CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Skilled Nursing Facility

Quality Reporting Program Provider Training

Overview of Current SNF QRP Quality Measures

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Acronyms in This Presentation

- CMS – Centers for Medicare & Medicaid Services
- DRR – Drug Regimen Review
- DTC – Discharge to Community
- IMPACT Act – Improving Medicare Post-Acute Care Transformation Act
- IRF – Inpatient Rehabilitation Facility
- LTCH – Long-Term Care Hospital
- MSPB – Medicare Spending Per Beneficiary
- NH – Nursing Home
- NQF – National Quality Forum
- OT – Occupational Therapy

Acronyms in This Presentation (cont.)

- PAC – Post-Acute Care
- PPR – Potentially Preventable 30-Day Post-Discharge Readmission
- PPS – Prospective Payment System
- PT – Physical Therapy
- QM – Quality Measure
- QRP – Quality Reporting Program
- SNF – Skilled Nursing Facility
- SOM – State Operations Manual

Objectives

- Become familiar with the quality measures that are currently publicly reported in the SNF QRP, as well as quality measures that are being updated or added to the SNF QRP for FY 2020.
- Understand the key components of each quality measure and how they are used to calculate the quality measure.
- Understand the data submission deadlines and reporting timeline for FY 2020 and subsequent years.

Assessment-Based QMs

Key Concepts Used to Calculate Quality Measures

- **Stay**: A Medicare Part A SNF Stay includes consecutive time in the facility starting with the Medicare Part A Admission Record (PPS 5-Day assessment (A0310B = [01])) through the Medicare Part A Discharge Record (Part A PPS Discharge Assessment (A0310H = [1])) or Death in Facility Tracking Record (A0310F = [12]) at the end the SNF stay and all intervening assessments.

- **Look back scan:** The look-back scan is conducted to review all qualifying Reasons for Assessments (RFAs) within a Medicare Part A SNF Stay to determine whether certain events or conditions occurred during that stay. The look-back period consists of the entire Medicare Part A SNF Stay specific to a resident.

Key Concepts Used to Calculate Quality Measures (cont.)

- **Denominator**: The total number of Medicare Part A SNF Stays that don't meet the exclusion criteria in each facility.
- **Numerator:** Total number of Medicare Part A SNF stays in the denominator that meet the criteria for the measure numerator in each facility.
- **Exclusion**: Medicare Part A SNF stays that are excluded if the measure exclusion criteria are met.
- **Observed performance**: the unadjusted score calculated by dividing the numerator by the denominator.
- **Covariates**: variables used to adjust scores for measures that are risk adjusted.

Two Types of SNF Stays

Type 1

A PPS 5-Day assessment matched with a PPS Discharge Assessment. No Death in Facility Tracking Record within the SNF stay.

Type 2

A SNF stay with a PPS 5-Day assessment matched with a Death in Facility Tracking Record.

Q1 What is a Type 2 SNF Stay?

A. A SNF stay with a PPS 5-Day assessment and Discharge Tracking Record.

B. A SNF stay with a matched pair of PPS 5-Day assessment and a PPS Discharge Assessment.

C. A SNF stay with a PPS 5-Day assessment and no Death in Facility Tracking Record.

D. A SNF stay with a PPS 5-Day assessment and a matched Death in Facility Tracking Record.

Current Assessment-Based Quality Measures:

Short Name	CMS ID #	Quality Measure Name	Implemented
Application of Falls	S013.01	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).	Oct 2016
Application of Functional Assessment/Care Plan	S001.02	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).	Oct 2016
Change in Self-Care Score	S022.01	SNF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).	**Oct 2018**
Change in Mobility Score	S023.01	SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).	**Oct 2018**
Discharge Self-Care Score	S024.01	SNF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).	**Oct 2018**
Discharge Mobility Score	S025.01	SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).	**Oct 2018**
Pressure Ulcer/Injury	S038.01	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	**Oct 2018**
DRR	S007.01	Drug Regimen Review (DRR) Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).	**Oct 2018**

SKILLED NURSING FACILITY
QUALITY REPORTING PROGRAM

Falls With Major Injury

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
- This QM reports the percentage of Medicare Part A Type 1 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.
- Lower percentages are better.
- Finalized in the FY 2016 SNF PPS Final Rule.
- Data collection for this measure began October 1, 2016.

Falls With Major Injury (cont. 1)

Numerator

Total Number of Medicare Part A Type 1 SNF Stays in the denominator with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.

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Denominator

Total number of Medicare Part A Type 1 SNF Stays with one or more assessments that are eligible for a look-back scan (except those with exclusions).

Falls With Major Injury (cont. 2)

- Look-back scan for falls:
- Qualifying Reasons for Assessments (RFAs) for the look-back scan include:
  - Federal OBRA Assessments: A0310A = [01, 02, 03, 04, 05, 06]; or
  - Medicare Part A PPS Assessments: A0310B = [01, 02, 03, 04, 05, 07]; or
  - OBRA Discharge Assessment: A0310F = [10, 11]; or
  - SNF Part A PPS Discharge Assessment: A0310H = [1].
- Exclusions:
  - J1900C. Falls with Major Injury = [-].
  - Resident died during the SNF stay (i.e., Type 2 SNF stays).

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

- 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).
- This QM reports the percentage of Medicare Part A SNF stays (Type 1 and Type 2) with an admission and discharge functional assessment and at least one goal that addresses function.
- Higher percentages are better.
- This measure was finalized in the FY 2016 SNF PPS Final Rule.
- MDS Sections GG0130 and GG0170 were added to the MDS in 2016 and enhanced in 2018.
- Data collection for this measure began October 1, 2016.

Documenting Function Items: Section GG

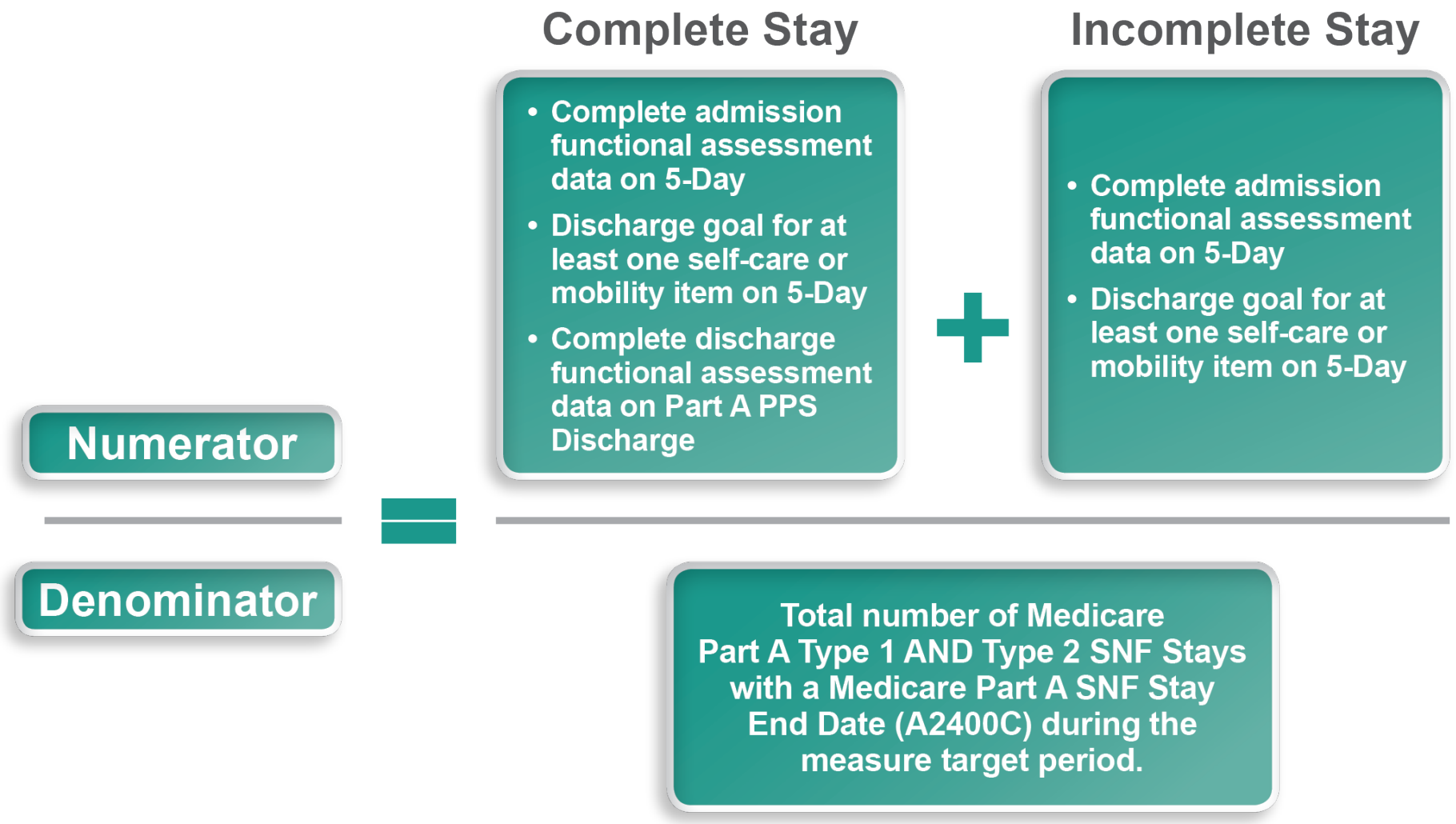
Question:

What documentation is required to support coding of the resident's self-care and mobility abilities?

Answer:

- Data entered in Section GG should be consistent with the clinical assessment documentation in the resident's medical record.
- Therapy and nursing notes may be used to support coding.

Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (cont. 1)



Incomplete Stay for Application of Functional Assessment/Care Plan

Unplanned discharge A0310G = 2 (Unplanned) [as indicated on an OBRA Discharge (RFA: A0310F = [10, 11]) with discharge date (A2000) on same day or the day after the End Date of Most Recent Medicare Stay (A2400C)]

OR

Discharge to acute, psychiatric, or long-term care hospital A2100 = [03, 04, 09]. [as indicated on an MDS Discharge (RFA: A0310F = [10, 11]) with a discharge date (A2000) on same day or the day after the End Date of Most Recent Medicare Stay (A2400C)].

OR

Incomplete Stay

SNF PPS Part A stay less than 3 days ((A2400C minus A2400B) < 3 days)

OR

The resident died during the SNF stay (i.e., Type 2 SNF Stays). 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])

Q2 All of the following are determinants of an incomplete stay except…

A. Death.

B. SNF PPS Part A stay greater than 3 days.

C. Discharge to acute, psychiatric, or long-term care hospital.

D. Unplanned discharge.

Functional Outcome Measures

There were four new QMs finalized in the FY 2018 SNF PPS Final Rule:

Change in Self-Care Score	• Estimates the risk-adjusted mean change in self-care score between admission and discharge for Medicare Part A Type 1 SNF stays.
Change in Mobility Score	• Estimates the risk-adjusted mean change in mobility score between admission and discharge for Medicare Part A Type 1 SNF stays.
Discharge Self-Care Score	• Estimates the percentage of Medicare Part A Type 1 SNF stays that meet or exceed an expected discharge self-care score.
Discharge Mobility Score	• Estimates the percentage of Medicare Part A Type 1 SNF stays that meet or exceed an expected discharge mobility score.

Functional Outcome Measure: Change in Self-Care Score

- This measure estimates the risk-adjusted mean change in self-care score between admission and discharge for Medicare Part A Type 1 SNF stays.
- There is not a simple form for the numerator and denominator.
- The change in self-care score is calculated as the difference between the discharge self-care score and admission self-care score.
- Target population: Total number of Medicare Part A Type 1 SNF stays, except those that meet the exclusion criteria.
- This measure is risk-adjusted.
- Higher scores indicate greater independence.

Functional Outcome Measure: Change in Self-Care Score (cont. 1)

- Exclusions: Medicare Part A SNF stays are excluded if:
  - Medicare Part A SNF stay is an incomplete stay.
  - Resident:
    - Independent with all self-care activities at the time of admission.
    - Has the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema, or compression of brain.
    - Younger than 21 years old.
    - Discharged to hospice or received hospice while a resident.
    - Did not receive physical therapy (PT) or occupational therapy (OT) services as reported on the 5-day PPS.
    - Not a Medicare Part A beneficiary.

Functional Outcome Measure: Self-Care Assessment Items Used for Change in Self-Care Score Calculations

Self-Care Assessment Items:	
GG0130A	Eating.
GG0130B.	Oral hygiene.
GG0130C.	Toileting hygiene.
GG0130E.	Shower/bathe self.
GG0130F.	Upper body dressing.
GG0130G.	Lower body dressing.
GG0130H.	Putting on/taking off footwear.

Response codes include:

- 6-point rating scale.
- Activity not attempted codes.

Functional Outcome Measure: Change in Self-Care Score (cont. 2)

- Calculations for admission and discharge self-care scores use the following procedure:
  - If the code is between 01 and 06, then use the code as the score.
  - If the code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
  - If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the score.
  - Sum the scores of the admission self-care items to create an admission self-care score for each stay-level record.
  - Scores can range from 7 to 42, with a higher score indicating greater independence.

Functional Outcome Measure: Change in Mobility Score

- This measure estimates the risk-adjusted mean change in mobility score between admission and discharge for Medicare Part A Type 1 SNF stays.
- There is not a simple form for the numerator and denominator.
- The change in mobility score is calculated as the difference between the discharge mobility score and admission mobility score.
- Target population: Total number of Medicare Part A Type 1 SNF Stays, except those that meet the exclusion criteria.
- This measure is risk-adjusted.
- Higher scores indicate greater independence.

Functional Outcome Measure: Change in Mobility Score (cont. 1)

- Exclusions: Medicare Part A SNF stays are excluded if:
  - Medicare Part A SNF stay is an incomplete stay.
  - Resident:
    - Independent with all mobility activities at the time of admission.
    - Has the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema, or compression of brain.
    - Younger than 21 years old.
    - Discharged to hospice or received hospice while a resident
    - Did not receive PT or OT services as reported on the 5-day PPS.
    - Not a Medicare Part A beneficiary.

Functional Outcome Measure: Self-Care Assessment Items Used for Change in Mobility Score Calculations

Mobility Assessment Items:			
GG0170A.	Roll left and right.	GG0170J.	Walk 50 feet with two turns.
GG0170B.	Sit to lying.	GG0170K.	Walk 150 feet.
GG0170C.	Lying to sitting on side of bed.	GG0170L.	Walking 10 feet on uneven surfaces.
GG0170D.	Sit to stand.	GG0170M.	1 step (curb).
GG0170E.	Chair/bed-to-chair transfer.	GG0170N.	4 steps.
GG0170F.	Toilet transfer.	GG0170O.	12 steps.
GG0170G.	Car transfer.	GG0170P.	Picking up object.
GG0170I.	Walk 10 feet.		

Response codes include:

- 6-point rating scale.
- Activity not attempted codes.

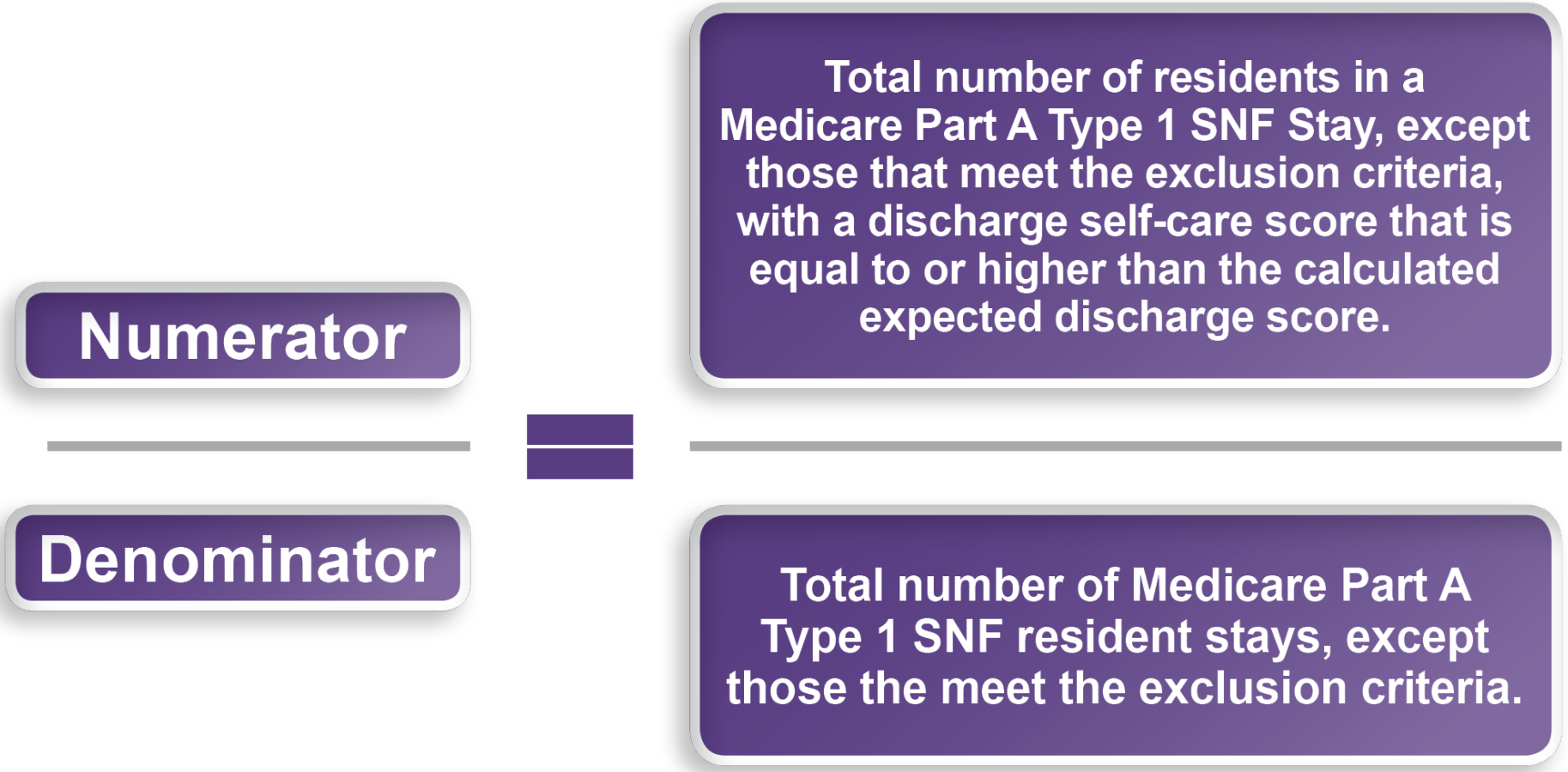
Functional Outcome Measure: Change in Mobility Score (cont. 2)

- Calculations for admission and discharge mobility score use the following procedure:
  - If the code is between 01 and 06, then use the code as the score.
  - If the code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
  - If the mobility item is skipped (^), dashed (-), or missing, recode to 01 and use this code as the score.
  - Sum the scores of the admission mobility items to create an admission mobility score for each Medicare Part A stay.
  - Scores can range from 15 to 90, with a higher score indicating greater independence.

Functional Outcome Measure: Discharge Self-Care Score

- This measure estimates the percentage of residents in a Medicare Part A Type 1 SNF stay 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.

Functional Outcome Measure: Discharge Self-Care Score (cont. 1)



Functional Outcome Measure: Discharge Self-Care Score (cont. 2)

- Exclusions: Medicare Part A SNF stays are excluded if:
  - Medicare Part A SNF stay is an incomplete stay.
  - Resident:
    - Has the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema, or compression of brain.
    - Younger than 21 years old.
    - Was discharged to hospice or received hospice while a resident
    - Did not receive PT or OT services as reported on the 5-day PPS.
    - Not a Medicare Part A beneficiary.

Functional Outcome Measures: Self-Care Assessment Items Used for Discharge Self-Care Score Calculations

Self-Care Assessment Items:	
GG0130A	Eating.
GG0130B.	Oral hygiene.
GG0130C.	Toileting hygiene.
GG0130E.	Shower/bathe self.
GG0130F.	Upper body dressing.
GG0130G.	Lower body dressing.
GG0130H.	Putting on/taking off footwear.

Response codes include:

- 6-point rating scale.
- Activity not attempted codes.

Functional Outcome Measure: Discharge Self-Care Score (cont. 3)

- Calculations for discharge self-care score use the following procedure:
  - If the code is between 01 and 06, then use the code as the score.
  - If the code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
  - If the self-care item is skipped (^), dashed (-), or missing, recode to 01 and use this code as the score.
  - Sum the scores 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.

Functional Outcome Measure: Discharge Mobility Score

- This measure estimates the percentage of residents in a Medicare Part A Type 1 SNF stay 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.

Functional Outcome Measure: Discharge Mobility Score (cont. 1)

Numerator = Total number of residents in a Medicare Part A Type 1 SNF Stay, 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 = Total number of Medicare Part A Type 1 SNF resident stays, except those the meet the exclusion criteria.

Functional Outcome Measure: Discharge Mobility Score (cont. 2)

- Exclusions: Medicare Part A SNF stays are excluded if:
  - Medicare Part A SNF stay is an incomplete stay.
  - Resident:
    - Has the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema, or compression of brain.
    - Younger than 21 years old.
    - Was discharged to hospice or received hospice while a resident
    - Did not receive PT or OT services as reported on the 5-day PPS.
    - Not a Medicare Part A beneficiary.

Functional Outcome Measures: Mobility Assessment Items Used for Discharge Mobility Score Calculations

Mobility Assessment Items:			
GG0170A.	Roll left and right.	GG0170J.	Walk 50 feet with two turns.
GG0170B.	Sit to lying.	GG0170K.	Walk 150 feet.
GG0170C.	Lying to sitting on side of bed.	GG0170L.	Walking 10 feet on uneven surfaces.
GG0170D.	Sit to stand.	GG0170M.	1 step (curb).
GG0170E.	Chair/bed-to-chair transfer.	GG0170N.	4 steps.
GG0170F.	Toilet transfer.	GG0170O.	12 steps.
GG0170G.	Car transfer.	GG0170P.	Picking up object.
GG0170I.	Walk 10 feet.		

Response codes include:

- 6-point rating scale.
- Activity not attempted codes.

Functional Outcome Measure: Discharge Mobility Score (cont. 3)

- Calculations for discharge mobility score, use the following procedure:
  - If the code is between 01 and 06, then use the code as the score.
  - If the code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
  - If the mobility item is skipped (^), dashed (-), or missing, recode to 01 and use this code as the score.
  - Sum the scores of the discharge mobility items to create a discharge mobility score for each Medicare Part A SNF stay.
  - Scores can range from 15 to 90, with a higher score indicating greater independence.

Coding Function Items: Section GG

Question:

Who should be involved in coding the Section GG self-care and mobility data elements?

Answer:

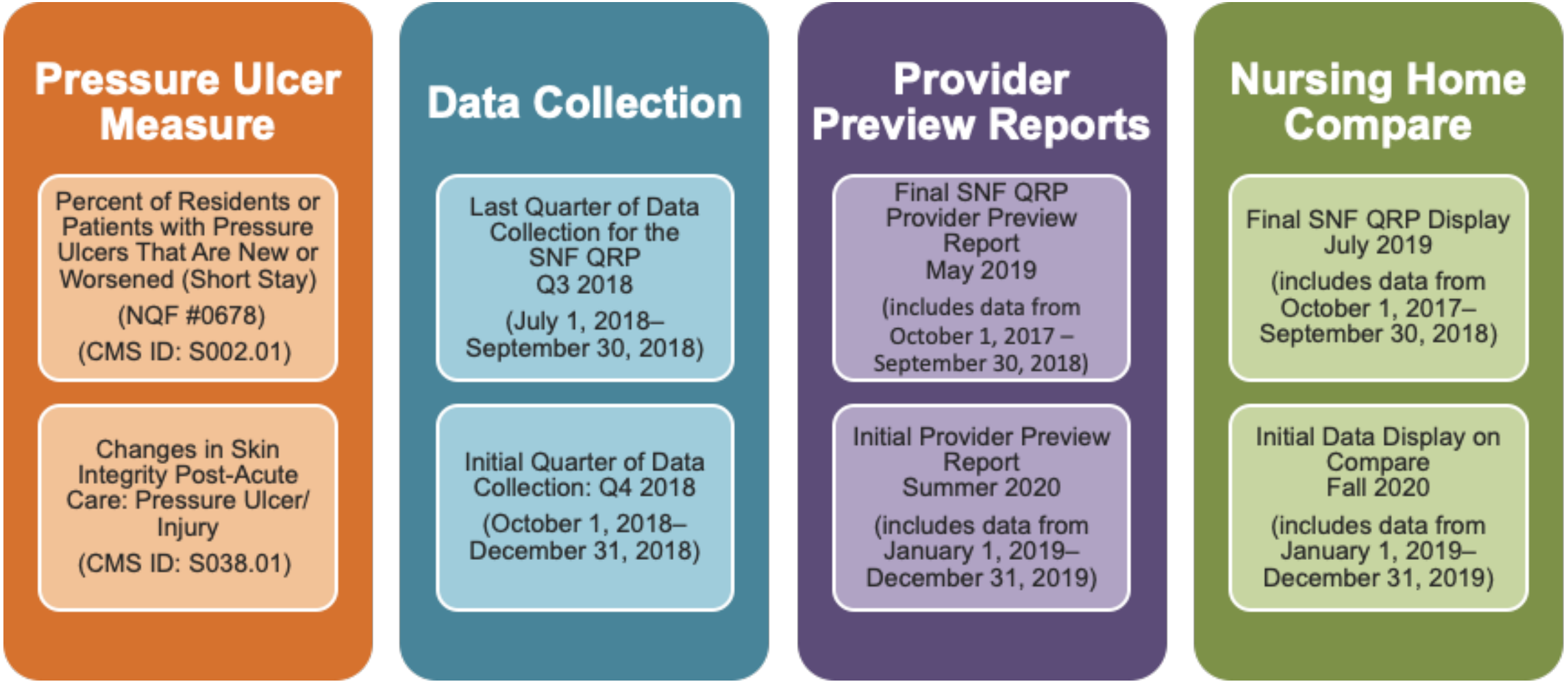
- CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the resident.
- Resident assessments are to be done in compliance with facility, State, and Federal policies.

Pressure Ulcer/Injury Measures

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMS ID: S038.01).

- The Changes in Skin Integrity Post-Acute Care measure replaced the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678) measure in the SNF QRP.
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) (CMS ID: S002.01) no longer in the QRP, continues to be to available to accommodate DNH adoption of the measure.

Pressure Ulcer/Injury Measure Transition (cont. 2)



Pressure Ulcer/Injury Measure Transition

- Data collection for the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMS ID: S038.01) measure began on October 1, 2018.
  - Adopted to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act in the domain of skin integrity and changes in skin integrity.

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

- Reports the percentage of Medicare Part A SNF Type 1 stays with Stage 2–4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, nonremovable dressing/device, or deep tissue injury, that are new or worsened since admission.

- In contrast to the old pressure ulcer QM, the numerator for this new pressure ulcer QM includes new or worsened unstageable pressure ulcers.

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 1)

- The Changes in Skin Integrity Post-Acute Care Measure is calculated by starting with the number of pressure ulcers/injuries at the time of discharge (M0300B1 through M0300G1), and subtracting the number of these pressure ulcer/injuries that were present on admission at the same stage (M0300B2 through G2)
- This measure is a cross-setting standardized PAC measure.
- Lower percentages are better

Coding Tips

- The M0300B1-G2 items are used for measure calculation. A pressure ulcer/injury on discharge (M0300X1) that is not coded as present on admission (M0300X2) on the PPS discharge assessment is included as a new or worsened pressure ulcer/injury.
- If M0300X1 – M0300X2 >0, then a pressure ulcer/injury is counted as new or worsened.

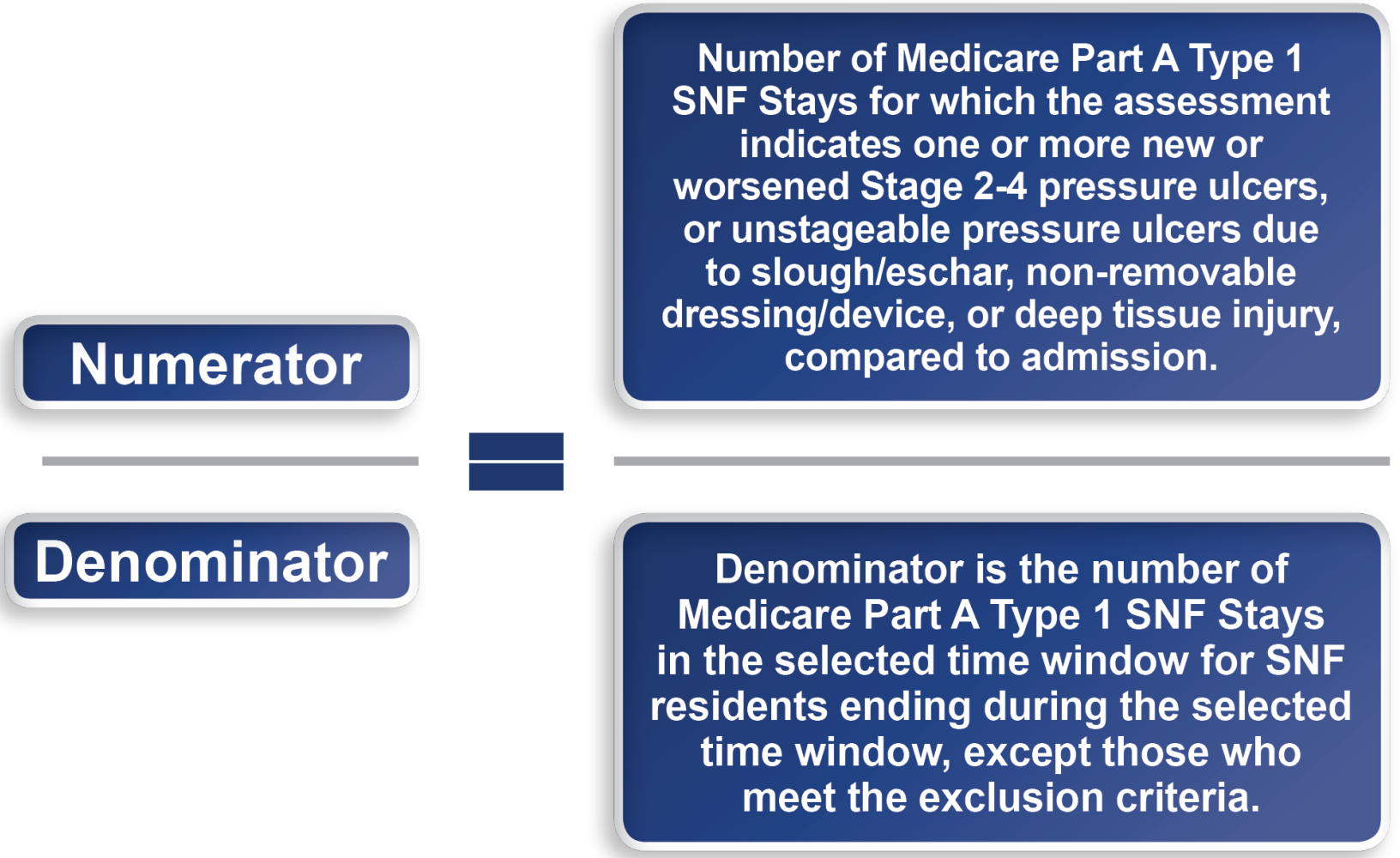
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 2)

- Medicare Part A SNF stays are excluded if:
  - Missing data (i.e., dash [-]) on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, at discharge.
  - Resident died during the SNF stay (i.e., Type 2 SNF stays).

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 3)

- This measure is risk-adjusted for the following at admission:
  - Dependent or substantial/maximal assistance for Lying to Sitting on Side of Bed.
  - Bowel Incontinence.
  - Diabetes mellitus, peripheral vascular or arterial disease.
  - Low body mass index.

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (cont. 1)



Coding Tips

When coding items M0210 and M0300, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code as a pressure ulcer/injury in Section M.

Coding Tips (cont. 1)

If a numerically staged pressure ulcer becomes unstageable due to slough or eschar during the resident's stay, the pressure ulcer/injury is coded at M0300F on discharge and should **not** be coded as "present on admission."

Coding Tips (cont. 3)

If a pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later, it **should** be considered as "present on admission" **at the stage at which it first becomes numerically staged**.

HOWEVER, if it subsequently increases in numerical stage, that higher stage should **not** be coded as "present on admission."

Drug Regimen Review (DRR) Conducted with Follow-up for Identified Issues

NEW

Reports the percentage of Medicare Part A Type 1 SNF stays in which a DRR 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.

- Adopted to meet the requirements of the IMPACT Act domain of medication reconciliation.

- Higher percentages are better.
- Data collection for this measure began October 1, 2018.

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

Numerator

Total number of Medicare Part A Type 1 SNF stays in the denominator during the reporting period in which both of the following criteria are met:

1. The facility conducted a drug regimen review on admission which resulted in one of the following three scenarios:
   - 1.1 No potential or actual clinically significant medication issues were found during the review (N2001 = [0]); or
   - 1.2 Potential or actual clinically significant medication issues were found during the review (N2001 = [1]) and a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day (N2003 = [1]); or
   - 1.3 The patient 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 admission or patient was not taking any medications (N2005 = [9]).

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Denominator

Total number of Medicare Part A Type 1 SNF stays during the reporting period.

Defining DRR

Question:

How is DRR defined?

Answer:

- A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.
- The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

Note: SOM requirements are different than QM requirements.

Coding DRR Items

Question:

Which staff members may complete the DRR?

Answer:

- Each facility delivers resident care according to its unique characteristics and standards.
- Thus, each facility self-determines its policies and procedures for determining who may complete DRR in compliance with State and Federal requirements.
- Providers should refer to State and Federal policies and guidelines to determine who may complete a DRR.

Performing DRRs

Question:

How often should a DRR be performed?

Answer:

- The provider uses clinical judgement to determine when a resident's medication regimen is reviewed, including medication review throughout the resident's stay.
- The timing of formal (and informal) DRR activities should be completed based on resident need, complying with State and Federal Regulations as well as facility policies and procedures.

Q3 Which of the following is **not** a SNF QRP QM?

A. Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).

B. SNF Functional Outcome Measure: Discharge Self-Care Score for Skilled Nursing Facilities.

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

D. Application of Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients.

Claims-Based QMs

SNF QRP Current Measures – Claims-Based

Short Name	Measure Name
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission (PPR) Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

For QM technical specifications relevant to the SNF QRP measures, see the Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual, Version 2.0 available on the SNF QRP website under SNF QRP Measures and Technical Information.

Medicare Spending Per Beneficiary (MSPB) – Post Acute Care for SNF QRP

This measure evaluates SNF providers' efficiency relative to the efficiency of the national median SNF provider. Specifically, the measure assesses the cost to Medicare for services performed by the SNF provider during an MSPB-PAC SNF episode.

- The measure is calculated as the ratio of the price-standardized, risk-adjusted MSPB-PAC amount for each SNF divided by the episode-weighted median MSPB-PAC amount across all SNF providers.
- Measure was finalized in the FY 2017 SNF PPS Final Rule on August 5, 2016 (81 FR 52021)
- No additional data collection required by facilities, besides claims data submitted during normal course of business.

Discharge to Community – Post Acute Care SNF QRP

- This measure reports a SNF's risk-standardized rate of Medicare fee-for-service 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.
- Community, for this measure, is defined as home or self-care, with or without home health services.
- Measure was finalized in the FY 2017 SNF PPS Final Rule on August 5, 2016 (81 FR 52021).
- Higher rates are better.
- No data collection required by facilities, besides claims data submitted during normal course of business.

Potentially Preventable 30-Day Post-Discharge Readmission (PPR)

- This measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions for residents (Medicare fee-for-service [FFS] beneficiaries) who receive services in skilled nursing facilities.

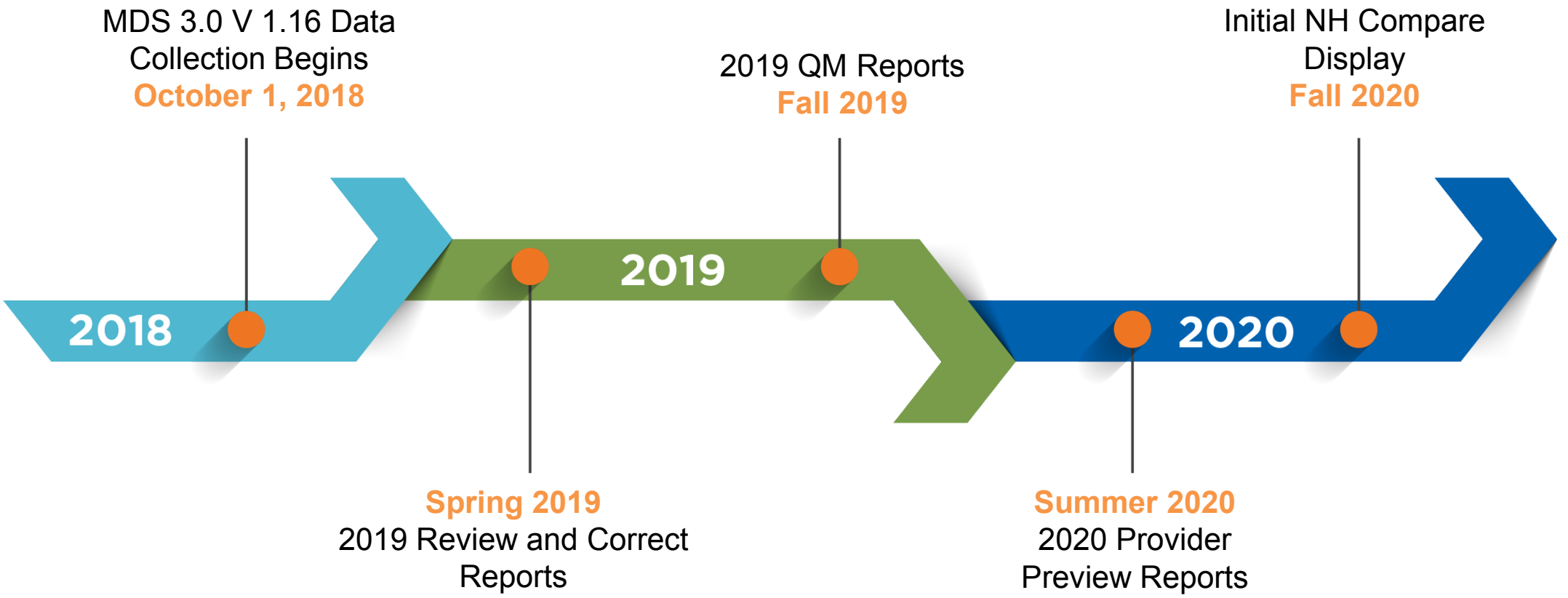
- The measure is currently suppressed, and therefore not available on Nursing Home Compare at this time, however you will still be able to see this data on your reports.

Data Submission Requirements

Data must be submitted/corrected by the Final Submission Deadline.

Data Source	Data Collection Time Frame	Final Submission Deadline
Assessment-Based QMs	January 1 – March 31	August 15
	April 1 – June 30	November 15
	July 1 – September 30	February 15
	October 1 – December 31	May 15
Claims-Based QMs	No additional data submission required by SNFs	

Reporting Timeline for QMs Implemented on October 1, 2018



NH Compare

The SNF QRP QMs are now available under "Additional Measures" on NH Compare.

https://www.medicare.gov/nursinghomecompare/search.html

Four Intended Purposes of QMs on NH Compare

1. Give consumers information about the quality of care to help them choose a NH or SNF.
2. Understand the data related to common conditions in NH/SNF populations.
3. Facilitate discussions with NH/SNF staff regarding quality.
4. Give NH/SNF staff data to support their quality improvement efforts.

Summary

- In this lesson you learned:
  - About all 11 SNF QRP QMs and are able to name at least 5.
  - The key components of each quality measure and how they are used to calculate the quality measure.
  - The data submission deadlines and reporting timeline for FY 2020 and subsequent years.

Record Your Action Plan Ideas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