

Independence at Home: A New Chronic Care Coordination Benefit for Medicare's Most Frail Elders That Reduces Costs
April 19, 2010

- I. **Independence at Home becomes law**—On March 23, 2010, the Independence at Home provision was signed into law as part of the Patient Protection and Affordable Care Act (PPACA) Pub. L. 111-148.ⁱ

That provision requires the Secretary of HHS to make a new chronic care coordination benefit available to 10,000 Medicare beneficiaries suffering from multiple high-cost chronic diseases in a three-year demonstration project.

Independence at Home is the only program in the health reform legislation that provides a new chronic care coordination benefit focusing on Medicare beneficiaries who receive the worst care at the highest cost and holds participating practitioners and providers strictly accountable for (a) minimum savings of 5% annually, (b) good outcomes and (c) patient/caregiver satisfaction.

The Independence at Home Act (H.R. 2560, S. 1131), authored by Congressman Ed Markey (D-MA) and Senator Ron Wyden (D-OR), received strong bipartisan support when introduced and unanimous bipartisan support when incorporated into health reform legislation.

The Independence at Home program is funded entirely from the savings it achieves and has been scored by the Congressional Budget Office as adding no new costs to Medicare.ⁱⁱ

- II. **The Independence at Home program addresses the public's principal concerns about the health reform law**—More than half of Americans oppose the new law and opposition is concentrated among those age 65 and older.ⁱⁱⁱ

Seniors are concerned that the cuts to Medicare used to fund health reform legislation will undermine their care.^{iv} A majority of Americans believe that the health care reform law will *increase* health care costs.^v PPACA also has been widely criticized for including few

reform programs that reduce health care costs, and most of those will take years to implement.^{vi}

The Independence at Home program addresses these criticisms by

- providing a new chronic care coordination benefit for frail Medicare beneficiaries who have difficulty getting to and from a physician's office;
- allowing beneficiaries to maximize their independence by bringing primary care to them in their homes furnished by physician-nurse practitioner-directed teams of health care professionals tailored to their chronic conditions;
- mandating reduced health care costs by at least 5% and
- authorizing IAH to be implemented immediately.

III. The Independence at Home measure permits implementation this year—The IAH provision states that the program must begin no later than January 1, 2012, however, it could be implemented this year because the Centers for Medicare and Medicaid Services (CMS) is to receive \$5 million in 2010 and each year thereafter through 2015 to cover the cost of implementation.

More than 70 health care organizations in 24 states and the District of Columbia already have indicated that they operate IAH-style programs and are ready and willing to participate. Such programs can be expanded at little or no additional cost.

IV. Inadequate and wasteful treatment of chronic illness is *the* most serious threat to elderly Americans and to the U.S. economy—Americans with multiple chronic diseases receive the worst quality health care because they have difficulty obtaining access to care, receive inadequate and conflicting treatment and medications and have poor outcomes.^{vii}

The Medicare benefit is fragmented and does not cover chronic care coordination services designed to avoid high cost hospitalizations, ER visits, nursing home admissions and physician office visits. CMS has acknowledged that "widespread failings in chronic care management are a major national concern."^{viii}

Medicare beneficiaries with multiple chronic illnesses:

- see an average of 13 different physicians;
- fill 50 different prescriptions a year;
- account for 76% of all hospital admissions,
- account for 88% of all prescriptions filled;
- account for 72% of physician visits; and
- are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.^{ix}

Two thirds of physicians treating patients with multiple chronic conditions believe that their training did not adequately prepare them to coordinate in-home and community health services and manage chronic pain.^x

The top 5%-25% of the most costly Medicare beneficiaries account for 43%-85% of Medicare costs.^{xi} By contrast, the least expensive 50% of beneficiaries account for only 4% of Medicare costs.^{xii} Beneficiaries are likely to be persistently high cost if they have two or more chronic diseases, and were users of high cost Medicare services in the past 12 months.^{xiii} This is also the fastest growing segment of the Medicare population.^{xiv}

According to the Congressional Budget Office—“the single greatest threat to budget stability is the growth of federal spending on health care” driven by an aging population and growth in per capita spending.^{xv} President Obama has concurred—“nothing else even comes close.”^{xvi}

V. The Independence at Home program provides a new chronic care coordination benefit for the following Medicare beneficiaries—Those who have been users of high cost Medicare services in the past 12 months and are suffering from two or more chronic diseases such as:

- congestive heart failure;
- diabetes;
- dementias;
- chronic obstructive pulmonary disease (COPD);
- ischemic heart disease;

- stroke;
- Alzheimer's Disease and neurodegenerative diseases; and
- other high cost diseases designated by HHS; and
- need assistance to perform two or more activities of daily living.

VI. The Independence at Home program addresses the public's three greatest fears about chronic illness:

- not being able to pay for care;
- loss of independence; and
- becoming a burden to family and friends.^{xvii}

VII. Independence at Home programs include the following key features—Under the IAH program, Medicare pays for results rather than volume of services.

- Practitioners and providers voluntarily enter into an agreement with CMS under which they agree to provide care coordination services to eligible high cost beneficiaries and to be held strictly accountable for minimum savings of 5%, good outcomes, and patient/caregiver satisfaction in return for a share of any savings they achieve beyond 5%.
- Beneficiaries receive primary care in their homes and care coordination across all treatment settings. Care coordination services are furnished by a physician or nurse practitioner-directed team of health care professionals who make in-home visits and are available 24/7 to carry out plans of care tailored to the beneficiary's individual needs.
- There is no financial risk to Medicare. Independence at Home organizations receive no payment from Medicare unless they reduce the projected costs of eligible beneficiaries while producing good outcomes and patient/caregiver satisfaction. IAH programs that fail to achieve the minimum 5% savings or quality of care standards can have their agreements terminated while those that achieve the minimum performance standards may continue.
- Beneficiaries retain freedom of choice. Eligible beneficiaries have complete freedom of choice to enroll or disenroll in an IAH

program, use any provider or practitioner, and do not relinquish any existing Medicare benefit.

--IAH organizations generate a source of reinvestment for improved technologies and innovation.—Independence at Home organizations split savings, beyond the first 5%, with Medicare (on an 80%/20% basis in the IAH Act) and have a strong incentive to reinvest their share of the savings in innovation including health information technology, remote monitoring technologies and mobile miniaturized technologies to enable them to produce good outcomes at even lower cost in future years.

--The Independence at Home program aligns incentives for practitioners, providers and Medicare.—The traditional Medicare fee-for-service and capitation reimbursement methodologies create an incentive to avoid the highest cost, most complex chronically ill Medicare beneficiaries which has led to this beneficiary population receiving the worst care and the worst outcomes. IAH organizations have an incentive to seek out and enroll beneficiaries who are costing Medicare the most and are receiving the worst care because the potential for savings and improved outcomes and satisfaction is the highest with this patient population.

VIII. The Independence at Home program is health reform that has been proven to work—The IAH program is modeled on hundreds of successful programs across the country that have existed for years including the VA's Home-Based Primary Care Program that is operating in over 138 locations in 48 states and has reduced hospital days by 62%, nursing home days by 88% and overall costs by 24%.^{xviii}

Other successful IAH-style programs include:

Virginia Commonwealth Medical Center house calls program in Richmond, VA that has been operating for 23 years and has reduced hospital costs by 60% for high costs beneficiaries with multiple chronic diseases.

Call Doctor Medical Group that has operating for 25 years in San Diego, CA focused on Medicare beneficiaries with multiple chronic diseases and has reduced ER visits by 59% and generated per capita savings of \$1,075.

Home Physicians program in Chicago, IL that has been operating for 15 years and currently treats 7,000 high cost Medicare beneficiaries with multiple chronic illnesses that has shown a reduction in ER visits and hospitalizations of 35%-60%.

House Call program at Montefiore Health System in the Bronx, NY that has been operating for 5 years treating high cost elders with multiple chronic diseases, currently has an enrollment of 400 patients and has shown a 42% reduction in hospitalizations and a 33% reduction in total costs.

Mount Sinai Visiting Doctors program in New York City, NY that has been operating for 14 years treating elders with multiple chronic diseases, has an annual census of 1,100 beneficiaries and has reduced hospitalizations for those patients by 66%.

House Call program at the Washington Hospital Center, in Washington, D.C. that has been operating for 10 years, has an active census of 600 patients with 3 or more chronic diseases and has produced a 25% reduction in hospital length of stay and a 75% reduction in hospitalizations at the end of life.

Geriatric Care of Nevada (now Geriatric Specialty Care) house call program in North Central Nevada that has been operating for 8 years with a patient census of 850 patients with multiple chronic diseases and has reduced hospitalizations by 27% and per patient total costs by \$750.

GRACE house calls program in Indianapolis, IN that has been operating for more than 5 years and has reduced ER visits by 50% and hospitalization rates by 43% for this high cost beneficiary population.

Medicare spending could be reduced at least \$15 billion a year (more than \$150 billion over ten years) with a fully implemented Independence at Home program (conservatively applying the results of the VA's Home Based Primary Care).

IX. Independence at Home programs have high satisfaction ratings among patients and caregivers—The VA's Home Based Primary Care program has received a patient satisfaction rating of 82.7% which is the highest satisfaction rating ever received by a VA health care program.

The Mount Sinai Visiting Doctors program has found that 100% of the patients/caregivers believe the program improved their quality of life, 92% reported the quality of care as "outstanding" or "very good" and 88% reported that the program "definitely meets their needs."

HomeCare Physicians, an IAH-style program in Wheaton, Ill. conducted a survey of its patients in 2008 in which 78% of patients felt that the house calls program has reduced their visits to the ER, 81% felt that the program had helped them avoid hospitalizations, and 72% felt that the program had helped them avoid being placed in a nursing home.

Many IAH-style programs report that they have waiting lists of patients with multiple chronic diseases who wish to enroll in their programs.

X. The Independence at Home program has been endorsed by a broad range of organizations representing consumers, practitioners, providers, and technology companies including the following:

- AARP;
- Adobe Systems, Inc.;
- Continua Health Alliance;
- The Alzheimer's Foundation of America;
- The Alzheimer's Association;
- The American Academy of Home Care Physicians;
- The American Academy of Neurology;
- The American Academy of Nurse Practitioners;

The American Academy of Physicians Assistants;
The American Association of Homes and Services for the Aging;
The American College of Nurse Practitioners;
The American Geriatrics Society;
The American Nurses Association;
The American Psychotherapy Association;
The American Society of Consultant Pharmacists;
The Family Caregiver Alliance/National Center on Caregiving;
The National Academies of Practice;
Housecalls Doctors of Texas;
Intel Corp.;
The Maryland-National Capital Home Care Association;
The Massachusetts Neurologic Association;
MD2U Doctors Who Make Housecalls (Louisville, KY);
Medicare Rights Center;
National Partnership for Women and Families;
Personalized Physician Care, Inc.;
The National Council on Aging;
The National Family Caregivers Association;
The Schizophrenia and Related Disorders Alliance of America;
U.S. PIRG;
The Visiting Nurse Associations of America;
The Visiting Nurse Association of Greater Philadelphia;
The Visiting Physician Services; and
Wyeth (now Pfizer)

Independence at Home is the future of health care—that can be implemented NOW—Medicare beneficiaries and their caregivers should not continue to suffer and Medicare should not continue to waste billions of dollars on ineffective health care when we know how to do better.

Independence at Home programs have been the subject of televised media coverage by

CNN-

<http://www.cnn.com/2009/HEALTH/05/25/hm.doctor.house.call/index.html#cnnSTCVideo>

<http://www.cnn.com/2009/HEALTH/05/25/hm.doctor.house.call/index.html#cnnSTCText>

***provided by Senator Ron Wyden's Office

PBS Nightly Business Report-

<http://www.pbs.org/nbr/info/video-share.html?s=nbre07s2dd4q669>

NBC Nightly News-

<http://www.msnbc.msn.com/id/3032619/#34246775>

The following individuals would be glad to answer questions about existing IAH-style programs:

**Dr. Tom Edes, Department of Veterans Affairs,
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ⁱ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3024 (2010).

ⁱⁱ Congressional Budget Office letter to the Honorable Nancy Pelosi, Table 5, 4 (March 20, 2010).

ⁱⁱⁱ Ricardo Alonso-Zaldivar, Resistance to Health Care Law Still Strong, Poll Shows, April 15, 2010, http://news.yahoo.com/s/ap/20100415/ap_on_bi_ge/us_ap_poll_obama_health_care.

^{iv} *Id.*

^v *Id.*

^{vi} Cost-Cutting Takes a Back Seat in Health Bills, Los Angeles Times (Nov. 10, 2009); Health Bills Too Timid on Cutting Costs Experts Say, The Washington Post (Nov. 4, 2009); Even if Health Bill Passes Soon, Wait for Reforms Could Be Long, The Washington Post (Nov. 4, 2009).

^{vii} Chronic Care: A Call to Action for Health Reform, AARP, 57-76 (2009); G. Anderson, Chronic Conditions: Making the Case for Ongoing Care, Johns Hopkins University, p. 4 (Dec. 2002).

^{viii} Finding by the Centers for Medicare and Medicaid Services, 69 Fed. Reg. at 22,066 (April 23, 2004).

^{ix} Senate Special Committee on Aging, "The Future of Medicare: Recognizing the Need for Chronic Care Coordination," Serial No. 110-7, 19-20 (May 9, 2007) (Testimony of Gerard F. Anderson, Ph.D., Johns Hopkins Bloomberg School of Public Health, Health Policy and Management); Chronic Conditions, *supra*, note vii, at 15.

^x "Chronic Conditions: Making the Case for Ongoing Care," *supra* note vii, at 35.

^{xi} High-Cost Medicare Beneficiaries, Congressional Budget Office, 2 (May 2005).

^{xii} *Id.*

^{xiii} High-Cost Medicare Beneficiaries, *supra* note xi, at 9.

^{xiv} K. Peaz, et al., *Rising Out-of-Pocket Spending For Chronic Conditions, A Ten Year Trend*, **Health Affairs**, Jan./Feb. 2009, at 22.

^{xv} Budget and Economic Outlook: Fiscal Years 2010 to 2020, the Congressional Budget Office, 1 (Jan. 2010).

^{xvi} Speech by President Barack Obama (Sept. 9, 2009).

^{xvii} Making the Case for Ongoing Care, *supra* note vii, at 30.

^{xviii} *Veterans' Affairs Home Based Primary Care, 25 Clinics in Geriatric Medicine*, 1, 153 (Feb. 2009).