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The collective hard work and dedication of so many people, over the years in the development, testing, writing, formatting, and ongoing review and maintenance of the MDS 3.0 RAI Manual, MDS 3.0 Data Item Set, and MDS 3.0 Data Specifications are too numerous to list, but their dedication has resulted in an RAI process that increases clinical relevancy, data accuracy, clarity, and notably adds more of the resident voice to the assessment process. CMS acknowledges and thanks the many people, organizations, and stakeholders that have contributed to making these updates and enhancements possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.

Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at: *https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual*.

CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining their highest practical level of well-being.

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities/recreational therapy in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.[1]

Persons generally enter a nursing home because of problems with functional status caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. Sometimes, the individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment, and/or rehabilitation is needed for the resident to maintain and/or restore function or to live safely from day to day. While there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). This is true for both long-term residents and residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice.

[1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006.

1.2 Content of the RAI for Nursing Homes

The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as "items") in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data elements for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, OBRA Discharge, Entry Tracking, PPS item sets) can be found on CMS's website at https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.
- **Care Area Assessment (CAA) Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been identified or "triggered," nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include:
  - **Care Area Triggers (CATs)** are specific coding responses for one or a combination of MDS data elements. The triggers identify residents who have or are at risk for developing specific problems and require further assessment.
  - **Care Area Assessment** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The **CAA** resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources is not mandatory and the list of Web links is neither all-inclusive nor government endorsed.
  - **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning.
- **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. The Utilization Guidelines, also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, includes instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from *https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual*).

1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS has also been adapted for use by non-critical access hospitals (non-CAHs) with a swing bed (SB) agreement. Non-CAH SBs are required to complete the MDS for reimbursement under the SNF PPS.

- **Medicare and Medicaid Payment Systems.** The MDS contains data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection instrument to classify Medicare residents into PDPM components. The PDPM classification system is used in the SNF PPS for skilled nursing facilities and non-CAH SB programs. States may use PDPM, a Resource Utilization Group (RUG)-based system, or an alternate system to group residents into similar resource use categories for the purposes of Medicaid reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at *https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms* for comprehensive information on SNF PPS, including, but not limited to, SNF coverage, SNF policies, and claims processing.
- **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs), which are derived from data collected on the MDS, were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the QMs for opportunities to improve their effectiveness, reliability, and validity.
- **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Medicare Care Compare tool (https://www.medicare.gov/care-compare/) provides public access to information about a variety of health care providers, including nursing homes. Information available regarding nursing homes includes their characteristics, staffing data, and quality of care measures for certified nursing homes.

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

(1) who should participate in the assessment process,

(2) how the assessment process is completed, and

(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483.35(e) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative).

b. **Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating their needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.

c. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident's active participation in the process.

d. **Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

e. **Implementation**—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the "how" and "when" of resident care.

f. **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.

The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, care plan development, care plan implementation, and finally to evaluation. This manual will refer to this process throughout several chapter discussions.

If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to successfully using the RAI process is to understand that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), and the interdisciplinary team, residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases.
- **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing the CAAs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is accommodated in the care plan.

- **Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident goals, needs, interests, strengths, problems, preferences, and lifestyle choices. When considering all of this information, staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.
- **Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

The purpose of this manual is to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help nursing home staff achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. This tool assesses a resident's ability to perform daily life functions, identifies significant impairments in a resident's functional capacity, and provides opportunities for direct resident interview. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

Furthermore, with the consistent application of item definitions, the RAI ensures standardized communication both within the nursing home and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.5 MDS 3.0

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008; available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReport.pdf).

Goals

The goals of the MDS 3.0 revision were to introduce advances in assessment measures, increase the clinical relevance of data elements, improve the accuracy and validity of the assessment instrument, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the instrument's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement (via Patient Driven Payment Model [PDPM] classification).

In addition to improving the content and structure of the MDS, the RAND/Harvard team also aimed to improve user satisfaction. User attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the MDS are often cited as a reason that nursing homes have not fully implemented the information from the MDS into targeted care planning.

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and residents in a Medicare Part A SNF PPS stay in non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

1.7 Layout of the RAI Manual

The layout of the RAI manual is as follows:

- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

Appendices

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Locations RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: Patient Health Questionnaire (PHQ)-Scoring Rules and Instruction for BIMS (When Administered in Writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Forms

Section	Title	Intent
A	Identification Information	Obtain key demographic information to uniquely identify each resident, administrative information, nursing home in which they reside, reason for assessment, and potential care needs, including access to transportation.
B	Hearing, Speech, and Vision	Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and the resident's ability to see objects nearby in their environment.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information, and whether the resident has signs and symptoms of delirium.
D	Mood	Identify signs and symptoms of mood distress and social isolation.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for their daily routine and activities.
GG	Functional Abilities	Assess the need for assistance with self-care and mobility activities, prior function, admission performance, discharge performance, functional limitations in range of motion, and current and prior device use.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident. Also includes use and indication of high-risk drug classes, antipsychotic use and drug regimen review to identify potentially significant medication issues.
O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.
P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices or an alarm was used at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation and expectations of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	To identify an MDS record already present in iQIES system for modification or inactivation.

Section	Title	Intent
Z	Assessment Administration	Provide billing information and signatures of persons completing and attesting to the accuracy of the assessment, as well as the signature and date by the RN Assessment Coordinator verifying the assessment is complete.

1.8 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.70(i) and 483.75(i)(4), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at *https://www.cms.gov/about-cms/information-systems/privacy/privacy-act-1974-and-privacy-act-requests*.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Internet Quality Improvement Evaluation System (iQIES). The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Contractual Agreements

Providers who are part of a multi-facility corporation may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in 42 CFR at 483.10(h)(3)(i)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS
Long Term Care-Minimum Data Set (MDS) System of Records revised 04/28/2007

(Issued: 9-6-12, Implementation/Effective Date: 6-17-13)

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

   (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

   (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

   (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

   (4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;

   (5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

   (6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

   (7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

   (8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of Resident or Sponsor Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.