TO:
Senate Finance Committee-Chronic Care Working Group
A Proposal for Expanding Independence at Home (IAH)

The Working Group's December Policy Options document asked for additional input on expanding IAH. Our proposal addresses two areas;

1. How to identify additional beneficiaries with multiple chronic conditions
2. Attracting additional practices to IAH

I - Dual Eligibles - expand IAH to include these beneficiaries

CMS's most vulnerable and expensive beneficiaries are the 10 million Dual Eligibles - those enrolled in both Medicare and Medicaid. Last year, CMS' Medicare-Medicaid Coordination Office launched a program for duals that, within a few months, had a 90% national dropout rate. This unfortunate result was caused by the reliance on managed care organizations and their restrictive networks of providers. Duals have multiple comorbidities. They get their care from a variety of specialists who often do not participate in the same or any networks. The decision by most Duals to drop the program was wholly appropriate and understandable. They require continuity of care to remain healthy and out of institutions.

IAH's reliance on traditional Medicare, which does not have managed care's restrictive networks, eliminates this barrier. IAH rewards physicians who care for the sickest and frailest Medicare beneficiaries at home with a gain-sharing incentive.

Conversely, a different form of managed care -- Managed Long Term Care (MLTC) -- is vital to this population. MLTCs provide the services (home health aides, durable medical equipment, etc.) that enable these beneficiaries to stay out of institutions. Coupling the physicians in an IAH Organization with an MLTC would provide a better solution for the Duals population. Gain-sharing on the Medicare side would fund the increased Medicaid services needed from the MLTCs to truly decrease the use of hospitals and nursing homes.

Legislation is required to permit such a structure.

II - Including Independent Solo and Small Group Practices in IAH

In July, 2015 the AMA conducted a survey that showed the following:

- More than 60% of physicians practice in the solo or small group setting.
- More than 50% of physicians practice in physician owned organizations.

None of the IAH demonstration projects include these physicians.

In order to attract more independent physicians, CMS must:

- Make More timely payment of gain-sharing. CMS should make monthly payments based on early and admittedly incomplete utilization results.CMS has the date with which to construct an algorithm that can reliably predict the ultimate utilization from the initial data and adjust going forward.
- Hold Harmless from antitrust. Independent physicians who form IAH Organizations must be protected from antitrust and profit sharing rules for this population.

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(Dr. Resnick was one of 97 people appointed as a CMS Innovation Center Fellow. His application for that position described a program to spread IAH throughout New York City. The latter follows this proposal starting on page 3.

The following document previously shared with the New York State Department of Health and the CMS Office of the Duals has more details on how to expand IAH into that population.)

Independence at Home for Duals

CMS will soon release the results of the Independence at Home (IAH) demonstration. It will likely demonstrate savings of over 15% to Medicare. *(Subsequent to the writing of this memo, in May , 2015 CMS announced 24% overall savings in the IAH demos.)*

IAH has no managed care networks. It creates Independence at Home Organizations -- groups of physicians and nurse practitioners -- and incentivizes them with gain sharing. Beneficiaries are free to see any Medicare provider at will. Savings rely completely on the beneficiaries' 24/7 access to their personal physicians.

The duals population would be well served by adapting such a program to its needs. CMS could marry this Medicare program with the Medicaid benefit package so that savings from the former can enrich the latter.

IAH for Duals Organizations (IDO) could be effected as follows:

- Enter into tripartite contracts between CMS, IAH organizations (IAHO) and Managed Long Term Care Companies (MLTC).
- The MLTCs continue to receive a monthly capitation for the Medicaid benefit package.
- The IAHOs continue to be paid on a fee-for-service basis for their Medicare services.
- IAH-style Medicare gain-sharing incentivizes both the IAHO and the MLTC.
    - The first 5% of savings are retained by CMS
    - Savings beyond 5% are split 80/20 between CMS and the IDO
    - The IDO divides its savings allocation using the ratio of the Medicare risk adjusted spending targets and the MLTC capitation.

For example, assume the following:

- The monthly MLTC capitation is $2,000 pmpm
- The risk adjusted Medicare monthly target is $2,500 pmpm.
- Medicare actual costs are $2,000 pmpm -- a $500 pmpm savings -- a rate of 20% on the Medicare target

Gain Sharing is calculated as follows:

- Medicare retains the first 5% of the savings -- $125 pmpm
- The IDO receives the remaining 15% -- $375 pmpm.
- The MLTC:IAHO gain-sharing ratio is 4:5 -- i.e. MLTC capitation : risk adjusted Medicare target
    - MLTC gain-sharing = $167 pmpm (4/9 of $375)
    - IAHO gain-sharing = $208 pmpm (5/9 of $375)

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Dear Dr. Resnick,

I am pleased to confirm that the Task Force on Independent Practice of the Medical Society of the State of New York has voted to endorse the proposal you are submitting to the Senate Finance Committee-Chronic Care Working Group on expanding Independence at Home. The Task Force will be forwarding its recommendations for consideration by MSSNY Council.

Members were impressed at the effectiveness of the Independence at Home model and agreed that expanding it by identifying more beneficiaries with multiple chronic conditions and attracting additional medical practices to participate in IAH is a laudable goal.

As recommended in your proposal, more timely gain-sharing payments and shielding practices from antitrust charges are critical to engaging independent practices in IAH.

Thank you for sharing your proposal with the Task Force.

Sincerely,

Eunice Skelly
Vice President for Membership