# S. 3130 INDEPENDENCE AT HOME ACT OF 2016
# ACCOUNTABILITY

| PROVISION | DESCRIPTION | IMPACT |
|---|---|---|
| **BENEFICIARY AND PROGRAM PARTICIPANT CRITERIA** | | |
| ELIGIBILITY CRITERIA **LIMITS PARTICIPATION TO HIGH-NEED AND HIGH-COST BENEFICIARIES**<br><br>**Section 2 (e)** | • Only the sickest and most frail Medicare beneficiaries are eligible to participate in IAH.<br><br>• Within the past 12 months, IAH beneficiaries must have had a non-elective hospitalization and received skilled nursing care, rehab services, or home health services, and must have two chronic conditions and two functional dependencies. | • IAH eligible beneficiaries are already receiving high-cost Medicare services.<br><br>• An actuarial analysis of potential IAH beneficiaries shows there are 2 million eligible beneficiaries and we project about half — 1 million beneficiaries — would join IAH practices over a 10-year period. |
| **STRICT PRACTICE RULES REQUIRE EXPERIENCED PROVIDERS WHO MUST BE AVAILABLE 24-7 AND USE EHR TECHNOLOGY**<br><br>**Section 2 (b) (iii) line 9 and (iv-vii)** | • ‘‘(iii) The entity—‘‘(I) has experience in furnishing home-based primary care services to applicable beneficiaries, as determined appropriate by the Secretary; ‘‘(II) makes in-home visits; and ‘‘(III) is available 24 hours per day, seven days per week.”<br><br>• “The entity enters into an agreement with the Secretary” to furnish services to “AT LEAST 200 applicable beneficiaries” and must use “certified electronic health record technology and may use remote monitoring and mobile diagnostic technology.”<br><br>• ‘‘The entity meets such other criteria as the Secretary determines to be appropriate to participate in the Program.” | • The requirement for actual experience in providing home-based care is critical to IAH success. Practices are required to have experience providing home-based care, and must be available 24-7 to patients.<br><br>• Practices are bound by strict requirements of the legal agreement. Providers must serve at least 200 beneficiaries and use certified EHRs; if they do not, they are ineligible to participate.<br><br>• The Secretary can add other requirements to ensure accountability with program growth. |

| PROVISION | DESCRIPTION | IMPACT |
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| **UNIQUE SHARE SAVINGS MODEL TIED TO SAVINGS AND QUALITY** | | |
| **SHARED SAVINGS DESIGN INCENTIVIZES PRACTICES TO TAKE HIGH-NEED AND HIGH-COST PATIENTS**<br><br>**Section 2 (d)(1) and (e)** | • IAH beneficiaries are a limited and tightly defined population who are by definition high need and high cost.<br><br>• Providers' use of primary and urgent care services, rather than more expensive "rescue" services in an institutional setting, is directly incentivized. | • Care provided at home is by its very nature less expensive than hospital care.<br><br>• Unlike FFS, managed care, or ACOs, IAH provides incentive for practitioners to continuously identify highest cost beneficiaries and find savings via better clinical management.<br><br>• Upcoding is counterintuitive because shared savings is more remunerative than FFS payments. |
| **INCENTIVE PAYMENTS REWARD ONLY THOSE PRACTICES THAT EVIDENCE SUCCESS**<br><br>**Section 2(d)(2) line 17** | • Participants are eligible for incentive payments ONLY if they achieve a <u>minimum 5% annual savings</u> requirement AND meet <u>threshold quality metrics</u>.<br><br>• Coupled with Mandatory and Permissive Termination, this provision serves as a condition of continuing participation. | • IAH is the ONLY health care delivery model where practices must prove minimum savings of 5% and satisfaction of quality metrics threshold BEFORE they can share in any savings beyond the 5% minimum. There are no upfront payments to participating practices.<br><br>• IAH is the only program where 100% of the first 5% of savings goes to Medicare. |
| **IAH IS CONSUMER-DRIVEN,** COMPLETELY VOLUNTARY FOR BENEFICIARIES, AND QUALITY CONTROLLED<br><br>**Section 2(e)(3)** | • "Enrollment in an Independence at Home medical practice shall be voluntary."<br><br>• Patient/caregiver satisfaction is tied directly to savings. Poor scores on patient/caregiver satisfaction triggers removal of practice. | • Voluntary nature of the program ensures patient choice, allowing them to opt out.<br><br>• CMS will be alerted if certain practices show a high-opt out rate and CMS can examine patient/ caregiver satisfaction reports. Patients are empowered by market competition to seek practices with higher quality consumer service. |

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| **SHARED AUTHORITY AND RESPONSIBILITY: SECRETARY, CONGRESS, & PRACTICES** | | |
| **SECRETARY HAS MANDATORY** AND PERMISSIVE **TERMINATION AUTHORITY DIRECTLY TIED TO QUALITY AND SAVINGS**<br><br>**Section 2(j)(1) & (2)** | • The Secretary must terminate any IAH program that CMS "estimates or determines" will not achieve at least 5% savings for a third consecutive year or fails to achieve a minimum number of quality standards in any year.<br><br>• "The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary." | • With no upfront payments to practices and mandatory termination if practices do not measure up, practices take real risk to participate.<br><br>• The Secretary has additional authority to remove practices for other reasons: failure to meet compliance criteria, suspected fraud or abuse, or poor patient/caregiver satisfaction scores. |
| **CONGRESS RETAINS FULL OVERSIGHT AUTHORITY; PROGRAM EXPANSION BRINGS SAVINGS RATHER THAN INCREASED COSTS**<br><br>**Section 2(a)** | • "Title XVIII of the Social Security Act is amended by inserting after section 1866E the following new section: ''INDEPENDENCE AT HOME MEDICAL PRACTICE PROGRAM"<br><br>• Because IAH is written outside of CMMI's ACA demonstration authority, Congress retains full authority to expand the program and for continuing oversight.<br><br>• Congress was required to extend the program for two years because IAH was written into the Social Security Act. Congress therefore retains the authority to expand the program. | • IAH does not increase overall new use of services because eligibility is for existing Medicare beneficiaries and is contingent on prior illness, disability, and utilization.<br><br>• Where programs save, they bring savings first to the Medicare program. Where they do not save, they are terminated.<br><br>• Savings model and interdisciplinary teams brings flexibility to practices to apply commonsense and often less costly solutions to patient care. |

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| **TEAM-BASED CARE AND TEAM-BASED COORDINATION AMONG PRACTICES** | | |
| **"LEARNING COLLABORATIVE"** PROMOTES BEST PRACTICES **AMONG PROGRAMS**<br><br>**Practice driven, CMS facilitated** | • Established through the regulatory process, IAH demonstration practices participate in a "Learning Collaborative" to share best practices and lessons learned. | • The Learning Collaborative is an invaluable tool for practices to learn from one another to deliver the best care and reduce costs. Under an expanded model, IAH's Learning Collaborative model should continue to educate and advance best practices among IAH providers. |
| **THE REQUIRED TEAM-BASED MODEL MEANS INCREASED COORDINATION OF CARE AND DECREASED LIKELIHOOD OF INDIVIDUAL, BAD ACTORS**<br><br>**Section 2(a)(1)** | • Practices must be "primary care teams that— ''(A) are directed by physicians, nurse practitioners, or physician assistants; and ''(B) emphasize home-based care that is designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries."<br><br>• The team-based model gives practices the flexibility to determine the teams needed to serve their patients. For instance, where social services or mental health counseling is needed, the team can manage and coordinate that care. | • These interdisciplinary teams have proven to be one of the most important elements of IAH for coordinated, "whole-person" patient care.<br><br>• IAH was written to directly address failures of past home care efforts such as individuals gaming the system by making false reports or practices increasing volume to make a profit.<br><br>o When a team is involved, the likelihood of fraud and elder abuse is diminished.<br><br>o The shared savings REQUIREMENT motivates better use of resources rather than use of more costly resources or increased volume. |
| **PROVISION** | **DESCRIPTION** | **IMPACT** |
| **OVER 20 YEARS OF EVIDENCE THAT IAH WORKS: VETERANS ADMINISTRATION HOME BASED PRIMARY CARE MODEL** | | |
| **IAH DEMO & LEGISLATION IS BASED ON OVER 20 YEARS OF EXPERIENCE IN PRODUCING SAVINGS AND QUALITY CARE FOR OUR NATION'S VETERANS.** | • The VA's Home Based Primary Care (HBPC) program reduced costs by 12% ($5k/patient-year) & achieved an 83% positive patient satisfaction rating. | • The Home-Based Primary Care (HBPC) model, as applied in the IAH demonstration and advanced in the legislation, enhances quality of care and reduces cost for seriously ill patients. |