MDS Alert

Post-Acute trends: Stay In The Know About The Post-Acute Demo

Get the scoop on the CARE instrument and what it could mean for the MDS.

The RUG-based prospective payment for SNFs, which revolutionized the SNF payment world, started out as a demonstration. And now another demo is picking up speed and potentially paving the way for a revamped post-acute landscape -- an initiative that you definitely need to keep on your radar screen.

What: **The Post Acute Care Payment Reform Demonstration or PAC-PRD**, as it's known for short, involves post-acute and acute-care providers in 10 markets that will be collecting data about post-acute beneficiary care needs and costs.

In addition to SNFs, the post-acute demo participants include home health providers, inpatient rehab facilities and long-term acute care hospitals in 10 markets. At press time, CMS had already kicked off data collection for the demonstration in Boston. And the **American Health Care Association** had at press time received word that CMS was expanding the demo in July in five more areas, according to **Sandra Fitzler, RN**, senior director of clinical services for AHCA. CMS reportedly plans to have the demo operational in the remaining markets by September (for a complete list of the markets, go to https://register.rti.org/pacdemo/).

Rationale for the demo: CMS is congressionally mandated to look at payment reform in post-acute settings, explains a CMS official. The goal is for the agency "to recommend a more logical and consistent payment approach in those settings -- that is the main ticket item," the official tells **Eli.** Congress has also legislatively mandated CMS to analyze outcomes achieved in each post-acute setting and the factors that influence where patients go from acute to post-acute and from post-acute to further care, she says.

Timeline and tools: Each market provider will collect data for nine months on fee-for-service patients, says the CMS official. CMS is supposed to report its findings and recommendations to Congress in 2011.

The demo providers use the CARE (Continuity Assessment Record and Evaluation) instrument to assess post-acute residents. There are five versions of the CARE instrument, which includes core assessment items, as well as specific ones, according to **RTI International,** CMS' contractor for the demo:

• one for acute hospital patients;

• one for post-acute care admissions and another for discharges;

• one for interim/change in condition;

• a very short one for patients who are deceased.

SNFs participating in the demo will do both the MDS and the CARE instruments.

A Closer Look at the CARE

The CARE tool has its plusses, including the fact that it's standardized and thus provides the same information across

provider sites, says Fitzler. "A second plus is that the information can be used to compare costs and outcomes in different settings. So that's a big step forward ..." Fitzler also notes that "in this age of electronic health records, we need standardization of data elements across the settings."

An Achilles' heel for rehab patients? Even though the CARE instrument has many positives, it doesn't adequately capture the extent of a rehab patient's active comorbidities, in the view of **Fran Fowle**r, managing director of **Fowler Healthcare Affiliates**, a Health Dimensions Group partner in Atlanta. And that's a problem because active comorbidities greatly influence a rehab patient's post-acute placement, says Fowler.

For example, long-term acute care hospital patients probably have between eight to 11 active comorbidities or one major system failure affecting other systems, Fowler says. For example, "the kidneys shut down in congestive heart failure or the person has a major infection." And sicker means more expensive.

How does the CARE instrument potentially affect the MDS? Fitzler says she's asked CMS, and the answer is that the agency doesn't know yet.

What is known: Currently the CARE instrument doesn't include questions to address specific assessment needs for the various post-acute sites, notes **Peter Arbuthnot**, regulatory analyst for **American HealthTech Inc.**, an MDS software developer in Jacksonville, MS. And it's not known whether nursing homes, for example, will continue to do the MDS or whether the CARE instrument will include unique sections for SNFs, home health, inpatient rehab facilities, etc., he says.

If the CARE tool is used in addition to the MDS, it could be used to prepopulate parts of the MDS for residents coming into the SNF, Fitzler predicts. "Then the staff would collect the rest of the information to complete the MDS. It might start off like that and then evolve ..."

Although CMS is looking at the CARE instrument as a way to measure patients consistently across post-acute settings, the agency won't be dictating where a patient with certain conditions has to go, the CMS official emphasizes. "As part of our analysis of the demonstration, we will look at costs in different settings and what it takes to treat patients with certain conditions."

The PAC-PRD is a demo not a done deal. "Remember," says Arbuthnot, "the MDS drives RUGs, QIs/QMs, RAPs and care planning. The OASIS drives payment in home health, as well." And "it would take an act of Congress to change those instruments and payment methods." Arbuthnot believes, however, that payment systems will have to eventually align across settings to accommodate pay-for-performance and "money follows the beneficiary" initiatives.

Others agree that CMS is moving toward looking at the bigger picture rather than segments of care for a beneficiary.

"Over time Medicare and Medicaid will look at episodes of care provided not only in the hospital but also follow-up settings," predicts **Mardy Chizek, RN, FNP, BSN, MBA, AA**S, principal of **Chizek Consulting Inc**. in Westmont, IL.