The newest “new” thing in the Washington health policy community is “pay for performance.” Everywhere you go, someone is touting their latest idea for how enhanced performance measures can be injected into the health system. The annual report of the influential Medicare Payment Advisory Commission (MedPAC) is brimming with suggestions on how providers might be rewarded for holding down costs and improving quality through performance measures.

Congress has recently authorized a series of demonstration projects to give medical group practices the opportunity to share in savings from averted Medicare expenditures. Health and Human Services Secretary Mike Leavitt and Centers for Medicare, and Medicaid Services Administrator Mark McClellan, are actively soliciting suggestions for expanding this trend.

Interestingly, there has not been much talk about the powerful role home care agencies can play to reduce physician and hospital expenditures. The technology and service delivery models exist. However, the financial incentives are not appropriately aligned. Medicare does not have any mechanism to pay home health agencies to use remote monitoring technologies to improve care, and avert the hospitalization of non-home care patient. Many home care agencies are convinced they can reduce physician and hospital costs with these new tools and delivery models, they just can’t get paid for it.

In April, NAHC CEO and President, Val J. Halamandaris, announced the creation of the Home Care Technology Association of America (HCTAA). HCTAA was formed to highlight public awareness about the important role that technology plays in improving the quality of care and quality of life for patients in their home.

HCTAA’s Board discussed the current trend towards incentivizing physicians and hospitals in pay-for-performance pilot or demonstration projects. The Board believes that there is sufficient data about the types of conditions, e.g., congestive heart failure, diabetes, that would be conducive to an incentive plan involving home health agencies. There also appear to be agencies and technology companies that would be willing to participate in such a risk sharing model.

The overall goal of pay-for-performance (P4P) initiatives are collaborative efforts among providers, stakeholders, and payers that reward or incentivize providers who can demonstrate real improvements in quality by creating a compelling set of incentives that will drive breakthrough improvements in the quality of health care and the patient experience. Quality improvement can be incentivized and tracked in clinical areas, around patient satisfaction, and for information technology investment.

P4P is getting widespread attention from public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the U.S. Congress, the Secretary of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Agency for Health Care Research and Quality (AHRQ), National Quality Forum (NQF), Joint Commission of the Accreditation of Health Care Organizations (JCAHO), National Committee for Quality Assurance (NCQA), American Medical Association (AMA) along with a variety of business groups, including: Aetna U.S. Healthcare, American College of Medical Quality, Bailit Health Purchasing, Central Florida Health Care Coalition, Empire Blue Cross, General Motors, HealthCare 21 Business Coalition, Integrated Healthcare Association, Leapfrog Group, and the Pacific Business Group on Health.

Chronic care is an area that has been targeted and is particularly appropriate for the home care community. For example, as part of the Medicare Modernization Act, CMS was directed to create a Chronic Care Improvement Pilot (CCIP)
program, which was to test a population-based model of disease management, whereby the participating organizations are paid a monthly per beneficiary fee for managing a population of chronically ill beneficiaries with advanced congestive heart failure and/or complex diabetes (MMA §721). These organizations, which include disease management vendors and larger organizations such as insurance companies, must guarantee CMS a savings of at least 5% plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment of fees is also contingent upon performance on quality measures and satisfaction of both beneficiaries and providers.

HCTAA believes that a case can be made to HHS Secretary Leavitt and CMS Administrator McClellan that home care agencies would be willing to negotiate pilot remote monitoring projects in a variety of geographic areas. Incentive payments could be provided to home care agencies based on savings associated with reduced Part A and B physician and hospital expenditures. These payments would not affect the reimbursement provided to home health agencies for traditional home care services. They would be focused on reducing non-home care costs. Nor would the pilots be limited to Medicare beneficiaries currently receiving home care services. Some of the greatest opportunities for savings may be tied to serving Medicare beneficiaries who have chronic health conditions, but do not qualify for home care.

You can help HCTAA promote this initiative by sending your letter of support for a remote monitoring pilot P4P project to hctaa@gcd.com. HCTAA will continue to pursue the manner in which a pilot project would be best received in the home care community, by Congress, and by the Administration. Once an agreement has been reached, HCTAA will draft and promote this legislation. At that point, your efforts at asking Members of Congress to support the legislation and actively working for its passage will be crucial. For more information about the Home Care Technology Association of America, please contact us at (202) 230 - 5103 or via email at hctaa@gcd.com.

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