



INDEPENDENCE AT HOME
Reducing Medicare Expenditures with Better Health Care That
Americans Want
December 2, 2008

1. What is the Independence at Home Act (S. 3613, H.R. 7114)?

A bipartisan bill that:

- **Provides a chronic care coordination benefit for the highest cost Medicare beneficiaries with multiple chronic illnesses who receive poor quality, fragmented health care;**
- **Is funded from the savings it achieves;**
- **Reduces Medicare expenditures by at least 5% starting with the highest cost beneficiaries in the highest cost states;**
- **Provides an incentive for additional savings for investment in health IT and other technologies that generate savings;**
- **Provides health care that beneficiaries want at home;**
- **Preserves beneficiary choice—beneficiaries retain all existing coverage and may enroll or disenroll in an IAH program at their discretion.**

The IAH Act begins reform of the 1965-style Medicare service delivery model from hospital first to home care first.

2. Why is the Independence at Home Act needed?

- **Per capita cost of the Medicare program is growing at an unsustainable rate. Medicare spending “could be cut by about 30 percent” and outcomes could be improved if more conservative approaches were taken in treating Medicare beneficiaries with multiple chronic conditions.ⁱ**
- **Each year 10% of Medicare beneficiaries with multiple chronic illnesses account for 2/3s of Medicare spending.ⁱⁱ**



- **“Even a small percentage reduction in spending for that group of beneficiaries could lead to large savings for the Medicare program.” By contrast, the least expensive 50% of the Medicare population accounts for only 4% of Medicare spending.ⁱⁱⁱ**
- **The Medicare FFS program encourages the fragmentation and overutilization of health care.**
- **Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians;**
- **They fill 50 different prescriptions a year;**
- **They account for 76% of all hospital admissions,**
- **They account for 88% of all prescriptions filled;**
- **They account for 72% of physician visits; and**
- **They are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.^{iv}**
- **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.^v**
- **High cost Medicare beneficiaries can be identified by whether they were high cost in the previous year, whether they were hospitalized in the previous year and whether they had two or more of specific high cost chronic illnesses.^{vi} The Independence at Home Act uses all of these approaches to target high cost Medicare beneficiaries.**

3. What are the key elements of the Independence at Home Act?



- **An Independence at Home Care Team is a team of health care professionals directed by a qualified IAH physician or nurse practitioner who coordinates all of an eligible beneficiary's health care across all treatment settings and makes house calls to the beneficiaries.**

- **IAH beneficiaries are those suffering from two or more specified high cost chronic illnesses, have utilized certain Medicare benefits in the past 12 months and have an inability to perform two or more activities of daily living.**

- **IAH organizations are comprised of Medicare providers and physician or nurse practitioner groups.**

- **IAH organizations may enter into an IAH agreement with the Secretary of HHS to provide IAH services if the organization demonstrates it has adequate experience in treating eligible beneficiaries in a home setting and has adequate health information technology.**

- **IAH organizations must meet the following three performance standards as a condition of maintaining their IAH agreements:**
 - a) **Minimum savings of 5% per year;**

 - b) **Outcomes appropriate for the beneficiary's condition; and**

 - c) **Patient satisfaction.**

- **IAH organizations that fail to achieve 5% savings must refund payments made during the year to make up any shortfall.**



- **IAH organizations that achieve savings beyond 5% split the additional savings with Medicare on an 80%/20% basis.**
- **The IAH program is completely voluntary—beneficiaries do not relinquish any existing Medicare benefit and they may withdraw from or change IAH programs at their discretion.**

4. Is the Independence at Home program based on any existing models?

Yes, the Independence at Home program is based on the physician house calls model which is currently operating successfully at hundreds of locations across the country and on the Home Based Primary Care delivery model operated successfully for years by the Department of Veterans Affairs. It is also grounded in the traditional model of health care delivery in the United States updated by the use of three types of technology—health information technology, remote monitoring technology and miniaturized mobile diagnostic technology.

5. What organizations have endorsed the Independence at Home Act?

The Independence at Home Act has been endorsed by

AARP;

The American Academy of Home Care Physicians;

The American College of Nurse Practitioners;

The National Family Caregivers Association;

The Family Caregiver Alliance/National Center on Caregiving;

The American Association of Homes and Services for the Aging;

The Maryland-National Capital Home Care Association;

The Visiting Nurse Associations of America;

Intel Corp.;

The National Council on Aging, and

U.S. PIRG



6. Who can I contact who could give me information about successful IAH-style programs?

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

Dr. George Taler, MedStar Health, Wash., D.C. (202) 360-7203

Dr. Peter Boling, Medical College of Virginia, (804) 828-5323

Dr. Gresham Bayne, JanusHealth, San Diego, CA (619) 851-1300

Dr. Tom Edes, Department of Veterans Affairs, (202) 461-6785

Connie Row, Executive Director, American Academy of Home Care Physicians, (410) 676-7966

For more information, contact:

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ⁱ “Research on the Comparative Effectiveness of Medical Treatments: A CBO Paper”, p. 15 (Dec. 2007), citing “The Implications in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care,” Elliot S. Fisher and others, *Annals of Internal Medicine*, vol. 138, no. 4 (Feb. 18, 2003), pp. 288-298.

ⁱⁱ CMS Chart Book June 2002 edition, Section III.A, p. 29, 69 Fed. Reg. at 22,066 (April 23, 2004).

ⁱⁱⁱ “High-Cost Medicare Beneficiaries,” Congressional Budget Office, p. 4 (May 2005).

^{iv} Testimony of Gerard F. Anderson, Ph.D., Johns Hopkins Bloomberg School of Public Health, Health Policy and Management, before the Senate Special Committee on Aging, “The Future of Medicare: Recognizing the Need for Chronic Care Coordination, Serial No. 110-7, pp. 19-20 (May 9, 2007).

^v “Chronic Conditions: Making the Case for Ongoing Care,” Partnership for Solutions, Johns Hopkins University, p. 35 (Dec. 2002).

^{vi} “High-Cost Medicare Beneficiaries,” CBO, p. 14 (May 2005).