



May 23, 2003

Rita Shapiro
Division of Ambulatory and Post Acute Care
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S3-02-01
Baltimore, MD 21244

Re: Refinement of the Minimum Data Set (MDS), Version 3.0

Dear Ms. Shapiro:

The California Healthcare Association (CHA), on behalf of its nearly 500 member hospitals and health systems, many of which operate skilled nursing facilities, respectfully submits our comments for the Minimum Data Set (MDS) 3.0 Town Hall meeting on June 2, 2003.

Positive Changes to MDS

Overall, we believe that the draft MDS 3.0 is an improvement over the MDS 2.0. Most of the changes and additions reflected in the MDS 3.0 are clinically sound, appropriate for the patient population, and consistent with the promotion of quality health care for nursing facility residents.

In particular, we are pleased to see improvement in the quality of the following new or expanded sections of the assessment tool:

- *Section E – Mood.* We support the addition of this section.
- *Section G – Functional Status, Neuromuscular Impairment.* We support the addition of this section.
- *Section J2 – Pain Assessment.* We support the changes made to this section.
- *Section J4 – Number and Classification of Falls.* We support the changes made to this section.
- *Section K1 – Swallowing/Nutritional Status.* We support the changes made to this section.
- *Section K3 – Weight Loss.* We support the addition of planned weight loss to the assessment.
- *Section K5 – Parental or Enteral Intake.* We support the addition of the items in K5b.
- *Section M1 – Staging Pressure Ulcers.* We support the addition of this section.
- *Section M2 – Other Ulcers.* We support the addition of non-pressure ulcers to the assessment.
- *Section M5 – Foot Problems and Care.* We support the addition of M5c.

- *Section N – Activity Pursuit Patterns.* We support the increased role of activities staff in measuring these data.
- *Section O2 – Received the Following Medication.* We support the addition of antibiotics to the list of medications tracked in this section.
- *Section T – Therapy Supplement for Medicare PPS.* We support the changes made to this section.
- *Section V – Resident Assessment Protocol Summary.* We support the changes made to this section.

In addition, the MDS 3.0 is better organized than the MDS 2.0. We appreciate the inclusion of the source of each item on the draft instrument, which was a significant aid in our evaluation of the draft form. We assume that this column will be removed from the final version, but that the information will be available in the crosswalk that the Centers for Medicare and Medicaid Services (CMS) will develop. Moving this information into a crosswalk would assist in keeping physical form itself to the minimum length while at the same time making the information available to facilities.

Increased Assessment Time

Although these new or expanded sections of the MDS gather valuable information, each addition to the assessment process increases the time it takes to complete the MDS. Any increase in assessment time translates directly into increased costs for providers. These costs, in turn, need to be covered by Medicare, Medicaid and private payers.

Due to the short notice, we were unable to test the time required to assess residents under the draft MDS 3.0. Based on our experience, however, we estimate that the new form will take an additional 10 minutes to complete per assessment. Given that the MDS 2.0 takes between 5 and 10 minutes to complete, this increase in time could have a significant adverse impact on providers. In addition, the burden would be greater for providers that serve a short-stay population, including many hospital-based nursing facilities, which on a per bed basis conduct assessments more frequently.

Concerns with the MDS 3.0

A number of areas within the MDS 3.0 could be improved. CHA has the following concerns with the draft form:

- *Section A15 – Admission/Discharge Status Code.* We recommend adding, “swing bed of an acute care facility” as an option for those facilities that have both swing beds and nursing facility beds.
- *Section E1B – Indicators of Possible Depression, Sad Moods.* While we believe it is valuable to assess a resident’s mood, this section could be significantly strengthened. As currently drafted, this section does not distinguish between a resident’s moods as a result of care provided in the facility from those that simply reflect the resident’s outlook on life. We

recommend adding a second level to this question that identifies whether the resident's negative mood is a recent change.

- *Section F1 – Quality of Life.* This section is too lengthy and not appropriate for short-stay residents. We recommend that this section not be required as part of the 5-day assessment.
- *Section H1 – Continence Self Control Categories.* Unlike the MDS 2.0, in the draft version, this section does not assess whether the resident's continence status is a recent change. We believe this information is helpful in evaluating the care provided in the facility. We recommend that it be added back into the assessment form.
- *Section I – Diagnoses.* The 8 pages of diagnoses are complex and time consuming and will require the services of a medical records coder as well as software with drop down screens for ICD-9 codes.
- *Section L - Oral Dental Status.* We believe that this section as contained in the MDS 3.0 is not an improvement over the current section being used in the MDS 2.0. As revised, this section is too lengthy. In addition, many of the options are not appropriate for short-stay residents. We recommend returning the current version of this section.
- *Section N3 – Loss of Interest.* Because it is common for residents to be uninterested in activities immediately after a hospitalization, we recommend that this section not be required as part of the five-day assessment.
- *Section P1 – Special Treatments, Procedures and Programs.* The MDS 3.0 eliminates suctioning as option “i.” Suctioning requires quite a bit of skill and qualifies as special care. We recommend adding suctioning back into the list of special care treatments.
- *Section P7 – Expected Length of Stay.* Estimating how long a resident will remain in a facility is more art than science. Thus answers to this section would be of questionable value. Moreover, physicians often turn to the interdisciplinary team for input when posed with this question. Obtaining physician compliance with completing this section will be highly problematic. We strongly recommend deleting this section.
- *Section X – Preventative Health.* Sections X2 and X3 are not appropriate for short-stay residents. Obtaining this information for residents who are in the facility for merely a few weeks is very difficult. Yet, if the facility is unable to obtain the data, the RAP for Infection Control would be triggered. We recommend eliminating this section.

Request for Clarification

In order to fully comment on the MDS 3.0, CHA requests that CMS clarify the following issues:

- *When will providers be required to use the MDS 3.0?* In order to fully evaluate the impact of the draft assessment, CMS needs to clarify when providers will be required to use it.

Specifically, will the MDS 3.0 only be required at the same times that a full assessment is now required? Will swing bed providers still be able to use the two-page MDS specifically for swing beds? Will providers still be able to use the MPAF as they do today? Will the quarterly MDS remain the same?

- *Will the eight page "Recommended Content for MDS 3.0 Disease and Diagnosis Question" which accompanies Section I be included as part of the MDS 3.0? While this section is valuable, including it as part of the MDS 3.0 adds substantially to the thickness of the MDS that becomes part of every resident's medical file.*

Training Manual

Several sections within the MDS 3.0 will require clarification in order for providers to complete the form in an accurate and consistent manner. We request that clarification be provided in the training manual that will accompany implementation of the MDS 3.0. We identified the following sections that would benefit from clarification:

- *Section B3 – Cognitive Skills for Daily Decision Making.* Because a resident's cognitive status can vary from day to day, it would be helpful for CMS to specify the number of days within the last week that would qualify a resident as "modified independence," "minimally impaired," or "moderately impaired."
- *Section C4 – Vision.* Often a resident's vision can vary between eyes. We request that CMS clarify how this section should be coded under such circumstances.
- *Section G4 – Devices and Aids.* Because residents that use wheelchairs often can propel the wheelchair themselves with some assistance, it would be helpful for CMS to clarify what level of assistance can be provided while still qualifying as self-wheeled.
- *Section G5 – Bedfast.* Currently, residents that get up out of bed everyday and are fully capable of ambulating but who choose to spend their time in their room are considered "bedfast." Because residents have the right to refuse activities and spend their day in their own room, we request that the definition of "bedfast" be changed to exclude these residents.
- *Section K 1 – Swallowing/ Nutritional Status.* Some residents receive their primary nutrition orally, but receive nutritional supplements by feeding tube. We request that CMS clarify how these residents should be coded.
- *Section K3 – Weight Loss.* When a physician prescribes a diuretic for a resident, it is expected that the resident will lose weight as a result of retaining less water. We recommend that CMS clarify that weight loss consistent with such circumstances be considered "planned weight loss."
- *Section M – Skin Condition.* Sometimes residents develop a pressure ulcer or other skin condition prior to admission to the nursing facility. In order to evaluate the quality of care

provided by the nursing facility, it is critical that CMS provide guidance on how an improving pressure ulcer be classified.

CHA commends CMS for all the work that has been put into the development of a revised MDS. We appreciate the opportunity to comment on the proposed changes to this important document.

Sincerely,



Danielle Lloyd
Vice President, Federal Reimbursement Programs



Judy Citko
Vice President, Continuing Care Services

DL/JC:saw