**The Independence at Home Act:**
**Paying for Clinical and Cost Effectiveness**
**February 19, 2008**

The Independence at Home Act which establishes a chronic care coordination benefit under the Medicare fee-for-service program that allows the growing number of America's seniors with multiple chronic illnesses the opportunity to remain independent and receive better health care and generates immediate savings under Medicare that can be used to pay for the program and for other purposes.

The Independence at Home Act:

1) Provides chronic care coordination services to Medicare beneficiaries with the highest cost multiple chronic conditions whose care under the traditional Medicare program has been fragmented and costly and has produced poor outcomes.

2) Provides sufficient savings to fund the program as well as minimum mandatory savings of 5% for the Medicare program annually.

3) Provides incentives for additional savings by allowing providers to retain 80% of savings beyond 5% to invest in health information technology, telemonitoring and mobile diagnostic technology.

4) Holds physicians and providers accountable annually for three performance standards—patient satisfaction, outcomes and savings.

5) Allows physicians making house calls to waive the coinsurance for participating beneficiaries.

6) Preserves all existing Medicare coverage.

7) Preserves freedom of choice by making participation voluntary and providing that beneficiaries may switch Independence at Home programs at any time.

8) Provides access to education and support for families and caregivers.

9) Allows the growing Medicare population with multiple chronic conditions to remain as independent as possible for as long as possible.

10) Avoids the need for a demonstration project by allowing programs to continue only if they meet the performance standards.

**Better Health Care and Savings Immediately**

The Independence at Home Act incorporates the lessons learned from chronic care coordination demonstration projects and Phase I of the Voluntary Chronic Care Improvement program as well as physician house call programs, to immediately

a) improve the quality of health care for the highest cost, most frail segment of the Medicare population;

b) provide this care through a self-funded program that generates savings that can be used for other purposes determined by Congress; and

c) begin reforming the 1965 Medicare service delivery model to meet the needs of the changing Medicare population now and in the future with available resources.

**Funding Better Health Care Through Savings**

The Independence at Home program is premised on the finding by the Congressional Budget Office (CBO) that "even a small percentage reduction in the spending of that group of [high cost, chronically ill] beneficiaries could lead to large savings for the Medicare program."[1] As has CBO noted recently, studies have shown that health care spending varies widely among regions of the country, and "could be cut by about 30% if the more conservative practice styles used in the lowest-spending one-fifth of the country could be adopted."[2]

The traditional Medicare fee-for-service reimbursement structure encourages fragmented, condition-oriented care ill-suited to meet the needs beneficiaries suffering from multiple chronic illnesses, while the capitated reimbursement system creates an incentive to avoid these patients. [3] The lack of chronic care coordination under Medicare has contributed to the following:

a) the United States spends more on health care per capita than most industrialized countries and yet has worse outcomes;[4]

[1] "High-Cost Medicare Beneficiaries", Congressional Budget Office, p. 4 (May 2005)
[2] "Research on the Comparative Effectiveness of Medical Treatments", CBO, p. 15 (December 2007).
[3] "Enhancing Value in Medicare: Chronic Care Initiatives to Improve the Program", p. 3, The Commonwealth Fund, testimony before the Senate Special Committee on Aging (May 9, 2007).
[4] Id. at p.4.

b) the top 25% of Medicare's costliest beneficiaries have multiple chronic conditions and account for "fully 85 percent of spending";[5]

c) these beneficiaries suffer from multiple chronic conditions such as congestive heart failure, diabetes, coronary artery disease, hypertension and dementias including Alzheimer's Disease[6];

d) they see an average of 13 different physicians a year, fill 50 different prescriptions, often receive conflicting diagnoses and advice from providers about the same set of symptoms, and are 100 times more likely to have a preventable hospitalization[7];

e) such high resource consumption by the chronically ill generally produces worse outcomes[8]; and

f) racial and ethnic disparities in health status are perpetuated due to the fact that chronic conditions are more prevalent in minority Medicare populations. [9]

The Independence at Home Act authorizes the Secretary of HHS to enter into three-year agreements with combinations of providers, physicians or other organizations approved by the Secretary to provide chronic care coordination services to Medicare beneficiaries suffering from multiple chronic conditions if they have used certain Medicare services in the past year and have impairments that prevent them from carrying out two or more activities of daily living. The qualifying chronic conditions include congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, Alzheimer's Disease and hypertension.

The providing organizations are held accountable annually for three performance standards:

a) beneficiary satisfaction;

b) outcomes appropriate to the beneficiary's condition; and

c) minimum savings of 5%.

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[5] CBO Finding, supra note 1 at p. 4.
[6] CBO Finding, supra note 1 at p. 6.
[7] Testimony of Gerald F. Anderson, Ph. D., Johns Hopkins Bloomberg School of Public Health, Health Policy and Management, (May 9, 2007).
[8] "The Care of Patients With Severe Chronic Illness", The Center for the Evaluative Clinical Sciences, Dartmouth Medical School (2006).
[9] Centers for Disease Control and Prevention Finding, 69 Fed. Reg. at 22,066.

Organizations that fail to fulfill the performance standards can have their agreements terminated.

Organizations will be paid a flat fee for geriatric assessments and a monthly fee per beneficiary for developing and implementing a chronic care coordination plan of care. Any organization that fails to achieve the 5% minimum mandatory savings will be required to make up the short fall by refunding a portion or all of the payments received during the year.

Organizations that achieve savings in excess of 5% will split those savings 80%/20% with Medicare and will have a strong incentive to invest those savings in three types of technology to enhance savings in the future:

health information technology,
remote monitoring technology and
mobile miniaturized diagnostic technology.

Savings are measured by comparing the cost to Medicare of beneficiaries enrolled in an Independence at Home program with the cost of comparable beneficiaries not enrolled in any program.

**Maximum Potential With Minimum Risk**

The Independence at Home Act presents the opportunity for significantly improving the quality of health care for a rapidly growing, high cost segment of the Medicare program with minimal risk. There is minimal risk to the beneficiaries because they relinquish no benefits and can enroll or disenroll or switch programs at any time.

There is limited risk to the providing entities because only those that believe they can achieve savings will participate, and they are at risk for, at most, the fees received during the year.

There is minimal risk for the Medicare program because providing entities are held accountable for a minimum savings of 5%, and they must provide assurances satisfactory to the Secretary that they can pay refunds necessary to achieve the minimum savings. Further, the Secretary can terminate the agreements of providers that do not meet the performance standards. This facilitates a “winnowing” process under which high quality programs expand and poor quality programs are eliminated.

The risk is further minimized by the fact that the Independence at Home program builds on the demonstrated success of numerous existing chronic care coordination programs and the well-established practice and experience of private practice physicians who have been making home visits and saving Medicare dollars by avoiding inpatient admissions and emergency room visits for

beneficiaries with multiple chronic conditions. A recent report from the largest randomized clinical trial testing the effect of physician-directed health care teams to maintain high cost patients in their homes found that such programs reduced both hospitals stays and emergency room visits. This is consistent with reports on other such programs.[10]

There is a strong potential for improving the quality of health care for participating beneficiaries because outcomes and patient satisfaction will be measured and the beneficiary's care will be coordinated under a health care plan tailored to his or her individual needs and conditions. The providing entities will have the potential to generate a profit based on the savings they achieve for Medicare which will allow them to invest in technologies that will enhance the potential for savings and profits in the future. If the providers meet the performance standards, their agreements will be renewed.

Medicare will have the potential for greater savings on the most costly beneficiaries as the successful Independence at Home programs increase enrollment. The IAH program also provides the strongest incentive to initiate programs in the highest cost regions of the country because the cost savings are computed based on the average cost to Medicare of eligible beneficiaries in each region. Savings will be more easily achieved in the higher cost regions. As the Independence at Home programs become more refined and the technology improves, the Secretary has the discretion to expand the list of chronic conditions that will allow beneficiaries to qualify for the coordination services.

**A Unique Opportunity for Sound Health Policy**

The Independence at Home Act presents Congress with perhaps the only opportunity to provide better health care to a poorly served segment of the Medicare beneficiary population, reduce the cost of the Medicare program where it is highest and most likely to increase, and provide health care in a manner that is popular with beneficiaries and their families. The Independence at Home program is likely to be popular with

patients, because it is voluntary;

physicians, because it has the credibility and confidence that comes with physician involvement; and

the payer (Medicare), because it generates savings.

As one health policy organization has concluded, it is difficult to believe that a well designed chronic care coordination program will not save money for Medicare and, in any event, the existing Medicare program could hardly provide

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[10] "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial", Journal of the American Medical Association, p. 2623, 2631, notes 15, 46-49 (December 12, 2007).

worse or more costly care for Medicare beneficiaries suffering from multiple chronic conditions. [11]

There is nothing in the Independence at Home Act that prohibits or restricts any authorized demonstration project that takes a different approach or targets a different beneficiary population. When the results of any such demonstration project become available some years in the future, they can be used to further reform Medicare or refine this program, if they prove valuable. But Congress has an opportunity to provide for better health care and savings by now.

The Independence at Home Act will not only be popular with beneficiaries but also with caregivers many of whom are elderly and suffering from chronic conditions themselves. It will also be popular with younger members of the middle class known as the "sandwich generation" who are struggling to hold down two or more jobs while trying to raise children and take care of elderly parents suffering from chronic conditions. The program builds primary care capacity for Medicare's sickest beneficiaries, supports seniors' desire to remain independent and age in place in a voluntary program, and relieves pressure on the Medicare budget.

In short, the Independence at Home Act provides for health care that Americans want and need.

The following organizations have endorsed the Independence at Home Act:

1. AARP;

2. The National Family Caregivers Association;

3. The Family Caregiver Alliance/National Center on Caregiving;

4. The American Association of Homes and Services for the Aging;

5. The Maryland-National Capital Home Care Association;

6. The American Academy of Home Care Physicians;

7. The Visiting Nurse Associations of America, and

8. Intel Corp.

For more information, contact:

[11] Testimony of Commonwealth Fund before Senate Special Committee on Aging (May 9, 2007).

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