Independence at Home Demonstration Performance Year 3 Results

Home-based primary care allows health care providers to spend more one-on-one time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve the overall quality of care and quality of life for patients served, while lowering health care costs by avoiding costly hospital care and forestalling the need for care in institutional settings.

The Independence at Home (IAH) Demonstration is authorized by Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), and extended for two years by the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015 and as further extended and amended by section 50301 of the Bipartisan Budget Act of 2018 (BBA) for an additional two years, which began on January 1, 2019. The IAH Demonstration tests a payment incentive and service delivery model for home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses. The demonstration tests whether home-based primary care that is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need patients and to coordinate health care across all treatment settings reduces preventable hospitalizations, readmissions, and emergency room visits, improves health outcomes commensurate with beneficiaries' stage of chronic illness, improves the efficiency of care, reduces the cost of health care services, and achieves beneficiary and family caregiver satisfaction.

Beneficiaries' care is monitored using several quality measures. A savings benchmark is established that estimates what would have been spent for applicable beneficiaries in the absence of the demonstration. Practices that generate Medicare savings relative to their benchmark in excess of a minimum savings requirement may share in savings; the proportion of savings that a practice may receive as an incentive payment is adjusted based on its performance on these quality measures.

Summary of Results from Performance Year 3

In the third performance year of the demonstration, the Centers for Medicare & Medicaid Services (CMS) found that IAH practices saved approximately 4.7 percent, equating to $16.3 million, an average of $1,431 per beneficiary of their applicable beneficiaries. CMS will provide incentive payments to seven practices (as shown in Table 1) for an aggregate amount of $7,219,784. In the third performance year of the demonstration, 11,382 beneficiaries were enrolled in the demonstration at 15 participating practices. For the third performance year, 14 out of the 15 IAH practices improved on at least one quality measure from performance year 2. Five of the practices met the performance thresholds for all six quality measures.

Table 1
Performance Year 3 Results for Participating Practices

Independence at Home Practice Name	Year 3 Spending Target*	Year 3 Expenditures*	Practice Incentive Payment
Boston Medical Center	$3,435	$3,393	
Christiana Care Health System	$3,930	$3,901	
Cleveland Clinic Medical Care at Home	$3,576	$3,759	
Doctors Making Housecalls	$2,980	$2,666	$1,476,613
Doctors on Call	$4,291	$4,521	
Kindred House Calls	$4,142	$4,201	
Housecall Providers, PC	$2,251	$1,716	$570,777
MD2U-KY, MD2U-IN	$3,654	$3,693	
Mid-Atlantic Consortium	$3,180	$2,317	$2,095,912
Northwell Health House Calls	$3,486	$2,754	$1,280,686
VPA Dallas	$3,778	$3,876	
VPA Flint	$4,029	$3,643	$779,856
VPA Jacksonville	$3,367	$3,371	
VPA Lansing	$4,298	$3,798	$817,477
VPA Milwaukee	$3,086	$2,875	$198,462

* The Year 3 Spending Target and Year 3 Expenditures are on a PBPM basis.

Quality Measures

Under the IAH Demonstration, participating practices must meet the performance thresholds for at least three of the six quality measures in order to qualify for the incentive payment. The six measures are:

- Follow up contact within 48 hours of a hospital admissions, hospital discharge, or emergency department visit;
- Medication reconciliation in the home within 48 hours of a hospital discharge or emergency department visit;
- Annual documentation of patient preferences;
- All-cause hospital readmissions within 30 days
- Hospital admissions for ambulatory care sensitive conditions; and
- Emergency department visits for ambulatory care sensitive conditions.

Beneficiary Enrollment

The original statute limited participation for practices in the demonstration so that no more than 10,000 beneficiaries could participate in the demonstration. With performance year 3 enrollment slightly exceeding the 10,000 beneficiary limit, CMS used a method to reduce the number of beneficiaries proportionately across all practices so that the beneficiary limit was not exceeded in the calculation of the incentive payments. This proportionate reduction occurred only for the purposes of the incentive payment calculations. No limits were imposed on the number of beneficiaries that practices could enroll in the demonstration.

As noted above, the BBA extended the IAH Demonstration for an additional two years, which began on January 1, 2019. It also increased the participation limit to not exceed 15,000 beneficiaries in those additional two performance years.

Shared Savings Methodology Modifications

Prior to beginning the demonstration, we developed a risk-based actuarial methodology (the "original actuarial methodology") for calculating shared savings. In response to questions raised by the IAH practices during the first performance year regarding the risk scores used in the demonstration, we explored a different approach to the original actuarial method, and developed a second methodology, the "regression-based methodology." For the first performance year of the Independence at Home Demonstration, the regression-based methodology was predominantly used to determine demonstration savings. Under the regression-based methodology, CMS derived the savings estimates by making comparisons between the treatment group, or demonstration beneficiaries, and a matched comparison group of beneficiaries identified in CMS' administrative data who meet the demonstration eligibility criteria and do not receive home-based primary care. For the second performance year of the demonstration, CMS identified potential issues under the regression-based methodology with the comparability between the treatment group and the matched comparison group used in the analysis of the demonstration savings. CMS conducted many analyses concerning the comparability issues, and made several changes to address these issues in a third methodology, the "revised regression methodology". More information is available on these methodologies in the 2018 Report to Congress, available at: https://innovation.cms.gov/Files/reports/iah-rtc.pdf.

Participants using the regression methodology in the first performance year had the choice between the original regression methodology and the revised regression methodology for the second performance year. For the third year of the demonstration, practices had the choice of their previously selected methodology or the option of calculating their shared savings under either the original actuarial methodology or the revised regression methodology. In summary, 3 practices' (Northwell, Mid-Atlantic Consortium and Housecall Providers, PC) Performance Year 3 results were calculated under the original actuarial methodology and the remaining 12 practices' results were calculated under the revised regression methodology.