

PAY FOR PERFORMANCE: WILL HOME CARE PROVIDERS BE INCLUDED? PART II *Vernon Pertelle RRT MBA*



Home care & HME providers have begun to feel the effects of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). There have been sweeping changes with the way businesses are run, purchases are made and the acquisition activities that were prevalent in the industry during the early 2000's have slowed considerably. The type of equipment now available to providers has allowed them to structure their deliveries for patients who require long-term oxygen therapy (LTOT) in a manner that reduces expense while continuing to meet the therapeutic needs of the patient. In addition, the traditional delivery methods for patients that require continuous positive airway pressure (CPAP) therapies in which the patient was visited by a respiratory therapist in their homes have in some degree been replaced with patients visiting a clinic location to have one-on-one instruction or in a group setting; as well as delivery via the mail with an instructional video and materials for patients to fit themselves with a mask and operate their equipment and only be visited by a respiratory therapist if they experienced difficulty with "self-set-up". Providers have yet another opportunity to repackage themselves and incorporate quality and outcomes measures to demonstrate the effectiveness of their services to prepare for pay-for-performance (P4P) reimbursement methodology. The MMA grants the Centers for Medicare & Medicaid Services (CMS) the authority to conduct pay-for-performance or P4P initiatives and demonstrations throughout the continuum of care. Home care & HME providers can't ignore CMS' statutory authority to conduct P4P

demonstrations in the industry as the mechanism is gaining speed and could become a major determining factor for Medicare payments sooner than providers think. The current reimbursement system under CMS structures payment based on the quantity of services provided, regardless of the quality of or need for the services provided. The current P4P programs as well as those that will affect home care & HME providers in the future compensate providers based on compliance with explicit and specific performance standards. The standards implemented for competitive bidding (CB) were the prelude to P4P methodology for home care & HME providers (Part B) as CMS is currently conducting several P4P demonstrations in home health care (Part A) settings and it is just a matter of timing and opportunity for the system to be implemented for Part B payment methodology. In a P4P system providers that meet or exceed performance standards established by CMS will receive bonus payments for managing the case of Medicare beneficiaries - - however keep in mind - - it is a budget neutral focus; which simply means that CMS has not budgeted additional money to support P4P, so it is highly possible that those that do not demonstrate acceptable performance are at risk for receiving less reimbursement for their services. With that in mind, it is imperative that providers establish a system to measure and document outcomes from their services to prevent further reductions that will occur due to lack of preparation for dealing with the changes imposed by P4P programs.

Some say: "P4P Methodology in the HME Industry - Anathema!"

Many providers that are aware of P4P believe that it would be premature to implement the system in the industry before improvements to the current system are made. Further, a P4P system should not be subject to budget neutrality or be used as a means of reducing patient access to services or lessening the "playing field" by forcing providers to go out of business if they don't adhere to a minimum set of quality standards or demonstrate outcomes. There is also anxiety about linking payments to performance in the absence of a health information technology infrastructure that supports a central database for HME providers to provide data and create national and regional benchmarks of performance.

Many home care & HME providers that are prepared to demonstrate the quality from their services are in favor of pay-for-performance. These organizations, which are far and few in the industry believe that shifting the focus to quality will help achieve reductions in health care costs while improving their reimbursement. Some of you are saying to yourselves: in home care & HME? You got to be kidding! It is this type of thinking that has led to a mode of reaction with the challenges the industry faces; short-sighted, reactionary and ill-prepared for change. In order to successfully change the landscape and deal directly with the challenges associated with reimbursement providers must develop programs that demonstrate outcomes, create reliable and valid performance measures and the process must be established and abided by the industry as a whole. Publicly available measures of performance have been reported by CMS for home health care since 2003. The measures can potentially be modified and incorporat-

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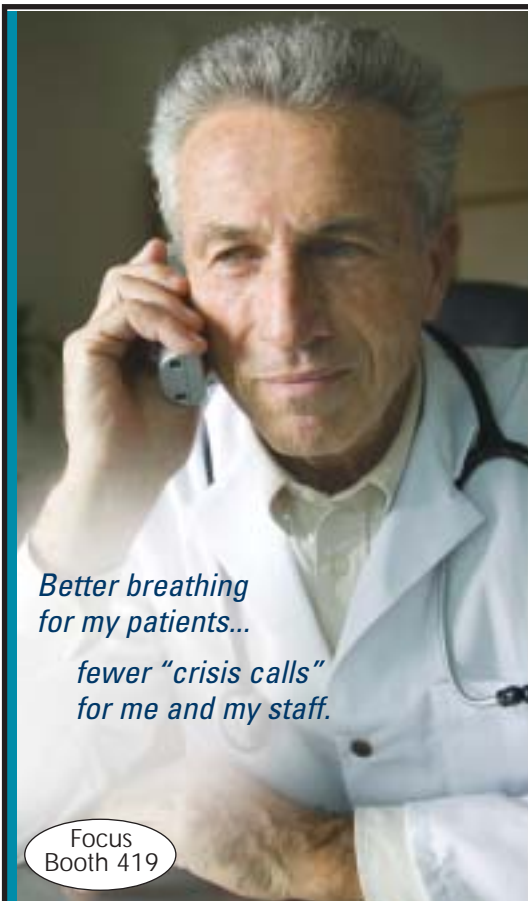
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ed in the home care & HME industry and allows the industry at the very least to implement measures currently performed in home health care relating to: (1) improvement in getting around; (2) meeting the patient's activities of daily living; (3) preventing medical emergencies (ER admissions); and (4) living at home after an episode of acute care hospitalization ends. The home health care industry with the support of the Home Care Technology Association of America (HCTAA) and the National Association for Home Care & Hospice (NAHC) successfully lobbied and influenced members of the senate and congress to introduce legislation that provides for demonstration projects for remote monitoring or telemedicine which laid the foundation for Telehealth to help them improve their performance and assist with measuring outcomes. Medicare has been enthusiastic about this concept [of Telehealth] since it helps reduce costs associated with the care of patients through monitoring that identifies the need for assessment and/or treatment of a patient before an acute episode happens requiring readmission to the hospital. This sort of technological support is ideal particularly for alternative delivery methods in home care & HME because the patient is remotely assessed during the early phases of their services to ensure compliance with therapy as well as identify improvement - - or outcomes - - from treatment. Much of the experience associated with this approach in the HME industry is with regards to CPAP compliance monitoring. In fact, during my tenure with a former employer lead to the adoption of a compliance monitoring HCPCS code along with reimbursement by Medicare for patients who are treated with CPAP. The system of compliance monitoring for patients treated with CPAP is proven and as such many manufacturers have incorporated the technology in the designs of new devices that are introduced to the market. The industry has been exploring this concept for oxygen devices to monitor patients for

years although little has been done regarding these modalities yet the opportunity to demonstrate the types of outcomes gained through Telehealth for oxygen patients would be supportive of P4P.

Congress has expressed substantial interest in exploring P4P programs. In fact, the Medicare Payment Advisory Committee has identified various "targets of opportunities," such as health plans and hospitals, physicians and home health care. Home care & HME providers are likely to be included among such "targets of opportunities" in the near future. The pilots in home health care are designed with the intended result of a value-based purchasing and reimbursement program. In particular, CMS plans to test the process in a home health care P4P model, and if successfully demonstrated would roll out the model to the entire home health care industry beginning in 2008, with value-based payments made to those home health agencies that, based upon quality measurement data, have either substantially improved the quality of care over the prior year, or exceeded a threshold of care established by CMS. This is really an imminent change in the payment system and as such is more evidence that P4P initiatives are likely to be at the forefront of policy discussions in the near future regarding the HME industry. We have just begun to feel the effects of competitive bidding and under its statutory authority CMS potentially will incorporate other locations in CB to gain additional savings.

P4P will be the next policy change that becomes commonplace in the industry and unless the industry keeps informed of these important issues it will again be caught off guard and resort to the old adage of reaction versus taking a proactive approach to prepare for P4P.

Vernon Pertelle, MBA, RRT is Senior Director/Assistant Vice President for Tri-City Home Care, Occupational Health & Wellness and Rehabilitation Services, San Diego, CA. He can be reached at vpertelle@aol.com