

The Home Health Pay-for-Performance Demonstration

Demonstration Overview and Terms & Conditions of Participation

Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
7500 Security Blvd. MS C3-24-07
Baltimore, MD 21244

Jim Coan, Project Officer

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Henry B. Goldberg, Project Director

The Policy Issue

The purpose of the demonstration is to determine the impact of offering financial incentives to Home Health Agencies (HHAs) to strive to achieve the best possible patient outcomes among their peers. The underlying question is whether the prospect of financial rewards to HHAs can affect the quality of care provided by an agency to its Medicare patients and, ultimately, reduce Medicare's overall cost of caring for beneficiaries who use home health care.

Pay for Performance (P4P)

The Centers for Medicare & Medicaid Services (CMS) has determined that Value-Based Purchasing, in which providers are rewarded on the basis of patient outcomes and efficiency, may have an important impact on improving quality and cost of care. This demonstration has been designed to determine the impact of making incentive payments to HHAs who consistently provide the highest quality of care, as well as those who demonstrate significant improvements in the quality of care they are providing to Medicare beneficiaries. This budget-neutral demonstration will assess the direct impact on quality of care provided by HHAs and the indirect impact on Medicare's overall service costs for those beneficiaries served by demonstration agencies.

The Demonstration

- Where:** Seven States covering all four U.S. Census Regions: *Midwest:* Illinois; *Northeast:* Connecticut and Massachusetts; *South:* Alabama, Georgia, and Tennessee; and *West:* California.
- Who:** All Medicare-certified HHAs in the demonstration states are eligible to participate. The demonstration sample is anticipated to include HHAs from urban and rural locations, small and large HHAs, and HHAs of proprietary, voluntary/not-for-profit, and governmental ownership.
- How:** Abt Associates Inc., a private research firm, is under contract with CMS to implement the demonstration. Another research organization, the University of Colorado Health Sciences Center, has been contracted to conduct an independent evaluation of the demonstration.

Why: To determine whether financial rewards for providing high quality services or for significant improvements in quality result in an overall increase in quality of care. To determine whether financial incentives for quality care result in a decrease of total Medicare costs for patients who use home health services.

When: Demonstration enrollment will begin on October 1, 2007. Demonstration operations will begin on January 1, 2008 and are scheduled to continue for 2 years.

Potential Benefits of Participation

There are several reasons why agencies should volunteer to participate:

- Agencies in the treatment group will have the opportunity to receive financial rewards for providing the highest quality care and/or improving their patient outcomes.
- Agencies that volunteer to participate will not experience any administrative burden from participating, as all performance assessment and cost saving calculations assessments are made using data that is already collected.
- Participation in the demonstration offers agencies the opportunity to influence home health care policy in the making and to have their agency's experiences and practice patterns considered in those decisions.
 - These decisions will need to be made in any case – they will be better decisions if they are based on the experiences of actual operating home health agencies.
- Every agency in a demonstration state has a 50 percent chance of being assigned to the treatment group, but agencies in the control group also help to ensure that an appropriate comparison is made when determining the value of a pay-for-performance program.
- All participating agencies will receive data that they might not otherwise have on patient outcomes by payment source.

Demonstration Design

Participation. Participation in the demonstration is strictly voluntary. All Medicare-certified HHAs located in one of the demonstration states are eligible to participate. Half of the agencies that volunteer will be randomly assigned to the treatment (P4P) group, while the other half of the agencies will serve as a control group and continue operations as usual. All agencies in the demonstration (both the treatment and control groups) will be reimbursed through the regular Home Health Prospective Payment System (PPS). Agencies in the treatment group will have the opportunity to receive additional payments based on assessment of their patients' outcomes relative to their peers and on the demonstration's overall impacts on total Medicare costs for patients in their region. No agency will experience reduced reimbursement due to participation in the demonstration.

Performance Assessment Population. Only Medicare Fee-for-service (FFS) home health episodes will be included in the outcomes assessment and Medicare cost savings calculations in the demonstration. Medicaid, Medicare Advantage (HMO), and private pay patients will not be included in these calculations. (However, demonstration agencies will receive reports that show patient outcomes for these populations.) As is the case for the OBQI reports and the Home Health Compare website, each year's assessment will be based on episodes that both start and end during the year.

Performance Assessment. Performance will be assessed on 7 quality measures individually:

- Incidence of Acute Care Hospitalization,
- Incidence of Any Emergent Care,
- Improvement in Ambulation / Locomotion,
- Improvement in Bathing,
- Improvement in Management of Oral Medications,
- Improvement in Status of Surgical Wounds, and
- Improvement in Transferring.

Agencies will be ranked on their patient outcomes separately in each state, and separately for the treatment and control groups. Agencies will be ranked in terms of absolute level on each measure, as well as their percentage improvement on each measure relative to the base year (the 12-month period before the start of the demonstration.). Outcomes will be measured using the same OASIS episode records used to calculate the outcomes shown on agency OBQI reports and on the Home Health Compare web site, but only the records for Medicare FFS episodes will be used. As with the Home Health Compare website, scores for each measure will be computed only for those with more than 30 episodes with that measure in the database.

Ranking Performance. Performance will be ranked on each quality measure in terms of absolute *performance* level and percentage *improvement* in performance relative to the base year. Agencies scoring in the highest 20 percent of a particular quality measure will be considered “high performers” on that quality measure and will be eligible for incentive payments.¹ Agencies potentially eligible for an *improvement* incentives are those that (a) will not receive a high performance award in that measure, (b) have a score above the 30th percentile for that measure, and (c) show a positive (i.e., non-negative) change in the measure. Eligible agencies with improvement percentages in the highest 20 percent will be eligible for incentive payments for that measure. A single agency can qualify for payments based on high performance in some measures and high improvement in other measures.

Estimating Medicare Cost Savings. Because the demonstration is budget-neutral, incentive payments to agencies qualifying for an award will be funded with total Medicare cost savings anticipated to result from improved outcomes among the treatment group beneficiaries. Medicare cost savings will be determined by region and will equal the difference between the total Medicare program costs per day for patients served by agencies in the treatment group and total Medicare program costs per day for patients served by control group agencies. The observation time period assessing patient costs will be from the first visit until 30-days after the last visit in a payment episode or series of episodes.² Total Medicare program costs will include payments for home health services, other Part A services (e.g., hospitals, SNF, rehab facilities) and Part B services (physician and DMEPOS outpatient hospital.) Payments for Medicare Part D or Medicare Advantage plans will not be included due to the lack of service-based claims. If the calculations show that the demonstration failed to generate any Medicare cost savings in a demonstration region during a particular year, there will be no incentive payments issued in that region for that year. If there are savings, 100% of the savings will be distributed among to the treatment group agencies in that region, as described below.

¹ In the case of a tie, where a number of agencies share the score that falls at the 80th percentile, all the agencies with that score will be considered “winners”, even though that means that more than 20% of the agencies are considered winners.

² In the case of patient transfers between treatment and control group agencies, adjustments to this calculation will be made to avoid double-counting.

Incentive Payments. The total calculated Medicare cost savings for each region will be divided into pools for *performance* and *improvement* payments for each of the quality measures based on the formula shown in Example 1. Seventy-five percent of the pool for each quality measure will be allocated for *performance* payments and 25 percent of each quality measure pool will be allocated for *improvement* payments. There is a larger allocation to performance payments because the demonstration places greater emphasis on high performance. Also, since the highest performing 20% and lowest performing 30% of agencies are not eligible for improvement payments, there are only half as many improvement payments to be issued.

Example 1: Allocation of Medicare Savings for a State by Quality Measure and Payment Type

Quality Measure	Performance	Improvement	Total
	Pool	Pool	
Incidence of Acute Care Hospitalization	22.5 %	7.5 %	30 %
Incidence of Any Emergent Care	15 %	5 %	20 %
Improvement in Ambulation / Locomotion	7.5 %	2.5 %	10 %
Improvement in Bathing	7.5 %	2.5 %	10 %
Improvement in Management of Oral Medications	7.5 %	2.5 %	10 %
Improvement in Status of Surgical Wounds	7.5 %	2.5 %	10 %
Improvement in Transferring	7.5 %	2.5 %	10 %
Total	75 %	25 %	100 %

The performance and improvement payment pools for each quality measure will then be divided among the agencies qualifying for a performance or improvement award for that particular quality measure. The amount allocated to each agency will be proportional to that agency's share of total Medicare patient days provided during the performance period by agencies qualifying for payments from that pool. "Medicare patient days" are the days within the observation time period used for the Medicare savings calculation (see above.) An agency can qualify for payments on each measure, and its share of the total pool for each measure will vary from measure to measure based on the level of Medicare activity of the other agencies qualifying on each individual measure. Payments will be issued by electronic funds transfer, and will not be reported as Medicare revenue on the Medicare Cost Report

Payment Schedule. Due to lags in OASIS assessment data availability, agencies will receive performance reports and notification of qualification for performance and/or improvement awards approximately 3 to 6 months after the end of the performance period. Due to the greater delays in processing of Medicare claims for the wide variety of service types used in the Medicare savings calculation, the calculation of savings and issuance of any incentive payments will not take place until approximately 9 months to 1 year after the end of each performance period. This schedule assumes that data are available from CMS on normal processing schedules; if there are delays, agencies will be notified and payments will be calculated as quickly as possible after data become available.

Administration and Monitoring. CMS has selected Abt Associates Inc. to implement the demonstration. Abt Associates will receive OASIS episode data from CMS and calculate risk-adjusted outcomes separately for Medicare fee-for-service patients for use in scoring agency performance. Abt Associates will send reports of risk-adjusted outcomes by payer type (Medicare FFS, Medicare HMO, Medicaid, Other) to all treatment group agencies at least annually, and more often if feasible. Control group agencies will receive these reports at the conclusion of the demonstration operational period only, to avoid any potential impact on their behavior during the demonstration period.

Waiver of Medicare regulations. Because there are no special procedures required of home health agencies participating in the HHP4P Demonstration, participating agencies shall continue to be subject to existing regulations, rules, and procedures pertaining to Medicare participation and reimbursement and

shall be subject to any future changes in these regulations, rules, and procedures (unless specifically waived under the Demonstration).

Demonstration Roles

Abt Associates Inc. (Implementation Contractor)

- Design the demonstration
- Recruit home health agencies representative of all auspices, sizes, and locations, implement random assignment and notify agencies of status
- Monitor demonstration operations
- Assemble performance data and Medicare claims to calculate agency performance standings, Medicare savings, and incentive payments
- Provide support and assistance to participating agencies related to demonstration operations

Home Health Agency (Participants)

- Sign Demonstration Application form, commit to two years of participation
- Continue regular completion OASIS assessments and Medicare patient claims
- Continue efforts to maximize quality of care and patient outcomes

CMS (Sponsor)

- Collaborate on demonstration design
- Collect and process data from OASIS assessments and Medicare patient claims

University of Colorado (Evaluation Contractor)

- Obtain data implementation contractor on agency performance and beneficiary service utilization.
- Solicit agency voluntary cooperation in evaluation activities
- Conduct analysis to determine impact of pay-for-performance on participating agencies, beneficiaries, and the Medicare program

For Further Information

For further information, please contact:

For General Information: www.hhp4p.info

Or, call the Home Health Pay-for-Performance Demonstration toll-free information number:
(800) 608-0829

Or fax: (617) 386-7695 [*backup fax: (617) 349-2675*]

Or email to: hhp4p@abtassociates.com

Medicare Home Health Pay for Performance Demonstration

The Centers for Medicare and Medicaid Services (CMS) with the assistance of Abt Associates has designed a Home Health Pay-for-Performance demonstration to determine the impact of incentive payments to Home Health Agencies (HHAs) for improving the quality of care of Medicare beneficiaries who receive home health services. Pay-for-performance (P4P) initiatives are a CMS priority. For purposes of this demonstration, pay-for-performance can be defined as any purchasing effort aimed at improving health care quality, outcomes or safety by rewarding improvements based on measurements of quality, efficiency and outcomes. Reductions in the need for additional, more costly care should result in overall cost savings to Medicare.

This demonstration will determine the impact of offering incentive payments to HHAs for improving the quality of care rendered to Medicare beneficiaries when such quality of care results in reduced need for additional services and reduces cost. Incentive funds will be generated from within current spending levels. Recruitment for participation in the demonstration began in October 2007 with implementation of the demonstration expected to start in January 2008 and continue through December 2009.

The demonstration will be implemented in the following States:

- Northeast: Connecticut, Massachusetts
 - Midwest: Illinois
 - South: Alabama, Georgia, Tennessee
 - West: California
- (multiple states were chosen in region where no single state could provide a sufficient sample of beneficiaries.)*

All Medicare certified home health agencies in each of the demonstration areas will be notified by letter of their opportunity to participate in the demonstration. Participation is voluntary. A packet of information including background and application materials will be provided. Of those agencies choosing to participate, a randomization process will determine which agencies will participate in the intervention or control group. Only those participating in the intervention group will be eligible for performance incentives. Agencies will not be at any financial risk or be required to collect any additional data as a result of participating in this demonstration.

An incentive pool will be generated out of savings accrued from the reduction in the use of more costly Medicare services. The pool will be shared with home health agencies that produced the highest level of patient care or produced the greatest improvement in patient care as measured by seven OASIS measures.

- Incidence of Acute Care Hospitalization
- Incidence of Any Emergent Care
- Improvement in Bathing
- Improvement in Ambulation / Locomotion
- Improvement in Transferring
- Improvement in Management of Oral Medications
- Improvement in Status of Surgical Wounds

Seventy-five percent of the incentive pool will be shared with those agencies in the top 20% of the highest level of patient care. Twenty-five percent of the incentive pool will be shared with the top 20% of those making the biggest improvements in patient care. If there are no savings, there will be no incentives.