MDS Alert

MDS & LTC Trends: Are You In The Info Loop? Get The Latest Scoop On What's Coming Down The MDS, Payment And Compliance Pike

Speakers at AANAC, American Health Lawyers' LTC conference bring conferees up to speed.

In the MDS and long-term care world these days, there's a steady drumbeat of new and ongoing developments. And speakers recently provided the latest updates at the **American Association of Nurse Assessment Coordinators** spring meeting in Baltimore and at the **American Health Lawyers**' Long-Term Care and the Law annual meeting held in New Orleans.

Here's What's Up

MDS 3.0 and STRIVE. CMS and industry experts discussed the MDS 3.0, which is slated for implementation in October 2009. They noted that the revamped instrument gives the resident more voice in the assessment process -- and was shown in a validation study to require 45 percent less time to complete compared to the 2.0 version. The MDS 3.0 may take less time because structured resident interviews included in a number of sections may actually be faster than the 2.0 data collection process, surmises **Rena Shephard, RN, RAC-MT, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego and founding chair and executive editor for AANAC (for details, see the previous issue of MDS Alert).

In addition, "the 2.0 has fewer skip patterns than the 3.0, which is another reason it's quicker to do the 3.0," says **Nathan Lake, RN, MHA**, director of clinical design for **American HealthTech**. "But the skip patterns for the 3.0 aren't as clear cut as the ones for the 2.0 ... . We have talked to CMS about the need to make the skip patterns [for the MDS 3.0] more data-driven rather than leaving it up to clinical judgment whether to skip an item(s) ... for example, if the answer to item x is such and such, then do this or that," Lake tells **Eli.**

The STRIVE (Staff Time and Resource Intensity Verification) project, which is still in progress, will help provide a fiscal structure for how the MDS 3.0 drives payment. CMS' **Sheila Lambowitz** told AHL attendees that it's her job to make sure that the new assessment instrument doesn't produce payment swings in either direction.

"We have a very big job to make sense of all of this," Lambowitz said. She also noted that during the transition from RUG III to RUG IV, CMS will calculate the RUGs for both RUG versions.

Recovery Audit Contractors (RACs). The RACs are authorized to review SNFs, said CMS' Lambowitz in a session on Medicare payment at the AHL conference. Congress has mandated CMS roll out the RACs by 2010, although CMS has said it's committed to doing so faster than that.

RACs function like bounty hunters, working on a contingency basis, but they are "tasked with looking for underpayments" as well as overpayments, said **Glenn P. Hendrix, JD**, speaking at AHL. An example of an underpayment, said Hendrix, might be one where a provider claimed 15 minutes of therapy when the record shows it should have been 30 minutes, which would have changed a RUG score. Or auditors might discover that a diagnosis left off the MDS would have changed a RUG, he said. (For more information on the RACs, see p. 60.)

The Quality Indicator Survey (QIS). CMS is refining this new approach to the survey in which surveyors conduct the survey in two stages -- a preliminary investigation in stage 1 and a more in-depth investigation in stage 2 based on stage 1 triggers, complaints and sentinel events, according to presentations at AANAC and AHL by **Andrew Kramer, MD**, who has been involved in the QIS development.

CMS officials also updated providers on the status of the QIS in a Feb. 27 SNF/LTC Open Door Forum where CMS'

Lambowitz fielded questions from AHL in New Orleans. Speaking from Baltimore on the ODF call, CMS' **Cindy Graunke** reported that the QIS demonstration project is moving into its next phase. CMS tested the QIS in Florida and is implementing the QIS statewide in states that participated in the demonstration (CA, CT, FL, KS, LA, MN and OH). CMS has selected three other states for implementation, as well, but Graunke declined to name them at this point.

QIS findings to date: Overall, about 40 percent of facilities had fewer or the same number of citations under the QIS, according to Kramer's presentation. Zero-deficiency surveys still occurred, but facilities receiving Quality Indicator Surveys had two or more citations on average. Examples of deficiencies cited at higher rates in the QIS, according to Kramer, included:

Resident Rights: Inform resident of services/rights (F156).

Quality of Life: Notice before room change (F247); Activity program meets individual needs (F248); Choices (F242).

Resident Assessment: Comprehensive assessments (F272).

Quality of Care: Provide necessary care for highest practicable well- being (F309); Unnecessary drugs (F329); Maintain nutritional status (F325); ADL care for dependent residents (F312).

Nursing Services: Nurse staffing (F356).

Dental Services (F411, F412).