# MDS 3.0 Data Driven Compliance and Risk Management in LTC

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## The History of RAI

- **1987** Congress passed Omnibus Budget Reconciliation Act (OBRA) which required the Department of Health and Human Services to specify a minimum data set of core elements for use in conducting comprehensive assessments in the nursing home setting.  
  - Intended to guide the clinical care planning process and support external and internal quality assurance and improvement initiatives.
- **1991** All nursing homes were required by HCFA to implement the MDS.
- **1992** MDS modified to include additional elements to support development of the Resource Utilization Groups (RUG) reimbursement system (MDS+).
- **1995** MDS 2.0 was developed, included items to describe residents receiving post-hospital care:
  - Items added to support Quality Indicators and RUG III.
  - Modified to allow for computerization of the MDS and facility data entry.
- **1996** States implemented MDS 2.0.
- **1998** Facility computerization of the MDS was mandated. (June)  
  - July 1998 – CMS implements the RUG III Prospective Payment System (PPS) for residents in a Medicare Part A Skilled Nursing Facility stay.
- **1999** CMS establishes the Quality Indicator reporting system.
The History of RAI

- **2003** Draft MDS (MDS 3.0) released
- **2004** CMS establishes the publicly reported enhanced Quality Measures
- **2005** CMS merges the Quality Indicators and Quality Measures. Oct - CMS adds Section W to the MDS related to Influenza and Pneumococcal vaccinations
- **2006** CMS releases updated Draft MDS 3.0
- **2006** CMS implements 4 new QMs (vaccinations and immunizations)
- **2010** CMS implements and mandates the use of the MDS 3.0 RAI

The Resident Assessment and Care Cycle (2.0)
Least You Think MDS 3.0 is Simply an Update of 2.0

Operational Implications of MDS 3.0

“Normal” MDS Item Totals

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Total MDS Items / Resident Interviews Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission/5 Day</td>
<td>510 / 451</td>
</tr>
<tr>
<td>14 Day</td>
<td>879 / 783</td>
</tr>
<tr>
<td>30 Day</td>
<td>1248 / 1115</td>
</tr>
<tr>
<td>60 Day/EOT OMRA</td>
<td>1617 / 1447</td>
</tr>
<tr>
<td>90 Day/Quarterly</td>
<td>1986 / 1779</td>
</tr>
<tr>
<td>Quarterly</td>
<td>2355 / 2111</td>
</tr>
<tr>
<td>Quarterly</td>
<td>2724 / 2443</td>
</tr>
<tr>
<td>Annual</td>
<td>3234 / 2894</td>
</tr>
</tbody>
</table>
## “Worst Case” MDS Item Totals

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Total MDS Items / Resident Interviews Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Day</td>
<td>369 / 332</td>
</tr>
<tr>
<td>SOT OMRA</td>
<td>413 / 376</td>
</tr>
<tr>
<td>Admission</td>
<td>923 / 827</td>
</tr>
<tr>
<td>14 Day</td>
<td>1292 / 1159</td>
</tr>
<tr>
<td>Discharge</td>
<td>1575 / 1404</td>
</tr>
<tr>
<td>Re-admission / Return</td>
<td>1944 / 1736</td>
</tr>
<tr>
<td>14 Day</td>
<td>2313 / 2068</td>
</tr>
<tr>
<td>30 Day</td>
<td>2682 / 2400</td>
</tr>
</tbody>
</table>

## “Worst Case” MDS Item Total (cont.)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Total MDS Items / Resident Interviews Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOT OMRA</td>
<td>2840 / 2534</td>
</tr>
<tr>
<td>Discharge</td>
<td>3123 / 2779</td>
</tr>
<tr>
<td>Re-admission / Return</td>
<td>3492 / 3111</td>
</tr>
<tr>
<td>SOT OMRA</td>
<td>3536 / 3155</td>
</tr>
<tr>
<td>14 Day</td>
<td>3905 / 3487</td>
</tr>
<tr>
<td>30 Day</td>
<td>4274 / 3819</td>
</tr>
<tr>
<td>EOT OMRA</td>
<td>4408 / 3953</td>
</tr>
<tr>
<td>Significant Change</td>
<td>4918 / 4404</td>
</tr>
</tbody>
</table>
Other Structural/Procedural Changes in MDS 3.0

- Workload has increased
- Assessment at discharge (e.g. hospital)
- Resident interviews
- Resident's discharge plan (Section Q)

A Word About MDS 3.0

- As a clinical tool
  - Internal scales
  - Past – present/current – future
- As a risk management tool
  - Current and future needs
- As a compliance tool
  - Survey and Certification/Access to care
- As a financial tool
  - Medicare/Medicaid
  - Overpayment/underpayment
### Deeper Dive Into Risk Management Implications

- Need for an interpreter to make needs/wishes/etc known
  - If identified, yet not provided
  - Care delivered outside of resident’s wishes
- Depression and thoughts of self-harm
  - Assessed depression must be treated or otherwise acknowledged
  - Indication of self-harm, along with follow up is captured
- Behavioral symptoms
  - Directed towards others
  - Impact on resident
  - Impact on others
- Rejection of care
  - May indicate a misalignment of resident wishes and care plan
  - This item is one example of coding clarification from CMS since implementation in October 2010

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### Deeper Dive Into Risk Management Implications

- Presence and frequency of wandering
  - High risk for elopement/falls, and other injury
- “No assessment was done to determine pressure ulcer risk”
  - Documented no assessment followed by development
- Resident is/is not at risk for pressure ulcers
  - Documented no assessment followed by development
- Worsening pressure ulcer since last assessment
Behavioral Symptoms

<table>
<thead>
<tr>
<th>Behavioral Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0200. Behavioral Symptom - Presence &amp; Frequency</td>
</tr>
</tbody>
</table>

**Coding:**
0. Behavior not exhibited
1. Behavior of this type occurred 1 to 3 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

**Enter Codes in Boxes**

A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rambling, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Impact on Resident

<table>
<thead>
<tr>
<th>Impact on Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0500. Impact on Resident</td>
</tr>
</tbody>
</table>

**Did any of the identified symptom(s):**

A. Put the resident at significant risk for physical illness or injury?
   - Yes
   - No
B. Significantly interfere with the resident’s care?
   - Yes
   - No
C. Significantly interfere with the resident’s participation in activities or social interactions?
   - Yes
   - No
## Impact on Others

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Put others at significant risk for physical injury?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>B. Significantly intrude on the privacy or activity of others?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>C. Significantly disrupt care or living environment?</td>
<td>No</td>
</tr>
</tbody>
</table>

## Wandering

### Section E Behavior

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stair, outside of the facility)?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>B. Does the wandering significantly intrude on the privacy or activities of others?</td>
<td>No</td>
</tr>
</tbody>
</table>
Depression/Self Harm

<table>
<thead>
<tr>
<th>1. Symptoms Presence</th>
<th>2. Symptoms Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Little interest or pleasure in doing things</td>
<td></td>
</tr>
<tr>
<td>B. Feeling down, depressed, or hopeless</td>
<td></td>
</tr>
<tr>
<td>C. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
</tr>
<tr>
<td>D. Feeling tired or having little energy</td>
<td></td>
</tr>
<tr>
<td>E. Poor appetite or overeating</td>
<td></td>
</tr>
<tr>
<td>F. Feeling bad about yourself— or that you are a failure or have let yourself or your family down</td>
<td></td>
</tr>
<tr>
<td>G. Trouble concentrating, or things, such as reading the newspaper or watching television</td>
<td></td>
</tr>
<tr>
<td>H. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
</tr>
<tr>
<td>I. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td></td>
</tr>
</tbody>
</table>

Self-Harm and Follow up

1. Thoughts that you would be better off dead, or of hurting yourself in some way

DO350. Safety Notification - Complete only if DO200=1 indicating possibility of resident self harm

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Was responsible staff or provider informed that there is a potential for resident self harm?

<table>
<thead>
<tr>
<th>Entry Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
Other Data Capture

- Survey and Certification – OSCAR/CASPER
- Incident and Accident Reports
- Random Risk Assessment Tools
- Staffing/Payroll Data
- Financial Data/UB-02

Major Uses of Data

- Operations
  - Clinical
    - Care planning
  - Quality
    - Quality Assurance
    - Performance Improvement
- Staffing
  - Resident needs
  - Facility census
- Resource use/Purchasing
  - Inventory
- Finance
  - Budgeting
  - Credit/Lease Covenants
### Major Uses of Data

- **Compliance**
  - Billing/Claims
  - Compliance with Medicare/Medicaid requirements
  - Requirements for Participation/Licensure Regulations
  - Compliance with 42 CFR §483 and State Licensure Rules
  - Federal and state fraud and abuse
  - Compliance with Stark Law and Anti-kickback Law

- **Risk Management**
  - Civil litigation/Claims
  - Prevention
  - Identification
  - Insurance Review/Audits
  - Required reviews by PL/GL carriers
  - Landlord/Investors/Financing Sources
  - Required disclosures to real property holders, investors and lenders
  - Audits or review by real property holders, investors and lenders
## Benefits vs. Risks

### Fundamental issues
- Are you going to use the data as a sword, shield or both?
  - Doing both maximizes the operational and financial return
- Are you going to do the minimum collection and use required by law or are you going to take it to the next level?
  - The pendulum is swinging towards the next level

### Risks
- Lots and lots of data
- Policies on collection and use with no implementation
- Paper Trail
  - Straight line to the smoking gun
- Improper use
  - Using same data set to understand how to maximize reimbursement but failing to use it to see quality trends such as increased falls and med errors
Benefits vs. Risks

- Benefits
  - Quality
    - Track specific events and get to root causes
      - Pressure ulcers
      - Med errors
      - Resident falls
  - Resident Safety
    - Prevention of accidents and undesirable outcomes
  - Corporate Integrity
    - Doing the right thing, all the time

Benefits vs. Risks (cont’d)

- Compliance
  - Meeting required and desired goals for regulatory compliance
- Risk Management
  - Prevention and detection
    - Getting ahead of the problems before they occur
    - Identifying issues before they get out of hand
- Attractive to investors and lenders
  - Data provides a much deeper understanding of the organization
    - Show stakeholders your ability to understand, operate, protect and grow your organization
<table>
<thead>
<tr>
<th>Wasn’t that easy....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions?</td>
</tr>
</tbody>
</table>