Independence at Home (IAH): HR 3263

Value of Home-Based Primary Care for Frail Elders and Medicare

Testimony of K. Eric De Jonge, M.D.

President-Elect, American Academy of Home Care Medicine (www.aahcm.org)

Before the House Energy and Commerce Committee, Health Subcommittee

July, 20, 2017

I am Dr. Eric De Jonge, a Geriatrician at MedStar Health in D.C. I have made House Calls for 25 years and serve as President-Elect of the American Academy of Home Care Medicine (AAHCM).

Thank you, Chairman Burgess, Ranking Member Green, and members of the Health subcommittee for inviting me to testify. I am here to give the Academy's full support to H.R. 3263, a 2-year extension of the Independence at Home (IAH) Medicare demonstration. Thank you, Representatives Burgess and Dingell, for introducing this important legislation, along with your colleagues Representatives Roskam and Thompson.

For the last five years, my team and I have participated in the IAH demonstration, which has tested a model of Home-Based Primary care for Medicare patients who have multiple chronic conditions and disability. The IAH model uses interdisciplinary teams of medical and social service professionals to care for patients in their homes, delivering high quality clinical care, excellent patient experience, and significantly lower costs for the Medicare program.

Today, I will…

- Discuss why Home-Based Primary Care and the IAH Model Work
- Review 5 years of IAH Demonstration Results, and
- Highlight the Value of a 2-year IAH Extension

IAH works for patients, caregivers, providers, health systems, and Medicare

For seriously ill elders, providing 24/7 medical and social services at home allows them to live a life with dignity and respect, where they want to be…at home. It brings peace of mind to family caregivers by coordinating all needed health services, prepares patients and families for managing serious illness, and supports them until the last day of life. IAH practices can deliver many services available in an urgent care center or hospital room – portable diagnostic, therapeutic, and monitoring technologies that allow the patient to stay at home, rather than come to the hospital. These services include urgent medical visits, blood tests, X-rays, EKGs, IV medications, oxygen, social work, and caregiver education. In sum, ill elders and families gain access to skilled primary care, maximize their time at home, call 911 less often, and are admitted less often to the hospital.

For providers and health systems, the practice of house calls is an old idea, improved with modern technology. By visiting the home, we build close relationships and trust with patients and families, leading to more accurate diagnosis and more effective treatment. We serve as the "quarterback" of a mobile team, coordinating medical care and social services that are often as important as medical treatment. For health systems, the IAH model offers a way to ensure that high-need and high-cost elders receive care in a more desired and appropriate setting, at a lower cost. This allows health systems to qualify for value-based revenues such as shared savings and prospective payments. IAH practices are measured on cost savings and – of equal importance – on the quality of care we provide. IAH providers only receive a full share of savings if they meet 6 major quality metrics for patient care. For example, at MedStar Health, we serve as part of an IAH consortium with Virginia Commonwealth University and University of Pennsylvania. With the help of shared savings payments, MedStar funded a new House Call team in Baltimore, enabling us to serve more elders and families, and generate more cost savings.

For Medicare, home-based primary care brings multiple rewards— these include enhancing quality of service for our nation's most ill elders and their families while achieving the important side effect of cost savings for Medicare. With mobile teams of Physicians, Nurse Practitioners or Physician Assistants, and Social Workers, we can address routine and urgent issues and manage nearly all needed care in the home. The IAH payment incentives reduce costs by requiring that program participants produce savings in order to remain in the program. This self-culling feature is an important part of the IAH demonstration that delivers high quality care and costs savings to the system. IAH also encourages innovation in telehealth services. For example, some IAH sites have implemented tele-video after-hours or used specially-trained paramedics to keep patients at home and out of the hospital.

IAH Demonstration Results

The IAH Medicare demonstration has enrolled over 11,000 Medicare patients since 2012 and is due to expire on September 30, 2017, just a few months away. IAH practices serve the 5% of Medicare patients with severe chronic illness and disability who are the most complex and costly patients. The Congressional Budget Office found that these 5% of patients represent nearly HALF of all Medicare costs. Each IAH patient, on average, costs Medicare $40,000-$50,000 a year.

Who are the IAH patients? The IAH demonstration strict eligibility criteria require patients have:

- Two or more permanent chronic illnesses;
- A serious disability—patient must need assistance with 2 or more "Activities of Daily Living" such as bathing or dressing; and
- Had a Hospital Admission and Post-Acute Rehabilitation or Skilled Care event in the past year.

In Year ONE of IAH, there were 17 IAH sites and in Year TWO, there were 15 sites (two practices left the demonstration). Providers only received savings if they exceeded 5% in Medicare cost reduction. In Year ONE, 9 of 17 IAH sites demonstrated total Medicare cost savings above the 5% threshold and received shared savings payments. The average savings was $3,070/ patient year. In Year TWO, 7 of 15 sites showed cost reductions over the 5% threshold and received shared savings payments, with an average savings of $1,010/ patient year. It is important to note that CMS retains the first 5% of savings and a portion of additional savings after the first 5%. <u>The total Medicare cost savings for Years ONE and TWO of IAH was $32 million, with half of those savings distributed back to IAH providers for financial support of their practices.</u>

In our Mid-Atlantic IAH Consortium, with our colleagues from VCU and Penn, we met all 6 of 6 major quality metrics and achieved total Medicare costs reductions of 20% in Year 1 and 12% in Year TWO. The range of our savings was $6,000-$12,000 per patient-year.

H.R. 3263: Two-Year Extension of IAH Demonstration

H.R. 3263 extends the IAH demonstration for an additional two years and expands the number of beneficiaries from 10,000 to 15,000. For the above reasons and more stated below, we offer our strong support for the legislation.

- H.R. 3263 helps the 15 IAH current sites continue the care they are providing and promotes the use of a value-based, shared savings payment model.
- H.R. 3263 gives IAH practices and all U.S. home based primary care providers the security of knowing this model will continue to be a priority for Congress.
- H.R. 3263 provides an opportunity to apply key lessons learned during the first 5 years of the demonstration, giving us an important chance in the next two years to make common sense adjustments to the model so that it continues to improve over time.

  For example, the IAH demonstration could:

  - Use more telehealth tools to enhance care and further reduce costs,
  - Enhance the timeliness and reliability of payments to support practice sustainability, and
  - Optimize the accuracy of the savings methodology.

In time, this IAH extension will provide a national platform and the needed data to expand home-based primary care to elders and providers in ALL states, and generate even greater Medicare cost savings. Thank You.

Resources and Evidence Base

www.AAHCM.org – The American Academy of Home Care Medicine is a professional organization of over 1200 physicians, nurse practitioners, physician assistants, social workers, and others working in the field of home care medicine. Academy member promotes the Art, Science, and Practice of Home Care Medicine.

IAH Year 1 and 2 Results from CMS: (www.cms.gov)
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html

https://innovation.cms.gov/Files/x/iah-yroneresults.pdf

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-09.html

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19.html

Published Articles

B Leff, P Boling. Comprehensive Longitudinal Health Care in the Home for High-Cost Beneficiaries: A Critical Strategy for Population Health Management. J Americ Geri Soc. 62:1974-76
http://onlinelibrary.wiley.com/doi/10.1111/jgs.13049/full

KE De Jonge et al. Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders. J Americ Geri Soc. 62:1825-31. Oct. 2014 http://onlinelibrary.wiley.com/doi/10.1111/jgs.12974/full

T Edes et al. Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care. J Americ Geri Soc. 62:1954-61. Oct. 2014
http://onlinelibrary.wiley.com/doi/10.1111/jgs.13030/full

Recent Media Coverage – Future of Home Care Medicine

http://www.commonwealthfund.org/publications/newsletters/ealerts/2017/jun/home-based-primary-care?view=newsletter_email&email_web=true&omnicid=EALERT1222972&mid=mh@cmwf.org

http://www.usnews.com/news/articles/2016-08-31/get-set-for-the-modern-house-call

http://www.hfma.org/Content.aspx?id=51244

https://www.brookings.edu/wp-content/uploads/2016/06/Rauch_LateLifeCare.pdf