

## **Independence at Home Demonstration Solicitation**

### **Background**

Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), directs the Centers for Medicare & Medicaid Services (CMS) to conduct the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses. Home-based primary care is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need patients and to coordinate health care across all treatment settings. Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's natural environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

Medicare beneficiaries with multiple chronic conditions have extremely high health care costs and may experience difficulty in independently performing many of life's daily activities, such as bathing, toileting, and getting in and out of bed. These beneficiaries are often very frail, have trouble managing their numerous health issues, and may find getting to the doctor extremely difficult. As a result, this population may lack a routine source of care or may often postpone routine follow-up care until an acute exacerbation of their condition leads to an emergency department (ED) visit or an inpatient hospital admission. Timely home-based primary care can prevent such ED visits and inpatient hospitalizations by bringing clinical expertise and mobile technology into the home when clinical instability is first developing. Treating people at home also allows primary care practitioners to provide more holistic care by observing how patients actually function in their day-to-day environment and identifying unmet needs for services that can help their patients to remain independent, such as home health, social supports, and other community-based services.

Individuals who are eligible for both the Medicare and Medicaid programs (Medicare-Medicaid enrollees) are likely to comprise a sizeable portion of the population eligible for IAH. Medicare-Medicaid enrollees are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, with many having multiple chronic conditions and significant health care needs. This group must navigate separate health care programs: Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. Greater care coordination, such as through IAH's home-based primary care model, has the potential to improve quality and lower health care costs for these beneficiaries. For Medicare-Medicaid enrollees participating in IAH, CMS would expect that IAH medical practices will coordinate care across Medicare and Medicaid to the greatest extent possible. CMS also encourages IAH medical practices to partner with States, particularly in better coordinating care for Medicare-Medicaid enrollees. While the IAH savings calculation is based upon Medicare spending for Medicare-Medicaid enrollees participating in IAH, CMS is also interested in and will evaluate the impact of IAH on Medicaid costs apart from any determination of potential shared savings for IAH medical practices.

### **Eligibility Requirements for Participation**

The statute establishes standards for participating primary care practices and patients for the IAH Demonstration.

*Provider Eligibility Requirements*

To be involved in the Demonstration, practices must be individual physicians or nurse practitioners or multidisciplinary teams composed of various members such as physicians, nurse practitioners, physician assistants, pharmacists, social workers, and other supporting staff. Such practices must be led by physicians or nurse practitioners and must have experience providing home-based primary care to patients with multiple chronic illnesses. These practices will be organized at least in part for the purpose of providing physician services. Providers of service or practitioners affiliated with the practice may share in any savings. Practices participating in Section 1899, the Medicare Shared Savings Program, may not also participate in the IAH Demonstration. In addition, practices and their beneficiaries participating in the Demonstration cannot participate in any other program or demonstration that uses shared savings because savings related to a beneficiary with more than one organization cannot be determined without confounding the IAH model of care with the effects of other interventions or models.

Each participating practice or entity must provide services to at least an average of 200 applicable beneficiaries during each year of the Demonstration. A practice's (or consortium's) enrollment may vary over the course of a year but must reach at least an average of 200 applicable beneficiaries during the first year and not drop below this yearly average for the remainder of the Demonstration. Because the size of the minimum savings requirement (MSR) is inversely related to the size of the IAH practice and could present a challenge to small practices, CMS will provide three options for Demonstration participation.

- Option 1: Any practice meeting the eligibility criteria may apply as a sole legal entity.
- Option 2: Multiple primary care practices within a geographic area may join as a consortium to participate. Any practices joining in this way must establish a legal entity and will be treated by CMS as one IAH practice for the purpose of establishing expenditure targets, evaluating quality, and determining incentive payments. A consortium of practices that applies must provide the Taxpayer Identification Numbers (TINs) of all the applying practices and must designate a single TIN that will act as the agent for the consortium and be responsible for distributing any incentive payments to all the individual practices that comprise the consortium.
- Option 3: Practices with a beneficiary case load of between 200 – 500 beneficiaries may select an option to become a part of a national pool of providers. Providers participating in a national pool will waive the right to have savings evaluated as a single practice and all financial targets will be calculated based on the pooled practices. Savings will then be distributed according to 1) practice level, risk and frailty adjusted beneficiary months of enrollment and 2) number of quality measures met at the individual practice level (see percentage of incentive payments under Payment Methodology: Quality Measures).

Once a practice elects to participate in a selected option, the practice will remain in that option for the entirety of the Demonstration.

From this point forward, references to practices or individual practices will encompass the above chosen option. Practices will enroll existing patients meeting beneficiary eligibility criteria. Participating practices must make in-home visits tailored to an individual patient's needs. Each

practice must be available 24 hours per day, 7 days a week to carry out plans of care. Practices must use electronic health information systems, remote monitoring, and mobile diagnostic technology. Practices are required to report information about their patients and the health care services provided. In addition, practices will be required to report data on the quality measures required for the Demonstration.

### *Beneficiary Eligibility Requirements*

Eligibility criteria are designed to target the most costly beneficiaries with advanced chronic illnesses and substantial disabilities. Beneficiaries must be entitled to Part A and enrolled in Part B, not enrolled in a Medicare Advantage plan or a Program for All-Inclusive Care for the Elderly, and cannot be enrolled in a practice that is part of the Medicare Shared Savings Program or other shared savings demonstrations. Applicable beneficiaries are defined as Medicare FFS patients who have at least two chronic illnesses, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke, dementias such as Alzheimer's disease, neurodegenerative diseases, and other diseases and conditions designated by the Secretary that result in high costs. Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. Beneficiaries must also need human assistance with two or more activities of daily living (ADLs), have had a non-elective hospital admission within the last 12 months, and have used acute or sub-acute rehabilitation services within the last 12 months. Although practices will report chronic conditions and ADL limitations, chronic conditions and ADLs are subject to medical record audit.

Note that this demonstration focuses on beneficiaries treated at home. Therefore, the Demonstration will not enroll beneficiaries who are long-term residents of nursing facilities. Beneficiaries who receive skilled nursing facility (SNF) services as a current Medicare benefit remain in the Demonstration. However, if the beneficiary remains in the facility and is not expected to return home when the SNF stay has ended, then the beneficiary will no longer be considered part of the Demonstration. Beneficiaries will continue to be enrolled in the Demonstration if they transition to hospice while under the care of an IAH practice.

Physicians or nurse practitioners whose practices are participating in this demonstration will be required to certify beneficiary eligibility and to enroll all eligible beneficiaries both at the onset of the Demonstration and throughout the Demonstration. As existing beneficiaries become eligible or new patients enter their practice, they will be considered a part of the practice's caseload. Eligible beneficiaries will remain enrolled throughout the Demonstration, unless their eligibility status changes, e.g., death, joining an MA plan, or loss of Part A or Part B.

Participating providers will be required to notify their patients of the practice's participation in the Demonstration. Beneficiary participation in the Demonstration is automatic when eligible beneficiaries agree to be seen in their homes by a provider in the participating practice. Practices are required to submit a list of their eligible patient caseload to CMS. CMS will verify the Medicare home visits in the claims data by accessing the practice's designated TIN and National Provider Identification number and will verify patient eligibility, e.g., by utilizing the Medicare Enrollment Database, claims to verify hospitalizations and post-acute care. To ensure that IAH practices are enrolling all eligible beneficiaries, CMS will analyze Medicare claims of patients associated with the

practices to identify those who have had a hospitalization and post acute care use in the previous 12 months.

Applicable beneficiaries enrolled in one year of the Demonstration do not have to have another hospitalization or use post-acute care to remain in the Demonstration in the following years. Providers will not be required to re-certify in subsequent years, although the beneficiary must continue to have two or more chronic conditions and two or more human assisted ADL impairments.

### **Data to be Provided by Participating Practices**

Participating practices must agree to provide data on quality and other measures for the purposes of monitoring, evaluation, and determining eligibility for any incentive payment under the demonstration. Additional measures may be included in the Demonstration if it is found to be necessary for achieving the Demonstration goals. Data on these measures are to be submitted on an ongoing basis throughout the Demonstration using an electronic data collection mechanism to be administered by CMS for this purpose.

### **Quality Measures**

The CMS has identified a set of quality measures for performance monitoring and, in part, for determining incentive payments. These measures were selected based on an extensive review of the literature, consultation with clinical experts, national quality standards (e.g., National Quality Forum and Agency for Healthcare Research and Quality), and analysis of Medicare claims data. Additionally, some of the measures have been established specifically for the IAH Demonstration (Table 1).

CMS considered various criteria for inclusion of quality measures. Many of the measures included were mentioned in the legislation (e.g., utilization). CMS also sought to identify measures that are likely to make a difference in the goals of improving quality (e.g., follow-up after hospital discharge) and reducing costs. In particular, measures were chosen that can be impacted by primary care, either directly or through care coordination. Finally, CMS sought items that can be measured on a timely basis and used to provide feedback, technical assistance, and payment during the implementation of the Demonstration instead of items that would require a longer period for the availability of data for analysis.

The selected quality measures will provide a broad range of perspectives in assessing demonstration progress. Many of the selected quality measures assess patient utilization (hospitalization rate for ambulatory-care sensitive conditions, re-hospitalization rate, and ED visit rate for ambulatory-care sensitive conditions), indicate aspects of health status (pain control, depression screening), or highlight processes of care (contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED, in-home safety assessments). Quality measures tied to the incentive payment include hospital admission for ambulatory-care sensitive conditions, readmission, and ED visit rates for ambulatory-care sensitive conditions; contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED; medication reconciliation in the home; and whether patient preferences were documented.

In addition to the measures to be used for determining the incentive payments, quality measures will be required for performance monitoring in order to identify assessment, planning, implementation, and monitoring/evaluation priorities and activities for the Demonstration. This information will include,

but are not limited to, identification of goals for the patient and family caregiver; screenings/assessments conducted including depression, home safety evaluation, risk of falling, cognitive deficits; symptom management (e.g., pain, shortness of breath, cognitive deficits, fatigue, sleep disturbances); medication management; caregiver stress; voluntary disenrollment rate; and referrals made to home health, community/social services, and hospice. Satisfaction will be measured as a part of the evaluation of the Demonstration and these data will be collected by a third party. Practices may be required to provide additional information to CMS during the Demonstration.

Table 1: Quality Measures

Quality measure	Measure tied to incentive payments
Number of inpatient admissions for ambulatory-care sensitive conditions per 100 patient enrollment months	Yes
Number of readmissions within 30 days per 100 inpatient discharges	
Number of ED visits for ambulatory-care sensitive conditions per 100 patient enrollment months	
Contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED	
Medication reconciliation in the home	
Patient preferences documented	
Beneficiary/caregiver goals	No
Screenings/assessments	
Symptom management	
Medication management	
Caregiver stress	
Voluntary disenrollment rate	
Referrals	
Patient satisfaction	

**Payment Methodology**

Under this 3-year demonstration, IAH providers will continue to bill and be paid standard Medicare FFS reimbursement, subject to beneficiary deductibles and coinsurance, and balance billing rules.

Spending Target

CMS will establish a practice-specific spending target derived from claims, based on expected Medicare FFS utilization for each of the beneficiaries in the practices in the absence of the Demonstration. Annual spending targets will be calculated for each participating practice at the end of each performance year. The spending target will be derived from a base expenditure amount equal to the average payments under Part A and Part B.

The spending target for each practice will be risk adjusted and frailty adjusted to reflect each practice’s patient population using the following formula:

$$\text{Average FFS Cost in County of Residence} * \text{Trend} * (\text{Risk Adjustment Score} + \text{Frailty Factor})$$

The Average FFS Cost in County of Residence (per beneficiary per month), Trend, and Frailty Adjustment factors are established each year by CMS. The trend applied will represent the expected average increase in the per beneficiary per month Medicare Part A and B costs. Applying a trend factor is necessary because the FFS county costs will have been reported for a time period prior to the performance year.

Risk scores will be derived using the CMS Hierarchical Chronic Condition (CMS-HCC) model. The frailty factor is added to the risk score to reflect a beneficiary’s impairments with ADLs that may increase the costs of care. All new enrollees of IAH providers will receive a prospective CMS-HCC risk score based on the prior calendar year’s diagnoses and demographic factors, plus a frailty factor. The risk score and frailty factor for continuing enrollees will be updated only for changes in demographics (such as age and Medicaid status).

An individual practice’s spending target will equal the average of these per beneficiary predicted costs, weighted by the number of months of each beneficiary’s participation.

Savings Calculation

Savings will be calculated as the difference between each practice’s spending target and actual FFS costs. A projected spending target will be provided to each practice based upon its projected population and CMS will calculate a spending target at the completion of each Demonstration performance year. Annual expenses per beneficiary will be truncated at the 99th percentile of all Demonstration beneficiaries prior to calculating savings. Truncation is performed to reduce the effect of an unexpectedly high number of high-cost patients that a practice may treat in any given year. These high-cost patients could negatively impact the calculation of a practice’s savings and truncation significantly reduces this impact.

Per the IAH legislation, each participating practice must meet an MSR to be eligible to share in savings. The use of an MSR is to ensure that differences between the target and actual spending represent actual savings rather than differences owing to normal variation in Medicare spending. The size of this MSR is inversely related to the size of the IAH practice. Table 2 provides examples of MSRs for practices of different sizes based on simulations for beneficiaries determined to be eligible for IAH based on claims and assessment data analysis. The MSRs in Table 2 represent an estimate of the MSRs that will be used in the Demonstration. This table presents MSRs calculated at both the 5 percent significance and the 10 percent significance levels. These different levels of significance factor into the incentive payments as described below.

Table 2: MSR for sample practice sizes

Practice Size*	Minimum Savings Requirement	
	5% significance level	10% significance level
200	14.1%	11.4%
500	9.3%	7.5%
800	7.4%	5.7%

1000		6.4%		5.0%
2000		4.4%		3.5%
5000		2.8%		2.2%
*CMS will count all beneficiary months of enrollment in a practice divided by 12 to arrive at an estimate of the number of beneficiaries in the practice for the year.				

If a practice’s difference between actual FFS spending and its target is greater than the MSR, then we are confident that the difference represents actual savings that may be shared with the practice if the practice achieves performance on a set of quality measures tied to payment. Note that CMS will retain the first 5 percent of savings, consistent with statute.

Practices that meet the MSR at the 5 percent significance level and that meet the quality requirements (See Quality Measure section) may receive up to 80 percent of any savings beyond the first 5 percent retained by CMS. Practices that meet the MSR at the 10 percent significance level and that meet quality requirements may receive up to 50 percent of any savings beyond the first 5 percent retained by CMS. Incentive payments will be proportional to the level of savings and proportional to the number of quality measures achieved. Examples of these savings calculations follow:

- Practice A, with 500 applicable beneficiaries, achieves a spending reduction of 12 percent relative to the calculated spending target. This 12 percent reduction exceeds the 9.3 percent MSR at the 5 percent significance level. This practice qualifies to share in savings. CMS will retain the first 5 percent of the savings and the remaining 7 percent (12 percent total savings minus the first 5 percent retained by CMS) of the savings will be shared with CMS based on quality performance as described below.
- Practice B, also with 500 applicable beneficiaries, achieves a spending reduction of 8 percent, which is less than the 9.3 percent MSR at the 5 percent significance level but greater than the 7.5 percent MSR at the 10 percent significance level. This practice qualifies to share the 3 percent of the savings with CMS (8 percent total savings minus the first 5 percent retained by CMS). Savings will be shared with CMS based on quality performance as described below.
- Practice C, with 500 applicable beneficiaries, achieves a spending reduction of 5 percent relative to the calculated spending target. This does not meet the MSR to qualify for an incentive payment at either the 5 percent significance level or the 10 percent significance level for a practice of this size and, therefore, the practice does not qualify for any incentive payment.

Patients who are currently enrolled in a practice as eligible beneficiaries for more than 6 months within a performance year and voluntarily disenroll will be included in the patient population of the practice for the entire practice performance year for purposes of establishing the expenditure target and calculating savings. Patients who are currently enrolled in a practice as eligible beneficiaries for fewer than 6 months within a performance year and voluntarily disenroll will be excluded from the patient population of the practice for the entire practice performance year for purposes of establishing the expenditure target and calculating savings. Voluntary disenrollment refers to disenrollment for reasons

other than a change in Medicare status, death, transition to long-term care placement in a nursing facility, or relocation of residence outside of a practice's service area.

### Quality Measures

To qualify for incentive payments, each practice must meet or exceed performance requirements on at least three of six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures will not be eligible for incentive payments. Below are the percentages of incentive payments a practice will receive if it meets or exceeds the performance requirements of the specified quality measures.

- A practice that meets all six of the quality measures that are tied to payment will receive 100 percent of savings that qualify for sharing (i.e., 100 percent of maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets five of the six quality measures that are tied to payment will receive 83 percent of savings that qualify for sharing (i.e., 83 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets four of the six quality measures that are tied to payment will receive 67 percent of savings that qualify for sharing (i.e., 67 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets three of the six quality measures that are tied to payment will receive 50 percent of savings that qualify for sharing (i.e., 50 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).

Minimum performance values for quality measures that are tied to payment will be determined in one of two ways (Table 3). Minimum thresholds for quality measures will be measured either at an individual 80 percent threshold, or will be based on average mean utilization for a similar comparison population calculated from CMS data prior to the Demonstration. This comparison population will meet the same eligibility criteria as the IAH beneficiary population and it will be matched by metropolitan statistical area; its utilization rates will be adjusted for CMS-HCC scores.

Table 3. Quality Measure Threshold Values

<b>Quality Measures</b>	<b>Threshold Value</b>
Number of inpatient admissions for ambulatory-care sensitive conditions	Threshold equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments
Number of readmissions within 30 days	
Number of ED visits for ambulatory-care sensitive conditions	
Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED	80% of the time
Medication reconciliation in the home	80% of the time
Patient preferences documented in medical record	80% of the time



## **Monitoring and Evaluation**

CMS will conduct program monitoring throughout the Demonstration. Monitoring will include review of quarterly submissions of required data. Data submitted will be used to determine incentive payments, adequate provision of care to applicable beneficiaries, and provider performance. Practices that do not meet quality standards during any year of the Demonstration or consistently fail to achieve savings over two consecutive years will be terminated from the Demonstration.

An independent evaluation will be conducted for this demonstration. Demonstration practices are required to provide full cooperation to the implementation and evaluation contractors and associated CMS Contracting Officer Representatives. In addition to the evaluation, CMS will prepare a report to Congress, including, but not limited to, an assessment of best practices, coordination of care, expenditures, applicable beneficiary access to services, and quality of health care services provided to applicable beneficiaries.

## **Application Process**

Applicants must submit completed applications following the format outlined in the Demonstration application instructions in order to be considered for review by CMS. Pursuant to Section 1866E (e) (7) of the Social Security Act, this information collection requirement is not subject to the Paperwork Reduction Act of 1995. The application is available online at [http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH\\_FactSheet.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf).

All questions regarding the application must be submitted in writing to the IAH Demonstration email box at [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov).

Applicants must submit at least one electronic copy on CD-ROM of the application and are required to submit a paper version of the application with an original signature. Because of staffing and resource limitations, we cannot accept applications by facsimile (FAX) transmission. Hard copies and electronic copies must be identical.

Applications will be reviewed by CMS only if they are received on or before 5:00 p.m. EST Monday, February 6, 2012. For practices applying as a consortium, the application date will be extended until Friday, May 4, 2012, to allow adequate time to form the legal entity as required above. However, potential consortium practices must submit a letter of intent to participate in the Demonstration by Monday, February 6, 2012, unless the consortium is able to submit a completed application by the original date. At a minimum, applicants should ensure that their applications and supplemental materials include the information requested in the application section.

### **IAH Practice Application**

Please fill out all sections of the application. The application will capture the IAH practice characteristics, practitioner information, and applicable beneficiary eligibility characteristics. If any part is left unanswered, the application will be deemed an incomplete application and will not be reviewed by CMS.

Selection of organizations for the IAH Demonstration will be from among the most highly qualified applicants and will take into consideration a number of factors, including, but not limited to,

operational feasibility, geographic location, and Medicare program priorities (e.g., testing a variety of provider-directed approaches for delivering services). This process will focus only on meeting the overall balance to adequately measure the impact of the Demonstration and the practice selection will be from only those applicants that meet all of the criteria.

If the eligible applicant pool exceeds the 10,000 applicable beneficiary maximum, CMS will select a subset of eligible practices to participate in the Demonstration. Should this occur, practices will be selected to ensure balance among participants for evaluation purposes using the following criteria: location (high cost area, State and region, urban and rural), size of the practice's patient population (variation will be based upon actual applicant pool), and practice readiness (all criteria met at the time of application submission). CMS may also limit the number of beneficiaries per practice to ensure that the Demonstration does not exceed the statutory maximum size of 10,000 beneficiaries.

CMS reserves the right to conduct one or more site visits before making awards.