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/Regulations-and-Guidance/Guidance/Manuals/index.html 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 home*s. 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.