The Home Health Pay-for-Performance Demonstration

Demonstration Overview and
Terms & Conditions of Participation

Centers for Medicare & Medicaid Services
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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 then 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.

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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 Pool	Improvement Pool	Total
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).

The Enrollment Process

Enrollment in the Home Health Pay-for-Performance demonstration is now underway. Abt Associates is contacting every Medicare-certified home health agency in the demonstration states and providing information about the project through mailings, press releases, and contacts through state associations. Interested providers are asked to complete the simple *Demonstration Application* and sign it to certify that the agency agrees to participate in the demonstration for two years regardless of random assignment to the treatment or control group. Agencies that choose to participate will be informed of their assigned group before the demonstration begins. During the demonstration period, agencies are not required to complete any additional tasks. All data is collected from regularly submitted OASIS assessments and patient claims. Agencies may be approached by the Evaluation contractor at a later date and requested to participate in activities such as site visits or telephone interviews, but these will be voluntary.

Agencies may enroll at any time before November 30 by completing, and returning the original, signed Demonstration Application Form:

- By mail to: **Home Health P4P Demonstration**
  Abt Associates Inc. - Attn. Candis Joseph
  55 Wheeler St.
  Cambridge, MA 02138
- By fax to: **(617) 386-7695**
  (backup fax: (617) 349-2675)
  (with hard copy signed original to address above)
- By emailing an electronic copy to: **<hhp4p@abtassociates.com>**
  (with hard copy signed original to address above)

All submissions will be acknowledged. An agency will not be considered enrolled until the hard copy, original signed, Demonstration Application has been received.

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

Answers to Some Questions About the HHP4P Demonstration

What is the authority used for conducting the demonstration?

This demonstration will be conducted in accordance with the Secretary's demonstration authority under section 402(a)1)(A) of the Social Security Amendments of 1967,42 U.S.C. 1395b-1(a)(1)(A):

"(I) The Secretary of Health and Human Services is authorized, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services.

How will home health agencies be selected to participate in the demonstration?

Participation in the demonstration is strictly voluntary. All Medicare-certified home health agencies in the 7 demonstration states (Alabama, California, Connecticut, Georgia, Illinois, Massachusetts, and Tennessee) are eligible to participate. The implementation contractor will stratify volunteers by agency size, urban/rural location, and profit/non-profit status before random assignment to treatment and control groups to ensure even representation within each category. Agencies that are members of chains will be assigned independently.

What will be required of participating home health agencies?

Once agencies enroll in the demonstration, no further requirements need to be completed by agencies for participation in the demonstration. Agencies will be informed whether they were randomly assigned to the treatment or control group before the demonstration begins. Performance will be monitored via OASIS assessments that agencies already submit to the state repositories, and Medicare cost savings will be calculated from Medicare claims files at CMS.

What will happen to agencies that are assigned to the Control group?

Agencies assigned to the control group will operate exactly as they would in the absence of the demonstration. Agencies will receive reports by payer on their performance on the demonstration measures at the conclusion of the demonstration, but will not be eligible to receive any incentive

payments. Home health payments to agencies in the control group will occur through the Medicare Home Health payment system, exactly the same as in the absence of the demonstration.

How will agencies assigned to the Treatment group be paid?

Agencies assigned the treatment group will be reimbursed for Medicare home health services through the Home Health PPS, exactly the same as in the absence of the demonstration. However, agencies in the treatment group will be eligible to receive incentive payments that are supplemental to reimbursement through the Home Health PPS. These payments will be issued to agencies who qualify by electronic funds transfer. Agencies will be notified whether or not they qualified for an incentive payment for each year of the demonstration 3 to 6 months after the end of the demonstration year and will receive the payment 9 to 12 months after the end of the demonstration year.

How will the size of incentive payments be calculated?

The calculation of the size of an incentive payment for an individual agency is:

[Total Medicare cost savings for region] x
[Quality Measure Performance / Improvement Pool Fraction from Example 1] x
[Number of patient days served by individual agency] /
[Number of patient days served by all agencies receiving the same Incentive payment]

Also, see "Sample Calculations" below.

Can we appeal the performance ranking or the payment calculation?

Because the performance ranking and incentive payment calculations do not involve the regional home health intermediaries, neither intermediary hearings nor administrative review are available on these calculations. However, the Office of Research, Development and Information (ORDI) at CMS will consider requests to review decisions on these issues where the amount in dispute is $10,000 or more. In such cases, the decision of ORDI shall be final.

Will I know which quality measure I received payment for and whether it was for high performance or greatest improvement?

Yes. Although incentive payments will be made to agencies in one lump sum for each year of the demonstration, participants will also receive a summary of the calculation showing how payment amounts are determined, including which measure payment was based on and whether payment was received for high performance or improvement.

Will patients covered through Medicare Advantage or Medicaid only be included in the demonstration?

No, only Medicare Fee-for-service beneficiaries will be included in the demonstration, for both the quality assessment and the Medicare cost savings calculation.

How will Medicare savings be calculated in the demonstration?

Medicare cost savings will be calculated by comparing total Medicare costs (for Part A and Part B services) for patients receiving home health care from an agency in the treatment group with patients receiving treatment from an agency in the control group and the rate of change relative to the base year (12 months before the demonstration). Medicare cost savings will be calculated at the region level.

Will participating Home Health Agencies have access to data during the demonstration period?

All agencies have access to agency level statistics for all quality measures used in the demonstration on a quarterly through existing OBQI reports. Data on demonstration agency performance and rankings will be produced at least once a year, for the purposes of calculating incentive payments. If possible (depending on data availability), interim reports will be generated and distributed during the year.

Will the quality measures be risk adjusted?

All quality measures used in the demonstration will be risk adjusted using existing models under OBQI.

Can an enrolled agency drop out of the demonstration?

Since the demonstration does not require any specific activities by participating agencies, it is not anticipated that agencies would have any reason to disenroll. It is anticipated that agencies in the treatment group will show varying degrees of response to the P4P incentives, just as would be anticipated under an ongoing P4P program.

Sample Calculations

Medicare Cost Savings Pool Calculation

The following calculation is for one region for year 1 of the demonstration. To calculate the Medicare cost savings due to the demonstration, we first calculate the change in Medicare costs during year 1 for the Control group (Row 3) and the Treatment group (Row 6). The Control group value is the "expected" rate of increase, and any difference between that rate and the Treatment group rate is considered to show the impact of the demonstration.

We calculate the difference between the change in actual Medicare costs per day for the Treatment and Control groups (Row 7). Next we calculate the actual Medicare cost savings per day due to the demonstration (Row 8) by multiplying the difference in the percentage change in Medicare costs per day (Row 7) by the baseline Medicare costs per day for the Treatment Group (Row 4).

Finally, the Total Medicare cost savings for the state (Row 10) is calculated by multiplying the Medicare cost savings per day (Row 8) by the total number of patient days served by the Treatment group in year 1 (Row 9). The Total Medicare costs savings for the state is the pool of money used to make the incentive payments.

Example 2: Medicare Cost Savings Pool Calculation for a State

1	CONTROL GROUP: Actual Medicare costs per day – baseline	$100
2	CONTROL GROUP: Actual Medicare costs per day – Demo Year 1	$110
3	CONTROL GROUP: Change in Actual Medicare costs per day	+10%
4	TREATMENT GROUP: Actual Medicare costs per day – baseline	$100
5	TREATMENT GROUP:| Actual Medicare costs per day – Demo Year 1	$105
6	TREATMENT GROUP: Change in Actual Medicare costs per day	+5%
7	DIFFERENCE: TREATMENT – CONTROL = Medicare Savings per day	-5%
8	**Medicare Savings per day, TREATMENT Group**	**$5.00**
9	Medicare days in observation period for TREATMENT Group	200,000
10	**Total Medicare Savings = Medicare Savings per day * Number of Days**	**$1,000,000**

Incentive Payment Calculation

The Medicare cost savings pool will be used to fund the incentive payments to qualifying agencies. The Medicare cost savings pool will be divided up according to Example 1, with 30 percent of the pool going for 'Incidence of Acute Care Hospitalization', 20 percent for 'Incidence of Any Emergent Care', and 10 percent for the other measures. For each of the 7 pools for each quality measure, 75 percent of the pool will go toward high performance incentive payments and 25 percent of the pool will go toward high improvement incentive payments.

If the Medicare cost savings pool is $1,000,000 (as in the example above), the individual pools will be as follows:

Example 3: Incentive Payment Pool Calculation

Quality Measure	Performance Pool (75%)	Improvement Pool (25%)	Total
Incidence of Acute Care Hospitalization	$225,000	$75,000	**$300,000**
Incidence of Any Emergent Care	$150,000	$50,000	**$200,000**
Improvement in Ambulation / Locomotion	$75,000	$25,000	**$100,000**
Improvement in Bathing	$75,000	$25,000	**$100,000**
Improvement in Management of Oral Medications	$75,000	$25,000	**$100,000**
Improvement in Status of Surgical Wounds	$75,000	$25,000	**$100,000**
Improvement in Transferring	$75,000	$25,000	**$100,000**
Total	**$750,000**	**$250,000**	**$1,000,000**

Each agency that qualifies for an incentive payment will receive a fraction of the appropriate pool listed above. The fraction is determined by the proportion of that agency's Medicare patient days to the total provided by all qualifying agencies. (Agencies that created savings for more patients will receive a greater reward.) To calculate the incentive payment for an individual agency, multiply the appropriate pool from Example 3 by:

$$\frac{\text{[number of Medicare patient days per individual agency]}}{\text{[number of patient days by all qualifying agencies]}}$$

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