Independence at Home Demonstration Performance Year 10 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 patient 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 expenditures by avoiding costly hospital care and forestalling the need for care in institutional settings.

The Independence at Home (IAH) Demonstration was authorized by Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), extended for two years by the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015, further extended and amended by section 50301 of the Bipartisan Budget Act of 2018 (BBA) for an additional two years, and further extended and amended by the Consolidated Appropriations Act, 2021, for an additional three years, which began on January 1, 2021, and concluded on December 31, 2023. The IAH Demonstration tested a payment incentive and service delivery model for home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses and functional limitations. The Demonstration tested whether home-based primary care that was designed to (1) provide comprehensive, coordinated, continuous, and accessible care to high-need patients and (2) coordinate health care across all treatment settings reduced preventable hospitalizations, readmissions, and emergency department visits; improved health outcomes commensurate with beneficiaries' stage of chronic illness; improved the efficiency of care; reduces the cost of health care services; and achieved beneficiary and family caregiver satisfaction.

Beneficiaries' care was monitored using several quality measures. IAH participants (i.e., individual home-based primary care practices or consortia) that reduced their applicable beneficiaries' Medicare expenditures sufficiently below their spending targets were eligible to receive an incentive payment, which was a portion of the difference between expenditures and the spending target, adjusted based on performance on the associated quality measures.

Summary of Results from Performance Year 10

In Performance Year 10 of the Demonstration (January 1, 2023 – December 31, 2023), just one IAH participant remained in the demonstration. The Centers for Medicare & Medicaid Services (CMS) found that the expenditures for the IAH participant's applicable beneficiaries were approximately 34.0 percent (equating to $7.6 million) below their spending target, an average reduction of $18,727 per beneficiary. The IAH participant reduced the per-beneficiary-per-month (PBPM) expenditures relative to their PBPM spending target.

IAH participants were eligible for incentive payments if they served at least 200 applicable beneficiaries, had positive savings percentages, had spending targets that exceeded a minimum confidence threshold, and met or exceeded the minimum performance threshold on at least three of the six quality measures. In Performance Year 10, the IAH participant met these requirements and will receive an incentive payment.

Table 1. Performance Year 10 Results

Independence at Home Practice	Year 10 Spending Target*	Year 10 Expenditures	Practice Incentive Payment, with Sequestration^
Northwell Health House Calls	$6,436	$4,249	$5,108,734
Total	$6,436	$4,249	$5,108,734

* The Year 10 Spending Target and Year 10 Expenditures are on a PBPM basis.

^ All Medicare expenditures were reduced by 2 percent due to sequestration, beginning April 1, 2013. Sequestration was suspended under the CARES Act beginning May 1, 2020; it was fully reimposed on July 1, 2022.

Quality Measures

Under the IAH Demonstration, participating practices and consortia were required to meet the performance thresholds for at least three of the six quality measures to qualify for the incentive payment. The six measures were:

- Follow up contact within 48 hours of a hospital admission, 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.

Methodology Modifications

Prior to beginning the Demonstration, CMS developed a risk-based actuarial methodology (the "original actuarial methodology") for calculating incentive payments. In response to questions raised by IAH participants in early performance years regarding the risk scores used in the Demonstration, CMS explored a different approach to the original actuarial method and developed a second methodology (the "regression-based methodology"), which was later revised (the "revised regression-based methodology").

Starting with Performance Year 6, all calculations used a revised actuarial methodology, which generated practice-specific PBPM target expenditures based on historical Medicare fee-for-service (FFS) per capita expenditures for the Medicare FFS population in the same counties as IAH-applicable beneficiaries. The per capita expenditures were then adjusted to reflect the

average CMS Hierarchical Condition Category (CMS-HCC) risk score, the average frailty score (used in the Program of All-inclusive Care for the Elderly [PACE]), and a utilization factor of the IAH-applicable population in each practice. The utilization factor reflected the level of risk that was not captured by the CMS-HCC model for beneficiaries with a hospitalization and post-acute care in the 12 months prior to their enrollment date in the performance year. Finally, the adjusted per capita expenditures were trended to the performance year by the increase in total per capita Medicare FFS expenditures, as estimated by CMS' Office of the Actuary. Determination of any incentive payment was based on a comparison of costs incurred to the target expenditures and performance on payment-related quality measures.

Starting with Performance Year 8 and continuing through Performance Years 9 and 10, target expenditures for non-ESRD beneficiaries were calculated using the CMS-HCC version 24 (V24) risk model. Prior to Year 8, the V21 CMS-HCC model was used. The V21 model software was last updated by CMS in 2019, with no plans to continue updating the model in the future, as there were no Medicare Advantage or PACE plans that were paid using this model after 2019.

More information on the Independence at Home Demonstration and these methodologies is available at: https://innovation.cms.gov/innovation-models/independence-at-home.