Congress of the United States
Washington, DC 20515

June 29, 2010

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Tavenner:

As the House and Senate sponsors of the Independence at Home (IAH) Demonstration Program enacted as Section 3024 of the Patient Protection and Affordable Care Act (PPACA), we are writing to convey our strong interest in continuing to work closely with CMS to ensure that the IAH program is implemented as effectively and as soon as practicable pursuant to the PPACA. CMS provided valuable technical assistance throughout the legislative process, and we look forward to a collaborative relationship during implementation of this important provision.

The IAH program focuses on improving care and reducing expenditures for the highest cost Medicare beneficiaries – those individuals with multiple chronic diseases who account for up to 85 percent of Medicare spending and typically have poor outcomes under the current, highly fragmented, fee-for-service, traditional Medicare reimbursement system. Through utilization of physician and nurse practitioner directed home-based, multi-disciplinary primary care teams, the IAH program is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need populations at home while coordinating their health care across all treatment settings. Using this approach, the IAH program aims to reduce preventable hospitalizations, lower the need for hospital readmissions, reduce emergency room visits, and improve health outcomes commensurate with the beneficiaries' stage of chronic illness while achieving increased beneficiary and family caregiver satisfaction.

The IAH program is tailored to attract organizations that have existing expertise furnishing health care to this high-need beneficiary population. Specifically, according to the PPACA, organizations that contract with the Department to participate in the IAH program are held strictly accountable for achieving a minimum of 5 percent in savings for caring for the severely, chronically ill participants in the IAH program compared to the costs of care for this population in the absence of the program. At the same time, the IAH program is crafted so that these savings cannot be achieved to the detriment of quality care, as all IAH organizations are responsible for improving outcomes commensurate with the beneficiary's chronic illnesses and achieving beneficiary and family caregiver satisfaction. In return, IAH organizations receive a share of the savings they achieve beyond the first 5 percent. In this way, the IAH program aligns the interests and incentives of patients, providers and payers.

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The Independence at Home Act had strong bipartisan support when it was introduced as free-standing legislation on May 21, 2009 in the House and Senate (H.R. 2560 and S. 1131, respectively) and received unanimous bi-partisan approval when its provisions were added to both the House and Senate health reform bills. The Congressional Budget Office scored the IAH program as adding negligible costs to Medicare over ten years. The IAH program has been endorsed by more than 32 organizations representing a broad range of consumers, caregivers, providers, and technology organizations (see attached).

As you know, Section 3024 of the PPACA stipulates that the IAH demonstration "shall begin no later than January 1, 2012". At the same time, Congress provided that, for each of the Fiscal Years 2010 through 2015, CMS will receive from the Part A and Part B Trust Funds $5 million for the purposes of administering and carrying out the IAH program; therefore, CMS will receive significant funding for the IAH program this fiscal year, which could be used to begin the implementation process.

We believe strongly that there are numerous reasons for implementing the IAH program sooner rather than later. It is well established that Medicare beneficiaries with multiple chronic diseases –the same population served by the IAH program - receive poor quality and unnecessarily costly, disjointed care with often conflicting diagnoses for the same symptoms while accounting for the majority of Medicare's costs. Implementation of the IAH program as soon as possible would appear to us to be clearly in the best interests of the frail, chronically-ill Medicare beneficiaries eligible to participate in the IAH program, as well as their caregivers and the Medicare program.

There is also strong evidence that the clinical house call model at the heart of the IAH program works and can be implemented quickly. For example, the Department of Veterans Affairs' well-established Home-Based Primary Care program, which is similar to the IAH program, has operated for many years at 138 locations in 48 states and has achieved reductions of 62 percent in hospital days, 88 percent in nursing home days, 24 percent in VA costs and 11 percent in Medicare costs for high cost chronically ill patients. Other IAH-style programs have been operating for decades across the country and have been successful in reducing high cost care, improving outcomes and achieving patient and caregiver satisfaction for chronically ill patients – the same metrics in the PPACA for gauging the success of the IAH program. We have been made aware of more than 70 such organizations in 24 states that appear to have the experience, qualifications and the interest to begin operating IAH programs immediately (see attached).

We understand that the PPACA tasks CMS with a broad array of new responsibilities. Nevertheless, we strongly believe that the $5 million in annual funding provided in the PPACA for implementation of the IAH program beginning in FY10 and continuing through FY15, the wide recognition that IAH-eligible Medicare recipients currently receive substandard,

unnecessarily resource-intensive care, and the large number of experienced organizations already engaged in IAH-style care would make implementation of the IAH program before 2012 an early success for patients, providers and payers that would favorably demonstrate the type of innovative delivery reforms within the PPACA. **Therefore, we request that CMS implement the IAH program before the statutory 2012 deadline, with a goal of implementation within the next 6 months.**

The physician and/or nurse practitioner-led practices that participate in the IAH demonstration assume an economic risk, as they are required to achieve the 5 percent savings stipulated in Sec. 3024 to be eligible for any incentive payments under the statute. For this reason, the Independence at Home Act as introduced in the House and Senate provided that IAH organizations that achieved a threshold savings of 5 percent for the Medicare program would receive 80 percent of any additional savings in excess of 5 percent with the remaining 20 percent going to Medicare. A similar 80 percent/20 percent savings sharing mechanism was used in the successful Physician Group Practice Demonstration. **Accordingly, we recommend that the implementing specifications for the IAH demonstration program provide for an 80 percent/20 percent split of savings beyond the first 5 percent during the 3-year term of the IAH demonstration.**

We also believe that language with respect to applicable beneficiaries eligible to participate in the IAH demonstration should be included in the implementing guidelines for the IAH program. Specifically, the definition of "applicable beneficiaries" in PPACA did not include those who have in the past 12 months received Medicare covered home health services, though it was agreed during technical assistance discussions with CMS staff that such language would be an appropriate addition during a House-Senate conference committee which, ultimately, did not occur. **Accordingly, we request that this language be included in the implementing specifications to carry out the original intent of IAH.**

We believe that CMS should endeavor to include a sufficient number of IAH organizations in the demonstration program to ensure that the IAH model is thoroughly tested. The PPACA specifies that "the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000." **We suggest that, if practicable, CMS enter into agreements with a sufficient number of Independence at Home organizations so that at least 5,500 beneficiaries participate.**

Finally, pursuant to the language in Section 3024, the IAH demonstration program is terminated in 2015, regardless of whether the program achieves its objectives of saving money and improving patient outcomes. However, in Section 3021 of PPACA, the Secretary has the authority under the CMS Innovation Center to expand, including on a nationwide basis, delivery reforms if the Secretary determines that such expansion is expected to reduce spending without reducing the quality of care or improve the quality of care and reduce spending and the Chief

Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending.

As authors of the IAH provision, it was our intent to enable successful IAH practices to be extended and expanded according to these same criteria. Indeed, high quality, established organizations are more likely to participate in the IAH program in Section 3024 if they will have the opportunity, dependent upon their high quality performance, to continue and/or expand their activities if they are successful in achieving the objectives stipulated in the Act . **Accordingly, we request that CMS implement the IAH with the goal of further expanding the program if it is successful according to the same criteria for delivery reforms in PPACA.**

We appreciate your consideration and look forward to your response.

Sincerely,

Edward J. Markey
U.S. Representative

Ron Wyden
U.S. Senator