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SNF QRP Measures A Deep Dive

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APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
 - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
 - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
 - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 30 days



Learning Objectives

SNF QRP Measures

- Understand the SNF QRP
- Recognize the SNF QRP measures
- Appreciate the complexity of the MDS based technical specifications
- Identify the SNF QRP reporting requirements
- Apply an understanding of the SNF QRP to daily practice

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- **SNF QRP Resources:**

- SNF QRP
- Reporting tables for FY 2025
- Reporting Tables for FY 2026
- SNF QRP Technical Specifications
- COVID-19 Vaccination Among HCP Specifications
- Influenza Vaccination Coverage Among HCP
- Data Collection & Final Submission Deadlines
- Unified PAC Report to Congress
- MDS 3.0 v1.18.11
- Health Equity Confidential Feedback Report educational Material

IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.
- The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), **Skilled Nursing Facilities (SNFs)**, Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, **the Minimum Data Set (MDS) for SNFs**, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.
- The IMPACT Act requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADES).
- The Act also requires the submission of data pertaining to measure domains pertaining to resource use, and other domains.
- In addition, the IMPACT Act requires assessment data to be **standardized** and **interoperable** to allow for **exchange of the data among post-acute providers and other providers**.
- The Act intends for standardized post-acute care data to **improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning**.

SNF Quality Reporting Program (QRP)

- **Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) FY 2024: MDS Reporting Requirements**
 - CMS is increasing the SNF QRP Data Completion thresholds for the Minimum Data Set (MDS) Data Items beginning with the FY 2026 SNF QRP.
 - SNFs will need to report 100% of the required quality measure data and standardized resident assessment data collected using the MDS on at least 90% of the assessments they submit to CMS.
 - Starting with data collected in CY 2024, any SNF that does not meet the requirement that 90% of all MDS assessments submitted contain 100% of required data items, will be subject to a reduction of 2 percentage points to the applicable FY annual payment update beginning with FY 2026.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the SNF QRP. One option we are considering is including **social determinants of health (SDOH) as part of new quality measures.**
- CMS is considering whether health equity measures we have adopted for other settings, such as hospitals, could be adopted in post-acute care settings.
- CMS is exploring ways to incorporate SDOH elements into the measure specifications. For example, CMS is considering **a future health equity measure like screening for social needs and interventions.**
- **With 30 percent to 55 percent of health outcomes attributed to SDOH,** a measure capturing and addressing SDOH could encourage SNFs to identify residents' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness.

SNF VBP/QRP Connection: Health Equity

- **Health Equity Update SNF PPS FY 2024**
- CMS could specify a health equity measure using the same SDOH data items that we currently collect as standardized patient assessment data elements under the SNF.
- These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need or want of an interpreter).
- CMS also sees value in aligning SDOH data items across all care settings as we develop future health equity quality measures under our SNF QRP statutory authority.

Health Equity Confidential Feedback Reports

- In October 2023, CMS posted provider specific health equity confidential feedback reports in IQIES related to two SNF QRP claims based measures.
 - Medicare Spending per beneficiary (MSPB)
 - Discharge to community (DTC)
- In these reports, the data related to these two measures have been broken apart so that facilities can see from a health equity perspective, i.e., dual eligible, non-dual, white, and non-white, how they compare to other related groups of residents within their own organization and in subsets of the broader SNF population.
- Helpful information includes provider's percentage of dually eligibles and non-dually eligibles compared to their peers in the region, state and nationally.

SNF Quality Reporting Program (QRP)

- **FY 2024 Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is adopting two measures in the SNF QRP,
 - the removal of three measures from the SNF QRP, and
 - the modification of one measure in the SNF QRP. In addition,
 - the final rule would also make policy changes to the SNF QRP, and
 - begin public reporting of four measures.

New QRP Measures

FY 2024 Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- CMS is adopting the **Discharge Function Score (DC Function) measure** beginning with the FY 2025 SNF QRP. (Five-Star Impact)
- This measure assesses functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the Minimum Data Set (MDS).
- This measure will replace the topped-out process measure – the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment/a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure.

New QRP Measures

FY 2024 Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- CMS is adopting of the **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine)** measure beginning with the FY 2026 SNF QRP.
- This measure reports the percentage of stays in which residents in an SNF are up to date with recommended COVID-19 vaccinations in accordance with the Centers for Disease Control and Prevention's (CDC's) most recent guidance.
- Data will be collected using a new standardized item on the MDS (with initial reporting through NHSN).

00350. Resident's COVID-19 vaccination is up to date

Enter Code

☐

0. No, resident is not up to date

1. Yes, resident is up to date

FY 2024 Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Modified QRP Measures

- CMS is modifying the **COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure** beginning with the FY 2025 SNF QRP.
- This measure tracks the percentage of healthcare personnel (HCP) working in SNFs who are considered up to date with recommended COVID-19 vaccination in accordance with the CDC's most recent guidance.
- The current version of this measure reports only on whether HCP had received the primary vaccination series for COVID-19.
- This modification will require SNFs to report the **cumulative number of HCP who are up to date with recommended COVID-19 vaccinations** in accordance with the CDC's most recent guidance.

Removed QRP Measures

FY 2024 Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- CMS will remove the **Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan)** measure beginning with the FY 2025 SNF QRP.
- CMS is removing this measure for two reasons.
 - **First**, the Application of Functional Assessment/Care Plan measure meets the conditions for measure removal factor one: measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
 - **Second**, this measure meets the conditions for measure removal factor six: there is an available measure (the DC Function measure) that is more strongly associated with desired resident functional outcomes.

Removed QRP Measures

FY 2024 Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- CMS will remove the **Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score)** measure; and the **Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score)** measure beginning with the FY 2025 SNF QRP.
- CMS is removing these two measures because these measures meet the condition for measure removal factor eight: the costs associated with a measure outweigh the benefits of its use in the program.
- Additionally, these measures are similar or duplicative of other measures within the SNF QRP.

Removed QRP Measures

Notice of Upcoming SNF QRP Measure Removals

- The Centers for Medicare & Medicaid Services (CMS) is alerting Skilled Nursing Facility (SNF) providers of upcoming measure removals from the SNF Quality Reporting Program (QRP).
- The following quality measures are planned for removal from the iQIES Review and Correct Reports, Facility-Level Quality Measure (QM) Reports, and Resident-Level QM Reports in January 2024:
 - Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
 - Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
 - Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
- Once removed from reports, users will no longer have access to any data or measure results for these measures.
- These measures will last appear in the April 2024 Provider Preview Reports for the July 2024 Refresh of SNF QRP data.
- Starting with the October 2024 Release, these measures will be removed from Care Compare and Provider Data Catalog. Once removed, the historic publicly reported measure data will continue to be available in the Nursing Homes Including Rehab Services Data Archive files on the Provider Data Catalog.

IMPACT Act QMs

IMPACT Act Measure	Source
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. ★	Assessment
Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment
Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment
Discharge Function Score ★	Assessment
Drug Regimen Review	Assessment
Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment
Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment
Medicare Spending Per Beneficiary	Claims
Discharge to Community ★	Claims
Potentially Preventable 30-Day Post-Discharge Readmission	Claims
SNF Healthcare Associated infections	Claims
Influenza vaccination HCP	NHSN
COVID-19 Vaccination HCP Up-to-date	NHSN
COVID-19 Vaccination Resident Up-to-date	NHSN

Application of
Percent of
Residents
Experiencing One
or More Falls with
Major Injury
(Long Stay)
(CMS ID: S013.02)

- **Measure Description:** This quality measure reports the percentage of Medicare Part A SNF stays where one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) were reported during the SNF stay.
- **Numerator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).
- **Denominator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) with one or more assessments that are eligible for a look-back scan (except those with exclusions).
- **Exclusions** - Medicare Part A SNF stays are excluded if:
 - 1. The number of falls with major injury was not coded; i.e., J1900C (Falls with Major Injury) = [-].
 - 2. The resident died during the SNF stay (i.e., Type 2 SNF Stays).
- **Covariates:** None

Drug Regimen
Review Conducted
With Follow-Up for
Identified Issues—
Post-Acute Care
(PAC) Skilled
Nursing Facility
(SNF) Quality
Reporting Program
(QRP)

(CMS ID: S007.02)

- **Measure Description:** This measure reports the percentage of Medicare Part A SNF stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay.
- **Numerator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator meeting each of the following two criteria:
 - 1. The facility conducted a drug regimen review on admission which resulted in one of the three following scenarios:
 - a. No potential or actual clinically significant medication issues were found during the review (N2001 = [0]); OR
 - b. Potential or actual clinically significant medication issues were found during the review (N2001 = [1]) and then a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day (N2003 = [1]); OR
 - c. The resident was not taking any medications (N2001 = [9]).
 - 2. Appropriate follow-up occurred each time a potential or actual clinically significant medication issue was identified during the stay (N2005 = [1]); or no potential or actual clinically significant medications issues were identified since the admission or resident was not taking any medications (N2005 = [9]).

Drug Regimen
Review Conducted
With Follow-Up for
Identified Issues—
Post-Acute Care
(PAC) Skilled
Nursing Facility
(SNF) Quality
Reporting Program
(QRP)
(CMS ID: S007.02)

- **Denominator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) during the reporting period.
- **Exclusions** - Medicare Part A SNF stays are excluded if:
 - 1. The resident died during the SNF stay (i.e., Type 2 SNF Stays).
 - a. Type 2 SNF Stays are SNF stays with a PPS 5-Day Assessment (A0310B = [01]) and a matched Death in Facility Tracking Record (A0310F = [12]).
- **Covariates:** None

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMS ID: S038.02)

- **Measure Description:** This measure reports the percentage of Medicare Part A SNF stays with Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that are new or worsened since admission. The measure is calculated by reviewing a resident's MDS pressure ulcer discharge assessment data for reports of Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that were not present or were at a lesser stage at the time of admission.
- **Numerator:** The number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator for which the discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, compared to admission.

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMS ID: S038.02)

- **Denominator:** The number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the selected time window for SNF residents ending during the selected time window, except those that meet the exclusion criteria.
- **Exclusions** - Medicare Part A SNF stays are excluded if:
 - Data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, are missing [-] at discharge,
 - The resident died during the SNF stay (i.e., Type 2 SNF Stays).
- **Covariates:**
 - Functional Mobility Admission Performance: Coding of dependent or substantial/maximal assistance for the functional mobility item Lying to Sitting on Side of Bed at admission
 - Bowel Incontinence
 - Peripheral Vascular Disease / Peripheral Arterial Disease or Diabetes Mellitus
 - Low body mass index (BMI), based on height (K0200A) and weight (K0200B)

Application of IRF Functional Outcome Measure:

Discharge Self- Care Score for Medical Rehabilitation Patients

(CMS ID: S024.05)

- **Measure Description:** This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge self-care score
- **Section GG items:**
 - The Self-Care assessment items used for discharge Self-Care score calculations are:
 - GG0130A3. Eating
 - GG0130B3. Oral hygiene
 - GG0130C3. Toileting hygiene
 - GG0130E3. Shower/bathe self
 - GG0130F3. Upper body dressing
 - GG0130G3. Lower body dressing
 - GG0130H3. Putting on/taking off footwear
- To obtain the discharge self-care score, use the following procedure:
 - If code is between 01 and 06, then use code as the value.
 - If code is 07, 09, 10, or 88, then recode to 01 and use this code as the value.
 - If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the value.
 - Sum the values of the discharge self-care items to create a discharge self-care score for each Medicare Part A SNF stay record. Scores can range from 7 to 42, with a higher score indicating greater independence.

Application of IRF Functional Outcome Measure:

Discharge Self- Care Score for Medical Rehabilitation Patients

(CMS ID: S024.05)

- **Numerator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with a discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.
- **Denominator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.
- **Exclusions:** Medicare Part A SNF stays are excluded if:
 - The Medicare Part A SNF stay is an incomplete stay:
 - Unplanned discharge
 - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
 - SNF PPS Part A stay less than 3 days.
 - The resident died during the SNF stay (i.e., Type 2 SNF Stays).
 - The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment):
 - Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
 - The resident is younger than age 18.
 - The resident is discharged to hospice or received hospice while a resident:

Application of IRF Functional Outcome Measure:

Discharge Self- Care Score for Medical Rehabilitation Patients

(CMS ID: S024.05)

- **Exclusions (cont.):** Medicare Part A SNF stays are excluded if:
 - The resident did not receive physical or occupational therapy services at the time of admission (i.e., on the 5- Day PPS assessment)
- **Covariates:** (Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stay.)
 - Age group
 - Admission self-care – continuous form
 - Admission self-care – squared form
 - Primary medical condition category
 - Interaction between primary medical condition category and admission self-care
 - Prior surgery
 - Prior functioning: self-care
 - Prior functioning: indoor mobility (ambulation)
 - Prior mobility device use
 - Stage 2 pressure ulcer
 - Stage 3, 4, or unstageable pressure ulcer/injury
 - Cognitive abilities
 - Communication Impairment
 - Urinary Continence
 - Bowel Continence
 - Tube feeding or total parenteral nutrition
 - Comorbidities

Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (CMS ID: S025.05)

- **Measure Description:** This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge mobility score.
- **Section GG items:**
 - The Mobility assessment items used for discharge Self-Care score calculations are:
 - GG0170A3. Roll left and right
 - GG0170B3. Sit to lying
 - GG0170C3. Lying to sitting on side of bed
 - GG0170D3. Sit to stand
 - GG0170E3. Chair/bed-to-chair transfer
 - GG0170F3. Toilet transfer
 - GG0170G3. Car transfer
 - GG0170I3. Walk 10 feet
 - GG0170J3. Walk 50 feet with two turns
 - GG0170K3. Walk 150 feet
 - GG0170L3. Walking 10 feet on uneven surfaces
 - GG0170M3. 1 step (curb)
 - GG0170N3. 4 steps
 - GG0170O3. 12 steps
 - GG0170P3. Picking up object
- To obtain the discharge self-care score, use the following procedure:
 - If code is between 01 and 06, then use code as the value.
 - If code is 07, 09, 10, or 88, then recode to 01 and use this code as the value.
 - If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the value.
 - Sum the values of the discharge self-care items to create a discharge self-care score for each Medicare Part A SNF stay record. Scores can range from 7 to 42, with a higher score indicating greater independence.

Application of IRF Functional Outcome Measure:

Discharge Mobility Score for Medical Rehabilitation Patients

(CMS ID: S025.05)

- **Numerator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with a discharge mobility score that is equal to or higher than the calculated expected discharge mobility score.
- **Denominator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.
- **Exclusions:** Medicare Part A SNF stays are excluded if:
 - The Medicare Part A SNF stay is an incomplete stay:
 - Unplanned discharge
 - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
 - SNF PPS Part A stay less than 3 days.
 - The resident died during the SNF stay (i.e., Type 2 SNF Stays).
 - The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment):
 - Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
 - The resident is younger than age 18.
 - The resident is discharged to hospice or received hospice while a resident:

Application of IRF Functional Outcome Measure:

Discharge Mobility Score for Medical Rehabilitation Patients

(CMS ID: S025.05)

- **Exclusions (cont.):** Medicare Part A SNF stays are excluded if:
 - The resident did not receive physical or occupational therapy services at the time of admission (i.e., on the 5- Day PPS assessment)
- **Covariates:** (Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stay.)
 - Age group
 - Admission mobility – continuous form
 - Admission mobility – squared form
 - Primary medical condition category
 - Interaction between primary medical condition category and admission mobility
 - Prior surgery
 - Prior functioning: indoor mobility (ambulation)
 - Prior functioning: stairs
 - Prior functioning: functional cognition
 - Prior mobility device use
 - Stage 2 pressure ulcer
 - Stage 3, 4, or unstageable pressure ulcer/injury
 - Cognitive abilities
 - Communication impairment
 - Urinary Continence
 - Bowel Continence
 - History of falls
 - Tube feeding or total parenteral nutrition
 - Comorbidities

Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC) (CMS ID: S043.01)

- **Measure Description:** This measure reports the percentage of SNF stays indicating a current reconciled medication list was transferred to the subsequent provider at the time of discharge. For residents with multiple stays during the reporting period, each stay is eligible for inclusion in the measure.
- **Numerator:** The number of stays (Type 1 SNF Stays only) for which the MDS 3.0 indicated that at the time of discharge, the facility provided a current reconciled medication list to the subsequent provider
- **Denominator:** The total number of SNF stays (Type 1 SNF Stays only) with a discharge date in the measure target period, ending in discharge to short-term general hospital, another SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.
- **Exclusions:** There are no denominator exclusions for this measure.
- **Covariates:** No Covariates

Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC) (CMS ID: S044.01)

- **Measure Description:** This measure reports the percentage of SNF stays indicating a current reconciled medication list was transferred to the resident, family, and/or caregiver at the time of discharge. For residents with multiple stays during the reporting period, each stay is eligible for inclusion in the measure.
- **Numerator:** The number of SNF stays (Type 1 SNF Stays only) for which the MDS 3.0 indicated that at the time of discharge, the facility provided a current reconciled medication list to the resident, family, and/or caregiver.
- **Denominator:** The total number of SNF stays (Type 1 SNF Stays only) with a discharge date in the measure target period, ending in discharge to Home (e.g., private home/apartment, board/care, assisted living, group home or transitional living or other residential care arrangements).
- **Exclusions:** There are no denominator exclusions for this measure.
- **Covariates:** No Covariates

Discharge Function Score (CMS ID: S042.01)

- **Measure Description:** This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge function score
- **The function assessment items used for discharge function score calculations are:**
 - GG0130A3. Eating
 - GG0130B3. Oral hygiene
 - GG0130C3. Toileting hygiene
 - GG0170A3. Roll left and right
 - GG0170C3. Lying to sitting on side of bed
 - GG0170D3. Sit to stand
 - GG0170E3. Chair/bed-to-chair transfer
 - GG0170F3. Toilet transfer
 - GG0170I3: Walk 10 Feet*
 - GG0170J3: Walk 50 Feet with 2 Turns*
 - GG0170R3. Wheel 50 feet with 2 Turns

Discharge Function Score (CMS ID: S042.01)

- **To obtain the discharge function score, use the following procedure:**
 - If code is between 01 and 06, use the code as the value.
 - If code is 07, 09, 10, 88, dashed (-), then use statistical imputation to estimate the item value for that item and use this code as the value.
 - If the item is skipped (^), dashed (-), or missing, then use statistical imputation to estimate the item value for that item and use this code as the value.
 - Sum the values of the discharge function items to calculate the observed discharge function score for each Medicare Part A SNF stay. Scores can range from 10 to 60, with a higher score indicating greater independence.
- **Numerator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with an observed discharge function score that is equal to or greater than the calculated expected discharge function score.
- **Denominator:** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.

Discharge Function Score (CMS ID: S042.01)

- **Exclusions: Medicare Part A SNF stays are excluded if:**
 - The Medicare Part A SNF stay is an incomplete stay:
 - Unplanned discharge
 - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
 - SNF PPS Part A stay less than 3 days.
 - The resident died during the SNF stay (i.e., Type 2 SNF Stays).
 - The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment):
 - Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
 - The resident is younger than age 18.
 - The resident is discharged to hospice or received hospice while a resident
 - The resident did not receive physical or occupational therapy services at the time of admission (i.e., on the 5- Day PPS assessment)

Discharge Function Score (CMS ID: S042.01)

- **Covariates:**
 - Age group
 - Admission function – continuous formc
 - Admission function – squared formc
 - Primary medical condition category
 - Interaction between admission function and primary medical condition category
 - Prior surgery
 - Prior functioning: self-care
 - Prior functioning: indoor mobility (ambulation)
 - Prior functioning: stairs
 - Prior functioning: functional cognition
 - Prior mobility device use
 - Stage 2 pressure ulcer/injury
 - Stage 3, 4, or unstageable pressure ulcer/injury
 - Cognitive abilities
 - Communication impairment
 - Urinary Continence
 - Bowel Continence
 - History of falls
 - Nutritional approaches
 - High BMI
 - Low BMI
 - Comorbidities

Feedback Reports and Monitoring

 iQIES Report



SNF QRP Facility-Level Quality Measure (QM) Report

Requested Report End Date: 03/31/2024
Report Run Date: 02/21/2024
Report Version Number: 2.5

Facility ID:

Facility Name:

CCN:

City/State:

Source: [Minimum Data Set 3.0 \(MDS 3.0\)](#)

Data Calculation Date: 02/15/2024

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	04/01/2023 - 03/31/2024	S038.02	04/01/2023 - 03/31/2024	3	49	6.1%	6.1%	2.7%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
Application of Falls	04/01/2023 - 03/31/2024	S013.02	04/01/2023 - 03/31/2024	1	49	2.0%	1.0%

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Feedback Reports and Monitoring

iQIES Report



SNF QRP Resident-Level Quality Measure (QM) Report

Requested Report End Date: 03/31/2024
Report Run Date: 02/21/2024
Data Calculation Date: 02/15/2024
Report Version Number: 2.4

SNF QRP Quality Measures Legend

QM #	Measure Name	Measure Interpretation	Report Period	CMS ID	CMS ID Discharge Dates
1	Pressure Ulcer/Injury	Undesirable Outcomes	04/01/2023 - 03/31/2024	S038.02	04/01/2023 - 03/31/2024
2	Application of Falls	Undesirable Outcomes	04/01/2023 - 03/31/2024	S013.02	04/01/2023 - 03/31/2024
3	Functional Status Outcome: Discharge Self-Care Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S024.04; S024.05	04/01/2023 - 09/30/2023; 10/01/2023 - 03/31/2024
4	Functional Status Outcome: Discharge Mobility Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S025.04; S025.05	04/01/2023 - 09/30/2023; 10/01/2023 - 03/31/2024
5	Discharge Function Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S042.01	04/01/2023 - 03/31/2024
6	DRR	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S007.02	04/01/2023 - 03/31/2024

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

Feedback Reports and Monitoring

SNF QRP Resident-Level Quality Measure (QM) Report

iQIES Report

				Undesirable Outcomes		Desirable Outcomes or Processes Performed			
Resident Name	Resident ID	Admission Date	Discharge Date	QM 1	QM 2	QM 3	QM 4	QM 5	QM 6
		10/11/2023	10/31/2023	NT	NT	X	X	X	X
		08/19/2023	10/27/2023	NT	NT	NT	X	X	X
		10/02/2023	10/21/2023	NT	NT	NT	NT	NT	X
		09/19/2023	10/10/2023	NT	NT	NT	X	X	X
		08/25/2023	10/05/2023	NT	NT	X	X	X	X
		09/26/2023	10/01/2023	NT	NT	NT	X	X	X
		06/21/2023	09/07/2023	NT	NT	NT	NT	NT	X
		07/01/2023	09/03/2023	NT	NT	X	NT	X	X
		06/15/2023	08/28/2023	NT	NT	X	X	X	X
		07/01/2023	08/25/2023	NT	NT	X	X	X	X
		05/01/2023	07/22/2023	NT	NT	NT	X	X	X
		06/13/2023	07/16/2023	NT	NT	X	X	X	X
		07/02/2023	07/15/2023	NT	NT	NT	X	NT	X
		04/04/2023	07/12/2023	NT	NT	NT	NT	NT	X
		05/22/2023	06/20/2023	NT	NT	NT	NT	NT	X
		05/05/2023	06/19/2023	NT	NT	X	X	X	X
		06/02/2023	06/18/2023	X	NT	NT	NT	X	X

Feedback Reports and Monitoring

iQIES Report



SNF QRP Review and Correct Report

Facility ID:

CCN:

Facility Name:

City/State:

Requested Quarter End Date:

Q4 2023

Report Release Date:

01/01/2024

Report Run Date:

02/21/2024

Data Calculation Date:

02/19/2024

Report Version Number:

3.1

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

Feedback Reports and Monitoring

SNF QRP Review and Correct Report

iQIES Report

MDS 3.0 QUALITY MEASURE

Application of Falls

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
Q4 2023	S013.02	10/01/2023	12/31/2023	05/15/2024	Open	0	15	0.0%
Q3 2023	S013.02	07/01/2023	09/30/2023	02/15/2024	Closed	0	8	0.0%
Q2 2023	S013.02	04/01/2023	06/30/2023	11/15/2023	Closed	1	20	5.0%
Q1 2023	S013.02	01/01/2023	03/31/2023	08/15/2023	Closed	0	22	0.0%
Cumulative	-	01/01/2023	12/31/2023	-	-	1	65	1.5%

Feedback Reports and Monitoring



FY 2026 SNF QRP Provider Threshold Report

CCN	Report Run Date	02/21/2024
Facility Name	Data Collection Start Date	01/01/2024
City/State	Data Collection End Date	12/31/2024

of MDS 3.0 Assessments Submitted: 19
of MDS 3.0 Assessments Submitted Complete: 19
% of MDS 3.0 Assessments Submitted Complete: 100%*

* FY 2026 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.

Feedback Reports and Monitoring

Resident _____ Identifier _____ Date _____

Section M - Skin Conditions CATs QM \$\$ ★ QRP

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued CATs QM \$\$ ★ QRP

Enter Number

E. **Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device

1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar CAA: *12, *16, N045.01 ★ S038.02 ★

Enter Number

2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry S038.02 ★

Enter Number

F. **Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury CAA: *12, *16, N045.01 ★, S038.02 ★,

Enter Number

2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry S038.02 ★

Enter Number

G. **Unstageable - Deep tissue injury:**

1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers CAA: *12, *16, N045.01 ★, S038.02 ★

Enter Number

2. Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry S038.02 ★

Next Steps

- Understand your measures
- Be aware of what is triggering while you're completing the MDS
- Keep Track of your data
- Run your threshold reports frequently
- Know the review and correct deadlines
- Make corrections as necessary
- Care Compare is your reflection.

QUESTIONS?