

The Independence at Home Act (H.R. 2560, S. 1131)

Frequently Asked Questions

Q: What is the Independence at Home Act?

A: The Independence at Home (IAH) Act creates a Medicare pilot project that brings coordinated, home-based primary care to Medicare beneficiaries with multiple chronic conditions. Through the model proposed in the bill, beneficiaries will receive primary care services and care coordination in their own homes by experienced, qualified professionals who are held accountable for improving care and reducing costs.

Q: What patient population will benefit from the IAH model?

A: The Independence at Home program benefits an especially vulnerable and high-cost Medicare population – beneficiaries with multiple chronic conditions and a functional impairment. The program is voluntary and participants may leave the program or switch to a different program at any time.

To participate in IAH, eligible Medicare beneficiaries must:

- Have two or more chronic conditions, including: congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, peripheral arterial disease, stroke, Alzheimer’s disease and other dementias, pressure ulcers, hypertension, neurodegenerative diseases (such as ALS, multiple sclerosis, and Parkinson’s disease), or other conditions specified by the secretary;
- Be unable to perform two or more activities of daily living, such as bathing, dressing, grooming, transferring, feeding, or toileting; and
- Have utilized certain Medicare Part A services within the past year, such as inpatient hospital, emergency room, skilled nursing, or rehabilitation services.

This particular population was targeted because Medicare beneficiaries with multiple chronic conditions account for a highly disproportionate share of Medicare spending and comprise the majority of all hospital admissions, prescriptions filled, and physician visits. However, they often receive disjointed care, including conflicting information and multiple diagnoses for the same symptoms. These patients are especially costly to Medicare because of poorly coordinated care, duplicative tests, unnecessary services, and preventable hospitalizations. The Independence at Home program seeks to provide this especially vulnerable population with better, coordinated care to improve their health outcomes and lower costs to Medicare.

Q: What type of health care provider or practitioner can participate in Independence at Home?

A: An IAH organization can be owned and operated by physicians, nurse practitioners, hospitals, home health agencies, or other providers that receive payments under Medicare.

Within participating organizations, care providers will form teams to meet the needs of individual patients. Each beneficiary will have an IAH Care Team composed of licensed health professionals including:

- An IAH Physician or IAH Nurse Practitioner, qualified as such by certification in geriatric care or experience in home care.
- An IAH Coordinator, who is a licensed health professional charged with overseeing and coordinating the patient's care.
- Other licensed health professionals to meet the patients particular needs, including, but not limited to, physicians, nurse practitioners, registered nurses, clinical nurse specialists, physician assistants, and pharmacists.

To participate, an IAH organization must enter into agreement with the Secretary of Health and Human Services to provide primary care, home health, and care coordination services to eligible beneficiaries. If the organization can not provide a service directly, they are responsible for providing that service to beneficiaries through a licensed health professional.

Participating organizations will be held accountable for improving patient outcomes, beneficiary and caregiver satisfaction, and demonstrating at least a 5% savings to Medicare. As an incentive, providers may keep 80% of the savings they achieve beyond the required 5%.

Q: How are providers compensated for services provided?

A: Each IAH organization will negotiate payment rates with the Secretary for IAH assessments and a per-beneficiary, per-month care coordination fee. Members of the IAH organization will continue to bill Medicare Part B for services provided.

At the end of each year, each IAH organization will be responsible for demonstrating at least a 5% savings to Medicare. This calculation will be based on a model developed prior to the pilot project, to be updated yearly, comparing the actual, total costs of caring for IAH beneficiaries with the predicted costs of the same population had they not participated in the Independence at Home model. Organizations that do not achieve at least 5% savings will be responsible for reimbursing Medicare for the shortfall.

Organizations that achieve greater than the required 5% savings will receive an incentive payment of 80% of the additional savings with the remainder retained by

Medicare. If the pilot project continues into phase II after 3 years, the incentive payment share will be adjusted to 50% only for savings achieved in excess of 25%.

Q: What is the IAH model based on? Are there similar programs in operation already?

A: The IAH model is based on the highly successful Home Based Primary Care program that has been operating for more than 30 years by the Veteran's Administration in 130 locations in 48 states with 17,000 patients. This program has demonstrated a 62% reduction in hospital days, an 88% reduction in nursing home days, and a 24% reduction in total costs. The VA's program has received a patient satisfaction rating of 83%, which is the highest satisfaction rating ever received by a VA health care program.

In addition, there are several examples of successful house calls programs across the country that have demonstrated reduced hospitalizations and lower costs through coordinated care and home-based primary care for patients with multiple chronic diseases.

Q: How will IAH reduce costs?

A: By coordinating care of the most costly Medicare beneficiaries, the Independence at Home model will reduce duplicative tests, overuse of prescription drugs and unnecessary services while preventing costly hospitalizations, nursing home admissions, and emergency room visits. The IAH model will provide participating patients with services such as medication monitoring, coordination of treatment, education, and counseling, which will help patients better manage their conditions and reduce overutilization of services.

Based on the experiences of many successful house calls programs around the country, there is very high potential for savings with the Independence at Home model.

Q: How is Independence at Home different from existing Medicare programs?

A: What makes IAH unique is that it: (1) targets the highest-cost population of Medicare beneficiaries - those with multiple chronic conditions who need help with at least two ADLs; (2) brings primary care to these patients in their homes; (3) involves care coordination to improve the quality of care and reduce costs through fewer hospitalizations and more effective, streamlined use of medications, etc.; and (4) holds providers accountable for a minimum savings of 5% in treating this beneficiary population compared to the Medicare costs that would otherwise have been incurred without IAH.

Q: How is IAH different from the Medical Home demonstration project?

A: IAH targets a specific patient population – Medicare beneficiaries with multiple chronic conditions – who comprise a majority of Medicare spending but represent a small segment of the Medicare population. On the other hand, the Medical Home is geared towards a much broader population such that a majority of Medicare beneficiaries likely can qualify.

IAH focuses on bringing primary care to the patient’s actual home or residence, whereas the Medical Home centers on delivering services at the physician’s own office. Additionally, IAH is a team-based approach, utilizing nurse practitioners and physician assistants to better meet the needs of beneficiaries. The Medical Home model only focuses on the physician’s role, while the IAH model focuses on the patient’s needs.

IAH requires a minimum 5% savings to Medicare, while Medical Home has no savings requirement. In addition, IAH provides incentives for savings achieved above the required 5%, which encourages organizations to coordinate care and utilize technologies that benefit the patient and the provider.

Q: How is IAH different from the Home Health benefit?

A: IAH targets a specific, high cost patient population – Medicare beneficiaries with multiple chronic conditions who need help with at least 2 ADLs, while the Home Health benefit serves only homebound patients. While there may be some overlap in populations served, IAH specifically targets the most costly population in Medicare, and therefore is expected to produce significant savings.

IAH provides beneficiaries with primary care services and care coordination, as well as with other services as needed, in all treatments settings. On the other hand, the Home Health benefit provides mainly nursing and therapy services only in the patient’s home.

IAH also requires a minimum 5% savings to Medicare, while Home Health has no savings requirement.

IAH is designed to reduce duplicative and unnecessary tests and prevent overutilization of services. On the other hand, the Home Health benefit is reimbursed based on volume of services, so providers are rewarded for the quantity, not quality, of care.

Nevertheless, Home Health providers are eligible to own and operate IAH organizations if they meet the requirements outlined in the bill. IAH organizations, through a physician, may also order home health services for their patients, as needed.

Q: How is IAH different from the hospice benefit?

A: IAH beneficiaries have multiple, debilitating chronic conditions and are severely ill, but may have several years left to live. Medicare's hospice benefit is limited to patients with a diagnosis indicating they likely have less than 6 months to live. Thus, hospice emphasizes palliative care, while the IAH model focuses on early intervention to avoid more acute care settings (e.g., emergency room, hospital) and coordination of care for these complex patients to deliver more efficient and effective care.

IAH also requires a 5% savings to Medicare, while the hospice benefit has no savings requirement.

Q: How will IAH affect the primary care shortage?

A: The IAH model develops a new, attractive career path for primary care physicians by enabling them to own and operate IAH organizations. All board-certified primary care physicians are eligible to participate in an IAH care team and receive reimbursement for house calls. Additionally, primary care physicians with who have a certification in geriatric medicine or have experience in home care are eligible to serve as an Independence at Home physician and be more directly involved with patient care coordination.

The IAH model also encourages nurse practitioners and physician assistants to serve in the primary treatment role within an IAH home care team under the direction of a physician and as permitted under State law. In a typical house calls program, physicians will make periodic visits with patients while nurse practitioners or physician assistants will make more frequent visits with patients. Through this model, patients will see a qualified health professional on a regular basis instead of resorting to costly emergency care on an episodic basis.

Q: What protections are in place to prevent abuse and fraud?

A: The IAH Act was developed in consultation with patients, caregivers, physicians, nurse practitioners, physician assistants, and representatives of the Centers for Medicare and Medicaid Services and the Office of the Inspector General at the Department of Health and Human Services to ensure that all participating parties were protected from unscrupulous health care providers. The following are some of the provisions included in the bill to protect against fraud and abuse.

- The IAH Act does nothing to impede existing laws that protect against Medicare fraud and waste, including current anti-kickback and gainsharing laws.
- The IAH Act requires organizations to provide information on their employees, contractors, and individuals with ownership interests. This information will help the Secretary detect fraudulent organizations.

- The IAH Act clearly defines the eligibility requirements for beneficiaries to participate in the program. This will prevent some organizations from using deceitful practices to enroll patients who do not qualify.
- The IAH program is completely voluntary – beneficiaries may leave the program or switch to another organization at any time.
- The Secretary of HHS is given the authority to terminate agreements with IAH organizations if necessary.
- The Secretary may invoke additional enrollment requirements, such as screenings, provisional periods, and disclosure of Medicare or Medicaid debt, prior to entering into agreements with organizations.
- The Independence at Home Assessment, which evaluates patients' eligibility and medical history, will be conducted by a health professional with no ownership interest in the IAH organization. This will prevent enrollment of ineligible beneficiaries for financial gain.
- IAH physicians and nurse practitioners are permitted to waive copayments, but only if the waiver is not advertised, is not routine, is for financial need, and the provider makes a reasonable effort to collect the coinsurance.

Q: How has the Independence at Home Act changed from the version that was introduced in the 110th Congress?

A: Minor changes were made in the bill text to support the goals of the Independence at Home Act, including the following:

- The description of the program, the program objectives, and the services to be provided were clarified.
- The demonstration project was changed into a pilot project to facilitate continuation into a full Medicare benefit pending the Secretary's review.
- Fraud and abuse protections were strengthened in accordance with technical assistance from the Office of the Inspector General of HHS (see question above).
- Physician assistants, acting under the supervision of a physician and in accordance with state law, are explicitly added to improve access to care.
- A “best practices” conference was added to the bill allowing participating organizations to share strategies for success with each other during phase I of the pilot project.
- Pharmacists were named as the experts in the monitoring and management of patient medications.
- Information on advance directives was added as elements of a patient's IAH care plan.

Q: How will it be determined if the pilot project will become a full benefit?

A: After the first 3 years of the pilot project, IAH organizations that have met the program objectives (improved patient outcomes, beneficiary/caregiver satisfaction, and at least a 5% savings to Medicare) will be able to renew their contracts, while agreements with organizations that have not met these requirements will be

terminated. In addition, the Secretary will review an independent evaluation of the program and terminate the program if its continuation is not in the best interest of beneficiaries or the government.

Q: Is there a sufficient supply of physicians and nurse practitioners to participate in the Independence at Home Model?

A: Currently, there are approximately 3,600-4,000 physicians nationwide in largely full-time home-based primary care practices. In addition, about half of all Family Practitioners and a third of all General Internists make 25-50 house calls annually, resulting in approximately 100,000 physicians. We anticipate this group of physicians to be a good reservoir of primary care docs who can participate in the Independence at Home model. (Source: American Academy of Home Care Physicians)

Furthermore, there are currently 3,000-4,000 NPs who would qualify for the Independence at Home model. (Source: American Academy of Nurse Practitioners), so at least 6,600-8,000 physicians and NPs would be qualified to participate in the Independence at Home model, which we feel is more than adequate to support the pilot project we are proposing. Based on the experience of some of the house calls doctors we have been working with, we expect that each physician/nurse practitioner can handle about 300 patients and each team can handle about 600 patients.

Q. What evidence is there of savings from house calls programs similar to the one proposed by the Independence at Home Act?

A. There are a significant amount of data from programs around the country and from the Department of Veterans Affairs, which has been operating a home-based primary care program for more than 30 years that is focused on a population of chronically-ill veterans similar to the one targeted by the Markey proposal. The VA program serves 17,000 veterans per year in 48 states. The attached paper from Clinics in Geriatric Medicine shows that in 2007, the VA program resulted in:

- 59% reduction in hospital bed days of care
- 89% reduction in nursing home bed days of care
- Combined reduction of 78% in total inpatient days of care
- 21% reduction in 30-day hospital readmission rates.