Operation overhaul

The rollout of the new MDS 3.0 has drawn mixed reactions, but providers and vendors are now looking toward the future with the system in place

Photo: Mather Life Ways

MDS 3.0 has put greater emphasis on resident interviews. Here a provider is using a "Pocket Talker" to help a resident hear questions.

By Julie E. Williamson

When MDS 3.0 took effect Oct. 1, it brought some of the most sweeping operational changes the long-term care segment has seen since the prospective payment system was introduced in 1999.

It also brought a mixed bag of emotions for providers and software vendors alike—from excitement and trepidation to outright fear and frustration.

No question, MDS 3.0 has already seen its fair share of challenges. In the weeks (and days) leading up to the full rollout, the Centers for Medicare & Medicaid Services was making eleventh-hour revisions to the regulations, which meant long-term care providers and software vendors had little lead time to acclimate to the changes and make the necessary adjustments.

"We didn't have time to test last-minute changes that were made to [our software] before going live, so that presented some challenges," confirmed Roseanne Reynolds, director of patient accounting to Trinity Senior Living Communities, Livonia, MI.

Some of CMS' final updates involved the RAI User Manual, a tool that offers guidance on proper use of the Resident Assessment Instrument, and the RUG-IV case-mix system, a key accompaniment to MDS 3.0 that had its full, official start date delayed by Congress until next October. The delay forced CMS to introduce three billing options late in the game; an interim RUG-IV is currently in place until CMS completes a hybrid RUG-III instrument. Reimbursement uncertainty under RUG-IV remains a challenge for providers, according to Robert C. Davis, chief executive officer of Optimus EMR Inc., Irvine, CA.

"These fears were compounded by the delays at CMS and the last-minute changes regarding the transition period," he noted.

A Friday implementation day, coupled with computer glitches at CMS that occurred throughout the first several weeks of October, further added to MDS 3.0 transition woes. The computer coding errors, which affected assignment of the RUG scores, led to mistakes in validation reports issued by CMS, and a temporary system shutdown.

Heightened tensions

Although CMS fixed the glitches and will not penalize providers for late MDS transmissions during the transition period, the processing problems nonetheless frayed nerves and tested patience of providers and software vendors.

"Delays in CMS processing [posed] a setback for most clients," acknowledged Lisset Sanchez-Schwartz, MBA, senior director of marketing for Fort Lauderdale, FL-based AOD Software. Because CMS' system errors weren't fixed until the latter part of October, she said many providers felt that the agency was "cutting it really close."

Indeed, the waiting and wondering took its toll on providers who were already somewhat anxious about closing out the month of September under MDS 2.0 and then immediately piggybacking with the Oct. 1 go-live date for MDS 3.0.

"We worked very hard to do our first assessments and pull everything together for our first submission to the state," noted Christina Moore-Sharon, MDS coordinator for Sanctuary at Bellbrook, a Trinity continuing care

retirement community in Rochester Hills, MI. "We submitted and waited for verification from CMS, but then we just sat in a holding pattern. We learned that because of the CMS [computing errors], validation reports that had been submitted needed to be redone. I'm a pretty easygoing MDS coordinator, but it was difficult waiting while they recalculated the RUGS score—which is how we all get paid—and then waiting for confirmation."

While some praised CMS for its humble acknowledgement of the processing errors, as well as its response to questions posed by confused and concerned long-term care providers and software vendors, not all were so quick to applaud the agency's efforts. Davis, for one, contends that the planning and execution by CMS for MDS 3.0 has been "poor at best."

"CMS was always behind in the delivery of committed information, which placed extreme and unnecessary pressure on the industry," he said, noting that if CMS had allowed the testing of submissions prior to the Oct. 1 effective date, much of the recent confusion could have been avoided. "No software company would attempt the activation of a program with the scope of MDS 3.0 without adequate testing. Why should CMS be allowed such a cavalier approach?"

Proactive pay-off

Despite the early obstacles—and some lingering concerns about RUG-IV—many sources said that the transition to MDS 3.0 was generally smooth. And advance planning and preparation by providers and software vendors can take much of the credit.

"Most of our customers have done very well with the transition," Davis said. "The only customers that appear to be struggling are those that took a 'wait and see' approach, assuming they would figure things out as the events unfolded."

Trinity was one of the many providers that took the proactive approach. Each of its facilities spent a year preparing for MDS 3.0, with data querying and weekly user group meetings at the heart of the preparations to keep staff and the software vendor up to speed on updates, concerns and required troubleshooting.

"Our vendor has been working diligently to make the roll-out of MDS 3.0 as seamless as possible, and we have all worked very hard as a team to make it a success. We're still meeting at least weekly as an interdisciplinary team to work out any kinks and keep things rolling as smoothly as possible," Moore-Sharon said.

One MDS 3.0 requirement that has proven particularly challenging for some providers is the resident interview component of the comprehensive assessment. Moore-Sharon's first comprehensive assessment took three hours. "It's very labor-intensive, but I know it's important and it'll get easier over time."

The time-consuming resident interview process has led some nursing home directors to take a closer look at staffing levels. It also is harder for other reasons. "A tool that's designed to meet the needs of the masses won't always be a great fit for some [residents],"

observed Norme Torres, executive director of Mather Pavilion, a Mather Lifeways nursing care community in Evanston, IL.

An eye on the horizon

Now that providers and vendors have the sometimes painful initial weeks behind them, there's hope that each passing month with MDS 3.0 will become easier—and organizational processes will continue to improve.

"MDS 3.0 is a good thing to happen to long-term care," noted Doc Devore, vice president of industry strategy for MDI Achieve, a software solutions provider with offices in St. Louis, Minneapolis and Dallas. "It is a considerably improved assessment tool that has long-term value and makes an organization's processes that much better. Once everyone gets through this transition phase, [they] will see how much easier and more efficient the tool is for their business."

Still, if providers are to accurately capture reimbursement and continue meeting the expectations of their residents—and surveyors—their diligence can't wane. RUG levels are a prime example. The new RUG rates have created larger reimbursement gaps between RUG levels, which is causing providers to analyze and understand MDS source information like never before, according to Devore. One aspect of MDS 3.0 that has proven particularly challenging, he said, is the short-term stay requirement, which requires eight criteria to be met.

Accurate documentation of activities of daily living is also more important than ever, added Sanchez-Schwartz.

"Just one ADL point could mean significant dollars when it comes to reimbursement," Sanchez-Schwartz stressed. "Having an integrated point of care system to capture those ADLs in MDS 3.0 is even more valuable than before."

Staying ahead of the MDS 3.0 and RUG curves also hinges on providers' commitment to capturing and analyzing source information long before the MDS is ready for submission, according to Larry Triplett, president of Resource Systems, New Concord, OH.

This "allows for early significant change detection, documentation error prevention and proper reference date setting," he said.

Of course, continuing to work closely with software providers and state and national associations for updates and ongoing education will also pay big dividends.

"We recommend to all facilities, regardless of the software they're [using], that they stay on top of receiving the updates from their software vendors, which at this time, should be numerous and frequent due to all of the changes still occurring with MDS 3.0," noted Sanchez-Schwartz.

Beyond that, providers need to be supportive of their MDS coordinators and understand that MDS 3.0 has been one of the biggest changes the industry has seen in years.

"MDS coordinators need all the positive reinforcement they can get," Devore stressed. "The last thing you want to have is turnover in those positions after all the hard work and training that has already been implemented." ■