# PAY FOR PERFORMANCE: WILL HOME CARE PROVIDERS BE INCLUDED?

*Vernon Pertelle RRT MBA*

There are emerging trends that have recently drawn significant attention in healthcare that will affect home care and HME providers; one term (or trend) that has been around in the past yet didn't quite take hold in the home care and HME industry is Disease Management (DM), the other more recent term that has been introduced and discussed in the last few years is known as Pay for Performance (P4P) and includes a myriad of approaches that incorporates DM. Home care & HME Providers can't simply ignore P4P as its gaining momentum throughout the healthcare continuum. According to Laurence Wilson, director of CMS (Centers for Medicare & Medicaid Services), Chronic Care Policy Group; the payment policies for many provider types are shifting toward "quality and outcomes," and P4P methodology is an important part of that focus. CMS will be conducting a demonstration project to test a home healthcare P4P model mid year 2007 and in my opinion will ultimately include HME providers. In contrast to Part B (HME Providers), many Part A providers (or home healthcare agencies) have already begun participating in the process voluntarily to prepare for the challenges and opportunities in the future; to improve reimbursement and the management of their operations. Some may argue that the impact of P4P will not occur for years in the HME industry but that is simply not the case. As such we may see an initial emergence of P4P in home care and HME, which will eventually be a part of the payment (or reimbursement) methodology for the services provided to Medicare beneficiaries. We have actually witnessed a prelude to this fact through the development of quality standards with the competitive bidding (CB) process. The standards were developed to establish minimum requirements for organizations participating in the program and laid the groundwork to standardize the industry and require participants in CB to adhere to a minimum set of quality and financial standards. This approach lends itself well to take the effort to the next level - P4P. Case in point, when a few of my colleagues and I met with Mr. Wilson and others at CMS during early discussions regarding the quality standards for CB he actually stated to me in a side-bar conversation that the agency (CMS) was moving towards outcomes-based payment methodology to improve quality of care and reduce costs. CMS has developed many programs focused on those efforts in the last few years. One that I actually engaged in [that was abandoned by my former employer] was the CMS' Chronic Care Improvement Program (CCIP), designed to optimize both cost and outcomes for Medicare beneficiaries with diabetes, CHF, and COPD. The DM Company we considered partnering with, LifeMasters®, was eventually awarded per member per month (PMPM) fees to engage in CCIP. CCIP is designed to address chronic conditions and health problems among Medicare beneficiaries to improve health outcomes and reduce utilization of expensive resources. CMS recognizes the inherent value of home care providers and their ability to impact health and economic outcomes. They view the industry as a solution to reduce healthcare expenditures. HME providers should recognize this and begin participating in the process at the very least to demonstrate their value as well as position themselves to receive additional reimbursement for their efforts. One of the ways in which HME providers can begin the effort is by contributing data generated from their services to an independent organization that provides benchmarks and targets for performance results. An example of an organization that assists in this regard is Outcome Concept Systems (OCS). OCS compiles blinded data from various organizations. OCS recognizes the potential upside of P4P for home care, HME, as well as other care providers and provides quarterly blinded comparison reports with recommendations for improvements to assist organizations to prepare to sustain through the difficulties while seizing competitive advantages during shifts in market dynamics related to P4P. This is the first of a two-part series, to give introductory information about P4P and will focus on an overview of the terms, programs and provide fodder for discussion to convince you to participate in the P4P program to improve your outcomes, quality of care and more importantly to many, your bottom line.

*Disease Management (DM)*

According to the Disease Management Association of America (DMAA), "DM is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." DM shifts the focus of care from treatment of episodes or periods of acute exacerbation of chronic conditions (e.g. COPD) to one of prevention through evidence-based practice guidelines and patient empowerment strategies through provider education and patient

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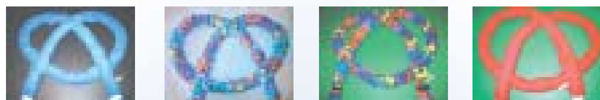

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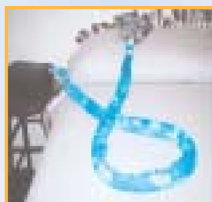

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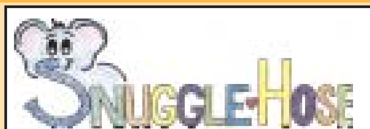


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self-assessment. DM programs do not seek to replace the care provided by physicians but actually augment their efforts through sustained monitoring, education and early identification of issues relating to the care of the patient by the home care provider before the patient requires admission to high cost acute care facilities. CMS understands the importance of DM and as such has invested millions of dollars in the effort through the CCIP pilot. The program is administered in select locations identified by CMS to have a large cohort of patients with the diseases that have been determined to be high-cost conditions (diabetes, CHF and COPD) and will test a population based model of disease management, in which participating organizations are paid a per member (or beneficiary) per month fee for managing the patients. The catch is the organizations must guarantee CMS a savings of at least 5% plus the cost of the monthly fees compared to a similar cohort of Medicare beneficiaries in other locations who are not included in the pilot. This is of course the challenge that discouraged many HME providers from participating because if the savings do not occur, the organization has to pay back the fees to CMS; the other challenge was that payment by CMS is contingent on the organization measuring and demonstrating positive health outcomes and patient satisfaction. A total of nine states were selected and in addition to LifeMasters® other companies included major insurance providers and a few DM companies. Should CCIP be successful; CMS intends to expand the program nationally. CCIP is one of many P4P initiatives that CMS has developed and implemented.

*Pay for Performance (P4P)*

CMS has developed the P4P programs to encourage quality and outcomes and to reward organizations that participate in the Medicare payment system that demonstrate good outcomes and quality with more reimbursement. Congress has essentially made up its mind to implement P4P and is merely working out the details now before passing requirements, and despite the change in the landscape with the majority (democrats versus the republican) the movement is expected to continue because it is evidence-based and proven in many demonstration projects. Examples of some of the P4P initiatives in addition to the CCIP includes but are not limited to: Hospital Quality Initiative (MMA section 501(b)); Premier Hospital Quality Incentive Demonstration; Physician Group Practice Demonstration (BIPA 2000); Medicare Care Management Performance Demonstration (MMA section 649); Medicare Health Care Quality Demonstration (MMA section 646); and Care Management For High Cost Beneficiaries. The P4P movement in home healthcare has already begun and Congress and CMS must decide on which measures they will judge - and pay - agencies based on performance. This approach to reimbursement is imminent throughout the continuum of care and is just a matter of time before the HME industry is explicitly included. P4P measures should be industry accepted, evidence-based, based on data collected with a standardized tool and risk adjusted. A P4P model can reward two categories - providers who achieve top measure scores or providers who improve their measure scores the most. While a P4P program should reward top performers, it is not designed create access problems for difficult patient populations. Should P4P occur sooner than later it is important for you to understand how it can impact your business in a positive manner.

For more on this topic and explanation on strategies and next steps, be sure to read part-2 of this review in the next edition.

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