starting with Quarter 4, 2021.

- CDC Data Reported to CMS
- Time Period
- Data Collection Start Date
- Data Collection End Date
- Data Submission Deadline
- Month 1
- Month 2
- Month 3
- Definitions:
  - Yes: The monthly reporting plan, event data and summary data submitted to the CDC
  - No: As of “reported to CMS Date”, one or more of the monthly reporting plan, event data or summary data is missing for the month
  - N/A: Data collection is not yet available or does not exist as of the report run date, or is from a swing bed provider.
  - CDC Data Reported to CMS: Date displayed on the report is the date of the most recent CDC data load prior to the report run date

**NOTE:** When available, publicly reported data on COVID-19 HCP vaccination rates for swing bed providers can be found in the Provider Data Catalog, within the dataset for the parent facility in which the swing beds reside. For example, if the swing-bed exists within a Long Term Care Hospital or Acute Care Hospital, the measure score for that parent hospital type includes the swing beds within that facility.

**Disclaimer:** The SNF Provider Threshold Report is available for the convenience of the provider. Extensions and exceptions approved according to CMS policy have not been applied in the score calculations. The score in this report is considered preliminary, and is not the final CMS calculation of SNF compliance with the requirements set out in 42 CFR 413.360(b)(2).

**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 QRP Provider Threshold Report – Page 1 Excerpt

CCN:  [Redacted]
Facility Name: [Redacted]
Facility City: [Redacted]
State: [Redacted]
Data Collection Start Date: 01/01/2022
Data Collection End Date: 12/31/2022

# of MDS 3.0 Assessments Submitted: 1

# of MDS 3.0 Assessments Submitted Complete: 1

% of MDS 3.0 Assessments Submitted Complete: 100%

* FY 2024 SNF QRP Annual Payment Update (APU) Determination Table is limited to the data elements that are used for determining SNF QRP compliance and are included in the APU submission threshold. There are additional data elements used to risk adjust the quality measures used in the SNF QRP. It should be noted that failure to submit all data elements used to calculate and risk adjust a quality measure can affect the quality measure calculations that are displayed on the Compare website.

SNF Definitions:

# of MDS 3.0 Assessments Submitted: The total number of PPS 5-Day and PPS Discharge assessments with a target date within the quarter and submitted to CMS by the data submission deadline for the Data Collection Start Date and Data Collection End Date identified on the report. This is the denominator. The data collection timeframes and submission deadlines are posted on the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Measures and Technical Information page. See: [www.cms.gov](http://www.cms.gov) > Medicare > Skilled Nursing Facility Quality Reporting Program (under the Quality Initiatives/Patient Assessment Instruments heading) > Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information > select the SNF QRP Table for Reporting Assessment-Based Quality Measures for the FY APU pdf at the bottom of the page for the 1st of the report.

# of MDS 3.0 Assessments Submitted Complete: The number of PPS 5-Day and PPS Discharge assessments identified in the denominator that do not contain dashes (-) for any of the required data elements used to determine APU compliance for the SNF QRP for the applicable fiscal year. This is the numerator.

% of MDS 3.0 Assessments Submitted Complete: Divide the numerator (# of PPS 5-Day and PPS Discharge assessments Submitted Complete) by the denominator (# of PPS 5-Day and PPS Discharge assessments Submitted) to calculate the SNF’s percent of complete assessments. SNFs with a percentage under 80% are determined to be non-compliant with the SNF QRP.

*Disclaimer: The SNF Provider Threshold Report is available for the convenience of the provider. Extensions and exceptions approved according to CMS policy have not been applied in the score calculations. The score in this report is considered preliminary, and is not the final CMS calculation of SNF compliance with the requirements set out in 42 CFR 413.360(b)(2).

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.
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

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 Primary Sort By drop-down list provides Discharge Date (the default), Admission Date, and Last Name, First Name sort-by options. You may select only one primary sort-by option.

The default sort order for the optional patient-level data is as follows:

- Discharge Date (newest to oldest)
- Admission Date (newest to oldest)
• Last Name, First Name (A to Z)
• Resident ID (smallest to largest)

**NOTE:** In the event two patients have the same Discharge Date, Admission Date, Last Name, and First Name, the Resident ID is used to determine the sort order.

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)
• Last Name, First Name (Z to A)
• Resident ID (largest to smallest)

Select the *Generate Resident-Level Data CSV* checkbox to generate a separate patient-level data comma-separated values (CSV) file that is placed in *My Inbox* on the CASPER Folders page.

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

• Facility ID
• CMS Certification Number (CCN)
• Facility Name
• City/State
• Requested Report End Date
• Report Run Date
• Data Calculation Date
• Report Version Number
• SNF QRP Quality Measures Legend providing the following for each measure:
  - QM #
  - Measure Name (Short)
  - Measure Interpretation
    - Undesirable Outcomes
    - Desirable Outcomes or Processes Performed
    - Change in Function Scores
  - Report Period
  - CMS ID
  - CMS ID Discharge Dates
• Table Legend
  o Dash (-): Data not available or not applicable
  o X: Triggered (Bold indicates an undesirable outcome)
  o NT: Not Triggered (Bold indicates a desirable outcome did not occur or process was not performed)
  o E: Excluded from analysis based on quality measure exclusion criteria
  o Change in Function Scores: Values are observed change in function scores from admission to discharge

The remainder of the report provides the following information and measure status for each resident:
  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 Undesirable Outcomes measures statuses by QM #
  o Desirable Outcomes or Processes Performed measures statuses by QM #
  o Change in Function Scores measures statuses by QM #

NOTE: The SNF QRP Resident-Level Quality Measure Report contains protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.
Figure 13-7. SNF QRP Resident-Level Quality Measure Report

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.
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
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:
Presssure 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:
Presssure 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**

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**

Fictitious, sample data are depicted.