Independence at Home Demonstration Performance Year 9 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 care expenditures 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), 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 tests 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 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 department 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. IAH participants (i.e., individual home-based primary care practices or consortia) that reduce their applicable beneficiaries' Medicare expenditures sufficiently below their spending targets receive an incentive payment, which is 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 9

In Performance Year 9 of the Demonstration (January 1, 2022 – December 31, 2022), the Centers for Medicare & Medicaid Services (CMS) found that the expenditures for IAH participants' applicable beneficiaries were approximately 21.0 percent (equating to $25 million) below their spending targets, an average reduction of $9,164 per beneficiary. All seven IAH participants (six practices and one consortium consisting of three practices) reduced the per-beneficiary-per-month (PBPM) expenditures relative to the participant's PBPM spending target.

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 9, six participants met these requirements and will receive incentive payments. The seventh participant reduced expenditures but met the threshold for only two of the quality measures and so will not receive an incentive payment.

Table 1. Performance Year 9 Results for Participating Practices

Independence at Home Practice	Year 9 Spending Target*	Year 9 Expenditures	Practice Incentive Payment, with Sequestration^
Northwell Health House Calls	$6,220	$4,338	$5,070,640
RMED, LLC	$4,201	$3,777	$208,142
Visiting Physicians Association of Texas, PLLC – Dallas	$4,818	$4,293	$579,248
Visiting Physicians Association, P.C. – Flint/Saginaw/Marysville	$3,970	$3,037	$2,028,361
Visiting Physicians Association, P.C. – Lansing/Ann Arbor	$3,830	$2,740	$987,117
Visiting Physicians Association, P.C. – Milwaukee	$3,419	$2,781	$0
Mid-Atlantic Consortium	$4,978	$3,899	$796,081
Total	$4,499	$3,554	$9,669,590

* The Year 9 Spending Target and Year 9 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 must meet the performance thresholds for at least three of the six quality measures to qualify for the incentive payment. The six measures are:

- 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 generates 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 are 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 reflects the level of risk that is 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 are 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 is 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 in Performance Year 9, 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 are no Medicare Advantage or PACE plans that were paid using this model after 2019. To avoid the risk of IAH participants' risk scores being under-predicted, CMS approved an update to use the CMS-HCC V24 model for the IAH non-ESRD population for Years 8 – 10.

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