iQIES MDS Reports

Stacey Bryan RN, BSN, RAC-CT
State RAI Coordinator
MO Department of Health & Senior Services
August 28, 2023

Topics

How to Obtain iQIES Access

iQIES On Demand Reports
- MDS 3.0 Missing OBRA Assessment Report
- MDS 3.0 Facility Level Quality Measure Report
- MDS 3.0 Resident Level Quality Measure Report

SNF QRP Program Overview

iQIES On Demand SNF QRP Reports
- SNF Provider Threshold Report
- SNF Review and Correct Report
- SNF Facility-Level QM Report
- SNF Resident-Level QM Report

Acronyms In This Presentation

- ACIP: Advisory Committee on Immunization Practices
- APU: Annual Payment Update
- ARD: Assessment Reference Date
- CDC: Centers for Disease Control
- CMS: Centers for Medicare and Medicaid Services
- CY: Calendar Year
- DTC: Discharge to Community
- DRR: Drug Regimen Review
- FY: Fiscal Year
- HAI: Healthcare Associated Infection
- HARP: HCQIS Access Roles and Profile
- HCQIS: Healthcare Quality Information System
- HCP: Health Care Personnel
- HHA: Home Health Agency
- IMPACT: Improving Medicare Post-Acute Care Transformation
- iQIES: Internet Quality Improvement and Evaluation System
- IRF: Inpatient Rehabilitation Facility

Acronyms In This Presentation

- LTCH: Long-Term Care Hospital
- MAC: Medicare Administrative Contractor
- MDS: Minimum Data Set
- MSPB: Medicare Spending Per Beneficiary
- NHSN: National Healthcare Safety Network
- OBRA: Omnibus Budget Reconciliation Act
- PAC: Post Acute Care
- PPR: Potentially Preventable Readmission
- PPS: Prospective Payment System
- PSO: Provider Security Official
- QM: Quality Measure
- QRP: Quality Reporting Program
- RAI: Resident Assessment Instrument
- SNF: Skilled Nursing Facility
- TOH: Transfer of Health
- VR: Validation Report

How to Obtain iQIES Access

iQIES
Internet Quality Improvement and Evaluation System

On April 17, 2023, CMS transitioned to the Internet Quality Improvement and Evaluation System (iQIES) for MDS record submissions and reports. iQIES is now the CMS National Reporting Database for MDS records.

Register for iQIES Access

If your organization has not yet identified and registered a Provider Security Official (PSO), you will not be able to complete a user role request. At a minimum, at least one PSO needs to be registered for each provider, but CMS highly recommends at least two PSOs are designated so there is a higher likelihood someone will be available to approve/reject iQIES access requests. The PSO must work for the provider and cannot be a vendor.

iQIES Access

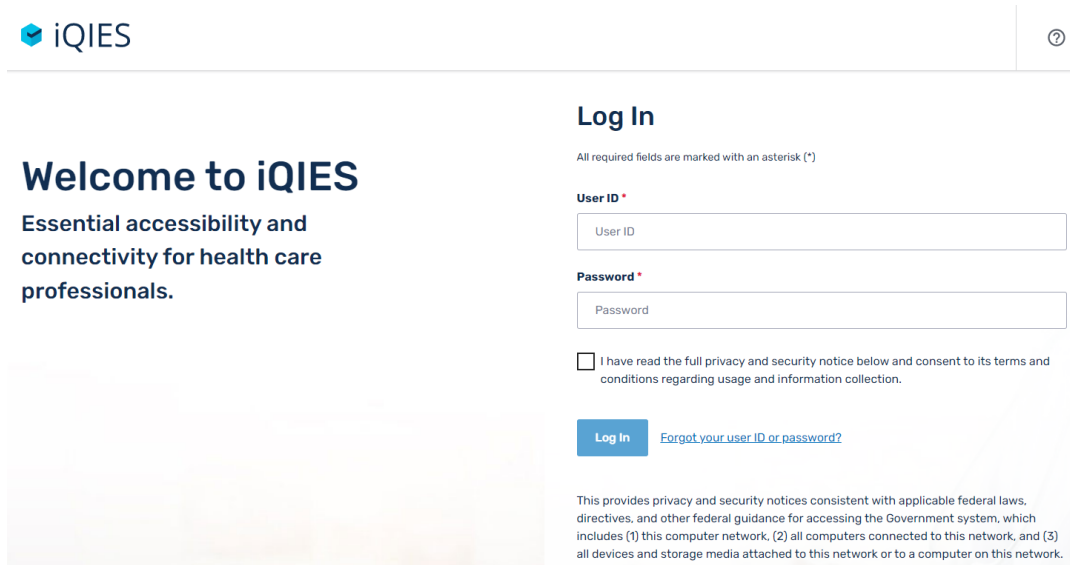
To receive access to iQIES, please complete the following steps below.

1. Create an account in the HARP system using your corporate email address* at: https://harp.cms.gov/register.
   - Note: HARP User IDs cannot be adjusted. As such, please refrain from using facility names or any special characters (such as # or &) when creating the HARP User ID.
   - *If the facility handles 2 or fewer providers and does not have a corporate email domain, a personal email address may be used.
2. Access iQIES at: https://iqies.cms.gov/ and log in with your HARP credentials (completed in step 1) to complete the process to request your User Role for your specific provider CMS Certification Number (CCN).
3. Once the user role request has been submitted AND approved, you will receive notification via email informing you that your iQIES account access request has been approved.

iQIES User Roles

Provider User Role	Permissions
Assessment Submitter	• **Upload patient assessments** • Generate/view reports
Provider Administrator	• Create/manage patient profiles • Create/manage/submit/modify/inactivate patient assessments • Generate/view reports
Provider Assessment Coordinator	• Create/manage patient profiles • Create/manage/submit patient assessments • Generate/view reports
Provider Assessment Viewer	• View patient profiles/assessments • Generate/view reports
Provider Security Official	• **Upload patient assessments** • Approve iQIES user accounts • Create/manage/submit/modify/inactivate patient assessments • Create/manage patient profiles • Generate/view reports

Go to https://iqies.cms.gov/
to submit MDS records and run/retrieve MDS reports.



iQIES Permanent System Folders

From the top menu **Reports** tab select **My Reports**

- **MDS 3.0 Final Validation Report** folder is where the system generated Final Validation Reports are stored.
- **MDS 3.0 Provider Preview Report** folder is where files such as the provider preview reports and SNF VBP files will be distributed.
- **Non-Compliance Notifications** folder is where the SNF QRP non-compliance notifications are deposited.

iQIES Reports

The iQIES Reports User Manual explains different ways on how to find, run, schedule, save and download on demand reports. This manual can be found at https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals.

- From the top menu **Reports** tab select **Find a Report.**
- In the Report Keyword box type "MDS" and select **Find Report**. This will bring up two pages of MDS reports (16 different reports).
- Select **Run Report** for the report you wish to run.
- Enter any required criteria and select **Run Report.**
- You can **Save to My Reports** and/or **Download.**

iQIES User Guides, Manuals, and Documents

iQIES MDS User Guides and Manual: Located at https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals

- iQIES MDS FAQs for Providers
- CMS iQIES MDS Upload an Assessment
- iQIES Reports User Manual
- CMS iQIES MDS Error Message

iQIES Documents: Located at https://qtso.cms.gov/software/iqies/reference-manuals

- iQIES Onboarding Guide
- iQIES Onboarding Process Quick Reference Guide – Provider Security Official
- iQIES Security Official: Manage Access Job Aide
- iQIES User Role Matrix

Additional iQIES Resources

Welcome to iQIES video: https://www.youtube.com/watch?v=dRbh-VOtrcM&list=PLaV7m2-zFKpj2t7Qhn7ONiM0Zb_A1MTIq&index=1

How to Run Reports video:
https://www.youtube.com/watch?v=6Xz9in9dgts&list=PLaV7m2-zFKpj2t7Qhn7ONiM0Zb_A1MTIq&index=4

Upload an Assessment for MDS Users video:
https://www.youtube.com/watch?v=cEU9MeBOKNk

How to View and Download Final Validation Reports for MDS Users video:
https://www.youtube.com/watch?v=mDmh0HYv5ho

If you have questions or require assistance, please contact the iQIES Service Center at iqies@cms.hhs.gov or by phone at (800) 339-9313.

iQIES On Demand Reports

MDS 3.0 Missing OBRA Assessment Report

Lists residents that CMS is expecting an OBRA assessment on:

- Residents for whom the target date of the most recent accepted OBRA assessment (other than a Discharge or Death in Facility MDS) is more than 138 days ago;
- Residents for whom no OBRA assessments were submitted for a current episode that began greater than 60 days ago.

The information included in this report is as current as the date of the last submission by the facility.

Run this report monthly to ensure there are no names on it.

15

MDS 3.0 Missing OBRA Assessment Report

- You do not want any names listed on this report.
- For a current resident listed on this report, if they are overdue for an OBRA comprehensive or quarterly assessment then complete and transmit one.
  - Do not backdate comprehensive or quarterly assessments. The ARD should not be earlier than the date you opened the comprehensive or quarterly assessment.
- For a former resident listed on this report, if an OBRA Discharge Assessment or Death in Facility Tracking Record is still needed then complete and transmit one.
  - This will need to be backdated to the date it occurred.
- If you are unsure why a resident is listed on this report, call the State Automation Coordinator. A merge may be needed if an additional resident was accidentally created in the iQIES system; this can happen when you transmit a MDS record with resident identifier changes from the previous MDS record.

16

iQIES Report

MDS 3.0 Missing OBRA Assessment Report

Note:* indicates an empty value

Facility ID [redacted]
Facility Name [redacted]
City/State [redacted]

Report Run Date 01/27/2023

Resident Identifiers:					Last Record Identifiers:		
Resident Internal ID	Resident Name	SSN	Date of Birth	Gender	OBRA A0310A	PPS A0310B	Target Date
[redacted]	[redacted]	[redacted]	[redacted]	F	03	99	09/07/2022
[redacted]	[redacted]	[redacted]	[redacted]	F	02	99	09/07/2022
[redacted]	[redacted]	[redacted]	[redacted]	F	99	99	12/01/2021
[redacted]	[redacted]	[redacted]	[redacted]	F	02	99	09/07/2022
[redacted]	[redacted]	[redacted]	[redacted]	F	01	01	09/08/2022
[redacted]	[redacted]	[redacted]	[redacted]	F	04	99	09/07/2022

This Centers for Medicare & Medicaid Services (CMS) report may contain privacy protected data and should not be released to the public. Any alteration to this report is strictly prohibited.

Page 1 of 1

MDS 3.0 QM Report Definitions

Report Period: The dates in this field reflect the reporting period that was selected by the user when the report was requested.

Short Stay: An episode with cumulative days in facility less than or equal to 100 days.

Long Stay: An episode with cumulative days in facility greater than or equal to 101 days.

Numerator: The # of residents who trigger for a QM.

Denominator: The # of residents who were at risk for triggering the QM.

MDS 3.0 QM Report Definitions

Comparison Group National Percentile: This column ranks facilities relative to other facilities in the nation on each measure. The values in this column represent the percent of facilities in the nation that are at or below the observed (or adjusted) percentage for the facility. For example, if the facility is at the 85th percentile for a measure, it means that 85% of the facilities in the nation have an observed (or adjusted) percentage that is at or below the facility's percentage. An asterisk identifies those measures that have crossed an investigative threshold and should be investigated on survey and/or on internal quality improvement.

19

MDS 3.0 Facility Level QM Report

- You select the timeframe. Defaults to the most recent completed six-month period prior to the month the data was last calculated.
- Identifies the facilities performance on MDS 3.0 QMs. Also, lists how the facility compares with other facilities in their state and in the nation.
- Helps identify possible areas for quality improvement.
- QM data for this report is calculated weekly for the assessments submitted since the previous week's data calculation.

20

iQIES Report

MDS 3.0 Facility-Level Quality Measure (QM) Report

Report Period: 01/01/2023 - 06/30/2023
Comparison Group: 12/01/2022 - 05/31/2023
Report Run Date: 08/01/2023
Data Calculation Date: 07/31/2023
Report Version Number: 3.03

Legend

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: C = complete; data available for all days selected, I = incomplete; data not available for all days selected
Note: * is an indicator used to identify that the measure is flagged
Note: For the Improvement in Function (S) Measure, a single * indicates a Percentile of 25 or less (higher Percentile values are better)

Facility ID: **Facility Name:** **CCN:** **City/State:**

★ = Used in Five-Star Rating QM calculation

MDS Measures

Measure Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
Hi-risk/Unstageable Pres Ulcer (L) ★	N015.03	C	5	33	15.2%	15.2%	9.3%	9.0%	**86***
Phys restraints (L)	N027.02	C	0	56	0.0%	0.0%	0.1%	0.1%	0
Falls (L)	N032.02	C	34	56	60.7%	60.7%	47.4%	43.7%	**89***
Falls w/Maj Injury (L) ★	N013.02	C	2	56	3.6%	3.6%	4.2%	3.5%	58
Antipsych Med (S) ★	N011.02	C	0	10	0.0%	0.0%	2.4%	1.9%	0
Antipsych Med (L) ★	N031.03	C	14	55	25.5%	25.5%	21.4%	14.8%	**88***
Antianxiety/Hypnotic Prev (L)	N033.02	C	1	38	2.6%	2.6%	8.4%	6.8%	30
Antianxiety/Hypnotic % (L)	N036.02	C	9	49	18.4%	18.4%	23.6%	19.5%	50
Behav Sx affect Others (L)	N034.02	C	5	52	9.6%	9.6%	19.5%	18.8%	33
Depress Sx (L)	N030.02	C	0	52	0.0%	0.0%	7.7%	9.1%	0
UTI (L) ★	N024.02	C	1	55	1.8%	1.8%	3.4%	2.5%	57
Cath Insert/Left Bladder (L) ★	N026.03	C	1	54	1.9%	2.0%	2.0%	1.7%	69
Lo-Risk Lose B/B Con (L)	N025.02	C	2	21	9.5%	9.5%	32.2%	48.7%	3
Excess Wt Loss (L)	N029.02	C	0	48	0.0%	0.0%	5.8%	6.5%	0
Incr ADL Help (L) ★	N028.02	C	10	47	21.3%	21.3%	17.9%	14.9%	**79***
Move Indep Worsens (L) ★	N035.03	C	11	38	28.9%	27.5%	18.9%	18.3%	**80***
Improvement in Function (S) ★	N037.03	C	8	9	88.9%	93.4%	69.8%	75.0%	87

SNF Measures

Measure Description	CMS ID	Numerator	Denominator	Facility Observed Percent	Facility Adjusted Percent	National Average
Pressure Ulcer/Injury[1] ★	S038.02	1	38	2.6%	3.4%	2.7%

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications and is based on 12 months of data (07/01/2022 - 06/30/2023).

MDS 3.0 Resident Level QM Report

- You select the timeframe. Defaults to the most recent completed six-month period prior to the month the data was last calculated.
- Lists the residents (active and discharged) by name.
- Identifies the QMs each resident triggers.
- Helps identify residents who trigger multiple QMs. These residents may merit special consideration or more intensive review.
- QM data for this report is calculated weekly for the assessments submitted since the previous week's data calculation.

24

iQIES Report

MDS 3.0 Resident-Level Quality Measure (QM) Report

Facility ID:		**Report Period:**	01/01/2023 - 06/30/2023
Facility Name:		**Report Run Date:**	08/01/2023
CCN:		**Data Calculation Date:**	07/31/2023
City/State:		**Report Version Number:**	3.03

Note: S = short stay, L = long stay; **X** = triggered, b = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected

MDS Measures - Active Residents

Reference page 1 of this report to locate the Table Legend

Resident Name	Resident ID	A0310A/B/F	Hi-risk/Unstageable Pres Ulcer (L)	Phys restraints (L)	Falls (L)	Falls w/Maj Injury (L)	Antipsych Med (S)	Antipsych Med (L)	Antianxiety/Hypnotic Prev (L)	Antianxiety/Hypnotic % (L)	Behav Sx affect Others (L)	Depress Sx (L)	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk Lose B/B Con (L)	Excess Wt Loss (L)	Incr ADL Help (L)	Move Indep Worsens (L)	Improvement in Function (S)	Quality Measure Count
Data			C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	
		03/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		02/99/99	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	b	b	1
		02/99/99	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	b	b	1
		02/99/99	b	b	b	b	b	X	b	X	b	b	b	b	b	b	b	b	b	2
		02/99/99	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	b	b	1
		02/99/99	X	b	X	X	b	b	b	b	b	b	b	b	b	b	b	b	b	3
		02/99/99	b	b	b	b	b	X	b	X	b	b	b	b	b	b	b	b	b	2
		02/99/99	b	b	b	b	b	X	X	X	b	b	X	b	b	b	b	b	b	4
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		03/99/99	b	b	X	b	b	X	b	X	b	b	b	b	b	b	X	X	b	5

MDS Measures - Discharged Residents

Reference page 1 of this report to locate the Table Legend

Resident Name	Resident ID	A0310A/B/F	Hi-risk/Unstageable Pres Ulcer (L)	Phys restraints (L)	Falls (L)	Falls w/Maj Injury (L)	Antipsych Med (S)	Antipsych Med (L)	Antianxiety/Hypnotic Prev (L)	Antianxiety/Hypnotic % (L)	Behav Sx affect Others (L)	Depress Sx (L)	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk Lose B/B Con (L)	Excess Wt Loss (L)	Incr ADL Help (L)	Move Indep Worsens (L)	Improvement in Function (S)	Quality Measure Count
Data			C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	
		04/99/99	b	b	X	b	b	b	b	b	b	b	b	b	b	b	b	X	b	2
		99/99/11	b	b	X	b	b	b	b	b	X	b	b	b	X	b	b	b	b	3
		99/01/99	b	b	X	X	b	b	b	b	X	b	b	b	b	b	X	b	b	4
		99/99/12	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
		99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1
		99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1
		99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1
		99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	X	1
		01/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0

SNF Measures

Reference page 1 of this report to locate the Table Legend

Resident Name	Resident ID	Admission Date	Discharge Date	Pressure Ulcer/Injury[1]
				b
				b
				X
				b
				b
				b
				b
				b
				b
				b
				b
				b

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications and is based on 12 months of data (07/01/2022 - 06/30/2023).

SNF Quality Reporting Program (QRP) Overview

SNF QRP

- As a result of the IMPACT Act, CMS requires the reporting of standardized QM data for Traditional Medicare Part A stays from the four PAC providers: SNFs (includes non-critical access hospital swing beds), IRFs, LTCHs, HHAs.
- CMS implements quality initiatives to assure quality health care for Medicare beneficiaries through accountability and public disclosure. Quality measures are tools that evaluate health care processes, outcomes, patient perceptions, and systems that are associated with the ability to provide high-quality health care.

SNF QRP

Data that CMS looks at for the SNF QRP includes:

- **MDS data**: Comes from the MDS records that are transmitted to the CMS iQIES system
- **Claims based data**: Comes from claims from the hospital and from the SNF
- **NHSN Data**: Comes from data transmitted to NHSN

SNF QRP

The SNF QRP requires that SNFs submit quality measure data to CMS. SNFs must meet or exceed two data completeness thresholds:

- One threshold, set at 80 percent, for completion of quality measures data collected using the MDS and submitted through the CMS iQIES system. **CMS is increasing this to 90% beginning with the CY2024 data.**
- A second threshold, set at 100 percent, for quality measure data collected and submitted using NHSN.

Failure to submit the required quality data may result in a two-percentage-point (2%) reduction in the SNF's annual payment update (APU).

SNF QRP Data Deadlines

- MDS and NHSN data are submitted to CMS based on deadlines established for the APU determination year. If corrections to the Quality Measure data need to be made, they must be submitted before the SNF QRP submission deadlines.
- Data submission deadlines for the SNF QRP quality measures can be found in the Downloads section of the SNF QRP Data Submission Deadlines webpage.

SNF QRP Compliance

For help monitoring compliance with the SNF QRP data submission requirements:

- CMS sends informational messages to SNFs that are **NOT** meeting Annual Payment Update (APU) thresholds on a quarterly basis ahead of each submission deadlines.
- **Email:** QRPHelp@swingtech.com to receive this information.
- Include your facility name and CMS Certification Number (CCN) with this request.

SNF QRP Noncompliance

- Any SNF found non-compliant with the QRP will receive a letter of notification from its MAC. Compliance letters will also be placed into the Non-Compliance Notification system-created permanent folder.
- If a SNF believes the finding of non-compliance is an error, or it has evidence that an extraordinary circumstance prevented timely submission of data, the SNF may file for a reconsideration within 30 days from the date at the top of the non-compliance letter.

SNF QRP MDS-Based QMs

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Application of % of Residents Experiencing One or More Falls with Major Injury
- Drug Regimen Review Conducted with Follow-Up for Identified Issues
- SNF Functional Outcome Measure: Discharge Self-Care Score for SNF Residents
- SNF Functional Outcome Measure: Discharge Mobility Score for SNF Residents

SNF QRP MDS-Based QMs

- Application of % of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function - Data collection ends 10-1-23
- SNF Functional Outcome Measure: Change in Self-Care Score for SNF Residents - Data collection ends 10-1-23
- SNF Functional Outcome Measure: Change in Mobility Score for SNF Residents - Data collection ends 10-1-23
- Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC) - Data collection begins 10-1-23
- Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC) - Data collection begins 10-1-23
- Discharge Function Score - Data collection begins 10-1-23

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

- Reports the percentage of Med A stays with Stage 2 – 4 pressure ulcers, unstageable pressure ulcers or deep tissue injury that are new or worsened since admission as reported on the PPS Discharge.
- Undesirable outcome so lower percentages are better.

Falls With Major Injury

- Reports the percentage of Med A stays where one or more falls with major injury were reported during the SNF stay as reported on any OBRA A0310A MDS, the PPS 5-day, an OBRA Discharge or a PPS Discharge.
- Undesirable outcome so lower percentages are better.

Drug Regimen Review (DRR) Conducted With Follow-Up for Identified Issues

Reports the percentage of Med A SNF stays in which a DRR was conducted at the time of admission and timely follow-up with a physician occurred each time potential or actual clinically significant medication issues were identified throughout the stay as reported on the PPS 5-day for N2001 and N2003 and the PPS Discharge for N2005.

- Process measure so higher percentages are better.

Functional Outcome Measure: Discharge Self-Care Score for SNF Residents

Estimates the % of Med A stays that meet or exceed an expected discharge self-care score.

- Expected scores are calculated and risk-adjusted based on resident characteristics.
- Higher scores indicate a higher percentage of residents met or exceeded expected discharge self-care scores.
- Sum the scores of the discharge self-care items to create a discharge self-care score for each Med A SNF stay.
- Each resident-stay's observed discharge self-care score is compared to the expected discharge self-care score, except those stays that are excluded.
- Desirable outcome so higher percentages are better.

Functional Outcome Measure: Discharge Mobility Score for SNF Residents

Estimates the % of Med A stays that meet or exceed an expected discharge mobility score.

- Expected scores are calculated and is risk - adjusted based on resident characteristics.
- Higher scores indicate a higher percentage of residents met or exceeded expected discharge mobility scores.
- Sum the scores of the discharge mobility items to create a discharge mobility score for each Med A SNF stay.
- Each resident-stay's observed discharge mobility score is compared to the expected discharge mobility score, except those stays that are excluded.
- Desirable outcome so higher percentages are better.

Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Reports the % of Med A SNF stays with an admission and discharge functional assessment and at least one goal that addresses function.

- Process measure so higher percentages are better.
- This measure will no longer have data collected as of 10-1-23

Functional Outcome Measure: Change in Self-Care Score for SNF Residents

Estimates the risk-adjusted mean change in self-care item scores between the 5-day and PPS Discharge.

- There is not a simple form for the numerator and denominator.
- Scores are summed for the self-care items from the 5-day and from the PPS Discharge.
- The Discharge self-care score minus 5-day self-care score equals the change in self-care score. This can be a positive or negative number; you want it to be a positive number.
- There is a change in self-care score for each Med A stay and a facility-level average self-care change score.
- This measure will no longer have data collected as of 10-1-23

Functional Outcome Measure: Change in Mobility Score for SNF Residents

Estimates the risk-adjusted mean change in mobility item scores between the 5-day and PPS Discharge.

- There is not a simple form for the numerator and denominator.
- Scores are summed for the mobility items from the 5-day and from the mobility items from the PPS Discharge.
- Discharge mobility score minus 5-day mobility score equals the change in mobility score. This can be a positive or negative number; you want it to be a positive number.
- There is a change in mobility score for each Med A stay and a facility-level average mobility change score.
- This measure will no longer have date collected as of 10-1-23

Transfer of Health Information - Provider

Reports the percentage of Med A stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at discharge.

- Process measure so higher percentages are better.
- Data collection begins 10-1-23

Transfer of Health Information - Patient

Reports the percentage of Med A stays with a discharge assessment indicating that a current reconciled medication list was provided to the patient/family/caregiver at discharge.

- Process measure so higher percentages are better.
- Data collection begins 10-1-23

Discharge Function Score

Reports the percentage of Medicare Part A SNF residents who achieve a risk-adjusted expected function score at discharge.

- The function score comes from self-care (GG0130) and mobility (GG0170) items.
- Data collection begins 10-1-23

SNF QRP MDS Data Deadlines

Data for 1/1/23 – 3/31/23 due by 8/15/23

Data for 4/1/23 – 6/30/23 due by 11/15/23

Data for 7/1/23 – 9/30/23 due by 2/15/24

Data for 10/1/23 – 12/31/23 due by 5/15/24

- At least 80% of qualifying MDS assessments for CY 2023 must contain 100% completion of the SNF QRP data elements necessary to calculate the QRP MDS-based QMs or the SNF will have a 2% reduction in their APU for FY 2025 (10/1/24 through 9/30/25).
- **For CY 2024 data, the compliance threshold requirement increases from 80% to 90%.**

SNF QRP MDS Data

- Complete a PPS 5-day and PPS Discharge for every Traditional Medicare Part A stay (unless the resident passes away during their Med A stay, then a PPS Discharge is not required).
- Only submit PPS assessments that are for Traditional Med A stays (don't submit PPS assessments for Medicare Advantage or HMO stays).
- Do not dash items that are required for QRP compliance. These items are listed in the SNF QRP Overview of Data Elements Used for Reporting Assessment-Based QMs APU Determination documents.

SNF QRP MDS Data

SNF QRP Overview of Data Elements Used for Reporting Assessment-Based QMs Affecting FY 2025 APU Determination document found at https://www.cms.gov/files/document/fy-2025-snf-qrp-apu-table-reporting-assessment-based-measures-and-standardized-patient-assessment.pdf

- These are the data elements needed to calculate the SNF QRP measures.
- Successful assessment completion means the assessment does not contain dashes for required data elements.

SNF QRP MDS Data

Error codes that will show up on the VR to assist providers in meeting their MDS data threshold requirement.

Payment Reduction Warnings:

- Error ID 3891: All discharge goals dashed on PPS 5-day.
- Error ID 3897: SNF QRP required item dashed on PPS 5-day or IPA.
- Error ID 3908: SNF QRP required item dashed on PPS Discharge.

SNF QRP Claims-Based QMs

Four claims-based measures are included in the SNF QRP. These measures are calculated through Medicare Fee-For-Service claims data and do not require SNFs to submit any additional data to CMS. The claims-based measures include:

- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP
- Discharge to Community – PAC SNF QRP
- Medicare Spending Per Beneficiary – PAC SNF QRP
- SNF HAI Requiring Hospitalization

Potentially Preventable 30-Day Post-Discharge Readmission

- This claims-based QM estimates the risk-standardized rate of unplanned, potentially preventable short-stay acute-care hospital or LTCH readmissions for Medicare fee-for-service beneficiaries within a 30-day window following discharge from the SNF.
- Includes discharges to non-hospital post-acute levels of care or to the community.
- Reflects readmission rates for residents who are readmitted with a principal diagnosis considered to be unplanned and potentially preventable.
- Observation window is 30-days after discharge from the SNF (excludes day of discharge and day after; 30 days starts 2 days after discharge).
- Undesirable outcome so lower percentages are better.

Discharge to Community

- This claims-based QM reports a SNF's risk-standardized rate of Medicare Part A residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community.
- Desirable outcome so higher percentages are better.

Medicare Spending Per Beneficiary

- This claims-based QM evaluates SNF providers' efficiency relative to the efficiency of the national median SNF provider by assessing the cost to Medicare for services performed by the SNF provider during a Medicare Part A stay.
- This measure evaluates the provider's actual spending on a beneficiary's episode compared to what they are expected to spend for that episode, given that particular beneficiary's health characteristics as predicted through the use of a risk adjustment model.
- A value greater than 1 indicates that overall, the provider's actual Medicare spending was more than expected. A value less than 1 indicates that overall, the provider's actual Medicare spending was less than expected in that performance period.

HAI Requiring Hospitalization

- This claims-based QM estimates the risk-standardized rate of HAIs acquired during SNF care that results in hospitalization during the time window beginning on day four after SNF admission and within day three after SNF discharge.
- It is important to recognize that HAIs in SNFs are not considered "never-events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs that result in hospitalization when compared to their peers.
- Undesirable outcome so lower percentages are better.

SNF QRP NHSN QMs

Two measures are included in the SNF QRP that are reported through NHSN.

- COVID-19 Vaccination Coverage among HCP
- Influenza Vaccination Coverage among HCP

SNF QRP NHSN QMs

COVID-19 Vaccination Coverage among HCP

- SNF QRP QM as of 10/1/21
- This CDC NHSN-based QM reports the percentage of HCP eligible to work in the facility for at least one day during the reporting period and who received a complete vaccination course against COVID-19.
- On 10-1-23 this measure updates to reflect the % of HCP that are "up to date" with CDC-recommended COVID-19 vaccines.
- Process measure so higher percentages are better.
- HCP who were determined to have medical contraindication or condition specified by FDA, CDC or ACIP recommendations for the COVID-19 vaccine are excluded from this QM.

SNF QRP NHSN QMs

COVID-19 Vaccination Coverage among HCP

- For this QM, providers are required to submit 1 week of HCP COVID-19 vaccination data per month. SNFs have the option of which week to report.
- If more than 1 week of data is submitted per month then the most recent week will be used to calculate the QM.
- Those 3 weeks (one week per month) out of the quarter will be used to calculate the quarterly rate.
- The QM will be calculated by the CDC and sent to CMS.

SNF QRP NHSN QMs

COVID-19 Vaccination Coverage among HCP
SNF QRP NHSN Data Deadlines

Data for 1/1/23 – 3/31/23 due by 8/15/23

Data for 4/1/23 – 6/30/23 due by 11/15/23

Data for 7/1/23 – 9/30/23 due by 2/15/24

Data for 10/1/23 – 12/31/23 due by 5/15/24

- 100% of the required NHSN COVID-19 vaccination among HCP data for CY 2023 must contain the data necessary to calculate the QRP NHSN QM or the SNF will have a 2% reduction in their APU for FY 2025 (10/1/24 through 9/30/25).

SNF QRP NHSN QMs

COVID-19 Vaccination Coverage among HCP Resources

Weekly HCP COVID-19 Vaccination CDC NHSN Webpage

Combined Covid-19 Vaccination Protocol for Healthcare Personnel

Long-term Care Weekly COVID-19 Vaccination Reporting Changes and Updates_508 DSD

COVID Vaccination HCP Form June 2023 508c

Operational Guidance COVID-19 Vaccination Reporting Rule

SNF QRP NHSN QMs

COVID-19 Vaccination Coverage among HCP Resources

Up to Date Vaccination Quick Reference Guide

Updated Quick Reference Guide, how to check create date DSD508_010923

Quick Reference Guide, How to Run Reports for Healthcare Personnel Safety (HPS) Component

For questions about reporting requirements email DNH_TriageTeam@cms.hhs.gov

For questions about SNF quality data submitted to CMS via CDC's NHSN, or NHSN Registration, email NHSN@cdc.gov

SNF QRP NHSN QMs

Influenza Vaccination Coverage among HCP

- SNF QRP QM as of 10/1/22
- This CDC NHSN-based QM reports the percentage of HCP who receive influenza vaccination.
- Process measure so higher percentages are better.
- Data collection for this measure will be from October 1st through March 31st of the following year.
- This measure requires that the provider submit a minimum of one report to the NHSN by the data submission deadline of May 15th for each influenza season following the close of the data collection period each year.

SNF QRP NHSN QMs

Influenza Vaccination Coverage among HCP
SNF QRP NHSN Data Deadlines

Data for 10/1/23 – 3/31/24 due by 5/15/24

- 100% of the required NHSN Influenza vaccination among HCP data for 10/1/23 through 3/31/24 must contain the data necessary to calculate the QRP NHSN QM or the SNF will have a 2% reduction in their APU for FY 2025 (10/1/24 through 9/30/25).

SNF QRP NHSN QMs

Influenza Vaccination Coverage among HCP Resources

Long-Term Care Facility Office Hours-May 2023 – YouTube: 16+ minute video

Emergency Flu Webinar_508_05162023 (cdc.gov): Slides for the 16+ minute video

HCP Influenza Vaccination Summary Reporting FAQs

Verification of HCP Influenza Data

SNF QRP NHSN QMs

Influenza Vaccination Coverage among HCP Resources

Guidance for SNFs to Report Annual Influenza Vaccination Data to NHSN for the SNF QRP

Tips for Submitting HCP Influenza Vaccination Summary Data for the SNF QRP

For questions about reporting requirements email DNH_TriageTeam@cms.hhs.gov

For questions about SNF quality data submitted to CMS via CDC's NHSN, or NHSN Registration, email NHSN@cdc.gov

iQIES On Demand SNF QRP Reports

SNF QRP On Demand Reports

SNF QRP Provider Threshold Report

SNF QRP Review and Correct Report

SNF QRP Facility-Level QM Report

SNF QRP Resident-Level QM Report

SNF QRP Provider Threshold Report

- You select the timeframe. Defaults to the most recent fiscal year for which there is data.
- **Allows providers to monitor their compliance status of the required data submission for the SNF QRP for the APU by FY.**
- The MDS information included in this report is as current as the date of the last submission by the facility.
- The HCP COVID-19 vaccine data in this report is updated quarterly in February, May, August, and November.
- The HCP Influenza vaccine data in this report is updated twice a year, in February and in May.

iQIES Report

FY 2024 SNF QRP Provider Threshold Report

CCN		**Report Run Date**	08/16/2023
Facility Name		**Data Collection Start Date**	01/01/2022
City/State		**Data Collection End Date**	12/31/2022

# of MDS 3.0 Assessments Submitted: 234
# of MDS 3.0 Assessments Submitted Complete: 232
% of MDS 3.0 Assessments Submitted Complete: 99%*

* 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.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 FY 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.

CDC Measures

Completion Threshold: "Yes" for each month in the reporting quarter

Definitions:
Yes = Monthly reporting plan, event data and summary data submitted to CDC

No = As of "Reported to CMS Date", one or more 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 (When available, publicly reported data on HCP COVID-19 vaccination rates and data for HCP Influenza vaccination rates for swing bed providers can be found in the Provider Data Catalog, within the data set 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.)

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

HCP COVID-19 Vaccine

CDC Data Reported to CMS: 05/16/2023

Time Period	Data Collection Start Date	Data Collection End Date	Data Submission Deadline	Month 1	Month 2	Month 3
CY 2022 Q1	01/01/2022	03/31/2022	08/15/2022	Yes	Yes	Yes
CY 2022 Q2	04/01/2022	06/30/2022	11/15/2022	Yes	Yes	Yes
CY 2022 Q3	07/01/2022	09/30/2022	02/15/2023	Yes	Yes	Yes
CY 2022 Q4	10/01/2022	12/31/2022	05/15/2023	Yes	Yes	Yes

HCP Influenza Vaccine

CDC Data Reported to CMS: 05/16/2023

Time Period	Data Collection Start Date	Data Collection End Date	Data Submission Deadline	Submission Status
2022-2023	10/01/2022	03/31/2023	05/15/2023	Yes

SNF QRP Review and Correct Report

- You select the timeframe. Defaults to the most recently completed calculated quarter.
- Identifies facility-level performance data for the MDS based QRP QMs. There is also an option to include resident-level data.
- Allows SNF providers to review their QRP data to identify if there are any corrections or changes necessary prior to the quarter's data submission deadline.
- Does not identify whether or not the 80% threshold for the SNF QRP APU is met.
- Updated weekly and on the first day of each quarter with assessments submitted since the previous calculation.

iQIES Report

SNF QRP Review and Correct Report

Facility ID:		**Requested Quarter End Date:**	Q2 2023
CCN:		**Report Release Date:**	07/01/2023
Facility Name:		**Report Run Date:**	08/16/2023
City/State:		**Data Calculation Date:**	08/07/2023
		Report Version Number:	3.0

Definitions

Dash (-):	Data not available or not applicable
X:	Triggered (Bold indicates an undesirable outcome)
NT:	Not Triggered (Bold indicates a desirable outcome did not occur or process was not performed)
E:	Excluded from analysis based on quality measure exclusion criteria.

MDS 3.0 QUALITY MEASURE

DRR

Reference page 1 of this report to locate the Table Legend

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
Q2 2023	S007.02	04/01/2023	06/30/2023	11/15/2023	Open	94	96	97.9%
Q1 2023	S007.02	01/01/2023	03/31/2023	08/15/2023	**Closed**	78	81	96.3%
Q4 2022	S007.02	10/01/2022	12/31/2022	05/15/2023	**Closed**	88	91	96.7%
Q3 2022	S007.02	07/01/2022	09/30/2022	02/15/2023	**Closed**	80	83	96.4%
Cumulative	-	**07/01/2022**	**06/30/2023**	-	-	**340**	**351**	**96.9%**

MDS 3.0 QUALITY MEASURE

DRR

Reference page 1 of this report to locate the Table Legend

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
Q2 2023					11/15/2023	Open	X
Q2 2023					11/15/2023	Open	X
Q2 2023					11/15/2023	Open	X
Q2 2023					11/15/2023	Open	X
Q2 2023					11/15/2023	Open	X
Q2 2023					11/15/2023	Open	X

MDS 3.0 QUALITY MEASURE

Pressure Ulcer/Injury

Reference page 1 of this report to locate the Table Legend

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
Q2 2023	S038.02	04/01/2023	06/30/2023	11/15/2023	Open	1	96	1.0%
Q1 2023	S038.02	01/01/2023	03/31/2023	08/15/2023	**Closed**	0	81	0.0%
Q4 2022	S038.02	10/01/2022	12/31/2022	05/15/2023	**Closed**	1	90	1.1%
Q3 2022	S038.02	07/01/2022	09/30/2022	02/15/2023	**Closed**	1	83	1.2%
Cumulative	-	**07/01/2022**	**06/30/2023**	-	-	**3**	**350**	**0.9%**

MDS 3.0 QUALITY MEASURE

Pressure Ulcer/Injury

Reference page 1 of this report to locate the Table Legend

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
Q2 2023					11/15/2023	Open	NT
Q2 2023					11/15/2023	Open	NT
Q2 2023					11/15/2023	Open	NT
Q2 2023					11/15/2023	Open	NT
Q2 2023					11/15/2023	Open	NT

SNF QRP Facility-Level QM Report

- You select the timeframe. Defaults to the end date of the most recently calculated quarter.
- Provides facility-level MDS, **Claims-based**, and NHSN QM values for a select 12-month period.
- Identifies the facilities performance on QRP QMs. Also lists the national average performance.
- MDS-based QMs updated on the first day of each month.
- Claims-based data updated annually, typically in October.
- The HCP COVID-19 vaccine data in this report is updated quarterly in February, May, August, and November.
- The HCP Influenza vaccine data in this report will be updated yearly in October, beginning in October 2023.

iQIES Report

SNF QRP Facility-Level Quality Measure (QM) Report

Requested Report End Date: 09/30/2023
Report Run Date: 08/16/2023
Report Version Number: 2.3

Facility ID: **Facility Name:** **CCN:** **City/State:**

Source: Minimum Data Set 3.0 (MDS 3.0)
Data Calculation Date: 08/01/2023

Table Legend
Dash (-): Data not available or not applicable

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Observed Percent	Facility Risk-Adjusted Percent	National Average
Pressure Ulcer/Injury	10/01/2022 - 09/30/2023	S038.02	10/01/2022 - 09/30/2023	0	13	0.0%	0.0%	2.7%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
Application of Falls (NQF #0674)	10/01/2022 - 09/30/2023	S013.02	10/01/2022 - 09/30/2023	0	13	0.0%	1.0%
Application of Functional Assessment/Care Plan (NQF #2631)	10/01/2022 - 09/30/2023	S001.03	10/01/2022 - 09/30/2023	13	13	100.0%	99.0%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Average Observed Discharge Score	Average Expected Discharge Score	Numerator	Denominator	Facility Percent	National Average
Functional Status Outcome: Discharge Self-Care Score (NQF #2635)	10/01/2022 - 09/30/2023	S024.04	10/01/2022 - 09/30/2023	25.3	26.8	3	8	37.5%	49.8%
Functional Status Outcome: Discharge Mobility Score (NQF #2636)	10/01/2022 - 09/30/2023	S025.04	10/01/2022 - 09/30/2023	37.4	43.0	1	8	12.5%	46.7%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
DRR	10/01/2022 - 09/30/2023	S007.02	10/01/2022 - 09/30/2023	11	13	84.6%	91.9%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Denominator	Average Observed Admission Score	Average Observed Discharge Score	Average Observed Change	Average Risk-Adjusted Change	National Average
Functional Status Outcome: Change in Self-Care (NQF #2633)	10/01/2022 - 09/30/2023	S022.04	10/01/2022 - 09/30/2023	8	23.3	25.3	2.0	6.4	7.2
Functional Status Outcome: Change in Mobility (NQF #2634)	10/01/2022 - 09/30/2023	S023.04	10/01/2022 - 09/30/2023	8	31.4	37.4	6.0	13.3	16.6

Source: Medicare Fee-For-Service Claims

Data Calculation Date: 06/28/2023

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

Note: Claims-based measures do not have iQIES Resident-Level Quality Measure results

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Number of Readmissions	Number of Eligible Stays	Observed Readmission Rate	Risk-Standardized Readmission Rate (RSRR)	95% Confidence Interval [a]	National Observed Readmission Rate	Comparative Performance Category
PPR	10/01/2020 - 09/30/2022	S004.01	10/01/2020 - 09/30/2022	2	13	15.38%	10.60%	(6.98%, 15.88%)	10.48%	No Different than National Rate

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Number of Discharges To Community	Number of Eligible Stays	Observed Discharge to Community Rate	Risk-Standardized Discharge to Community Rate	95% Confidence Interval [a]	National Observed Discharge to Community Rate	Comparative Performance Category
DTC (NQF #3481)	10/01/2020 - 09/30/2022	S005.02	10/01/2020 - 09/30/2022	2	4	50.00%	51.88%	(29.50%, 77.14%)	49.74%	No Different than National Rate

					AVERAGE SPENDING PER EPISODE			MSPB AMOUNT		
Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Number of Eligible Episodes	Spending During Treatment Period [b]	Spending During Associated Services Period [c]	Total Spending During Episode	Average Risk-Adjusted Spending	National Median	MSPB Score
MSPB (Your Facility)	10/01/2020 - 09/30/2022	S006.01	10/01/2020 - 09/30/2022	17	$24,859	$3,765	$28,623	$27,903	$29,601	0.94
MSPB (National)	10/01/2020 - 09/30/2022	S006.01	10/01/2020 - 09/30/2022	1,843,861	$18,762	$11,554	$30,316	$30,279	$29,601	1.02

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Number of Eligible Stays	Observed HAI Rate	Observed Number of HAIs	Risk Standardized HAI Rate	95% Confidence Interval [a]	Observed National Average	Comparative Performance Category
SNF HAI	10/01/2021 - 09/30/2022	S039.01	10/01/2021 - 09/30/2022	2	0.00%	0	6.76%	(3.43%, 13.09%)	6.87%	No Different than National Rate

Source: Centers for Disease Control and Prevention National Healthcare Safety Network (CDC NHSN)

Data Calculation Date: 05/19/2023

Table Legend

Dash (-): Data not available or not applicable

[d]: Data on the HCP COVID-19 Vaccine rates for swing bed providers can be found in the data for the parent facility in which the swing beds reside

Measure Name [d]	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
HCP COVID-19 Vaccine	10/01/2022 - 12/31/2022	S040.01	10/01/2022 - 12/31/2022	31	53	58.9%	87.6%

SNF QRP Resident-Level QM Report

- You select the timeframe. Defaults to the end date of the most recently calculated quarter.
- Identifies each resident with MDS records identifying a qualifying Med A stay used to calculate the facility-level QM values for a 12-month period.
- Displays each resident's name and indicates how/if the resident's MDS affected the SNF's MDS-based QRP QMs.
- Updated on the first day of each month.

SNF QRP Resident-Level Quality Measure (QM) Report

Requested Report End Date: 06/29/2023
Report Run Date: 08/16/2023
Data Calculation Date: 08/01/2023
Report Version Number: 2.2

SNF QRP Quality Measures Legend

QM #	Measure Name	Measure Interpretation	Report Period	CMS ID	CMS ID Discharge Dates
1	Pressure Ulcer/Injury	Undesirable Outcomes	07/01/2022 - 06/30/2023	S038.02	07/01/2022 - 06/30/2023
2	Application of Falls (NQF #0674)	Undesirable Outcomes	07/01/2022 - 06/30/2023	S013.02	07/01/2022 - 06/30/2023
3	Application of Functional Assessment/Care Plan (NQF #2631)	Desirable Outcomes or Processes Performed	07/01/2022 - 06/30/2023	S001.03	07/01/2022 - 06/30/2023
4	Functional Status Outcome: Discharge Self-Care Score (NQF #2635)	Desirable Outcomes or Processes Performed	07/01/2022 - 06/30/2023	S024.03; S024.04	07/01/2022 - 09/30/2022; 10/01/2022 - 06/30/2023
5	Functional Status Outcome: Discharge Mobility Score (NQF #2636)	Desirable Outcomes or Processes Performed	07/01/2022 - 06/30/2023	S025.03; S025.04	07/01/2022 - 09/30/2022; 10/01/2022 - 06/30/2023
6	DRR	Desirable Outcomes or Processes Performed	07/01/2022 - 06/30/2023	S007.02	07/01/2022 - 06/30/2023
7	Functional Status Outcome: Change in Self-Care (NQF #2633)	Change in Function Scores	07/01/2022 - 06/30/2023	S022.03; S022.04	07/01/2022 - 09/30/2022; 10/01/2022 - 06/30/2023
8	Functional Status Outcome: Change in Mobility (NQF #2634)	Change in Function Scores	07/01/2022 - 06/30/2023	S023.03; S023.04	07/01/2022 - 09/30/2022; 10/01/2022 - 06/30/2023

Table Legend

Dash (-): Data not available or not applicable
X: Triggered (Bold indicates an undesirable outcome)
NT: Not Triggered (Bold indicates a desirable outcome did not occur or process was not performed)
E: Excluded from analysis based on quality measure exclusion criteria
Change in Function Scores: Values are observed change in function scores from admission to discharge

Facility ID: Facility Name: CCN: City/State:

Reference page 1 of this report to locate the Table Legend

				Undesirable Outcomes		*Desirable Outcomes or Processes Performed*				*Change in Function Scores*	
Resident Name	Resident ID	Admission Date	Discharge Date	QM 1	QM 2	QM 3	QM 4	QM 5	QM 6	QM 7	QM 8
				NT	NT	X	E	E	X	E	E
				NT	NT	X	X	X	X	10	-16
				NT	NT	X	X	X	NT	5	34
				NT	NT	X	NT	X	X	-8	12
				NT	NT	X	NT	NT	X	-2	-10
				NT	NT	X	E	E	X	E	E

CMS QRP Websites

SNF QRP QMs and Tech Info

SNF QRP Submission Deadlines

SNF QRP Spotlights and Announcements

SNF QRP Training

SNF QRP Public Reporting

SNF QRP FAQs

SNF QRP Reconsideration, Exception, Extension

SNF QRP Help

References

MDS 3.0 Quality Measures User Manual Version 15.0

- Can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures

SNF QRP Program Measure Calculations and Reporting User's Manual Version 4.0

- Can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information

87

Subscribe to Section for Long-Term Care Regulation's weekly LISTSERV

https://cntysvr1.lphamo.org/subscribeltc.html

- Main form of communication from the State to providers.
- Includes changes/updates/educational opportunities.

88

State MDS Unit

Stacey Bryan
State RAI Coordinator
Stacey.Bryan@health.mo.gov
573-751-6308

Danette Beeson
State Automation Coordinator
Danette.Beeson@health.mo.gov
573-522-8421

89