Guide to Key MDS-Related CASPER Reports for the Nurse Assessment Coordinator (NAC)

A systematic approach to utilizing the Certification And Survey Provider Enhanced Reports CASPER reports is necessary for monitoring Quality Measures, managing MDS assessments, and reimbursement. While there are numerous reports available via CASPER, this tool highlights reports of interest to the Nurse Assessment Coordinator (NAC) and will serve as a guide for the NAC to coordinate utilization of these reports. Note that this tool does not include all reports available. For more in-depth information, access the CMS manuals detailing all report specifics.

CASPER: MDS 3.0 Quality Measure (QM) Reports

The nursing home QMs come from resident assessment data submitted via the MDS. The assessment data is converted into QMs, which then are used in programs such as the Five-Star Quality Rating System and give consumers, hospitals, Medicare Advantage plans, and preferred providers one source to evaluate the nursing home's performance. The QM data is also used by surveyors during the health inspection. Additional details about these reports can be found in section 11 (MDS 3.0 QM Reports) in the CASPER manual.

Primary Purpose of Reviewing Reports:

- Review accuracy of MDS coding
- Drive clinically-related QAPI efforts
- Prioritize and set goals for clinical improvement
- Trend clinical performance data over time
- Benchmark performance against national and state averages
- Identify person-centered care planning needs and interventions for each resident
- Support clinical survey readiness

Report	Description	Example Review Questions
MDS 3.0 Facility Characteristics Report	This report provides facility demographic information and includes comparison to state and national percentages for a specified timeframe. By comparing the facility percentages with the state and national average percentages, the DNS can determine whether the facility's demographic characteristics differ from the norm. This data gives the facility the opportunity to ensure that care and services are aligned with the needs of the demographic.	• How does the facility differ from the norm? • Does the facility meet the needs of its demographic and is this reflected in the Facility Assessment? • Do the staff competencies align with the needs of the facility's demographic? • Are there opportunities to improve the rate of discharge planning, which improves readmission rates? • Are there opportunities to increase admissions from other settings? • Are there care planning opportunities identified for varying demographics indicated in the report?
MDS 3.0 Facility-Level Quality Measure Report ***Best Practice:*** *Data for this report is calculated weekly with previous weeks submissions. This report can be generated weekly, but should be generated at least monthly and shared with leadership and the IDT.*	This report shows the facility QM percentages and how the facility compares with other facilities in their state and in the nation. This report helps facilities identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process.	• What QMs trigger at 75% and above of the national percentile, and why? • What compliance risks do the triggers pose? • What QMs indicate improving trends? • What QMs indicate declining trends? • What QMs should be the focus for improvement? • How does the facility compare to the state and national averages?

Special Notice: *Triggers above the 75th percentile on the Facility Level QM Report will be investigated during the health inspection. Surveyors will not only review the triggered items on individual residents, but also use this information to select a survey sample, investigate appropriateness and adherence to the care plan, and work through various critical element pathways.*

Report	Description	Example Review Questions
MDS 3.0 Resident-Level Quality Measure Report ***Best Practice:*** *The report is updated weekly with the previous week's submissions. This report can be generated weekly, but should be generated at least monthly and shared with the IDT.*	This report identifies the residents (active and discharged) who were included in the calculations for the facility and period that were used to produce the MDS 3.0 Facility Level Quality Measure Report. The report lists the residents by name and indicates the measures, if any, triggered by each.	• Is the trigger valid? • Is an appropriate care plan in place? Does the goal correspond to the resident's preferences, and is the care plan individualized? • Is the staff following the care plan? • Are triggers missing from residents?

CASPER: Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

The IMPACT Act of 2014 requires specified clinical assessment domains using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. CMS develops and implements QMs from five QM domains using standardized assessment data across providers. One of the primary goals is to enable interoperability and facilitate coordinated care, improved outcomes, and overall quality comparisons through the use of standardized QMs and standardized data. Failure to meet the required reporting threshold can result in a 2% reduction to the the SNF's Medicare Fee-For-Service Annual Payment Update (APU) in the forthcoming fiscal year. Additional information about these reports can be found in section 13 (SNF Quality Reporting Program) of the CASPER Manual.

Primary Purposes of Reviewing Reports:

- Monitoring accuracy and completeness of SNF PPS assessments of required MDS items to avoid 2% reduction to APU
- Assess appropriateness of dashes used for any SNF QRP data elements
- Drive clinically-related QAPI efforts
- Prioritize and set goals for clinical improvement
- Trend clinical performance data
- Benchmark performance against national averages

Report	Description	Example Review Questions
SNF Facility-Level Quality Measure Report ***Best Practice:*** *This report is a 12-month period calculated for the end date of the most recent calculated quarter. This report should be generated at least quarterly and shared with leadership and the IDT.*	This report provides facility-level Quality Measure values for a selected 12-month period.	• What QMs indicate improving trends? • What QMs indicate declining trends? • What QMs should be the focus for improvement? • How does the facility percent compare to the national average?

Report	Description	Example Review Questions
SNF Resident-Level Quality Measures Report ***Best Practice:*** *This report is a 12-month period calculated for the end date of the most recent calculated quarter. This report should be generated at least quarterly and shared with the IDT.*	This report identifies each resident with assessment records and a qualifying MDS 3.0 Medicare Part A Stay (SNF Stay). It is used to calculate the facility-level quality measure values for a select 12-month period. The report displays each resident's name and indicates how/ if the resident's assessment affected the SNF's Quality Measures.	• **Undesirable Outcome Measures** (i.e., Pressure ulcer/Injury, Application of Falls) ▪ **Bold X** indicates an undesirable outcome ◦ Example: Resident had a fall with a major injury ▪ **NT (not bold)** indicates the resident did not trigger ◦ Example: No falls with major injuries during Medicare stay • **Desirable Outcomes or Process Performed** (i.e., Application of Functional Assessment/Care Plan, Discharge Self-Care Score, Change in Self-Care Score, DRR) ▪ **X (not bold)** indicates desirable process measure ◦ Example: Drug regimen review completed throughout entire Medicare stay ▪ **Bold NT** indicates a desirable outcome did not occur or process was not performed ◦ Example: Drug regimen review was not completed on admission • Is the trigger valid? • Are triggers missing from residents? • Are the denominator and exclusion of residents accurate, are corrections necessary to increase the denominator? • If the process did not occur has the team identified the root-cause to the process not being completed? • If the team has identified a system failure for process-based measures, is this being addressed in QAPI? • Do the function scores for the self-care and mobility items match what is expected for each resident. • If a change in the function score is noted, were the reasons followed in the care plan?
SNF Provider Threshold Report ***Best Practice:*** *This report only displays complete Medicare stays and will calculate all completed Medicare stays in the selected APU fiscal year (current or prior). This report should be generated and shared with leadership monthly or quarterly.*	This report details the compliance with the SNF QRP reporting requirements. Failure to submit all required data elements on at least 80% of PPS Medicare assessments will result in a 2% reduction to the SNF's APU.	• Have 100% of the required data elements been completed on at least 80% of the PPS MDS submissions? • Was the use of any dashes [-] appropriately used to indicate that data was collected? • Has the team identified the root-cause and corrected any inappropriate dashes which impacted the reporting compliance? • Has the team identified any missed PPS assessments (5-Day or Part A PPS Discharge) and completed corrective action if indicated?

Report	Description	Example Review Questions
SNF Review and Correct Report ***Best Practice:*** *This report must be generated by the provider (is not automatic). The report is calculated weekly and on the first day of each quarter. This report should be generated and shared with leadership at least quarterly.* *All corrections must be completed by the correction period deadline:* *Q1 (1/1-3/31) – August 15* *Q2 (4/1-6/30) – November 15* *Q3 (7/1-9/30) – February 15* *Q4 (10/1-12/31) – May 15*	This report allows SNF providers to review their Quality Measure (QM) data to identify if any corrections or changes are necessary prior to the quarter's data submission deadline, which is 4.5 months after the end of the quarter. Best practice is to review this report at least monthly to make timely corrections.	• Has the team identified MDS coding errors? • Has the team identified missing PPS assessments? • Has the team identified system-process failures? • Are corrections necessary?

Special Notice: *CORMAC sends informational messages to SNFs that are not meeting annual payment thresholds on a quarterly basis ahead of each submission deadline. If you need to add or change the email addresses to which these messages are sent, please email QRPHelp@cormac-corp.com. Be sure to include your facility name and CMS Certification Number (CCN) along with any requested email updates.*

CASPER: MDS 3.0 Nursing Home Provider Reports

These reports should be incorporated into the processes the facility uses to ensure MDS submissions are accurate and timely. Additional details about these reports can be found in section 6 (MDS 3.0 NH Provider Reports) of the CASPER manual. MDS 3.0 reports are automatically purged after 60 days. Remember to save created reports as appropriate.

Note: *The MDS 0003D/0004D package of reports uses survey data to compile the reports, and does not require MDS or other types of data submission on behalf of the facility. These reports are used to support survey related initiatives.*

Primary Purposes of Reviewing Reports:

- Orientation to facility profile and survey history
- Ensuring MDS submissions are timely
- No missing MDS assessments

Report	Description	Example Review Questions
MDS 0003D/0004D Package Report Provider History Profile Provider Full Profile	This report presents provider profile and current survey information including the past three survey cycles and complaint-related deficiencies. Use this report to review past survey deficiency trends.	• What are the repeat deficiencies? • Are past deficiencies a current concern? • What are the high scope and severity compliance risks identified from this report?
MDS 3.0 Admission/ Reentry ***Best Practice:*** *This report should be run at least monthly and reviewed with the business office. Custom from and thru dates can be selected to display all submitted assessments during that timeframe being reviewed.*	This report lists the residents who were admitted to or re-entered a facility during a specified timeframe.	• Does this report align with the business office census records for the same time period?

Report	Description	Example Review Questions
MDS 3.0 Discharges ***Best Practice:*** *This report should be ran at least monthly and reviewed with the business office. Custom from and thru dates can be selected to display all submitted assessments during that timeframe being reviewed.*	This report lists the residents discharged (A0310F = 10, 11, or 12) from a facility during a specified timeframe. Timely completion and submission of Discharge Assessments impacts the accuracy of the census numbers in the PBJ data used for Five-Star.	• Does this report align with the business office census records for the same time period? • Any missing discharge assessments have been created, appropriately completed, and submitted? • Any errors on discharge dates have been corrected? (Either in census or modification of an MDS assessment - depending on the error.)
MDS 3.0 Missing Assessment ***Best Practice:*** *This report has a set review period and should be generated at least monthly.*	This report lists the residents for whom the target date of the most recent OBRA assessment (other than a discharge or death record) is more than 138 days prior to the report run date. The report also includes residents for whom no OBRA record was submitted for a current episode that began more than 60 days prior to the report run date.	• Are there any missing MDS assessments? • If missing assessments are identified, has the team identified appropriate correction and/or billing ramifications?

CASPER: MDS 3.0 Nursing Home Final Validation Report

This report should be incorporated into the processes the facility utilizes to ensure MDS submissions are accepted by CMS and that error messages are addressed. Failure to submit MDS assessments and confirm acceptance of the file can result in non-compliance with regulatory requirements, negatively impacting reimbursement, and Quality Measure ratings. Additional details about this report can be found in section 7 (MDS 3.0 NH Final Validation Report) in the CASPER manual.

Primary Purpose of Reviewing Report:

- Ensure all MDS assessments are accepted into the CMS database

Report	Description	Example Review Questions
MDS 3.0 Final Validation Report ***Best Practice:*** *This automatically-generated report must be reviewed after each MDS submission batch. No assessments should be billed without confirming that the assessment was accepted into the database.*	This report is automatically generated within 24 hours of submission of a file and provides detailed information about the status of select submission files. The report indicates whether the records submitted in each file were accepted or rejected and details the warning and fatal errors encountered.	• Were all MDS assessments accepted? • Have all fatal error messages been identified, corrected, and the assessment resubmitted with accepted status? • Have all non-fatal warnings been reviewed and corrective action taken as needed?
Special Notice: *While the MDS software may generate validation reports, it is recommended that a facility use the actual validation reports generated by CMS. The Final Validation Reports are only available for 60 days. As such, the facility should download a copy of the report while it is available and maintain an electronic or paper copy in its own records.*		