Primer on MDS 3.0: An Overview of MDS 3.0 for the October 1 Transition

By Rhonda Anderson, RHIA

Long-term care skilled nursing facilities must transition to the new Minimum Data Set (MDS) 3.0 by October 1, 2010. MDS 3.0 changes the assessment focus, using the resident's voice to more thoroughly assess residents and link to the care plan that meets the resident's needs. This change requires facility management and the interdisciplinary team look at their current skill set in the following areas:

- Clinical assessment methods, such as interview processes and observations
- Training the clinical team on the basic components of the MDS 3.0, Care Area Assessment process, and the Resident Assessment Instrument utilization guidelines
- Upgrading relevant software

HIM professionals working in long-term care facilities must familiarize themselves with MDS 3.0 in order to prepare for the October implementation.

The RAI Components

The Omnibus Budget Reconciliation Act of 1987 (OBRA) provides the regulatory basis for the Resident Assessment Instrument (RAI). Skilled nursing facilities use the RAI to help improve the quality of care and treatment services for Medicare and Medicaid residents. It provides a systematic method for all disciplines to develop individualized care, delivery, and evaluation of outcomes.

The RAI is a dynamic process that supports the resident's wishes, thoughts, and ideas about care planning. It supports the latest clinical approaches in nursing home care that are intended to identify resident care problems, which are addressed in an individualized care plan that incorporates resident preferences.

The RAI process consists of three basic components:

- MDS, which is a core set of screenings and clinical and functional status elements that make up the foundation of a comprehensive assessment for all residents in nursing homes certified to participate in the Medicare and Medicaid programs. Different prescribed assessment types are used for care and payment.
- Care Area Assessment, which is used to help assessors systematically interpret the information from the MDS and identify triggered issues to focus on during the care and treatment process. The CAA gives the team a direct approach to further evaluate the resident.
- Care Area Assessment Resources, which give the interdisciplinary team tools to consider in subsequent resident assessments.

MDS 3.0 Revisions

The MDS 3.0 revision advances assessment measures, increases the clinical relevance of items, improves the accuracy and validity of the tool, increases user satisfaction, and increases the resident's voice by introducing more interview items. The MDS has been constructed to identify OBRA reason for assessment and the skilled nursing facility prospective payment reasons for the assessment.

A partial list of assessment types are summarized in the sidebar below. Note this also includes swing-bed clinical change assessment for acute hospitals with swing beds.

Assessment Types for MDS 3.0

The MDS 3.0 has been constructed to identify OBRA reason for assessment and the skilled nursing facility prospective payment system reasons for the assessment. A partial list of assessment types is outlined below:

Federal OBRA Reason for Assessment

- Admission assessment (required by day 14)
- Quarterly review assessment
- Annual assessment
- Significant change in status assessment
- Significant correction to prior comprehensive assessment
- Significant correction to prior quarterly assessment
- Not OBRA required assessment

PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

- 5-day scheduled assessment
- 14-day scheduled assessment
- 30-day scheduled assessment
- 60-day scheduled assessment
- 90-day scheduled assessment
- Readmission/return assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

- Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

- Not PPS assessment

The time frames for assessment completion and look-back periods have changed for certain sections in the MDS 3.0. Most MDS 3.0 assessments now have seven-day look-back periods, while mood is assessed over the preceding two weeks and pain is assessed any time in the previous five days. Special treatments require a review of the treatment records and physician's orders for the past seven days. Skin conditions require a seven-day look-back period.

Besides the care and treatment services assessment and planning, the assessment period chosen may affect reimbursement, depending on the assessment date and resident status.

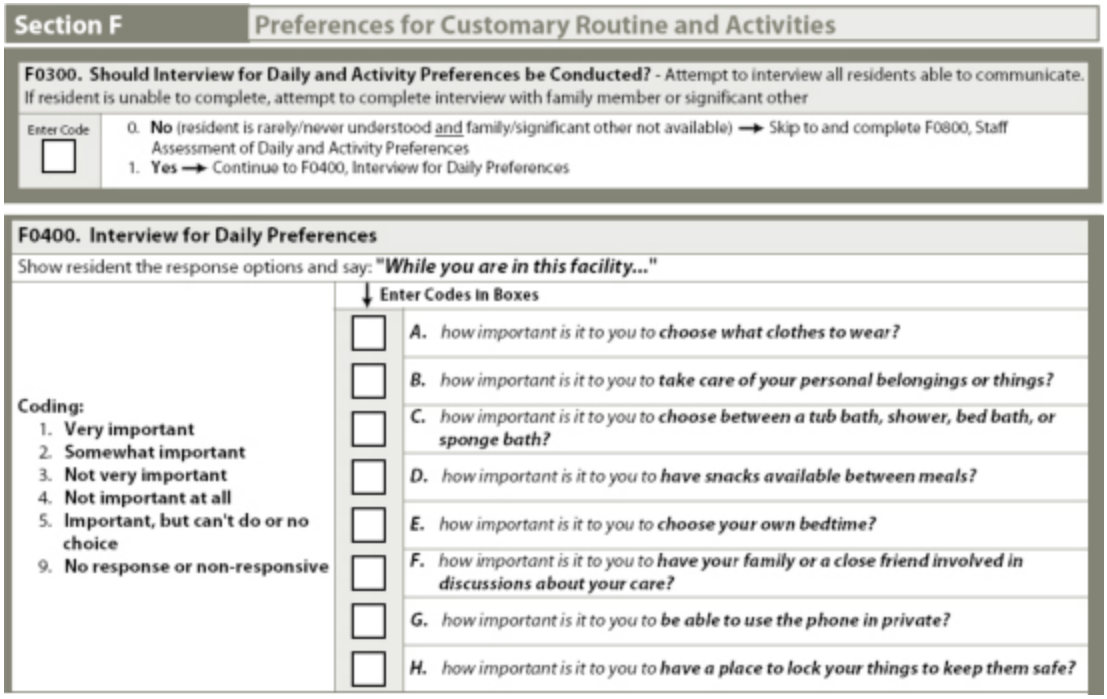
The MDS 3.0 includes items that nursing and social services would normally include in their assessments, such as activities, pain assessments, and preferences. It also requires interviews with all residents and distinguishes between interviews and observations. Through the interview process the "resident voice" is formalized and standardized for areas such as cognition and mood. When a resident is not capable of participating in the interview process, observations of the resident are recorded and used for planning and communication purposes with the resident, the resident's family or representatives, the physician, the therapist, and facility staff.

The completion of the MDS 3.0 instrument is carried out after the resident is assessed by a variety of clinical staff, including the nursing staff, social services, activities, speech, physical and occupational therapists, and the physician.

An example of the interview instruction in the MDS 3.0 is shown in the screen capture below.

MDS Interview Instruction

MDS 3.0 requires interviews with all residents and distinguishes between interviews and observations. Through the interview process the "resident voice" is formalized and standardized for areas such as cognition and mood. An example of the interview instruction in the MDS 3.0 is shown in the screen capture below.



Section F Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: "***While you are in this facility...***"

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

☐ A. *how important is it to you to* ***choose what clothes to wear?***
☐ B. *how important is it to you to* ***take care of your personal belongings or things?***
☐ C. *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
☐ D. *how important is it to you to* ***have snacks available between meals?***
☐ E. *how important is it to you to* ***choose your own bedtime?***
☐ F. *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
☐ G. *how important is it to you to* ***be able to use the phone in private?***
☐ H. *how important is it to you to* ***have a place to lock your things to keep them safe?***

There are changes and redefinitions of other MDS 3.0 areas, including:

- Skin conditions and pressure ulcer risk will not use reverse staging.
- Section Q incorporates the resident's participation in the assessment process, overall expectation for where the resident would like to live, the discharge plan, and referral.
- The intent of the assessment areas and the interpretation of the guidelines will affect care planning, reimbursement, and quality measures. One example of impact on reimbursement change is the intent of group therapy under Medicare Parts A and B, which is defined as the following in the *RAI User's Manual:*
    - **Medicare Part A**-treatment of two to four residents, regardless of payer source, who are performing similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals
    - **Medicare Part B**-treatment of two or more individuals simultaneously who may or may not be performing the same activity
- Activities of daily living are geared toward support provided by the staff over the last seven days. This is a pivotal area for data collection and has a strong impact related to reimbursement.
- Assessment for mental status and behavior is included in the MDS 3.0. Additional clinical assessment background will be helpful in determining the resident's level of functioning in these areas.

External Considerations for MDS 3.0 Transition

Data from the MDS 3.0 are used for external uses, including prospective payment for Medicare Part A using the Resource Utilization Groups (RUGs) triggered from the MDS. Some states use the MDS for their own state PPS systems.

In addition, the Patient Protection and Affordable Care Act includes a provision addressing Medicare payments for skilled nursing facilities in FY 2011. It mandates a delay in the introduction of RUGs version 4 (RUGs-IV) case mix classification

system until FY 2012 and requires that MDS 3.0 be implemented as planned in FY 2011. The provision also requires that certain specific components of RUGs-IV, specifically the concurrent therapy and look-back revisions, be applied in FY 2011.

While there is currently an existing grouper (the software program that uses assessment data to assign each resident to the appropriate RUG) that uses the 53-group RUGs-III system and the MDS 2.0 and a revised grouper that uses RUGs-IV and the MDS 3.0, a grouper that incorporates the particular combination of features mandated by the statute does not currently exist. The Centers for Medicare and Medicaid Services will apply interim payment rates effective October 1, 2010, that reflect the use of MDS 3.0 and the new RUGs-IV system in its entirety as finalized in the FY 2010 SNF PPS final rule. CMS will continue to build the payment infrastructure needed to incorporate the combination of features mandated by the Patient Protection and Affordable Act. Once the necessary infrastructure is in place, CMS will retroactively adjust the rates to reflect a hybrid RUGs-III (HR-III) system that incorporates RUGs-IV's specific revisions.

Data from MDS 3.0 are also used in MDS Quality Measure/Indicator Reports, which provide, by state, the average percent of nursing home residents who trigger one of the 24 quality indicators (32 with subcategories) during a quarter. The quality indicators (QIs) are triggered by specific responses to MDS elements. They identify residents who either have or are at risk for specific functional problems and require further evaluation. QIs are aggregated across residents to generate facility-level QIs, which is the proportion of residents in the facility with the condition.

In a similar manner, QIs can be aggregated across facilities to generate the state-level QIs presented in these reports. QIs are not definitive measures of quality of care but "pointers" that indicate potential problem areas that need further investigation. QI reports are used by the state departments responsible for licensing and certification as well. Note: the reports will likely become available in 2011 following implementation of MDS 3.0 in October 2010.

Finally, MDS 3.0 data are used in Facility Characteristic Reports, which are used by the state departments responsible for licensing and certification. (These will likewise be delayed with the new MDS.) These reports provide the averages at the facility, state, and national levels. They are a valuable tool for facilities' quality assurance and improvement processes and risk management.

Long-term care facilities and corporations use the Quality Measures, Indicator Reports, and PPS RUGs reports for their own internal quality improvement and benchmarking their own internal quality and reimbursement targets.

For more information regarding MDS 3.0, visit www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.

Rhonda Anderson (rhonda@ahis.net) is president of Anderson Health Information Systems, Inc.

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