# Perspectives on Trends within the Home Care Industry: Pay for Performance

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# Introduction

The Home Care industry is once again alive with discourse about potential changes in reimbursement. Discussions center on PPS adjustments, including changes in M0825 Anticipated Therapy, and the potential for a pay-for-performance (P4P) model of linking outcomes and payment. While we cannot be entirely certain that these projections will become realities any time soon, many experts warn that P4P may be right around the corner.

Any time that an industry experiences change, some businesses are on the leading edge and others take the time to adapt slowly. The same is true for home care—as the industry has evolved in recent years, some agencies have garnered a significant advantage through advanced preparation, while others have cautiously and slowly adapted their business. This scenario was true when the Prospective Payment System (PPS) was implemented in home care, and it will again be true if P4P becomes a reality. Therefore, there exists a significant opportunity for those agencies that prepare in advance of the implementation of P4P—an opportunity to take a quantum leap forward.

With that in mind, it is our objective in this white paper to provide agencies with information about P4P so that they can make strategic decisions about whether or not they choose to adapt business practices to proactively prepare for this potential industry development. Note that this white paper will include perspectives of proponents of a P4P in order to shed light on the arguments being used by those advocating for this model. These perspectives do not necessarily reflect OCS beliefs; rather, we wish to provide agencies with the information being actively discussed, as these main points may provide insight into the reasoning behind P4P and potential timeframes for implementation.

# What is Pay for Performance?

Pay for performance is a practice that attaches reimbursement to performance indicators such as outcomes, utilization, or process tracking measures. P4P represents a significant change in the focus of payments in health care. Just as capitation and the PPS fundamentally altered the way in which care is delivered to patients, the philosophy and mechanics around P4P are likely to impact processes, measurement, and (presumably) outcomes.

At present, most P4P programs focus on hospitals and physicians. Recently, however, there have been discussions at the federal level about applying P4P concepts to other areas of health care—including home care. Furthermore, private health plans are looking toward P4P as a means of encouraging and rewarding desired behaviors and outcomes.

Given that P4P programs are in the early stages of development, home care executives have a unique opportunity to learn about different P4P models and study related operational practices, long before home care experiences it first hand. With a firm foundation of knowledge surrounding underlying concepts, executives may be able to impact the actual design of a P4P model in home care, while preparing their organizations to succeed should P4P materialize in the near future.

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# Why Pay for Performance? Why Now?

Pay for performance concepts are largely based on the belief by some that current reimbursement methods have done little to curb health care inflation and enhance patient outcomes. Both payers and providers generally recognize that the current reimbursement system offers little reward for excellent performance—the highest performing providers receive the same payment as the providers with substandard outcomes. As a Centers for Medicare and Medicaid Services (CMS) leader recently expressed, "Nobody wants to be at the bottom of the list that says quality at the top."

The most recent impetus for today's P4P initiatives centers on a report by the Institute of Medicine (IOM) in 2001, Crossing the Quality Chasm: A New Health System for the 21st Century. In addition to highlighting fundamental problems with our nation's care for chronically ill patients, the IOM study recommended incentive payments to encourage and reward quality in the health care system. This recommendation followed the IOM's 1999 report that revealed a startling finding—medical errors are a leading cause of death in this country, ahead of breast cancer, AIDS, and motor vehicle accidents.

The IOM report focused on using payment reform (specifically P4P programs) to enhance quality in the following ways:

- Reduce clinical practice variation
- Reduce emergency room visits and unanticipated hospital admissions
- Improve the efficiency of care delivery
- Facilitate quicker and more effective coordination among providers by using new information technologies

In addition to their P4P recommendation, this same report suggested the utilization of evidence-based practice guidelines for chronically ill patients. This recommendation has been a significant contributor to growth in the disease management (DM) industry over the past several years.

Conceptually, P4P and DM are two sides of the same coin—DM trying to enhance quality through reducing clinical variation and P4P rewarding those behaviors through increased payment.

# Who Pays for Performance?

According to a PricewaterhouseCoopers report in 2004, "Pay for Performance's Small Steps of Progress," as many as a third of health plans say they have a P4P program in place, but most are in the earliest stages of development or implementation. Most P4P programs have fewer than five years of operational history. Below, we briefly summarize two examples of current private payor P4P programs, including the Bridges to Excellence program and the Integrated Healthcare Association program

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## Bridges to Excellence

A coalition of physicians, health plans, large employers, and others launched the “Bridges to Excellence” program as an effort to tie physician incentive payments to performance. Partners Community Healthcare, Inc., the Lahey Clinic, and the Cincinnati Children’s Hospital Medical Center, all among the nation’s most highly regarded medical institutions, helped to shape the initiative.

The program provides bonuses to physicians who meet established criteria in three areas: diabetes care, cardiovascular care, and patient care management. The program rewards top performing physicians with up to a 10 percent increase in salary in the form of bonuses. These physicians are also highlighted in provider directories with the goal of helping employees and their families identify doctors that either have a proven track record of outcomes for particular illnesses or whose patient care and support systems are exemplary.

## Integrated Healthcare Association (IHA)

The IHA created a P4P program that provides incentive payments to physician groups that meet performance measures developed by the National Committee for Quality Assurance (NCQA). The program judges physicians on patient satisfaction and whether their treatment met standards that define the best medical and most cost-efficient care.

This program includes a scorecard that measures success across three areas: clinical quality (50 percent), patient experience (40 percent), and investment in information technology (10 percent). The clinical quality area evaluates performance in treating three chronic conditions—asthma, diabetes, and coronary artery disease—and providing three preventive services—breast cancer screening, cervical cancer screening, and childhood immunizations. Patient satisfaction is based upon satisfaction as reported by individual patients in four areas—doctor-patient communication, quality of specialty care received, timeliness of care and service, and overall perception of quality. The information technology (IT) component measures the ability of a physician group to integrate data at the group level or provide physicians with data at the point-of-care.

## Medicare’s Pay for Performance Initiatives

In the last two years, CMS initiated two P4P programs—one that is open to all acute-care hospitals and another pilot project through the Premier Hospital Alliance. Below, we briefly summarize the programs (see suggested reading for additional reference information:)

Some 2,700 hospitals have signed up to participate in the Hospital Quality Initiative, which is truly more of a “pay-for-reporting” system. In this system, hospitals must report on 10 quality indicators to receive the full inflation update from Medicare.

The Premier Hospital Quality Incentive demonstration project provides financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care. CMS has partnered on this project with Premier, Inc., a
nation-wide organization of not-for-profit hospitals. The top performing among participating hospitals will receive bonuses based on evidence-based quality outcomes for in-patients across

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five categories—heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements.

The demonstration project's quality measures have an extensive record of validation through research. The measures were selected based on work by a consortium of agencies, including Quality Improvement Organizations (QIOs), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), the Premier system, and other CMS collaborators.

Hospitals will be scored specifically on the quality measures related to each condition included in the demonstration. CMS then will identify hospitals with the highest clinical quality performance for each of the five clinical areas listed above. Hospitals in the top 20 percent of quality for those clinical areas will be given a financial bonus for quality care. The bonus breaks down as follows: Hospitals in the top 10 percent will be paid a two percent bonus for the measured condition, while hospitals in the second 10 percent will be paid a one percent bonus. In the third year of the demonstration project, hospitals that do not achieve performance improvements above the demonstration baseline will have their payment reduced.

The Premier hospital alliance is a voluntary program involving Premier hospitals. Premier was selected because of its ability to track and report quality data for 34 quality measures across each of its more than 200 not-for-profit hospitals. This capability makes the Premier database operationally unique and enables a rapid test of the P4P concept. Participation in the demonstration is voluntary.

## What Types of Benchmarks are Used to Measure Providers?

As discussed earlier, P4P is a model that is inherently designed to change behavior—many believe that it will have the desired effect. Just as DRGs and capitation arguably increased efficiency, P4P is anticipated to steer providers toward higher clinical quality.

As payers develop these systems, however, they must be careful that their programs are not debilitated by unanticipated consequences. Incentive programs—whether in health care or more broadly in employee bonuses or sales commission structures—can often have unintended results as participants gain an understanding of the system and fine-tune the specific behaviors necessary to achieve the goal. As an example, it is key for P4P programs to ensure that there is not a built-in incentive to “cherry-pick” patients, thereby reducing access to care for those in need. Ways to avoid this specific problem include clearly stratifying patient groups, incorporating risk adjustment where appropriate, and limiting both measurements and incentive payments to a specific subset of patients.
Thus, the industry must carefully think through the benchmarks being used as a P4P foundation to ensure maximum success.
To measure provider performance, many health plans are collaborating with employers and providers to develop a system that includes measures that are well known and

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accepted by the provider community. Most plans that include a hospital bonus program use measures from Leapfrog, NQF, JCAHO, and/or CMS.

Furthermore, multiple measures might be utilized in a “balanced scorecard” approach. For a balance scorecard to be effective, it must include measures that are appropriate to the specific condition and patient population, while simultaneously weighing those measures based on how central they are to high quality care for that specific condition and population. For example, two reporting conditions within a P4P program may have unique combinations of measures of clinical process, patient satisfaction, and technology adoption, depending on which are most important to each specific condition. In addition, the reporting for one condition may put more weight or emphasis on measures than the other condition.

## Pay for Performance throughout the Continuum

Hospitals and physicians are not the only targets of CMS P4P programs; there has been significant discussion on the federal level regarding P4P across the continuum of care. In a September 2004 meeting, the Medicare Payment Advisory Commission (MedPAC) discussed their criteria for implementing P4P programs in general.

According to MedPAC, measures considered useful in a home care P4P program would need to meet the following criteria:

- Evidence-based
- Standardized mechanisms for data collection
- Adequate risk adjustment
- Measures that providers can impact and improve upon

Measures discussed and debated for home care have included:

- OBQI (Outcome Based Quality Improvement): Measures based on information gathered in the OASIS data set. These measures focus on stabilization and improvement in key functional areas, for example, patient ambulation or bathing.
- OBQM (Outcome Based Quality Monitoring): Measures based on information gathered in the OASIS data set. They focus on declining outcomes and/or adverse events, for example, emergency room visits for wound deterioration.
- ACOVE Measures (Assessing Care for Vulnerable Elders): Measures were recently developed by the RAND Corporation and are not universally collected, although some believe they may be better measures to determine patient status than OASIS-based measures.
- Patient experience measures: Measures related to patient satisfaction. Although many believe they are important measures, there is not yet a standardized tool or data set to assess patient experience.
- Given the need for standardized, generally accepted measures with adequate risk

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adjustment, many believe that OASIS-based measures—OBQI and OBQM—will form the foundation of a P4P model in home care as they most closely meet MedPAC's measurement criteria:

- Evidence-based: There has been extensive work around the validity of the OASIS and its resultant outcome measurement tools. While not universally agreed upon as the best method of measuring outcomes, the tool is widely accepted and has been adopted as a measurement tool by many, including CMS and JCAHO.
- Standardized data collection: All Medicare certified home health agencies (HHAs) are required to collect this information for their Medicare and Medicaid patients using a standardized data set.
- Adequate risk adjustment: A risk adjustment methodology currently exists for several OASIS OBQI measures. While the method is being consistently refined, and many argue that it does not fully adjust for patient difference, it is being actively used in CMS reporting via OBQI Reports and Home Health Compare (HHC).
- Measures that providers can impact: Both OBQI and OBQM data are integral parts of home care agency performance improvement (PI) plans. CMS encourages PI efforts grounded in the data reflected in OBQI Reports, with the goal of impacting outcomes accordingly. Many providers have observed changes in OBQI data as a result of their PI work.

A recent December 9, 2004 MedPAC meeting further validated plans to leverage the current outcome data infrastructure to implement a P4P model in home health. In that discussion, MedPAC officially recommended that "…the Congress should establish a quality incentive payment policy for home health agencies in Medicare."

MedPAC's recommendation was based upon the notion that P4P will align Medicare payments more directly with quality, the product that Medicare is trying to purchase from Home Health Agencies. The transcript states, "Rather than paying for visits or episodes, pay for performance in home health would allow Medicare to attach some of its dollars directly to purchasing better outcomes for patients who are cared for under this benefit."

## Considerations in Designing a Pay for Performance System—Payment

Pay for performance is an emerging, though not necessarily new, concept in health care. Thus, there exist a wide variety of perspectives on both the concept of "pay" and of "performance."

First, let's consider "payment." Providers commonly believe that more payment is needed to improve performance. This is based on an the underlying belief by many that our overall delivery system is under funded, at least in terms of payments to providers. Meanwhile, some payers and regulators believe that performance needs to be improved

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to justify the current payment level. People of this school of thought believe that providers are already being overpaid for the current quality of care, and any additional money must come from redistributing current dollars from the poor performers to the better ones.

Then there is the consideration of bonuses and withholds. A difficult question that must be answered in developing P4P programs—should excellent performance be rewarded by bonuses, or should withholding payment punish poor performance? There is also a debate about whether bonuses should be offered for providing the commonly held standard of good care, or if it is better to raise the bar and pay more for excellence.

Bonuses tend to be more popular among providers, due to the ease of administration and the notion that money will not be "taken away" (relating back to different beliefs about the adequacy of current payment levels). In most current programs, bonuses are paid out annually, but in some cases they are more frequent. Generally providers are rewarded for success in one condition; however, in some instances bonuses are provided for success in specific areas, such as outcomes or IT implementation.

Contrary to the provider opinion, payers must consider that bonus systems devoid of withholds require an influx of "new money" into the system. Payers therefore are left determining whether the higher level of quality justifies a long-term return on investment.

Withholds mean lower payments for providers who do not meet the agreed-upon standard. Withholds tend to be more acceptable to payers because there is no need to find "new money," but much less popular with providers who argue about the appropriateness and objectivity of the performance measures.

Regardless of the availability of new money, and the issues of carrots versus sticks, according to PricewaterhouseCoopers, "Most plans feel it is necessary to offer an incentive program that will add up to at least 10 percent earning potential to providers to gain the behavioral results desired." This concept may be tested in the Premier Hospital Program mentioned previously since the increase in DRG payments for excellence is considerably less than the 10 percent recommended by PricewaterhouseCoopers.

## Considerations in Designing a Pay for Performance System—Performance

Defining performance is an even more complex task than addressing payment. There are several issues related to performance that require agreement between the parties being measured and the parties doing the measuring. Three considerations include using outcome versus process measures, using absolute versus relative measures, and defining the appropriate patient groups.

### Process vs. Outcome Measures

One must consider the goal of measurement. If given the choice between a better outcome and a better process, a patient would probably choose a better outcome. Clinical outcomes, however,

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are not always within the control of the providers; rather, they are often the result of a number of factors, including diagnoses, disease process, patient age, living situation, economic factors, and many more patient and environmental factors. Therefore, providers often champion the notion of process measures.
Processes are more often within the providers' control. But there is a different level of commitment to process measures. By embracing process measures as a P4P construct, there is an underlying assumption that the identified processes are the optimal means to achieve the desired outcome(s).

Some of the process versus outcome debate is related to the fact that within the larger health care system, there are few actual outcome measures routinely collected and available while process measures are far more available. In home health care, this is reversed. With data from the OASIS, there is a standardized tool that measures outcomes of a significant segment of the patient population—adult Medicare and Medicaid patients. In addition, there is a risk adjustment methodology that could be used to adjust those outcomes. Commonly accepted process measures, however, are not as easily available in home health care.

### Absolute vs. Relative Measures

Absolute and relative measures are analogous to grading methodologies: The traditional 100-point grade scale versus a bell curve.

Proponents of relative measures (the bell curve) use comparative information as the basis of recognizing and rewarding organizations providing the "best" care. The definition of "best" is always relative to other providers—as competition increases, organizations will continuously strive to improve scores, and the curve will adjust accordingly.

Meanwhile, some believe that overall system-wide improvements will result from everyone treating patients in the same manner, and therefore all providers should meet a minimum standard. From this "absolute measure" perspective (the 100-point grade scale), incentives should be aligned to provide all patients a minimum acceptable standard of care with the hopes that by forcing the lower performing organizations to rise to the standards, the overall level of care is improved.

### Patient Groupings

Regardless of the issues noted above, most P4P programs apply bonuses or withholds to specific subsets of patients. The reasoning is simple—tie bonuses to outcomes and/or processes that are meaningful and relevant for certain kinds of patients. Patient subset groups tend to include chronic diseases (such as, diabetes, heart failure, and COPD) and high volume diagnoses (such as, hip replacements, and community acquired pneumonia).

## What Steps Can a Home Care Agency Take to Prepare for Pay for Performance?

Because P4P is still a relatively new concept in home care, some agencies question whether

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it will ever become a reality in the home care market and are hesitant to invest resources in preparatory activities. But forward thinking organizations, in addition to industry experts, recognize P4P as a practice that has a very high likelihood of being implemented in home care. Further, these companies see the opportunity in P4P programs, and they are identifying ways to prepare their organizations for success within a P4P environment, while simultaneously having a positive impact on care today.
In a 2004 survey of national thought leaders and home care corporate executives, OCS learned that the majority of leaders surveyed felt that P4P would be a reality within the next two years. Additionally, most respondents believed that P4P would ultimately be positive for the industry.

Regardless of an agency's perspective and position on the issue, agency management has the ability now to engage in several activities that will prepare their organization in advance of P4P's potential arrival. Below, we offer a few suggestions:

1. Educate yourself and your management team about P4P trends. Make it a goal to understand both current and proposed P4P programs and projects, both within the home care marketplace as well as outside of the traditional boundaries of home care. By understanding the market, your organization can determine how to identify and/or create opportunities. An example—the Premier Hospital Improvement Program was a direct result of Premier approaching CMS with a proposal for the program. Premier was not only able to create their own opportunity where none had existed before, but they were also uniquely position to help shape the program.

2. Know and understand your relative performance for specific diseases and conditions. In an effort to optimize the outcomes for which your agency may be paid, it is essential to understand your organizations' outcomes for specific diagnoses. It is not enough to understand your organization's overall performance, as these numbers may be masking opportunities or problems inherent in the data. For example, an organization with better than average hospital admission rates might have excellent rates associated with orthopedic patients, but poor rates associated with CHF patients. While the overall rates seem good, if the agency were to participate with a CHF P4P program, its leaders might be unpleasantly surprised by performance for this subset of patients. A thorough examination of key subsets of patients in comparison to benchmarks for similar patients is critical to preparing for success in a P4P environment.

3. Objectively measure and understand the efficacy of various interventions on specific conditions. In an effort to improve outcomes for chronic conditions, many agencies are considering implementing telemedicine, clinical pathways, care plans, or specialty programs. While these can all be excellent tools, it is critical that agency management clearly understands whether or not these tools actually achieve the desired results. For example, if the goal of your telemedicine program is to reduce hospitalizations in your CHF population, it is important to measure whether or not telemonitored CHF patients experience reduced hospitalizations. Likewise, if your clinical pathway is designed to reduce the number of visits and increase outcomes in medication management for your diabetic patients, it is important to determine if those goals have been achieved. Comparisons between patients with the intervention to similar patients in your agency and externally can be excellent tools in determining the best approach to your patient care.

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4. Understand your local market. Local market factors can be a significant factor in agency strategy. Discover whether there are P4P programs in the local market and determine what is happening at the state level. These activities may help agency management devise market specific strategies.

5. Challenge assumptions. Many home care executives doubt whether P4P will become an issue for the home care market. Given the history and trends in the industry, this is a reasonable viewpoint. Rather than view P4P as something potentially negative for the industry (that will never happen), consider how your organization could benefit in a P4P scenario. If there is an opportunity, perhaps a reasonable strategy may be to approach local payers to encourage them to incorporate P4P in their home care reimbursement. This could potentially provide agencies with significantly enhanced reimbursement.

6. Develop and implement a plan. This last step seems self-evident, but too often organizations do not actually take the step of clearly deciding on their strategy, defining the necessary steps to achieve it, and then executing on those plans. It may be that the strategy is to stay out of the P4P market. If so, that's fine, but it should be a strategy based on a thoughtful examination of the market and analysis of agency capabilities, goals, and opportunities. If the strategy is to take advantage of the P4P buzz, now is the time.

## Conclusion

Pay for performance is a concept that has recently received significant attention from payers, legislators, employers, and providers. Because CMS has indicated an interest in applying P4P concepts across the continuum of care, it has significant implications for the home care industry. This creates an opportunity for forward-thinking home care agencies to help define P4P practices and standards in their market and potentially enable them to take advantage of the changing landscape and secure an early and strong hold on the market. The key is to understand P4P concepts, agency strengths and weaknesses, and apply thoughtful leadership and planning to the opportunity.

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