Independence at Home Demonstration Performance Year 6 Results
Fact Sheet

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), and has been extended three times, most recently by the Consolidated Appropriations Act, 2021. 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. It does so through a payment incentive and service delivery model for home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses. Practices that reduce their applicable beneficiaries' Medicare expenditures sufficiently below their spending targets may share in a portion of the difference between the expenditures and the spending target, referred to as an incentive payment.

Under the IAH Demonstration, participating practices must meet the performance thresholds for at least three of the six quality measures in order 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.

A practice's incentive payment is adjusted based on its performance on the associated quality measures.

Summary of Results from Performance Year 6

In Performance Year 6 of the Demonstration (January 1, 2019 – December 31, 2019), the Centers for Medicare & Medicaid Services (CMS) found that the expenditures for IAH practices' applicable beneficiaries were approximately 13.8 percent (equating to $32.3 million) below their spending targets, an average reduction of $5,054 per beneficiary. Ten out of the 11 IAH practices reduced the per-beneficiary-per-month (PBPM) expenditures relative to the practice's PBPM spending target.

For Performance Year 6, CMS will provide incentive payments to 9 practices (as shown in Table 1) that met the requirements for an incentive payment and whose expenditures for applicable beneficiaries were more than 5 percent below their estimated spending target for an aggregate payment amount of $11,275,595 in May 2021.

A total of 6,388 beneficiaries were enrolled in the Demonstration at 11 participating practices (10 practices and 1 consortium consisting of 3 practices). Ten out of the 11 IAH practices met three or more of the six quality measures; three of those practices met the performance thresholds for all six quality measures. Only practices with at least 200 applicable beneficiaries, positive savings percentages, whose spending targets exceed a minimum confidence threshold, and which meet or exceed the minimum performance threshold on at least three of the six quality measures are eligible for an incentive payment.

Table 1.
Performance Year 6 Results for Participating Practices

Independence at Home Practice Name	Year 6 Spending Target*	Year 6 Expenditures*	Practice Incentive Payment, no sequestration^
Boston Medical Center	$3,091	$2,707	$0
Christiana Care Health System	$3,461	$3,517	$0
Comprehensive Geriatric Medicine P.C. d/b/a Doctors on Call	$4,109	$3,461	$1,657,122
Housecall Providers, PC	$2,761	$2,149	$741,827
Northwell Health House Calls	$4,772	$3,719	$2,931,808
RMED, LLC	$3,896	$3,619	$173,860
Visiting Physicians Association of Texas, PLLC – Dallas	$4,340	$3,938	$768,362
Visiting Physicians Association, P.C. – Flint/Saginaw/Marysville	$3,684	$3,202	$1,449,579
Visiting Physicians Association, P.C. – Lansing/Ann Arbor	$3,460	$2,952	$671,550
Visiting Physicians Association, P.C. – Milwaukee	$2,984	$2,387	$768,510

(continued)

Table 1.
Performance Year 6 Results for Participating Practices (continued)

Independence at Home Practice Name	Year 6 Spending Target*	Year 6 Expenditures*	Practice Incentive Payment, no sequestration^
Mid-Atlantic Consortium	$3,718	$2,898	$2,112,977
Total	$3,843	$3,314	$11,275,595

* The Year 6 Spending Target and Year 6 Expenditures are on a PBPM basis.

^Beginning April 1, 2013, all Medicare expenditures were reduced by 2 percent due to sequestration. Beginning May 1, 2020 and effective through December 31, 2020, sequestration was suspended as part of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The suspension was extended through December 31, 2021 (H.R. 1868, signed April 14, 2021). For this reason, the IAH practices' incentive payments were not subject to a sequestration reduction.

Performance Year 6 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 participating IAH practices 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").

For Performance Year 6, all calculations used a revised actuarial methodology, which generates practice-specific per beneficiary per month (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.

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