MDS FOR THE ADMINISTRATOR: WHAT YOU NEED TO KNOW

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OBJECTIVES

- Understanding factors why MDS's are so important in your home
- Identify the effects it places on your bottom line
- Learn why staff need to understand the importance of accurate documentation
- Learn what administrators can check on the MDS to ensure compliance

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OVERVIEW OF RAI

HISTORY OF THE MDS

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RESIDENT ASSESSMENT INSTRUMENT (RAI)

- General purpose of the RAI process is to
  - Provide a standardized method for comprehensive assessment of complex nursing home residents.
  - Establish a plan of care that serves as a basis for communication of care needs
  - Assist facility staff to look at residents holistically… as a whole person with individual problems, needs, strengths, and preferences

BE A VOICE FOR OUR RESIDENTS

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RESIDENT ASSESSMENT INSTRUMENT (RAI)

- Problem identification process used in long-term care
  - Assessment
  - Decision-making
  - Care planning
  - Identification of Outcomes
  - Implementation
  - Evaluation
- Mandated for all residents in "certified" LTC beds

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RESIDENT ASSESSMENT INSTRUMENT (RAI)

- The RAI consists of three basic components:
  - The Minimum Data Set (MDS) Version 3.0
  - The Care Area Assessment (CAA) process
  - The Care Plan
- The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. These can be found in the RAI manual 2-39.

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Resident Assessment Instrument (RAI)

One of the three components of the RAI process and how administrators can use the information to provide quality care for their residents while at the same time using it as a tool to identify key areas a home can improve upon in regards to both resident care and reimbursement.

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History of MDS

- Nursing home reform law of OBRA '87 created regulatory framework to ensure good clinical practice
- Developed as a "standardized" approach for clinicians to "assess, plan, and provide individualized care"
- Looks at the residents holistically

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History of MDS - OBRA 87'

The statutory authority for the MDS is found in section 1819 (f) (6) (A-B) for Medicare and 1919 (f) (6) (A-B) for Medicaid, as amended by the Omnibus Budget and Reconciliation Act of 1987 (OBRA 1987). Prior to the MDS, only aggregate quality-of-care data on nursing homes was available. With MDS, a nationally standardized person-level-of-care database is available. A state can now target quality improvement efforts within a nursing home or across nursing homes to assist particular groups of residents.

http://www.nasuad.org/documentation/aca/Reference%20Manual/2-developing%20an%20Implementation%20Strategy%20for%20your%20State/6-UsingMDStoFacilitateNursingHomeqTransition.pdf

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HISTORY OF MDS - STANDARDIZED APPROACH

The Minimum Data Set (MDS). According to the RAI Manual, the MDS is:

> A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.

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HISTORY OF MDS - HOLISTIC APPROACH

"When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is accommodated in the care plan."

RAI User's Manual Version 3.0 October 2014

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WHY MDS'S DRIVE YOUR BUILDING

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The Importance of MDS's in Your Home

The RAI process and everything it entails effects many areas of nursing homes:

- Resident Care
- Five-Star Reporting
- Quality Measures (QM)
- Reimbursement

The above are all key areas that are driven by the RAI process

Resident Care

a. Assessment - Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative).

Resident Care

b. Decision Making - Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.

RESIDENT CARE

Assessment (MDS) → Decision-Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation

c. Identification of Outcomes - Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident's active participation in the process.

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RESIDENT CARE

Assessment (MDS) → Decision-Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation

d. Care Planning - Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

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RESIDENT CARE

Assessment (MDS) → Decision-Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation

e. Implementation - Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the "how" and "when" of resident care.

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RESIDENT CARE

Assessment (MDS) → Decision-Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation

f. Evaluation - Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.

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QUALITY MEASURES

"In November 2002, the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, began a national Nursing Home Quality Initiative (NHQI). The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay" (MDS data).

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/20_shortstay20.asp

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QUALITY MEASURES

Current data collection periods
Nursing home quality measures

Short-stay residents		
Percentage of short-stay residents who made improvements in function.	1/1/2015	12/31/2015
Percentage of short-stay residents who were re-hospitalized after a nursing home admission.	7/1/2014	6/30/2015
Percentage of short-stay residents who have had an outpatient emergency department visit.	7/1/2014	6/30/2015
Percentage of short-stay residents who were successfully discharged to the community.	7/1/2014	6/30/2015
Percentage of short-stay residents who self-report moderate to severe pain.	1/1/2015	12/31/2015
Percentage of short-stay residents with pressure ulcers that are new or worsened.	1/1/2015	12/31/2015
Percentage of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine.	1/1/2015	12/31/2015
Percentage of short-stay residents assessed and given, appropriately, the pneumococcal vaccine.	1/1/2015	12/31/2015
Percentage of short-stay residents who newly received an antipsychotic medication.	1/1/2015	12/31/2015

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Quality Measures

Current data collection periods
Nursing home quality measures

Five-Star – Nursing Home Compare

Reimbursement

Skilled Nursing Facility PPS

CASE MIX PROSPECTIVE PAYMENT FOR SNFs BALANCED BUDGET ACT OF 1997: Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how payment is made for Medicare skilled nursing facility (SNF) services. Effective with cost reporting periods beginning on or after July 1, 1998, SNFs are no longer paid on a reasonable cost basis or through low volume prospectively determined rates, but rather on the basis of a prospective payment system (PPS). The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

MDS EFFECT ON BOTTOM LINE

REIMBURSEMENT

SNF Consolidated Billing Overview on Skilled Nursing Facility (SNF) Consolidated Billing (CB):
In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay.

REIMBURSEMENT

SNF PPS Payments Consists of Three Components:

Therapy	Nursing	Non-Case-Mix
• Physical therapy • Occupational therapy • Speech therapy • Evaluation for therapy	• Nursing services • Social services • NTA services	• Room and board • Administrative costs • Capital-related costs

RESOURCE UTILIZATION GROUPS

There are 66 RUG-IV Resource Utilization Groups used for SNF PPS reimbursement. The RUGs are divided into eight major characteristic classification categories. The categories are:

- Category I - Rehabilitation Plus Extensive Services
- Category II - Rehabilitation
- Category III - Extensive Services
- Category IV - Special Care High
- Category V - Special Care Low
- Category VI - Clinically Complex
- Category VII - Behavioral Symptoms & Cognitive Performance
- Category VIII - Reduced Physical Function

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RESOURCE UTILIZATION GROUPS

Table 1. Top Ten RUGs by Total Payment, 2013

RUG	RUG Description	Total Days	Unique Beneficiaries Served	Total Medicare Payment Amount
RUB	Ultra-High Rehab - ADL 6-10	15,801,830	634,995	$7,772,000,519
RUC	Ultra-High Rehab - ADL 11-16	11,731,618	426,023	$5,663,111,152
RUA	Ultra-High Rehab - ADL 0-5	8,129,548	406,508	$3,191,952,281
RVC	Very-High Rehab - ADL 11-16	5,605,485	290,557	$2,177,788,572
RVB	Very-High Rehab - ADL 6-10	6,062,535	348,863	$2,035,526,803
RVA	Very-High Rehab - ADL 0-5	4,513,546	276,946	$1,490,980,086
RHC	High Rehab - ADL 11-16	2,293,066	140,256	$731,069,932
RHB	High Rehab - ADL 6-10	1,940,641	134,687	$549,945,652
RHA	High Rehab - ADL 0-5	1,647,680	117,422	$397,568,297
RMC	Medium Rehab - ADL 11-16	1,407,948	106,469	$378,069,865

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RESOURCE UTILIZATION GROUPS

Table 2. Top Ten RUGs by Number of Days, 2013

RUG	RUG Description	Total Number of Days	Unique Beneficiaries Served	Average Medicare Payment Amount Per Day	Average Medicare Payment Amount Per Beneficiary
RUB	Ultra-High Rehab - ADL 6-10	15,801,830	634,995	$492	$12,239
RUC	Ultra-High Rehab - ADL 11-16	11,731,618	426,023	$483	$13,293
RUA	Ultra-High Rehab - ADL 0-5	8,129,548	406,508	$393	$7,852
RVB	Very-High Rehab - ADL 6-10	6,062,535	348,863	$336	$5,835
RVC	Very-High Rehab - ADL 11-16	5,605,485	290,557	$389	$7,495
RVA	Very-High Rehab - ADL 0-5	4,513,546	276,946	$330	$5,384
RHC	High Rehab - ADL 11-16	2,293,066	140,256	$319	$5,212
RHB	High Rehab - ADL 6-10	1,940,641	134,687	$283	$4,083
RHA	High Rehab - ADL 0-5	1,647,680	117,422	$241	$3,386
RMC	Medium Rehab - ADL 11-16	1,407,948	106,469	$269	$3,551

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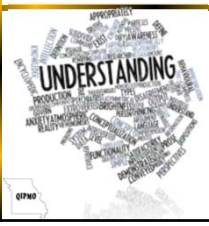
IMPORTANCE OF ACCURATE UNDERSTANDING



WHY ACCURATE DOCUMENTATION IS IMPORTANT

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DOCUMENTATION

Accurate documentation is essential for the RAI process. We all know the "*if it is not documented it did not happen"* saying, so make sure it happens! Why is it important?

- "Company to Pay $3.5M to Settle Rehab Billing Complaint"
- "SNF Agrees to Pay $1.3 Million to Resolve Allegations that it Submitted False Claims for Rehabilitation Therapy"
- "Chain Agrees to Pay $38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy"

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DOCUMENTATION

Remember the MDS is the document and critical part of the medical record that drives your reimbursement for PPS. **F 514** says, "In order to obtain and maintain Medicare certification:

- The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are - Complete, Accurately documented, Readily accessible, Systematically organized,
- The clinical record must contain - Sufficient information to identify the resident; A record of the resident's assessments; The plan of care and services provided; The results of any preadmission screening conducted by the State; and Progress notes."

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DOCUMENTATION

Accurate documentation is important to ensure continuity of care for residents. Remember to assess, take action, respond, and evaluate if the actions were effective. Document in chronological order and always be truthful. Documentation should be in keeping with acceptable nursing practice and only document what you are qualified to.

MDS COMPLIANCE

WHAT THE ADMINISTRATOR CAN DO

REPORTS

- Print and look at your 802 to see where your home is compared to other homes.
- Use your (Pepper) Program for Evaluation Payment Pattern Electronic Reports is an annual report that you can print in the spring. You don't want to be outlying too high or too low because that is a flag for an Audit. You want to be in the middle.

COMMUNICATION

- Make sure everyone doing MDS's has their own password
- Allow the MDS Coordinator time to get it done and done correctly

COMMUNICATION

- Include your staff in improving the quality of care
- Use the 802 at your Quality Assurance Meeting
- Utilize your INTERACT Tools to help your home improve in the 5-star rating

USEFUL REPORTS FROM THE MDS

- CASPER Reports to be brought to the QA/QAPI Meetings
  - QM package which includes the facility percentages and resident level
  - Missing resident assessment report
  - Resident roster

RESOURCES

- Quality Improvement Program for Missouri (QIPMO and Leadership Coaching) http://www.nursinghomehelp.org/index.html
- Rapid RUG IV Guide http://in.mslc.com/uploadedFiles/Rapid%20RUG%20Guide%20(Short%20Version).pdf
- Skilled Nursing Facility Center https://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html
- MDS 3.0 RAI Manual ***(Draft MDS 3.0 RAI Manual v 1.14 May 2016 Available here also)*** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html
- CMS' YouTube Channel https://www.youtube.com/user/CMSHHSgov

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RESOURCES

- SNF Quality Reporting https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html
- MDS 3.0 Training https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html
- WPS Government Health Administrators http://www.wpsmedicare.com/index.shtml

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