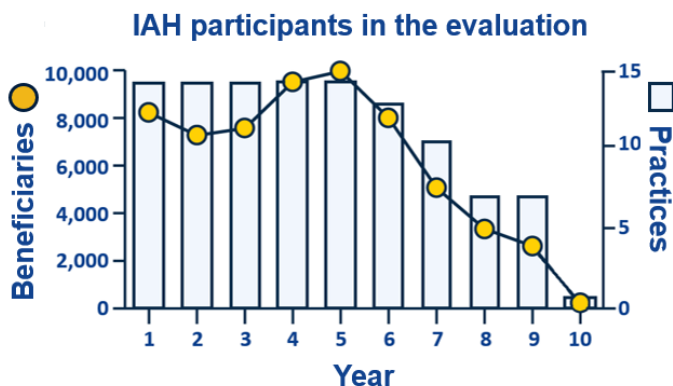


DEMONSTRATION OVERVIEW

The Independence at Home (IAH) demonstration was a Congressionally mandated test of whether home-based primary care (HBPC) could decrease spending and improve quality in response to a performance-based payment incentive.

Traditional Medicare beneficiaries who had at least two chronic conditions and needed help with two or more daily activities, such as eating or dressing, were eligible for IAH if they had a hospital admission and post-acute care in the prior 12 months.

IAH practices serving IAH beneficiaries had to have experience delivering HBPC, staff who were available at all hours, and teams led by physicians or nurse practitioners. IAH practices continued their general approach to delivering HBPC during the demonstration with minor adjustments. Participation in IAH decreased after Year 5, when several practices exited the demonstration to participate in other alternative payment models.



EVALUATING THE DEMONSTRATION

The evaluation's final report contained **two main analyses** to measure the effects of IAH by comparing changes in outcomes for IAH beneficiaries relative to changes in outcomes for similar beneficiaries not in the demonstration.

PERFORMANCE-YEAR ANALYSIS: Outcomes for new and existing HBPC users averaged across all performance years, relative to new and existing HBPC users in the year before IAH began.

Statistically significant impact
($p < 0.1$)

Not a statistically significant impact

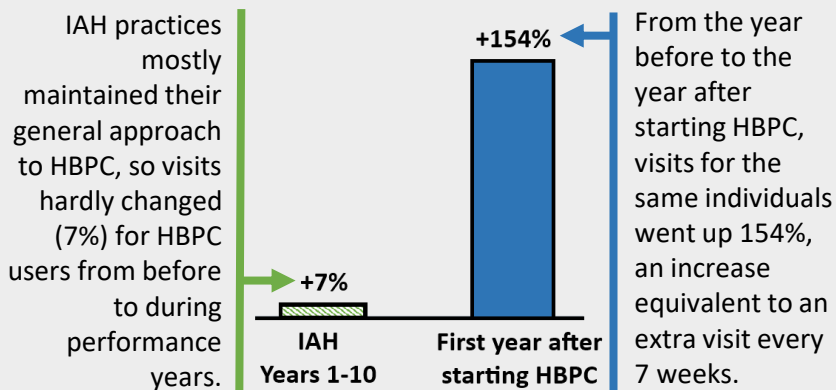
THREE-YEAR ANALYSIS: Outcomes for new HBPC users followed up to 3 years, relative to those same individuals before they started HBPC. In each demonstration year, about one-quarter of IAH beneficiaries were new users.

Statistically significant impact
($p < 0.1$)

Not a statistically significant impact

Starting HBPC increased visits

Results for primary care visits illustrate the differences in the two analyses. Primary care visits include visits at home as well as in office-based clinics.



KEY TAKEAWAYS

- The demonstration did not show conclusive evidence that the opportunity for IAH practices to receive an incentive payment reduced total spending nor improved other outcomes for new and existing HBPC users relative to HBPC users' outcomes before the demonstration.
- Starting HBPC reduced total spending in the first year and improved other outcomes for a longer period for the one-quarter of IAH beneficiaries newly receiving HBPC.

EFFECTS ON TOTAL MEDICARE SPENDING

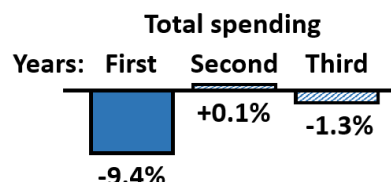
No conclusive evidence of savings to the Medicare program



The demonstration may have reduced Medicare spending, but the result was not statistically significant (-4.9%).

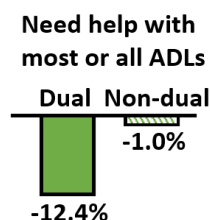
The demonstration did not convincingly reduce Medicare spending after accounting for incentive payments to IAH practices (-1.1%).

Analysis of new users showed large spending reductions in the first year

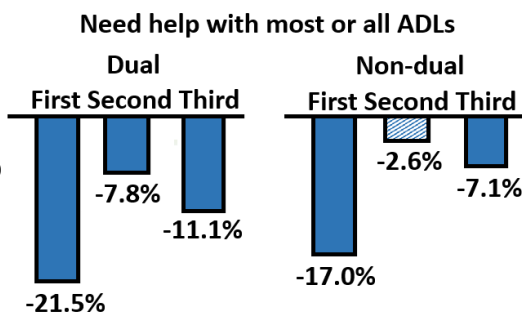


Starting HBPC during the demonstration reduced total Medicare spending in the first year (-9.4%) but did not reduce spending in the second or third years.

Spending reductions were particularly large for the those with the greatest needs



The demonstration reduced total spending among beneficiaries who were dually eligible for Medicaid and needed help with most or all activities of daily living (-12.4%).

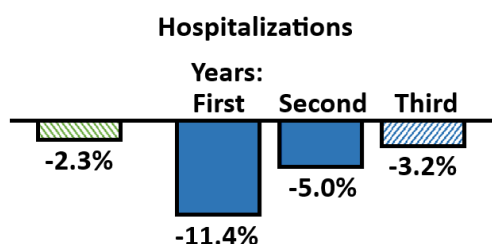


Starting HBPC during the demonstration reduced spending the most among beneficiaries who needed help with most or all activities of daily living, both for beneficiaries who were dually eligible for Medicaid (-21.5%) and those who were not (-17.0%).

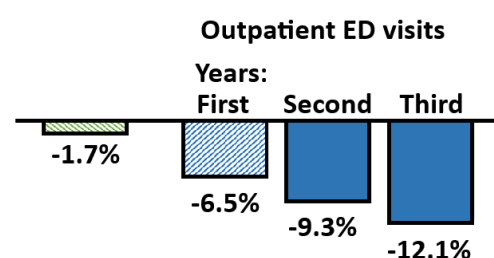
EFFECTS ON HOSPITAL AND EMERGENCY DEPARTMENT (ED) USE

Impacts on hospital and ED use were concentrated among new users

The demonstration probably did not decrease hospital or ED use.



Starting HBPC during the demonstration reduced hospital use in the first two years and led to a growing reduction in ED use over time.



For measures similar to ones used to calculate incentive payments, the demonstration did not reduce potentially avoidable ED use (1.7%), though it may have reduced potentially avoidable hospital admissions (-3.9%) and unplanned readmissions (-4.3%).

Several best practices were related to larger reductions in potentially avoidable admissions for new users of HBPC

- Lower daily clinician caseload, 3 to 7 patients per day rather than 8 to 15
- Smaller clinical panel sizes, 40 to 149 patients per clinician rather than 150 to 200
- Having nurse practitioners or physician assistants conduct at least half of HBPC visits
- Providing visits in the home by non-physician staff, such as nurses, social workers, and chaplains
- Providing patient visits when needed in settings outside the home, such as in a skilled nursing facility or hospital
- Using remote monitoring technology, such as to monitor beneficiaries' blood pressure or blood sugar levels