MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
Website: www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

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

Dear Ms. Shapiro:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed revisions to the Minimum Data Set (MDS), version 3.0. We appreciate your staff's work in revising this instrument. Our comments are limited to ways of ensuring that the MDS is a useful tool for determining skilled nursing facility (SNF) payments and monitoring the quality of SNF care. We recognize that SNFs may also use this tool for care management.

Using a uniform assessment instrument such as the MDS for payment, quality monitoring, and care management purposes is efficient both for CMS and for the providers who deliver skilled care. However, in part because this instrument is used for so many different purposes and was designed for long-stay nursing home patients, the instrument may be limited in what it can achieve for shorter-stay SNF patients who need more skilled care. Our comments focus on the following ways CMS could improve the payment and quality information it collects on SNF patients and minimize the burden of data collection:

- Evaluate each of the MDS data items according to its usefulness in determining payment and quality information specifically for short-stay SNF patients, segregate these items on the MDS form, and limit data collection on SNF patients to these items only.
- Improve the quality of care information derived from the MDS by requiring that functional status information be collected at the time of discharge from the SNF.
- Improve the information used for quality monitoring and payment purposes by using other information beyond that obtained from the MDS.

Evaluate MDS items according to their usefulness for payment and quality monitoring for short-stay SNF patients, segregate these items on the MDS form, and limit data collection for SNF patients to these items only—One of MedPAC's primary

concerns with the current SNF classification system—which we have recommended the Secretary replace with a new classification system—is that the MDS (the instrument used to assess SNF patients for classification purposes) was not developed for short-stay SNF patients.[1] It was originally developed as a care-planning tool for long-stay nursing home patients. As a result, MedPAC believes that many of the variables on the MDS are not useful for classifying short-stay SNF patients appropriately. Furthermore, the instrument does not adequately assess the more intensive needs of SNF patients, and has not been sufficiently tested on this population. We have two specific suggestions to improve the relevance of the MDS to short-stay SNF patients:

- **Define clear goals (payment or quality monitoring) for each item.** We urge the Secretary, as we did in MedPAC's March 2001 Report to the Congress, to define clear goals for the MDS in the areas of payment and quality monitoring for short-stay SNF patients, and use these goals to identify the minimum set of information needed to accomplish them. In this way, CMS minimizes the reporting burden and unnecessary complexity, while assuring that only necessary data items are collected for payment and quality monitoring. In this respect, we strongly support the recommendation in the November 2002 draft report of the Secretary's Advisory Committee on Regulatory Reform that specific uses of any data elements be defined prior to retaining them "as part of an overall streamlining process.[2]"

- **Segregate the SNF items on the form and require only these items for SNF patients**. Many of the variables on the proposed MDS 3.0 form, such as those in the quality of life and activity pursuit patterns sections, are not particularly relevant for patients who stay an average of 14 to 28 days in nursing facilities. Furthermore, only 3 of the quality measures CMS uses in the public quality reporting initiative apply to short-stay patients. Given this, we would suggest that CMS separate the short- and long-stay questions on the MDS, either by putting the short-stay questions at the beginning of the form or by creating an automated skip pattern for the electronic version of the form. SNFs should only be required to complete the short-stay questions for these patients. For long-stay patients, nursing facilities could continue to complete the entire form.

Improve information on quality by collecting information on functional status at discharge—MedPAC would like to encourage CMS to find ways of improving the usefulness of the MDS for monitoring the quality of care in SNFs. In addition to the current schedule for MDS reporting, we believe it is essential to require SNFs to report functional status (at a minimum) at the time of a patient's discharge from a SNF. This would allow for comparisons between patients' status at admission and at discharge; for

[1] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. March 2001. Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. March 2002. Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. March 2003.

[2] Secretary's Advisory Committee on Regulatory Reform, Department of Health and Human Services. Draft report of the Secretary's Advisory Committee on Regulatory Reform. Washington (DC), HHS. November 21, 2002.

many short-stay patients, this might be the only way CMS can truly monitor patients' level of improvement (or lack thereof) during the stay.

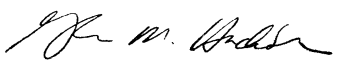
Consider using other sources of information, in addition to the MDS, for payment and quality monitoring purposes—The MDS provides some useful information for payment and quality monitoring purposes. However, CMS should look beyond the MDS for additional sources of information that would enhance the accuracy of SNF payments and improve our ability to monitor the quality of SNF care, such as:

- **Diagnosis information from the hospital record—**Analysis by at least one researcher shows that using diagnosis information from SNF patients' prior hospital stays enhances the ability of the SNF payment system to predict the costs of caring for these patients.[3] The most reliable such information comes directly from inpatient hospital records. We would encourage CMS, if at all possible, to develop an administratively simple way of obtaining diagnosis information directly from SNF patients' inpatient hospital records for both payment and quality monitoring purposes. This might obviate the need for providers to record this information on the MDS, unless the information is used for care management or other purposes. If CMS decides the information should be retained on the MDS, it needs to ensure that the collection and use of the information are consistent with that of the diagnosis information obtained directly from the inpatient hospital record.

- **Other sources of reliable SNF quality of care information—**The MDS provides some useful quality measures, such as functional status, but we believe that CMS should expand its information base by using other important measures derived from existing administrative data. For example, information on preventable hospital readmissions provides an important quality measure and is easily obtained from hospital claims data.

MedPAC is very interested in the process of designing an effective assessment tool that minimizes burden to providers, and we look forward to offering any assistance we can to CMS in this endeavor.

Sincerely,



Glenn M. Hackbarth, J.D.
Chair

GMH/km/m

[3] Kramer AM, Eilertsen TB, Ecord MK, Morrison MH, Morrison Informatics, Inc. and University of Colorado Health Sciences Center. A prospective study of new case-mix indices for subacute care, final report. June 1999.