Independence at Home Demonstration Provider Training Manual

October 2019

RTI INTERNATIONAL

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Training Manual Overview

The Centers for Medicare & Medicaid Services (CMS) is conducting the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) patients with multiple chronic conditions and functional impairments requiring human assistance. This *IAH Demonstration Provider Training Manual* contains reference materials that will be useful to practices participating in the demonstration, including information on the IAH Reporting System, patient eligibility, quality measures, and methods for data collection and the methodology for savings calculations. Below is an overview of each section of the IAH Training Manual.

Section 1: Reporting System Overview

The first section briefly describes how the system is used for data collection during the demonstration and the steps we are taking to ensure the protection of personally identifiable information (PII) and protected health information (PHI).

Section 2: Reporting System User Guide

The second section provides step-by-step instructions for using the IAH Demonstration Reporting System, including creating usernames and passwords, uploading the initial patient roster, adding new patients, entering additional information, submitting information, and viewing reports. There is also a section on troubleshooting and what to do if you forget your password, username, or security question and answer.

Section 3: Patient Eligibility Requirements

The third section details the patient eligibility requirements. Practices are required to enroll and submit information on all eligible patients via the IAH Reporting System. Claims data will be analyzed, and medical records may be audited, to ensure that all eligible patients are enrolled and that all enrolled patients are eligible. This section also includes information on how patient enrollment months will be counted for savings calculations, including when newly eligible patients will be added to the calculations and when patients who have left the practice will be excluded from calculations.

Section 4: Quality and Performance Measures

The fourth section specifies the quality measures tied to incentive payments and the additional performance measures that will be used to assess the performance of IAH practices during the demonstration. This section also includes the requirements that practices must meet for each of the quality measures to be considered in their incentive payment calculations, as well as how practices should report quality and performance measure data via the IAH Reporting System. Data collection methods for use in determining incentive payment calculations are also outlined.

Section 5: Methodology for Savings Calculations

The fifth section explains the methodology for savings calculations.

Section 6: Frequently Asked Questions

The sixth section includes a list of FAQs, such as questions about patient eligibility and other key issues related to use of the Reporting System.

Appendix A: Independence at Home Legislation

Appendix B: Independence at Home Legislation Extension

Appendix C: Independence at Home Solicitation

Section 1: Reporting System Overview

This section briefly describes how the IAH Reporting System is used for data collection during the demonstration and the steps we are taking to ensure the protection of personally identifiable information (PII) and protected health information (PHI).

Section 1A: Reporting System

The IAH Reporting System website (https://iahdemo.rti.org) was developed and is managed by RTI International, CMS's IAH implementation support contractor, in conjunction with CMS. The Reporting System is designed to achieve the implementation goals of timely information sharing, data management, and reporting. Practices must record patient information via the Reporting System to support IAH enrollment. Keeping accurate information is necessary to ensure that shared savings calculations are based on the enrolled population, their associated costs, and quality measures.

The Reporting System is a web-based tool created to aid practices in recording patient information and exchanging data. It also allows practices to add providers and manage system users. The CMS website (https://innovation.cms.gov/initiatives/independence-at-home/) contains additional supporting information on the IAH Demonstration. Check it regularly for additional announcements.

The Reporting System contains multiple tabs, which display different content areas: Announcements, Rosters, Input Patient Data, All About IAH, Manage Users, Reports, and Data Exchange. The following will provide a brief overview of each section of the Reporting System. More detailed information can be found in the User Guide in Section 2.

Announcements

The purpose of the Announcements tab is to inform the participating practices of new information and developments occurring throughout the demonstration period. All announcements relevant to the demonstration will be posted here, as needed. This tab also contains a section to note Recent Announcements.

Rosters

Practices use the Rosters tab to provide identifying information about their patients who meet the eligibility requirements for the demonstration, as well as their providers.

Patient Rosters. All IAH practices must maintain an updated list of their IAH-enrolled patients in the Reporting System. The Rosters tab offers a submenu of options for supplying patient identifiers. Patient information can be added to the system in one of two ways: adding a single patient or downloading and completing the roster template and then uploading multiple patients at one time. The IAH Reporting System assigns each added patient a unique IAH patient ID number to ensure privacy of patient information for the remainder of the data entry process. Practice staff may also use this tab to view the practice's patient roster, which includes the medical record number (MRN), date of birth, IAH patient ID, and status of each patient added to the system. Practices may upload patients into the roster who they believe will meet the patient

requirements before verifying and entering patient eligibility data. It is important for practices to upload patients to the roster as soon as possible.

Provider Rosters. All IAH practices must maintain an updated list of their IAH providers in the Reporting System. For the provider roster, practices can add the provider's first and last names, national provider identifier (NPI), current IAH status (e.g., active), and date the provider joined the practice (effective date). A termination date should be entered for providers that leave the practice, and the provider's status should be updated from "active" to "inactive" in the system at the time of termination. If a provider leaves the practice and then rejoins, that provider should be added again with a new effective date.

Input Patient Data

Practices will use the Input Patient Data tab to provide information on patient eligibility, patient assessment and management, and health utilization and follow-up events-. Practice staff must first enter eligibility information for a patient. A patient who meets the eligibility requirements and agrees to have his or her data used (see Section 3) automatically will be enrolled in the demonstration. Practice staff may then enter qualifying acute care utilization data and practice follow-up visits. They should continue to update this information throughout the demonstration. Practice staff are required to enter assessment and management measures annually, and the dates the measures were completed, for all patients for the duration of the patients' enrollment. The measures include documentation of patient preferences, depression screening, cognitive function assessment, identification of the patient's or family caregiver's goals, fall risk assessment, home safety evaluation, symptom management, assessment of caregiver stress, patient's medication management ability, and referral for services. If an enrolled patient leaves the practice for any reason, the Disenrollment subtab must be used to disenroll the patient from the demonstration.

Details for adding patients and inputting patient data can be found in the User Guide (Section 2).

All About IAH

The All About IAH tab includes information on training and key demonstration documents. Practices are encouraged to use this tab to review the IAH legislation (original and most recent legislation), review past presentations, and access training documents and FAQs. These materials can be viewed and downloaded at any time from the Reporting System.

Manage Users

The Manage Users tab allows the practice's primary contact to add new users. The primary account is authorized and maintained by RTI staff, who determine who may access the practice-specific data to enter patient details or view practice reports. Each staff person who will be entering patient information or viewing reports should have a unique username and password. Practices should designate a primary and a backup contact who will be able to create and delete user accounts. Each user account is tied to a specific practice and cannot be used to enter or access data from other practices. Additional information on adding and managing users can be found in the User Guide (Section 2).

Reports

Practices use this tab to receive reports on patient enrollment. The Reporting System calculates the number of patients on the basis of enrollment status, voluntary or involuntary disenrollment from the demonstration, and the practice's performance on three of the six quality measures tied to incentive payments that are based on practice entries into the Reporting System. These three Reporting System measures that are tied to incentive payments are as follows (a) follow-up within 48 hours after hospital admission, hospital discharge, and emergency department visits; (b) in-home medication reconciliation within 48 hours of hospital discharge and emergency department visits; and (c) annual documentation of patient preferences.

Data Exchange

Practices use this tab to access and return their Quarterly Workbooks and other secure files that need to be exchanged with RTI. Only practice users who are listed on the practice's data use agreement (DUA) with CMS will have access to download and upload files through the Data Exchange tab. When a file is available for download, users can download the encrypted, password-protected files. They can reach out to the IAH Help Desk for the password, and then they will be able to open the files using file zip software, such as SecureZip. When files are ready for return to RTI, practice users with DUA access can upload encrypted, password-protected files on the same tab for RTI to access.

Section 1B: Data Access, Privacy, and Security

The IAH Reporting System is hosted on a private server at RTI, which employs data security protocols in compliance with federal requirements to maintain data privacy and security for CMS projects. Security updates to the Reporting System will occur at regular intervals, per the recommendation of the RTI Global Information Technology team.

Practices upload patient PII and PHI via a secure process, and RTI staff secure these identifiable data to prevent any breach of patient identity. After a participating practice provides initial PII and PHI for its patients, it will then enter patient information and access patient data records using only minimal patient identifying information to ensure patient data privacy and security.

In addition to this *IAH Demonstration Provider Training Manual*, RTI staff support use of the Reporting System through an initial training session and through a help desk accessible by e-mail (helpiah@rti.org) and telephone (1-800-344-1397). RTI Help Desk staff provide as-needed support to practice staff who have questions about IAH Reporting System access and use. RTI will respond as quickly as possible during business hours to acknowledge the request and then to address the questions identified.

RTI authorizes and maintains user accounts. If a practice leaves the demonstration, all data will remain in the Reporting System through the end of the demonstration, but user accounts will be removed so that no additional data can be added or changed beyond the date of practice departure.

Staff affiliated with registered practices access the IAH Reporting System using authorized staff-level user accounts and affiliated passcodes. Practices must designate staff for whom user accounts should be created and provide that information during a registration process. Users also have the ability to change their passwords, as needed, using the Change Password tab in the Reporting System.

Reporting System users can access all tabs of the Reporting System. However, only Reporting System users who also are named on the practice DUA with CMS have the ability to receive and share files via the Data Exchange Tab. RTI maintains a list of general Reporting System users and Reporting System users who also are named on practice DUAs. Accordingly, practices do not need to specify whether Reporting System users also should have Data Exchange access; RTI will manage the correct level of access automatically for each user.

Practices are welcome to contact the IAH Help Desk with any questions about adding and removing users from the Reporting System.

Section 2: Reporting System User Guide

This section provides step-by-step instructions for using the IAH Demonstration Reporting System, including creating usernames and passwords, uploading the initial patient roster, adding new patients, entering additional information, submitting information, and viewing reports.

Section 2A: Detailed User Guide

RTI has developed a secure, interactive Reporting System for the IAH Demonstration. The Reporting System is used to enroll patients, record information for calculating quality and performance measures, and exchange project data reports (e.g., Quarterly Workbooks).

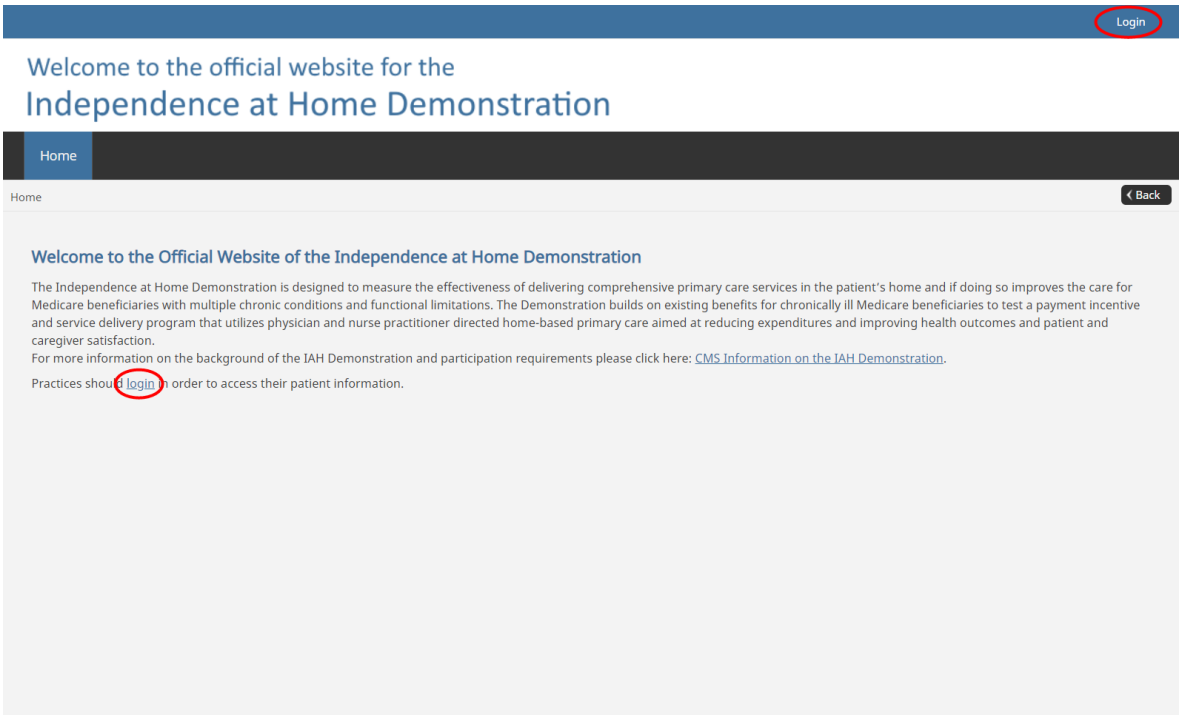
Use of the IAH Reporting System is informed by this Provider Training Manual. Section 2a details step-by-step instructions for the following objectives:

- creating usernames and passwords,
- uploading the initial patient roster,
- adding new patients,
- entering additional information,
- submitting information,
- viewing raw data reports, and
- exchanging data.

There is also information on troubleshooting and what to do if you forget your password, username, or security question and answer.

Accessing the IAH Reporting System

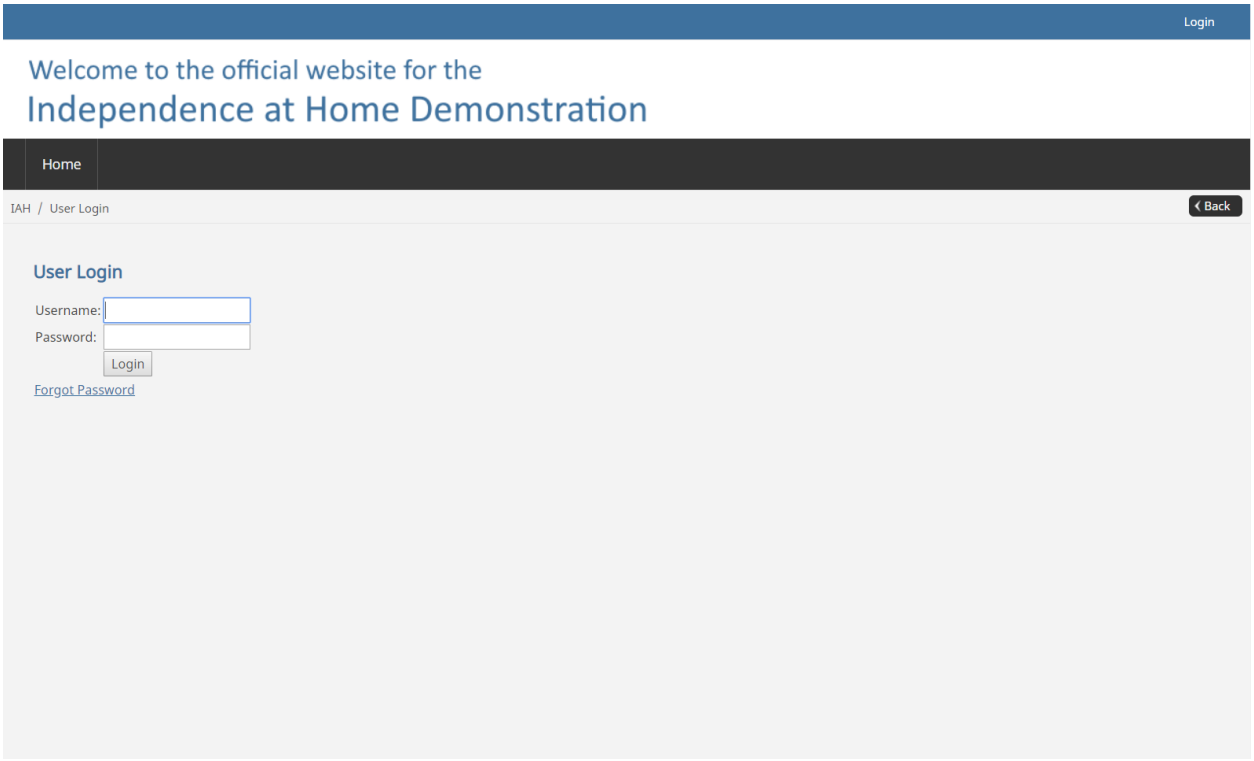
As discussed in Section 1B, all practices have authorized Reporting System users, and these users will access the Reporting System at **https://iahdemo.rti.org.** Once you have accessed this link, proceed to the *Login*, as shown below.



Login

Practices will email the IAH Help Desk (helpiah@rti.org) to inform RTI of the names and email addresses of any practice staff who should be added as new IAH Reporting System users. These new users will receive an email link from RTI, and clicking on that link will allow a new user to log in for the first time. At the first log in attempt, a new user will be required to change the assigned password. The new password must be at least eight characters long and should never be shared with other users or non-users.

To access the Reporting System from the IAH Demonstration home page, click on the *Login* link to access the login page:

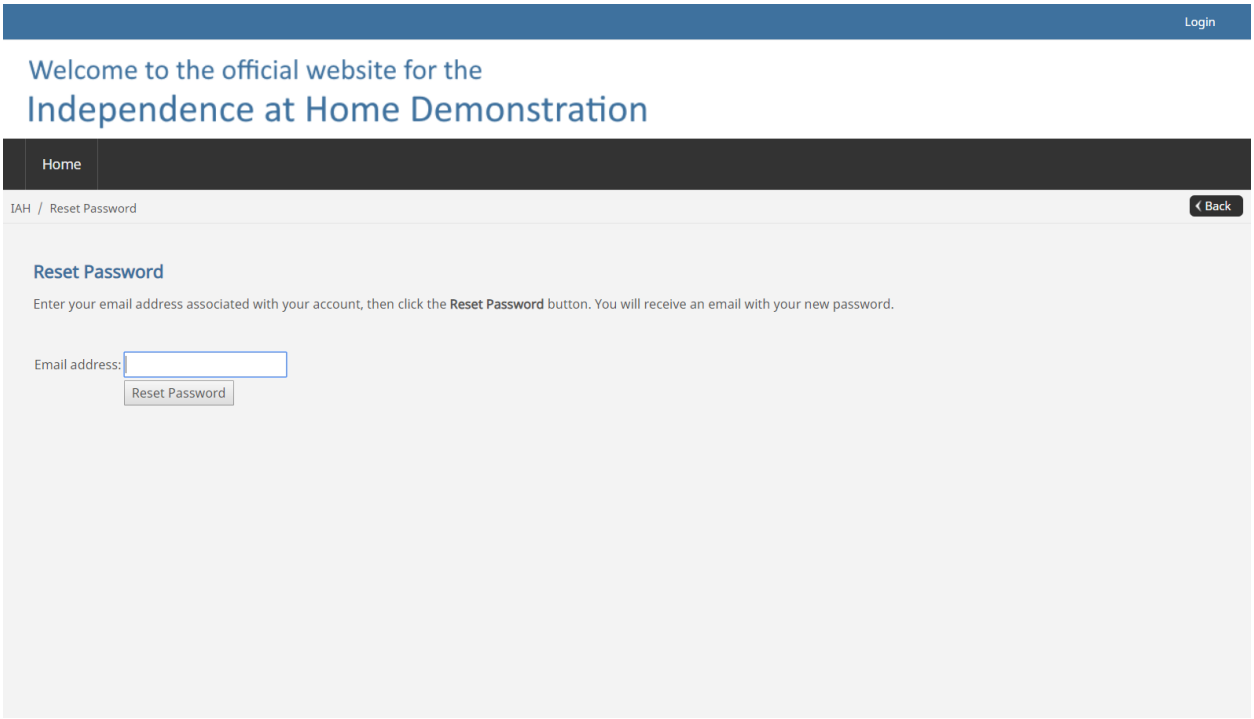


You will then be directed to a second login screen, where you will be asked to answer a security question to confirm your identity. Once your identity has been confirmed, you will be directed to the home page of the IAH Reporting System.

See the *Manage Users* tab in this section for detailed instructions on obtaining additional usernames and passwords for your practice.

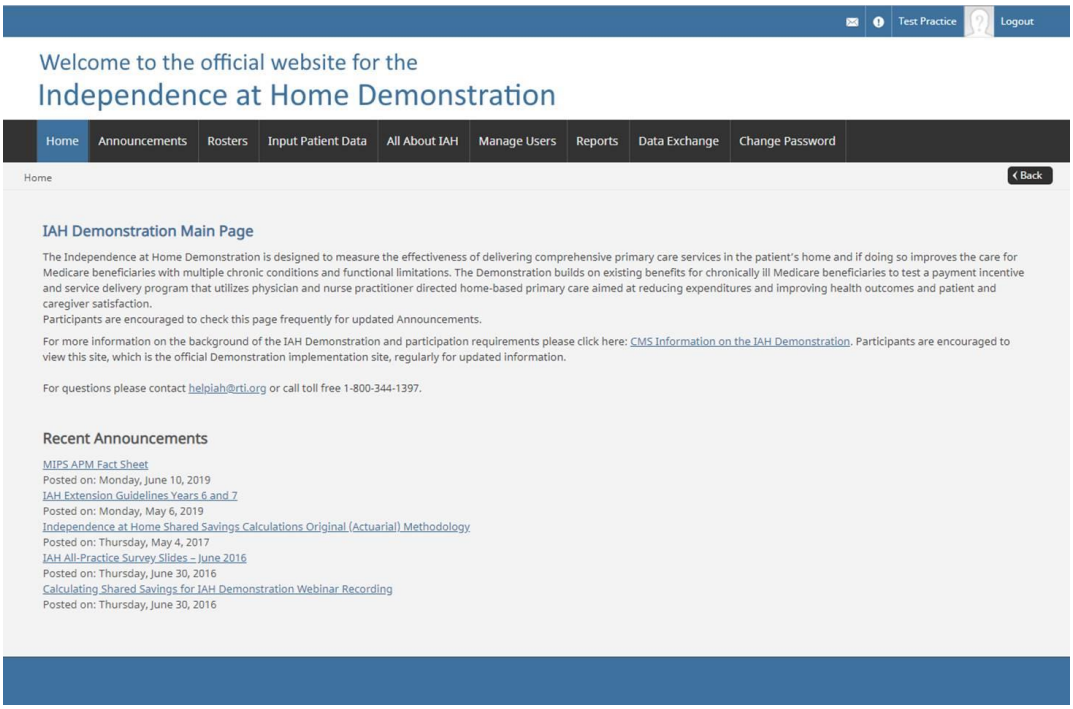
Login Help

If you forget your password, click on the *Forgot Password* link to be taken to the screen where you can enter and verify your user account. Enter your username and click the *Reset Password* button. If the system is able to verify your username, a new password will be e-mailed to you. You can then log in and change the password again, just as you would if you were a new user. If you are still unable to reset your password, contact the Help Desk at helpiah@rti.org.



IAH Reporting System Main Page

After logging in, you will see the IAH Reporting System Main Page:



From this page, you will be able to access the different parts of the Reporting System:

- Announcements
- Rosters
- Input Patient Data
- All About IAH
- Manage Users
- Reports
- Data Exchange
- Change Password

Below you will find information on each of the sections of the IAH Reporting System.

Announcements Tab

All announcements relevant to the demonstration, including new FAQs, blog posts, comments, and upcoming events, are posted here. On the left side of the page is a calendar with highlighted dates. Documents that may be useful to practices also are posted here.

Rosters Tab

The Rosters tab allows practice users to manage patient and provider rosters. When you roll your mouse over the Rosters tab, a submenu will appear with the following options:

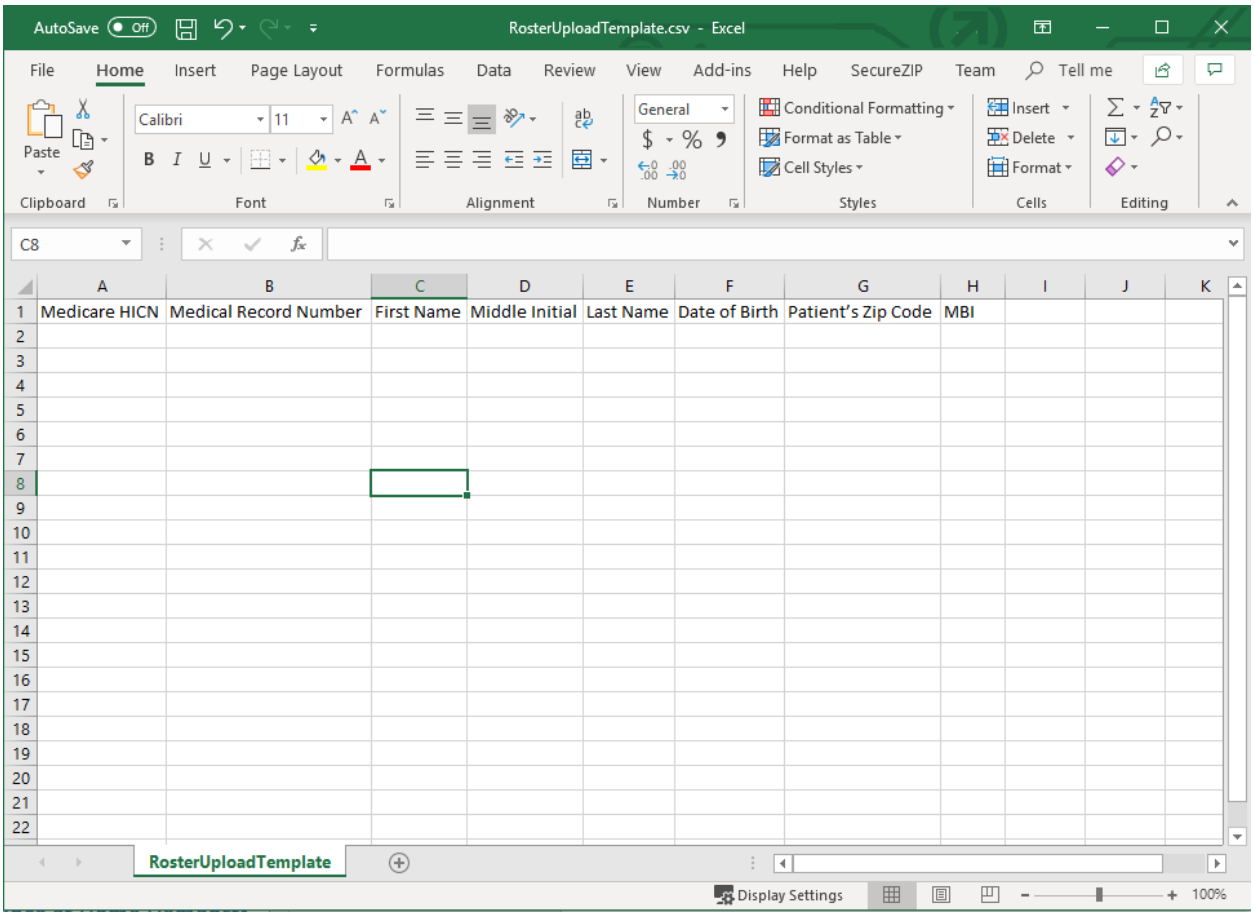
- Download Roster Template
- Upload Multiple Patients
- Add a Single Patient
- View Patient Roster
- Provider Roster

The following provides a description of each of the submenu items under the Patient Roster tab.

Download Patient Roster Template

The Patient Roster Template is the Excel file that is required for uploading multiple patients who have been identified by your practice as eligible for the demonstration. You can download the Patient Roster Template by selecting the link highlighted on the web page.

Patient upload information should be entered for all patients in your practice whom you believe to be eligible. Patients believed to be eligible should be uploaded into the IAH Reporting System as soon as possible, even if you are still in the process of confirming their eligibility or have not yet notified them of your participation in this demonstration. Once the Patient Roster Template has been downloaded, you can open the file from your computer and begin entering data:

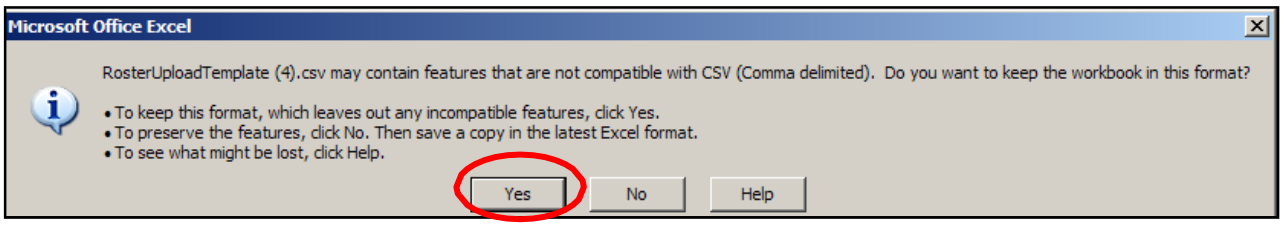


It is very important that you do not change the names or order of the columns and that you do not add or remove columns. You may, however, increase the width of the columns to fit the text that you are entering.

When using the Patient Roster Template, you will not be notified of errors until you upload the document. To avoid errors in upload, please keep the following in mind as you enter information into the spreadsheet:

- *Medicare Health Insurance Claims Number (HICN)*—The Medicare HICN must consist of only numbers 0-9 and letters A-Z and must have a length of 10, 11, or 12. **Reminder: As of January 1, 2020, HICN will be replaced by Medicare Beneficiary Identifier (MBI). Practices will not be able to enter HICN data as of this date.**
- *Medical Record Number (MRN)*—This is the number your practice assigns to each patient's medical record. Because the MRN is assigned by the practice, it is possible, though unlikely, for multiple practices to have patients with the same MRN. However, each MRN may exist only once in the system for your practice.
- *Date of Birth*—This must be formatted as MM/DD/YYYY. If a date is entered and Excel automatically reformats to read differently, please reformat the column:
  - Select all of Column F (*Date of Birth*)
  - Right click and select *Format Cells*…
  - From the Category list, select *Date*
  - From the Type list, select *03/14/01*
  - Click *OK*
- *Patient's Zip Code*—This must be five digits long. If the zip code starts with a zero (ex: 02191), enter a single apostrophe before the zip code (ex: '02191) to prevent Excel from dropping the leading zero.
- *Medicare Beneficiary Identifier (MBI)*—This must consist of only numbers 0–9 and letters A–Z, excluding S, L, O, I, B, and Z, and must have a length of exactly 11. **Practices may begin entering MBIs into the Reporting System in 2019, instead of HICN. As of January 1, 2020, practices must enter only MBIs for all patients. CMS is replacing HICN with MBI as of that date. All patients already entered into the Reporting System prior to January 1, 2020, will have MBIs added automatically; practices adding new patients after that date will need to include patients' MBIs.**

Once you have completed entering information into the Patient Roster Template, save the file to your computer. You may receive the following error message:

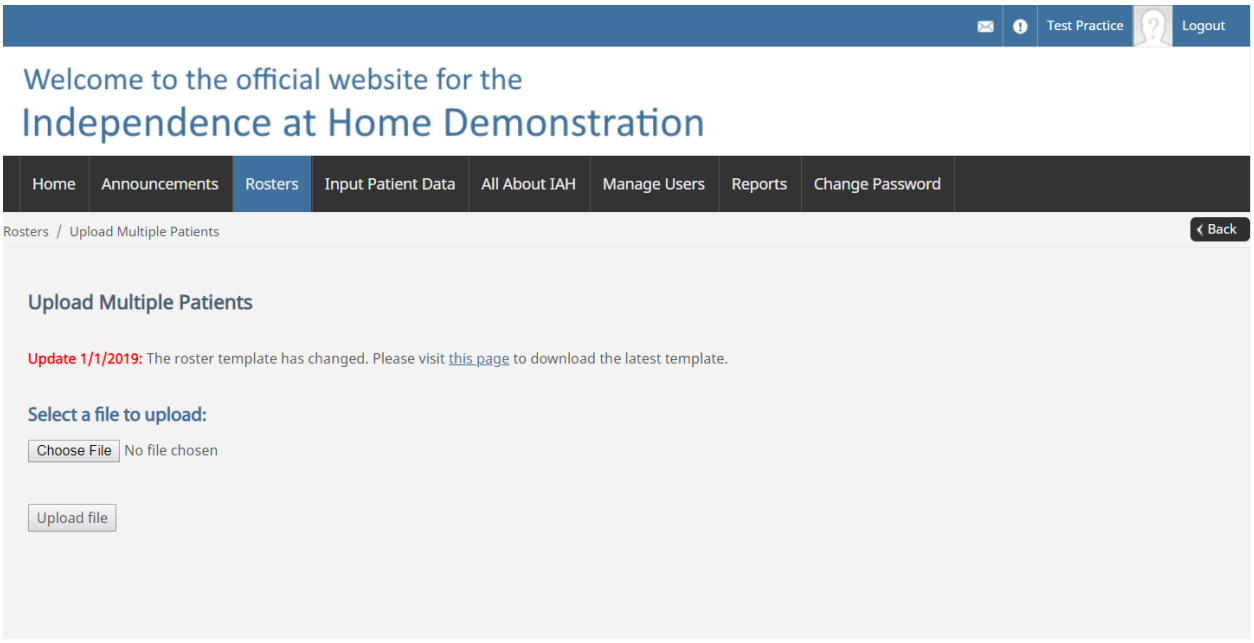


Click *Yes* and save the file to your computer.

It is very important that you do not change the file extension. **The Patient Roster Template must be saved as a .csv file.**

Upload Multiple Patients

The Upload Multiple Patients function in the Reporting System works jointly with the Patient Roster Template. After selecting *Upload Multiple Patients* from the Patient Roster menu, you will see the following screen:



Click on *Choose File* and select the file from your computer containing the information you entered into the Patient Roster Template. Once the appropriate file has been selected, click *Upload File*. The system will confirm that your file has been uploaded successfully. If the file was not uploaded successfully, you will receive a list of errors, including which records contain errors and what those errors are. Possible errors are shown in Table 1.

If you receive an error message, go back into the saved Patient Roster Template on your computer hard drive, make the necessary corrections, re-save the file (making sure you have used the .csv extension), and upload the new file to the Reporting System. If all of the errors listed have been addressed, you will receive confirmation that the file has been successfully uploaded.

Please note that, to prevent duplicate entries, the Reporting System has been designed to accept only complete Patient Roster Templates. If you receive even one error message after attempting to upload the template, none of the records within that template will be uploaded.

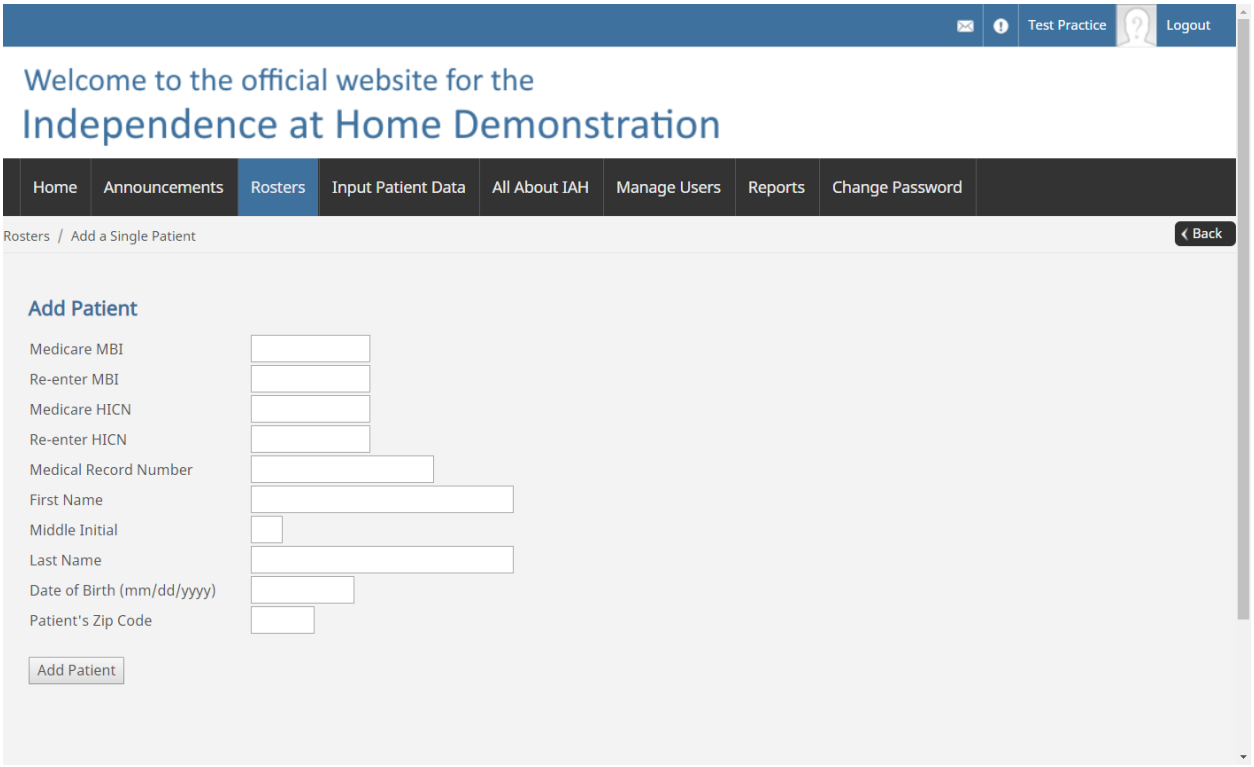
Table 1. Error Messages: Multiple Patient Upload

Error Description	Error Type
Row #X: (MRN XXXXXXX) You must enter either the MBI or HICN or both.	Missing MBI and HICN
Row #X: (MRN XXXXXXX) The Medicare HICN must consist of only numbers 0-9 and letters A-Z and must have a length of 10, 11, or 12.	Incorrectly formatted HICN
Row #X: (MRN XXXXXXXX) Medical Record Number is required.	Missing MRN
Row #X: (MRN XXXXXXXX) First Name is required.	Missing first name
Row #X: (MRN XXXXXXXX) Last Name is required.	Missing last name
Row #X: (MRN XXXXXXXX) Date of Birth is required.	Missing date of birth
Row #X: (MRN XXXXXXXX) Date of Birth must be formatted as mm/dd/yyyy.	Incorrectly formatted date of birth
Row #X: (MRN XXXXXXX) Date of Birth must be after 1/1/1900.	Date of birth outside of range
Row #X: (MRN XXXXXXX) Date of Birth cannot be in the future.	Date of birth outside of range
Row #X: (MRN XXXXXXX) Zip Code is required.	Missing zip code
Row #X: (MRN XXXXXXXX) Patient's Zip code must be five digits.	Zip code must be five numeric digits
Row #X: (MRN XXXXXXXXX) Medical Record Number already exists in the system for your practice. Please try again.	Duplicate MRN
Row #X: (MRN XXXXXXX) The Medicare MBI must consist of only numbers 0-9 and letters A-Z, excluding S, L, O, I, B and Z, and must have a length of exactly 11.	Incorrectly formatted MBI

Once the file has been successfully uploaded, your roster will be visible automatically in the *View Patient Roster* section of the Reporting System. Please note that some of the identifying information that was entered for patients in the Patient Roster Template file will not be visible in the *View Patient Roster* section of the Reporting System. This is to ensure that the Reporting System protects patients' privacy. For information on how to edit patient roster information after uploading has been completed, please see the View Patient Roster subsection of this section.

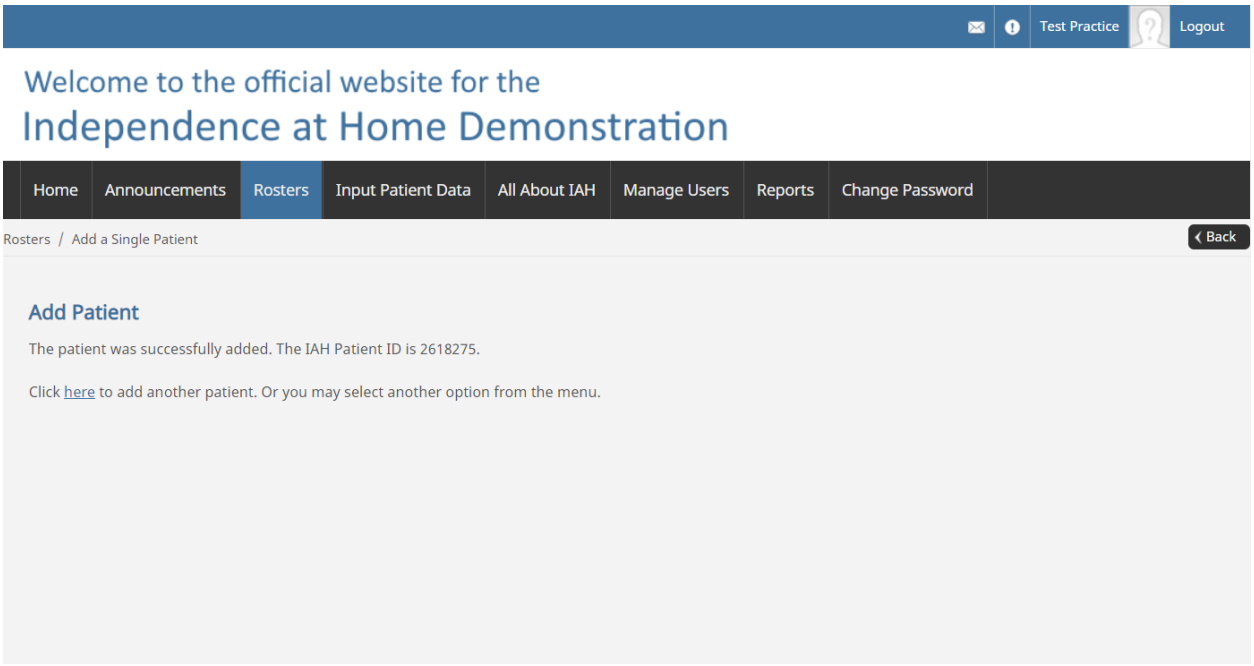
Add a Single Patient

In addition to adding multiple new patients via roster upload, information on a single new patient may be entered directly into the Reporting System. The information required for entering a single patient is the same as what is included in the Patient Roster Template.



For extra security, any text entered in the HICN or MBI textboxes is masked with asterisks, and you will need to enter either HICN or MBI twice. The two entries must match for the patient to be added to the Reporting System.

Once you have entered the information for the patient, click *Add Patient*. If the information is accepted, you will be directed to the following screen:



If there are errors, such as your practice having duplicate MRN for two different patients in the system, you will receive an error message and will be required to correct the information before the patient can be added to your roster.

Possible errors are shown in Table 2.

Table 2. Error Messages: Single Patient Upload

Error Description	Error Type
You must enter either the MBI or HICN or both. After January 1, 2020, the error message will read "You must enter MBI."	Missing MBI and HICN
The Medicare MBI must consist of only numbers 0-9 and letters A-Z, excluding S, L, O, I, B and Z, and must have a length of exactly 11.	Incorrectly formatted MBI
Medicare MBI entries must match.	Double entry verification
The Medicare HICN must consist of only numbers 0-9 and letters A-Z and must have a length of 10, 11, or 12.	Validation for HICN proper format
Medicare HICN entries must match.	Double entry verification
MRN is required.	Missing MRN
MRN already exists in the system for your practice. Please try again.	Duplicate MRN
First Name is required.	Missing first name
Last Name must not contain numbers.	Validation for alpha only

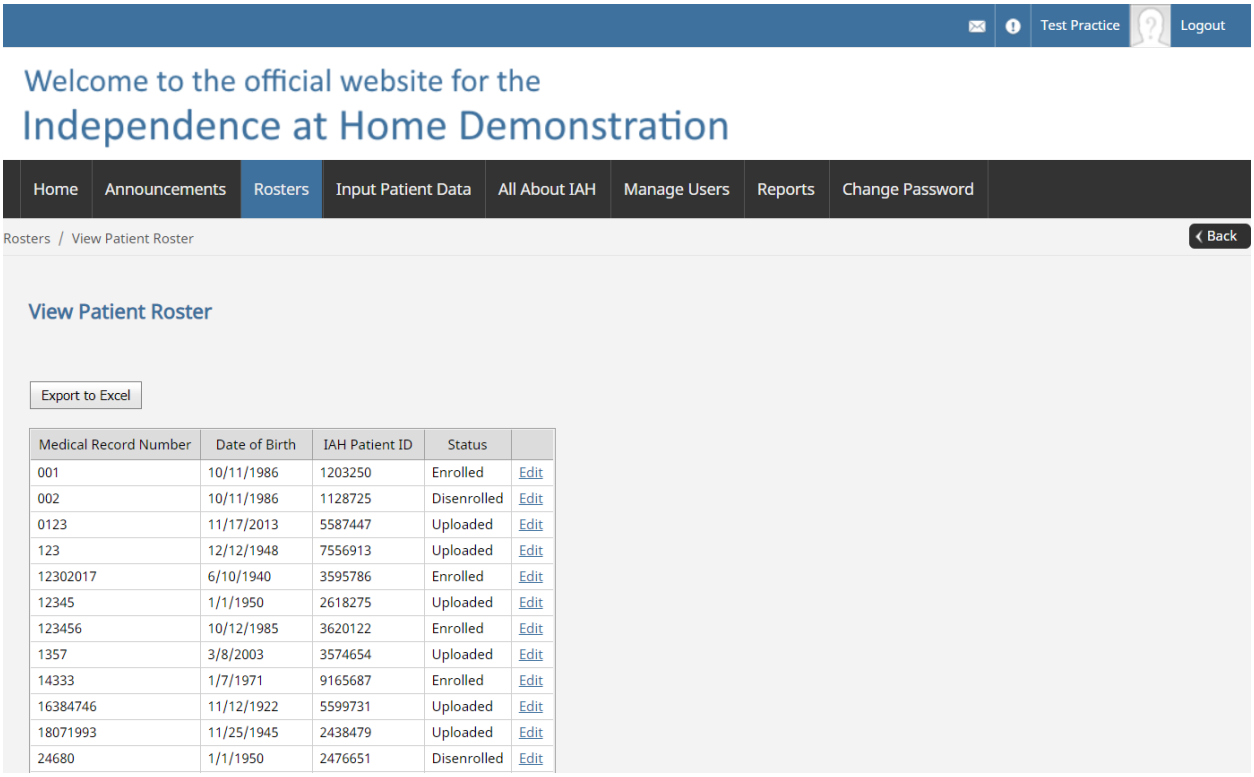
Last Name is required.	Missing last name
First Name must not contain numbers.	Validation for alpha only
Middle Initial must not contain numbers.	Validation for alpha only
Date of Birth is required.	Missing date of birth
Date of Birth must be formatted as mm/dd/yyyy.	Validation for date format
Date of Birth must be on or after 1/1/1900 and cannot be in the future.	Validation for date format
Patient's Zip Code is required.	Missing zip code
Patient's Zip Code must be five digits.	Validation for zip code format

Patients added using the *Add a Single Patient* option will appear in the Patient Roster immediately, and you may begin inputting data for them.

View Patient Roster

To view a practice's completed patient roster, select the *View Patient Roster* submenu from the Rosters menu. The patient roster contains a list of the MRN, date of birth, IAH patient ID, and status for each patient enrolled in the IAH Demonstration from that individual practice.

Practices that are part of a consortium will be able to see roster information only for patients from their own individual practices, not from all patients enrolled in practices that are part of the consortium.



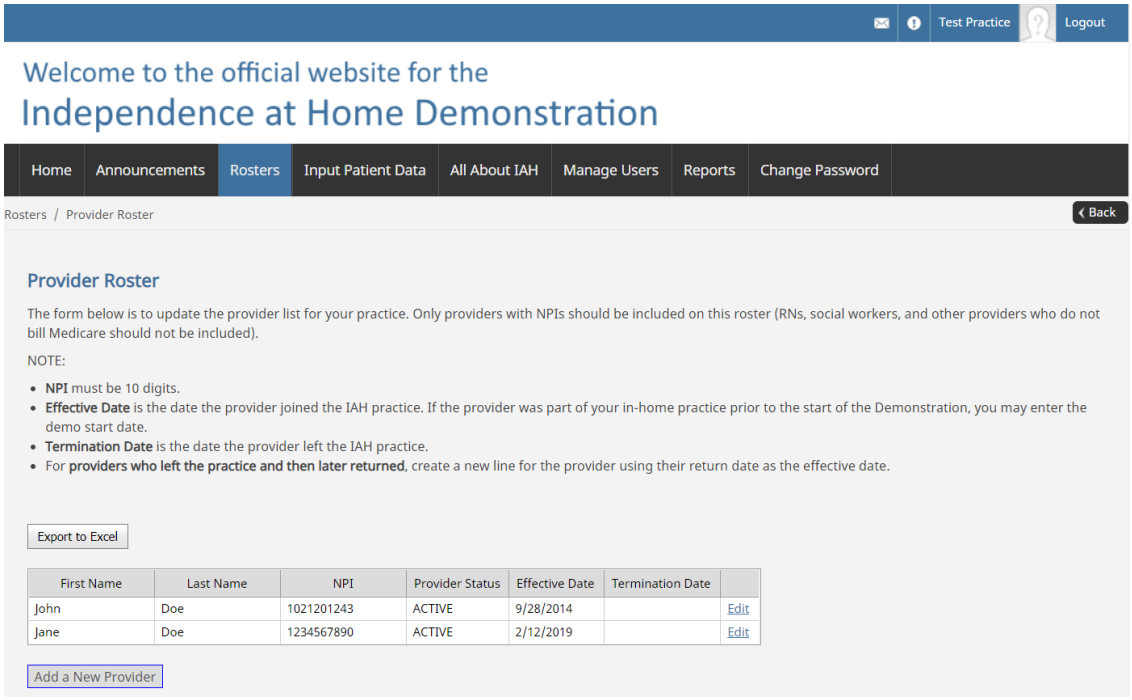
The Status column identifies each patient entered into the system as one of the following:

- **Enrolled**—The patient has been added to the system and the Patient Enrollment subtab has been completed.
- **Uploaded**—The patient has been added to the system, but the Patient Enrollment subtab has not been completed. This status will also be given to patients who were deemed not eligible on the basis of information entered in the Patient Enrollment subtab and to patients who were deemed eligible but did not agree to have their data included in the demonstration analysis.
- **Disenrolled**—The patient has been disenrolled from the demonstration via the Disenrollment subtab. Only patients who previously were certified as eligible and who have agreed to have their data used for the demonstration can be disenrolled. Do not use the Disenrollment tab to delete patients who were uploaded but never enrolled (e.g., because they did not meet the criteria or declined to have their data used in the demonstration).

To edit a previously uploaded patient's MRN or date of birth, select the *Edit* link next to the record in the patient roster that needs to be edited to be directed to a page where you can make changes to these data fields. If a change needs to be made to a patient's HICN, MBI, first name, last name, or zip code, contact the IAH Help Desk. To view the patient roster as an Excel file, click *Export to Excel*, download to your computer, and then open the file.

Provider Roster

The provider roster contains a list of the first name, last name, NPI, provider status, effective date, and termination date for each provider associated with an individual practice. To view your practice's provider roster, select the *Provider Roster* submenu from the Rosters menu.



To add a new provider to a roster, click the "Add a New Provider" button below the list. You will then be able to enter the provider's information in a new row. Click the Save link to save the data.

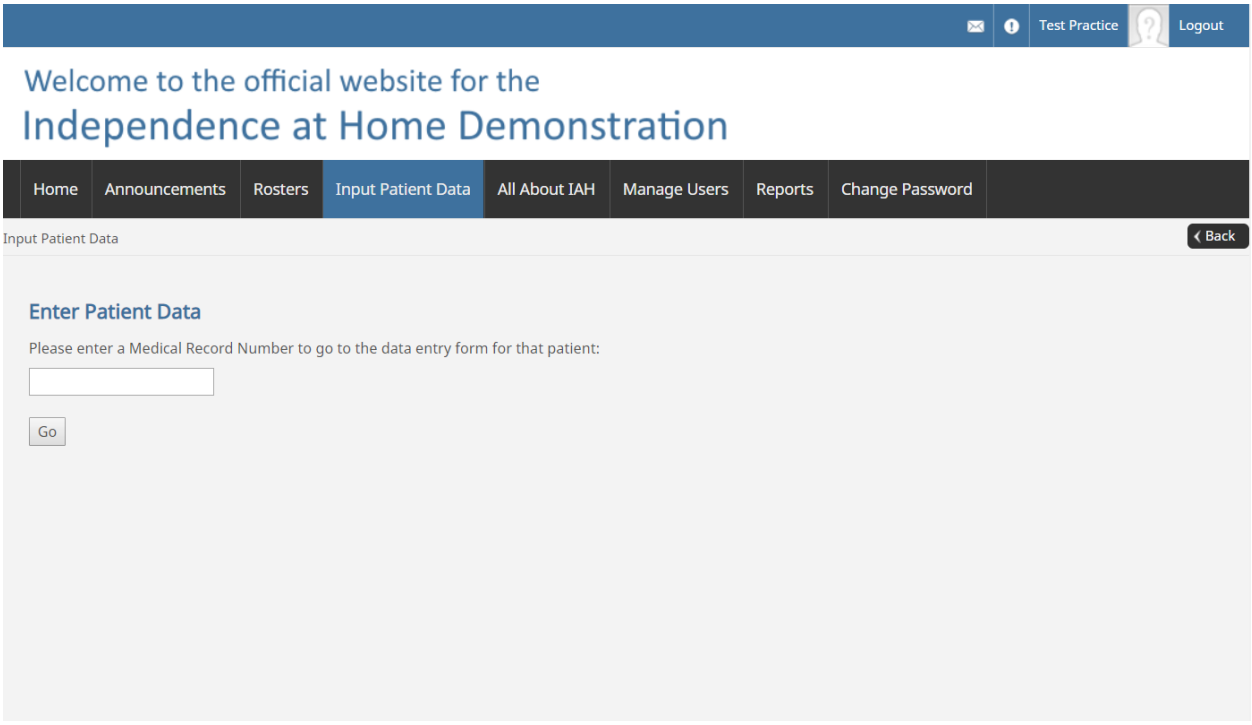
To edit a previously added provider's information, select the *Edit* link next to the record in the provider roster that needs to be edited. You will then be able to make changes to these data fields in the selected row. To view the provider roster as an Excel file, click *Export to Excel*, download to your computer, and then open the file.

Please note the following:

- NPI must be 10 digits.
- Effective Date is the date the provider joined the IAH practice. If the provider was part of your in-home practice prior to the start of the demonstration, you may enter the demonstration start date.
- Termination Date is the date the provider left the IAH practice.
- Provider Status must be "INACTIVE" before a termination date can be entered.
- Termination Date must be on or after the Effective Date.
- For providers who left the practice and then later returned, create a new line for the provider using their return date as the effective date.

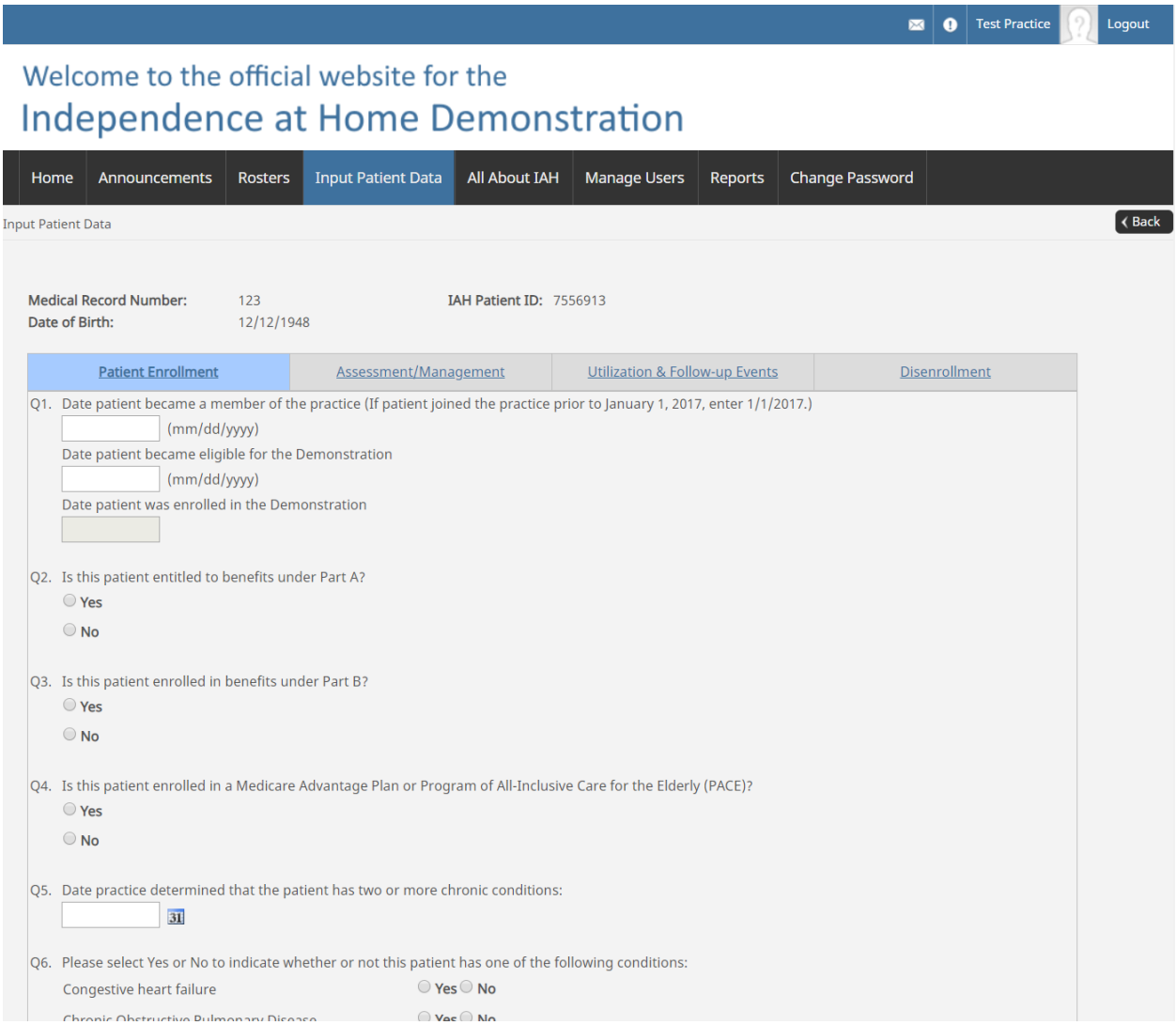
Input Patient Data Tab

The Input Patient Data tab allows practices to enter or update patient data. When you click on this tab, you will be asked to enter the patient MRN for whom you will be entering information.



After clicking *Go*, you will be directed to the Patient Enrollment subtab.

Patient Enrollment Subtab



This tab is used to confirm that the patient meets the eligibility requirements for the demonstration and to provide some additional information.

Patients to be enrolled in the demonstration must:

- be entitled to Medicare benefits under Part A and be enrolled in benefits under Part B;
- not be enrolled in a Medicare Advantage (MA) plan under Part C;
- not be enrolled in a Program of All-Inclusive Care for the Elderly (PACE) program under SSA Title 18 Sec 1894;

- have two or more chronic conditions;
- have had a hospital admission within the past 12 months;
- have received acute or subacute rehabilitation services within the past 12 months (including skilled nursing facility, home health, or inpatient or outpatient rehabilitation services); and
- have two or more functional dependencies requiring the assistance of another person (assistance may include supervision, cueing, or hands-on help).

The IAH Reporting System collects information in the Patient Enrollment subtab to help determine whether or not the patient is eligible for the IAH Demonstration. For example, the section asks questions related to the patient's enrollment in Medicare, when his or her last hospitalization occurred, whether or not the patient has two chronic conditions, and what specific activities of daily living (ADLs) limitations or functional dependencies the patient has. If you do not know the exact date of hospital admission or of rehabilitation services, enter your best estimate of when these services were utilized in the last 12 months. Once you have determined the exact date, you may go back into the Enrollment tab and make the correction.

Because the IAH Demonstration is using a broad definition of "chronic condition," the Reporting System asks practices to *specify* the chronic condition only for patients who are diagnosed with one of the three ambulatory care sensitive (ACS) conditions that are analyzed as part of the quality measures tied to incentive payments. The practice should determine whether a patient has any two or more chronic conditions first, and then they should indicate whether any of these are among the three ACS conditions associated with IAH quality measures. These conditions are congestive heart failure (CHF), diabetes, and chronic obstructive pulmonary disease (COPD). In addition, the IAH Demonstration requires that eligible patients have at least two ADL dependencies. Bathing, dressing, transferring, walking, toileting, and eating are the specific functional dependencies that establish IAH eligibility and are incorporated in developing the target expenditures for each practice. These ADLs were selected because CMS uses these functional limitations to calculate frailty factors in other programs. As a result, only these ADLs are listed as choices for indicating a patient's two ADLs for eligibility.

If the patient does not meet the eligibility requirements as laid out in the Patient Enrollment subtab, you will receive an error message stating, "Patient is designated as not eligible" below the question that disqualifies them.

As part of the enrollment process, practices are required to inform patients that the practice is participating in the IAH Demonstration. Patients must agree to have their data included in the demonstration, and the practice must record the date that the patient was informed of the practices' participation and the patients' subsequent agreement in the IAH Reporting System on the Patient Enrollment subtab. The date the patient notification letter was discussed must be included in the patient's medical record, but a signature is not required. If a patient is deemed eligible for enrollment but does not agree to have his or her data included in the demonstration analysis, you will not be able to save any of the enrollment information. If the patient is not eligible for reasons other than not agreeing to inclusion in the demonstration, again, you will not be able to save the enrollment information or move on to the other subtabs within the Input

Patient Data tab. Patients who are not eligible (either because they did not meet the eligibility requirements or because they did not agree to have their data included in the demonstration) will have their status listed as *Uploaded* on the View Patient Roster page, along with patients who have been uploaded initially but do not have data entered into the Patient Enrollment subtab.

Once you have clicked *Save* and the enrollment information has been accepted, you will be directed to the Assessment/Management subtab.

Assessment/Management Subtab

The Assessment/Management subtab is used for tracking assessments, patient management, and evaluations. This information should be documented at least annually, but it may be updated more frequently depending on the patient's needs. There are separate data fields for each year of the demonstration.

Please note that at the start of the IAH Demonstration, practices enrolled in one of two cohorts. Practices in Cohort 1 officially launched their participation in IAH in June 2012, and Cohort 2 practices launched their IAH participation in August 2012. Patient enrollment was permitted up to one month prior to these IAH launch dates (i.e., May 2012 and July 2012, respectively). Following IAH Demonstration Year 3, the cohort format was eliminated, and all practices participated on the same schedule.

The range for each date field in the Reporting System is as follows:

Year 1: Cohort 1 = 5/1/2012 to 5/31/2013
Cohort 2 = 7/1/2012 to 7/31/2013

Year 2: Cohort 1 = 5/1/2013 to 5/31/2014
Cohort 2 = 7/1/2013 to 7/31/2014

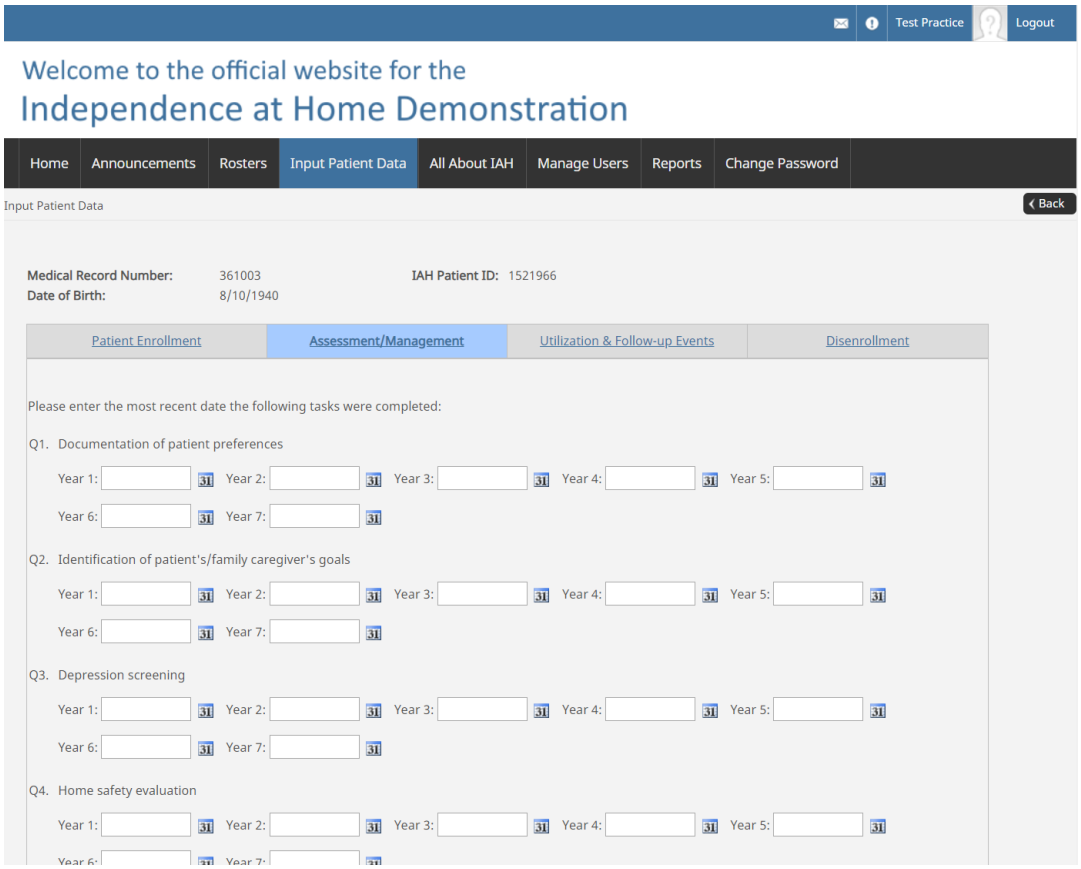
Year 3: Cohort 1 = 5/1/2014 to 5/31/2015
Cohort 2 = 7/1/2014 to 7/31/2015

Year 4: 9/1/2015 to 9/30/2016

Year 5: 9/1/2016 to 9/30/2017

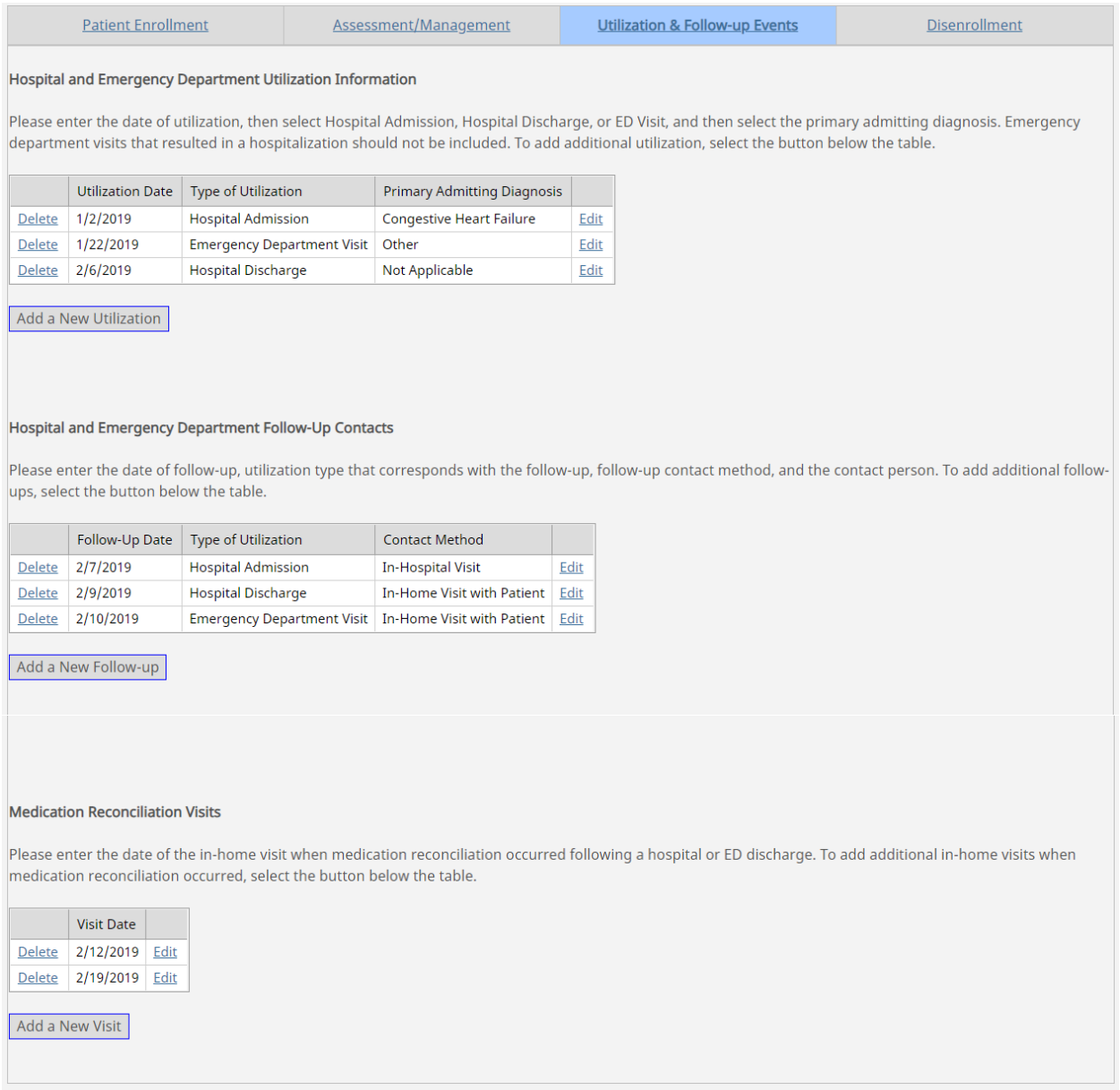
Year 6: 12/1/2018 to 12/31/2019

Year 7: 12/1/2019 to 12/31/2020


Test Practice
Logout
Welcome to the official website for the
Independence at Home Demonstration
Home
Announcements
Rosters
Input Patient Data
All About IAH
Manage Users
Reports
Change Password
Input Patient Data
Back
Medical Record Number: 361003
IAH Patient ID: 1521966
Date of Birth: 8/10/1940
Patient Enrollment
Assessment/Management
Utilization & Follow-up Events
Disenrollment
Please enter the most recent date the following tasks were completed:
Q1. Documentation of patient preferences
Year 1: Year 2: Year 3: Year 4: Year 5:
Year 6: Year 7:
Q2. Identification of patient's/family caregiver's goals
Year 1: Year 2: Year 3: Year 4: Year 5:
Year 6: Year 7:
Q3. Depression screening
Year 1: Year 2: Year 3: Year 4: Year 5:
Year 6: Year 7:
Q4. Home safety evaluation
Year 1: Year 2: Year 3: Year 4: Year 5:

Utilization & Follow-up Events Subtab

This subtab is used to document hospital and emergency department (ED) utilization, follow-up visits, and home visits at which medication reconciliation occurred. The Utilization & Follow-up Events subtab has also been updated to allow practices to collapse the list of patient utilizations, follow-ups, and medication reconciliations.



Utilization Data

To enter a new utilization, select *Add a New Utilization* and enter the utilization date, type of utilization (hospital admission, hospital discharge, or ED visit), and primary admitting diagnosis (for hospital admissions and ED visits), then click *Save*. Utilization dates must occur after the patient has been enrolled in the demonstration and cannot occur in the future. A calendar feature has been programmed into the system so that only eligible dates may be selected.

To edit a previously entered utilization, click *Edit*, make changes, and then click *Save*.

You must click *Save* before adding any new utilization information. Clicking *Add a New Utilization* will delete any unsaved utilizations.

To delete a utilization, click *Delete*, and you will receive a message asking you to confirm the deletion of that row.

Hospital and ED Follow-up Contacts

To enter a new follow-up contact, select *Add a New Follow-up* and enter the follow-up date, type of utilization, and contact method; then click *Save*. Follow-up dates must occur after the patient has been enrolled in the demonstration and cannot occur in the future. A calendar feature, which will allow only eligible dates to be selected, has been programmed into the system.

You must click *Save* before adding any new follow-up information. Clicking *Add a New Follow-up* will delete any information on unsaved follow-up visits.

To edit a previously entered follow-up, click *Edit*, make changes, and then click *Save*.

To delete a follow-up, click *Delete* and you will receive a message asking you to confirm the deletion of that row.

Medication Reconciliation Home Visits

To add a new date for an in-home visit at which medication reconciliation occurred, select *Add a New Visit* and enter the home visit date. Please note that home visits at which medication reconciliation occurred must also be entered as follow-up contacts in the follow-up section.

Home visit dates must occur after the patient has been enrolled in the demonstration and cannot occur in the future. A calendar feature, which will allow only eligible dates to be selected, has been programmed into the system.

To edit a previously entered medication reconciliation visit date, click *Edit*, make changes, and then click *Save*.

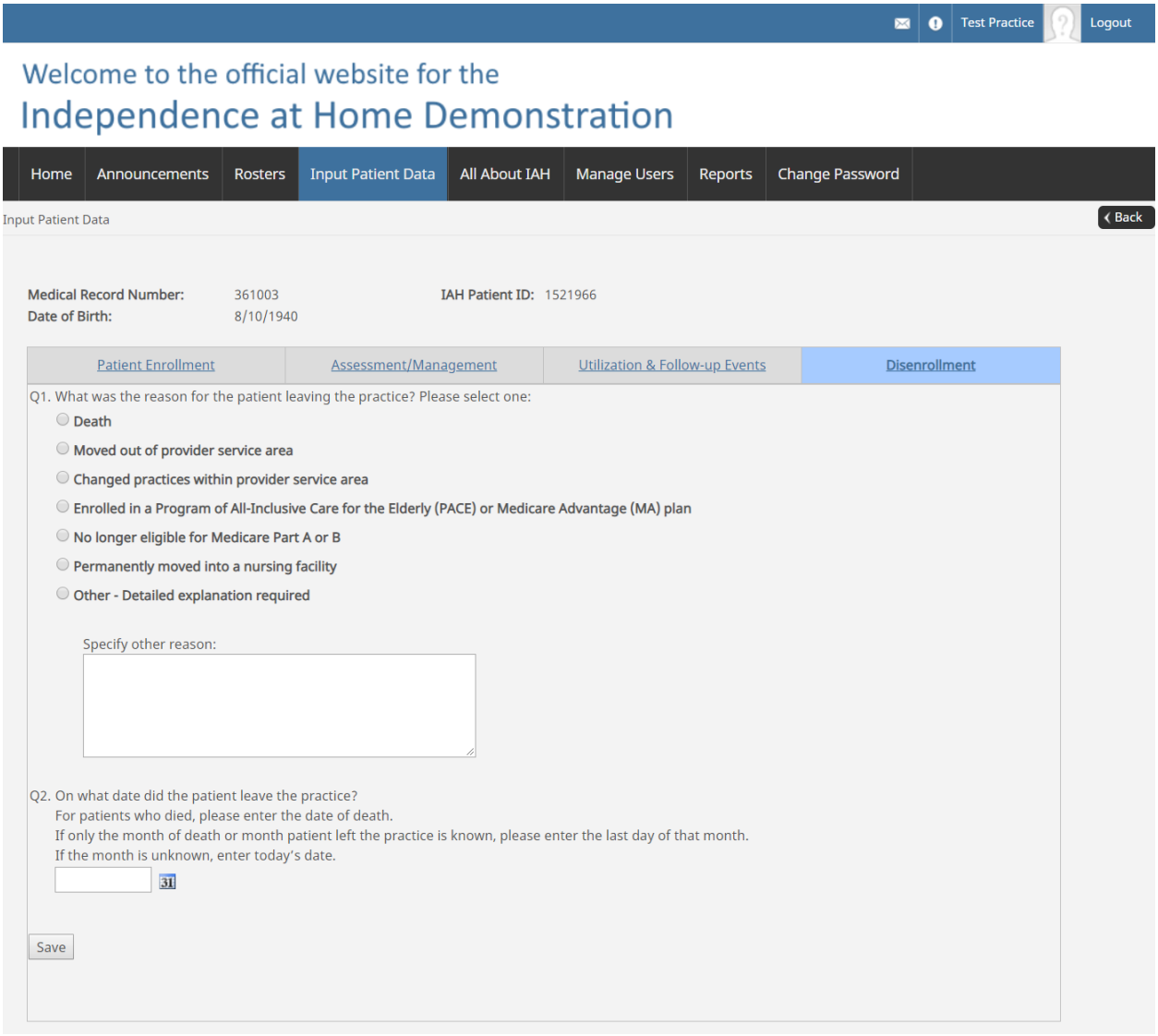
You must click *Save* before adding any new medication reconciliation visit dates. Clicking *Add a New Visit* will delete any unsaved visits.

To delete a medication reconciliation visit date, click *Delete*, and you will receive a message asking you to confirm the deletion of that row.

Disenrollment Subtab

Use this subtab only for disenrolling patients from the demonstration. A patient who leaves the practice for any reason or becomes ineligible must be disenrolled. This subtab asks for information on the reason for disenrollment and for the date on which the patient was disenrolled. Do not use this tab if you realize that a patient you uploaded into the roster did not meet the eligibility requirements or did not agree to have his or her data used for the

demonstration. These patients can remain in the Uploaded status. If you prefer to have these patients removed from your roster, please contact the Help Desk.

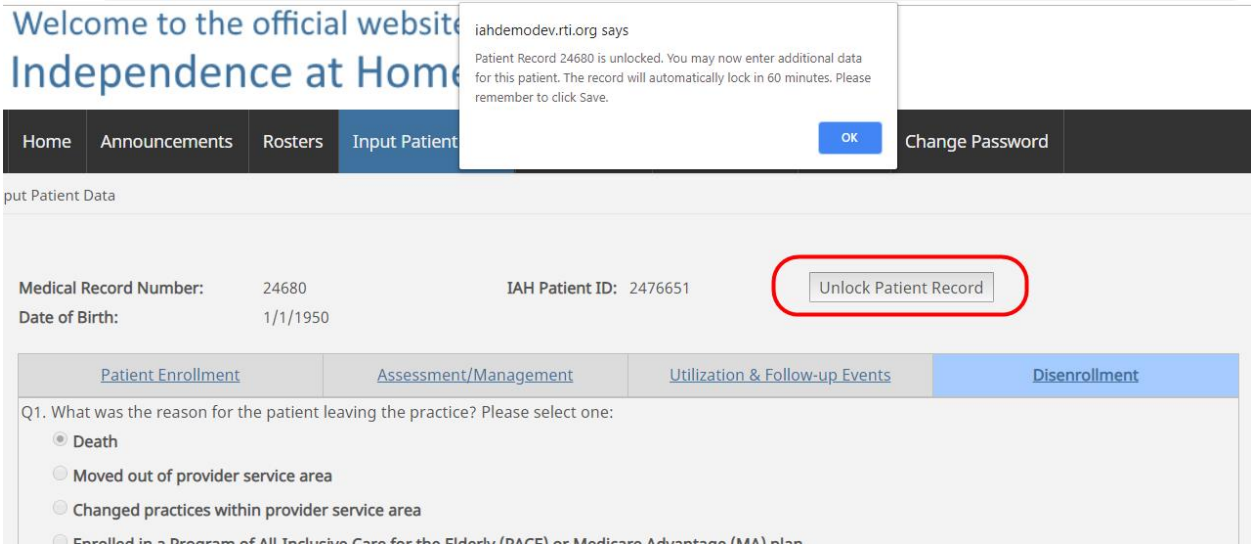


First, select the reason for disenrollment. If you select *Other*, you must specify the reason—for example, the patient is participating in another demonstration or another Medicare incentive payment program.

Next, select the date the patient left the demonstration. If you are unsure of the exact date of disenrollment, you may enter the last day of the known month and year of participation, and then edit the date later when that information becomes available. If the patient died, select the date of death. If only the month of death or the month the patient left the practice is known, please enter the last day of that month. If the month is unknown, enter today's date.

After a patient is disenrolled, all of the data fields become read-only on the Patient Enrollment, Assessment/Management, Utilization & Follow-up Events, and Disenrollment tabs, with the exception of the date the patient left the demonstration on the Disenrollment tab.

If you need to enter additional data for a disenrolled patient on the Assessment/Management or Utilization & Follow-up Events tabs, you may click the "Unlock Patient Record" button and the data fields will become editable on these two tabs only. The record will automatically lock in 60 minutes. Please remember to click the Save button to save any changes you make.



Please note: If a patient is mistakenly disenrolled or needs to be re-enrolled, you must contact the Help Desk at helpiah@rti.org. Patients cannot be re-enrolled via the Reporting System. Please contact the Help Desk for assistance. If a patient is disenrolled for less than 6 months, please provide the following information to the Help Desk: MRN and/or IAH Patient ID, original enrollment date, disenrollment date, disenrollment reason, intended re-enrollment date, and re-enrollment reason. If a patient is disenrolled for 6 months or more, the Help Desk will need to provide you with a re-enrollment form to confirm the patient's eligibility.

All About IAH Tab

When you roll your mouse over the All About IAH tab, a submenu will appear with the following options:

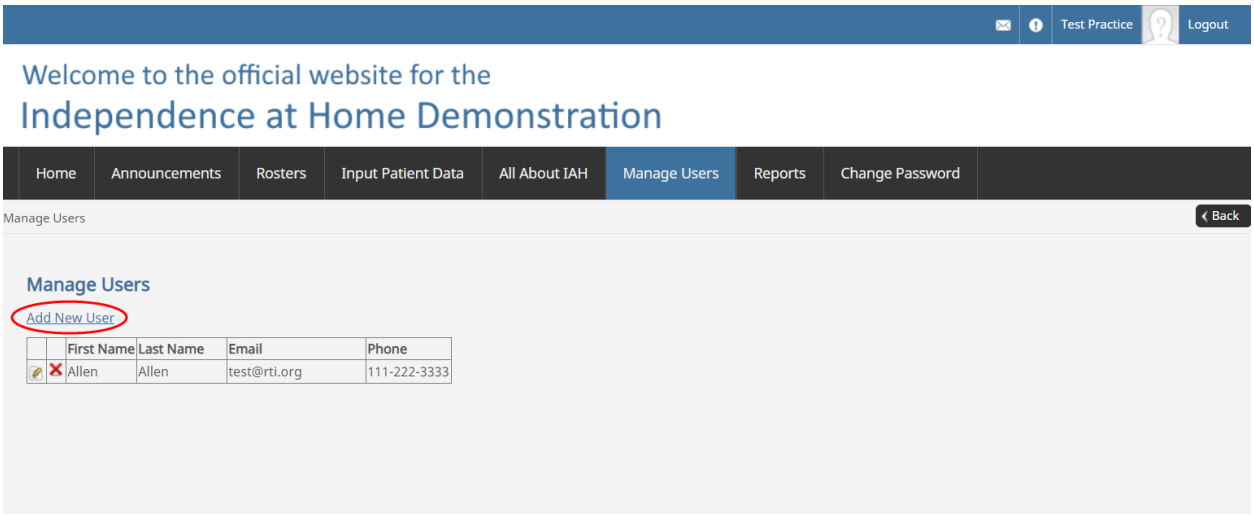
- Legislation
- IAH Presentations
- Training Documents
- Archives
- FAQs

These submenu tabs contain materials and files about the IAH Demonstration that you can view and download to your computer.

Manage Users Tab

The Manage Users tab allows the primary contact at each practice to add other users who can access practice-specific information. This is done so that multiple staff at each practice can have their own unique credentials and not have to share a single set of credentials. To add a new user, select the *Add New User* link (circled in red in the screenshot below). After the name, e-mail address, and phone number are entered for the new user, the system will send the user an e-mail with login credentials. As a reminder, new users will have access to all tabs, though only users who are also named in their practice's DUA will be able to receive and submit files via the data exchange.

Because this is a secure website for IAH practices and this demonstration requires PII and PHI, only those individuals registered in our system will have access to the website beyond the public home page. No one other than practice personnel will be provided access credentials to this website. Providers are not be permitted to share access credentials with any other individuals.



Reports Tab

When you roll your mouse over the Reports tab, a submenu will appear with the following options:

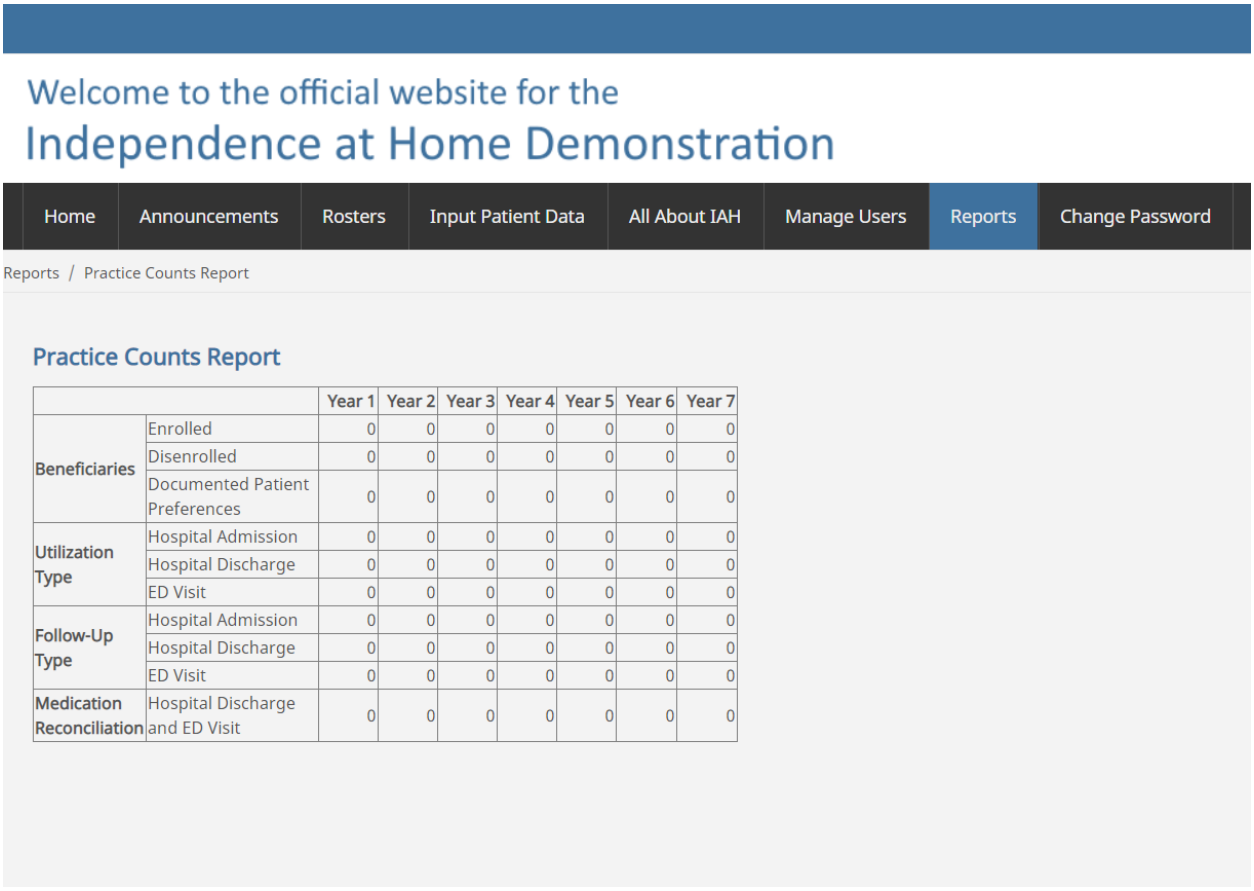
- Practice Counts Report
- Raw Data Export

Practice Counts Report

The Practice Counts Reports subtab presents counts by performance year, including:

- number of enrolled IAH patients,

- number of disenrolled IAH patients,
- number with documented patient preferences,
- number of utilizations by type,
- number of follow-ups by type, and
- number of medication reconciliation visits.



		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Beneficiaries	Enrolled	0	0	0	0	0	0	0
	Disenrolled	0	0	0	0	0	0	0
	Documented Patient Preferences	0	0	0	0	0	0	0
Utilization Type	Hospital Admission	0	0	0	0	0	0	0
	Hospital Discharge	0	0	0	0	0	0	0
	ED Visit	0	0	0	0	0	0	0
Follow-Up Type	Hospital Admission	0	0	0	0	0	0	0
	Hospital Discharge	0	0	0	0	0	0	0
	ED Visit	0	0	0	0	0	0	0
Medication Reconciliation	Hospital Discharge and ED Visit	0	0	0	0	0	0	0

Raw Data Export

The Raw Data Export page allows a practice to export the information they have entered into the Reporting System. Users have the option to download an Excel spreadsheet using the Export to Excel buttons. The types of data exports are:

- Patient Information
- Enrollment Information
- Patient Preferences
- Other Performance Measures
- Hospital and ED Utilization Information

- Hospital and ED Follow-Up Contacts
- Medication Reconciliation Visits

Data Exchange

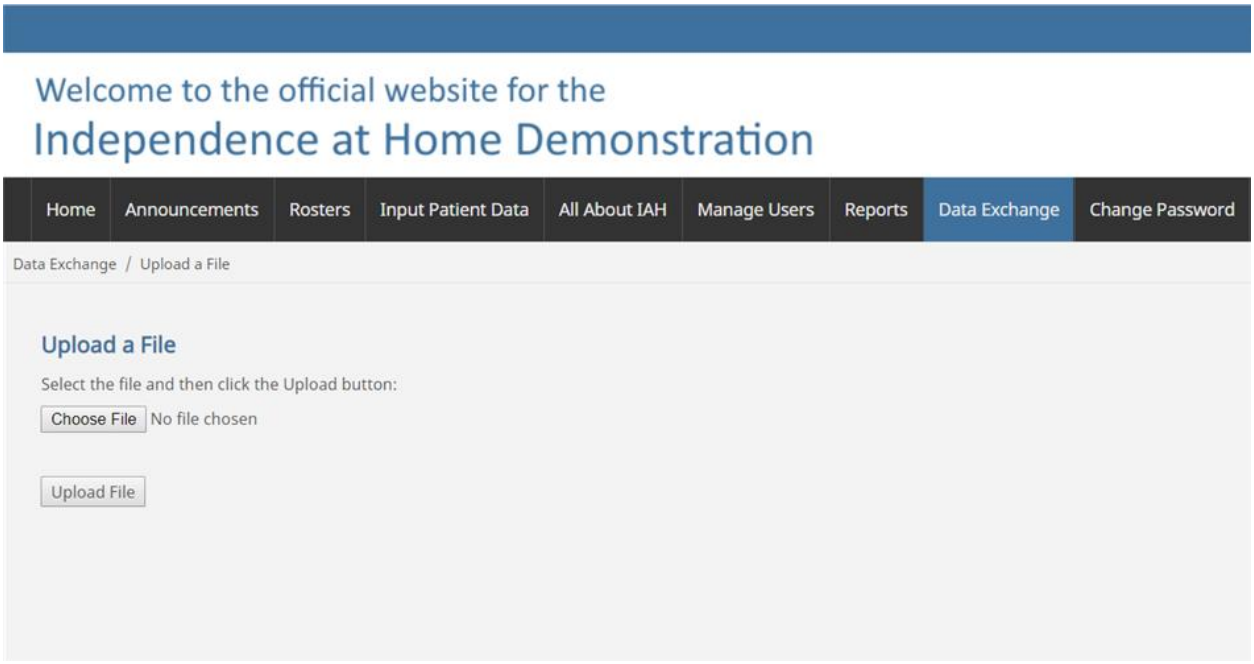
The Data Exchange tab allows users who are named on their practice's DUA with CMS to access and return secure files to RTI. When you roll your mouse over the Data Exchange tab, a submenu will appear with the following options:

- Upload a File
- Download File

Below is a description of each of the submenu items under the Data Exchange tab.

Upload a File

The Upload a File page allows a practice to upload an encrypted file to RTI. After selecting Upload a File from the Data Exchange menu, you will see the following screen:



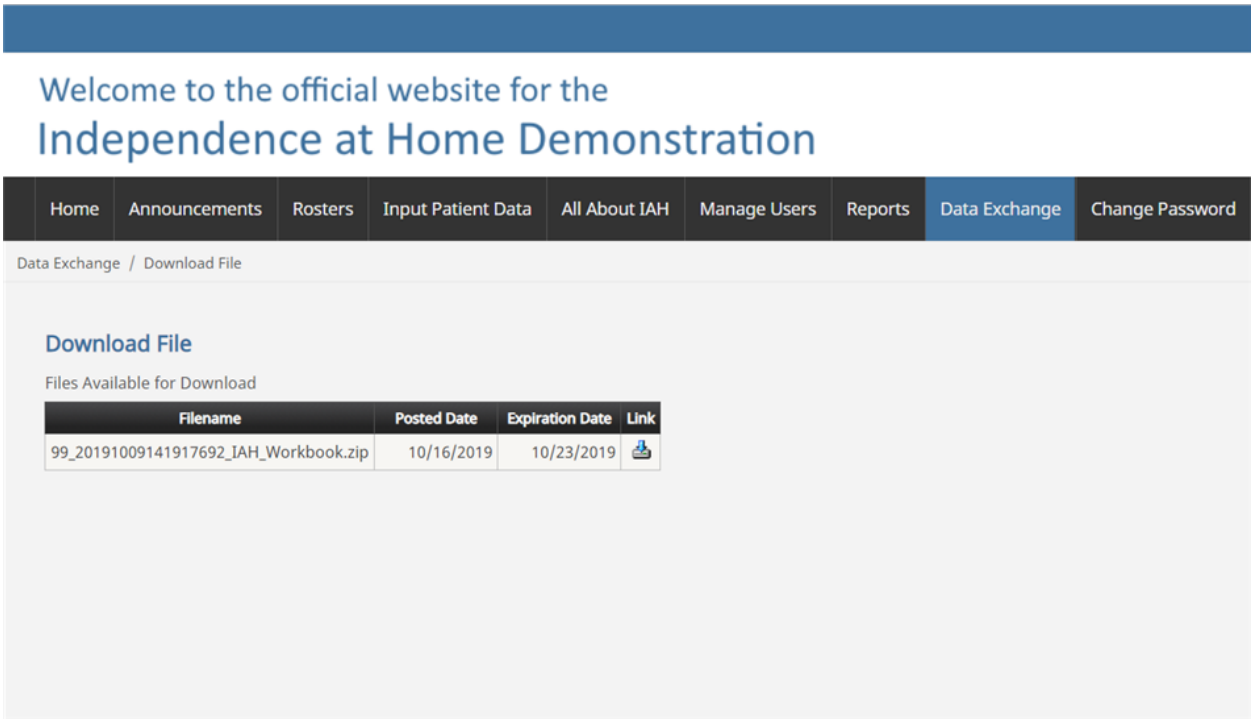
Click on *Choose File* and select an encrypted zip file from your computer. Once the appropriate file has been selected, click *Upload File*. The system will confirm that your file has been uploaded successfully.

Please note the following:

- File uploads must have a .zip extension.
- File uploads must be encrypted and password-protected using software such as SecureZIP or 7-Zip.

Download File

The Download File page allows a practice user who is on the practice's DUA with CMS to download an encrypted file from RTI. Only the DUA practice users will be able to access files. After a DUA practice user selects Download File from the Data Exchange menu, she/he will see the following screen:

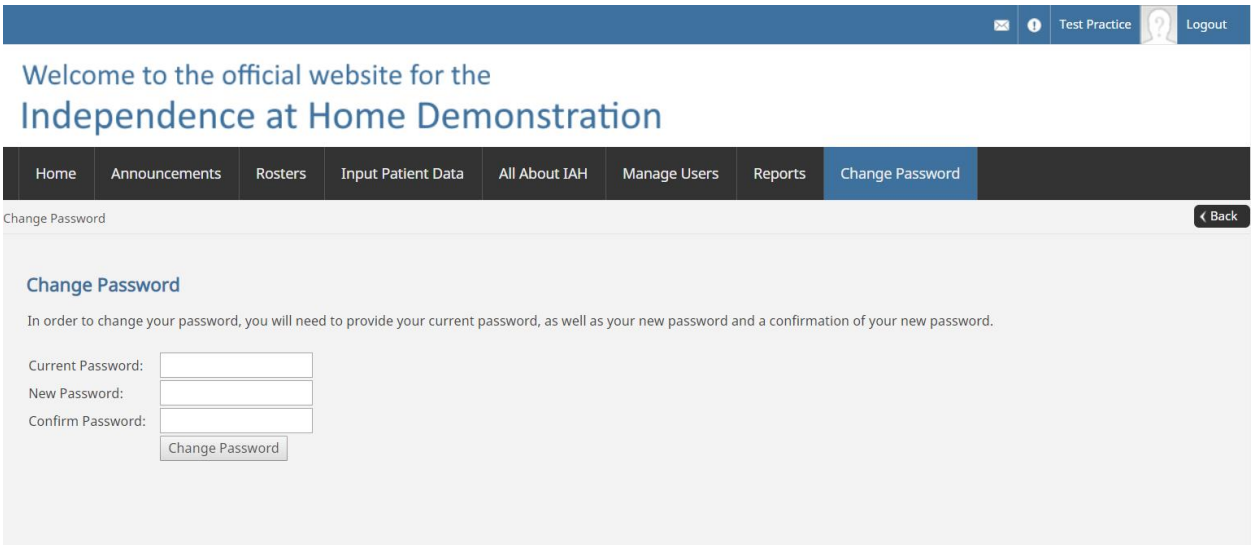


The Download File page displays a list of files that are available for download from RTI. To download a file, click the download icon in the Link column. Only individuals listed on their practice's DUA will be able to access these files.

RTI will alert practices when new files are available for download. Files expire seven days after RTI uploads them. When the expiration date passes, the file is deleted from the Reporting System and is no longer available for download.

Change Password Tab

Select the Change Password tab if you would like to change your password. You will need to provide your current password, as well as your new password and a confirmation of your new password.



Section 2B: Step-by-Step User Guide

1. Go to https://iahdemo.rti.org.
2. Click on the *Login* link at the upper right corner of the page.
3. Enter your username and password.
    a. If this is your first time logging in, you will be prompted to create your password and supply a security question and answer.
    b. Passwords must be at least eight characters long.
    c. If you forget your password:
        (1) Click *Forgot Password.*
        (2) Enter your username.
        (3) A new password will be sent to the e-mail address on file.
        (4) Log in using the new password.
        (5) Change your password to something of your own choosing.
            (a) Passwords must contain at least eight characters.
4. You are now in the IAH Reporting System and can select from the following tabs:
    a. Home
    b. Announcements
    c. Rosters
        (1) Download Roster Template
        (2) Upload Multiple Patients
        (3) Add a Single Patient
        (4) View Patient Roster
        (5) Provider Roster
    d. Input Patient Data
    e. All About IAH
        (1) Legislation
        (2) IAH Presentations
        (3) Training Documents
        (4) Archives
        (5) FAQs
    f. Manage Users
    g. Reports
        (1) Practice Counts Report
        (2) Raw Data Export

h. Data Exchange
i. Change Password

To Upload Multiple Patients

1. Select *Download Roster Template* from the Patient Roster tab.
2. Download the template.
3. Enter patient information.
4. Save the spreadsheet as a .csv file to your computer hard drive.
5. Select *Upload Multiple Patients* from the Patient Roster tab.
6. Click *Choose File* and select your completed roster template.
7. Click *Upload File*.
8. You will receive either confirmation that the file has uploaded or a list of errors.
    a. Upload confirmation—Your patient roster has been uploaded successfully and the information will be pushed to the Patient Roster tab.
    b. List of errors—Correct the errors, save the file, and upload the document.

To Add a Single Patient

1. From the Patient Roster tab, select *Add a Single Patient*.
2. Enter the patient information.
3. Click *Add Patient*.
    a. Error message—the patient has not been added. Correct the errors and try again.
    b. Patient was added successfully—you will be given the patient's unique IAH Patient ID and the patient is now included on the Patient Roster.

Input Patient Data

1. Select *Input Patient Data*.
2. Enter the MRN for the patient for whom you would like to enter information.
3. Click *Go*.
4. You will automatically be shown the Patient Enrollment subtab, even if the patient has already been enrolled.

Enrollment

1. Complete the tab to confirm the eligibility of the patient and to provide additional information.

2. Click *Save*.
    a. If the patient is not eligible or does not agree to have his or her data included in the demonstration analysis, the form will not save, and you will receive error messages next to the questions whose answers preclude eligibility. If the patient does not meet the eligibility requirements or does not agree to participation, you will need to go back to the main Input Patient Data page and select a different patient.
    b. If the patient is eligible, you will be directed to the Assessment/Management subtab.

Assessment/Management

1. Enter the date each assessment or evaluation was completed.
2. Date boxes may be left blank on the Assessment/Management subtab, but they should be filled in at least once during the performance year.
3. If you answer Question #7, Question #8 must also be answered.
4. If you answer Question #11, Question #12 must also be answered.
5. Click *Save*.
    a. If there is an error, you will receive a message telling you which question to correct.
    b. You will receive a message if the data were successfully saved.

Utilization & Follow-up Events

Hospital and ED Utilization Information

1. Click *Add a New Utilization*.
2. Enter utilization date.
3. Select utilization type.
4. Select primary admitting diagnosis.
5. Click *Save*.

Hospital and ED Follow-up Contacts

1. Click *Add a New Follow-up*.
2. Enter follow-up date.
3. Select utilization type.
4. Select contact method.
5. Click *Save*.

Medication Reconciliation Visits

1. Click *Add a New Visit*.
2. Enter visit date.
3. Click *Save*.

To Edit an Entry

1. Find the entry you would like to edit.
2. Click *Edit* on the right side of the entry.
3. Make edits.
4. Click *Save*.

To Delete an Entry

1. Find the entry you would like to delete.
2. Click *Delete* on the left side of the entry.
3. Confirm that you would like to delete this entry.

Disenrollment

1. Select the reason that the patient left the practice or is no longer eligible.
2. If *"Other"* is selected, you must specify the reason.
3. Enter the date the patient left the practice.
    a. If the patient died, enter the date of death.
    b. If only the month is known, and it is not the current month, enter the last day of that month.
    c. If the date is unknown or only the current month is known, enter today's date.
    d. If a patient died prior to their enrollment date, please list the enrollment date as the date of disenrollment. The purpose of this is to ensure that person is not included in a practice's final performance year population.

Section 3: Patient Eligibility Requirements

The eligibility criteria for the IAH Demonstration have been selected to target the most costly patients—those who have multiple chronic illnesses and functional impairments. All patients in your practice who meet these requirements must be enrolled in the demonstration, unless they decline to have their data included (see below for information).

Patients to be enrolled in the demonstration must:

- be entitled to Medicare benefits under Part A and be enrolled in benefits under Part B;
- not be enrolled in an MA plan under Part C;
- not be enrolled in a PACE program under SSA Title 18 Sec 1894;
- have two or more chronic conditions;
- have had a hospital admission within the past 12 months;
- have received acute or subacute rehabilitation services within the past 12 months (including skilled nursing facility, home health, or inpatient or outpatient rehabilitation services); and
- have two or more functional dependencies requiring the assistance of another person (assistance may include supervision, cueing, or hands-on help).

At the beginning of the IAH Demonstration, patients who were eligible as of the September 1, 2012, start date had a hospital admission and received acute or subacute rehabilitation services between September 1, 2011, and September 1, 2012. These patients were enrolled using the IAH Reporting System initial roster upload. All patients who subsequently became eligible, either through joining the practice or meeting the eligibility requirements after the start date, were considered enrolled in the demonstration on the first day of the month after the date they became eligible.

As of January 1, 2019, the beginning of the extension period for performance years 6 and 7, practices should continue enrolling all eligible participants throughout the 24-month extension period (January 1, 2019-December 31, 2020). For performance years 6 and 7, patients who were enrolled in IAH before October 1, 2017 will retain their original effective dates; there is nothing practices need to do to continue the enrollment of these previously enrolled patients in the demonstration. Any patients that became eligible between October 1, 2017, and December 31, 2018 (when the demonstration was inactive), and who were enrolled in the Reporting System during this time, were automatically enrolled as of January 1, 2019, assuming they still met the eligibility criteria on January 1, 2019. For patients who no longer met the eligibility criteria on January 1, 2019, because the date the patient met the eligibility requirements fell out of the 12-month look back period or the patient has otherwise had a change in eligibility (such as moving to managed care), you must either update the date the patient met the eligibility requirements in the Reporting System (if the patient meets the eligibility criteria as of January 1, 2019) or notify the Help Desk so that the patient can be removed from the Reporting System. If a patient that you enrolled during the lapse period has become ineligible for any reason before January 1, 2019, please notify the Help Desk so that they can be removed from the Reporting System.

The same eligibility requirements apply to all patients, including hospitalization and acute or subacute rehabilitation services in the previous 12 months. For example, if a patient meets all of the requirements except for having a hospital admission within the past 12 months, then has a qualifying admission on September 18, that patient will be enrolled in the demonstration starting on October 1. Patients who meet the eligibility requirements on the first day of the month will be enrolled starting on that day. It is the practice's responsibility to identify its eligible patients and add them to the practice roster using the IAH Reporting System.

As a reminder, IAH patient agreement letters may not be distributed until patients meet all eligibility criteria for enrollment in IAH.

Patients who are currently receiving hospice services are not eligible for the demonstration. A patient who is enrolled in the demonstration and then later receives hospice care is still eligible for the demonstration as long as an IAH physician is his or her Physician of Record. A patient who decides to change physicians after being referred to hospice should be disenrolled.

Informing Patients About the Demonstration

Practices are required to inform eligible patients of the practice's participation in this demonstration by providing patients with the information letter template sent to IAH practices by CMS. Patients may decline to have their data included in the demonstration analysis. The date of the conversation should be documented in both the patient's medical record and the IAH Reporting System. The date the patient agrees to have his or her data included in the demonstration does not affect the patient's eligibility or enrollment date. If a patient is eligible for the demonstration as of January 1, 2019, but does not agree to participate until a later date, the patient is still included in the demonstration as of January 1, 2019. However, patients who are eligible as of January 1, but not *uploaded to the patient roster* by January 20, will not be considered part of the demonstration for the month of January. All utilizations and follow-up visits that occur between the patient's enrollment date and the date he or she agrees to participate must be entered into the IAH Reporting System and will affect the quality measure and savings calculations.

Patient Enrollment Months

Practices are required to meet a minimum monthly average of 200 eligible patients each year. This average will be calculated on the basis of patient enrollment months. For example, a practice that has 100 patients for the first 6 months of the demonstration (100*6 months = 600 enrollment months) must serve a total of 300 eligible patients for the remaining 6 months (300*6 = 1,800). That is, 600 patient months + 1,800 patient months = 2,400/12 months = 200 patients per month.

Disenrollment

Patients who are enrolled in the demonstration may be removed from the demonstration for several reasons, including

- dying,
- moving outside of the provider service area,

- changing practices within the provider services area,
- enrolling in a PACE or an MA plan,
- becoming no longer eligible for Medicare Part A or B,
- permanently moving into a nursing facility, or
- having other reasons, which you will be required to specify. They include participating in another demonstration or another Medicare incentive payments program.

For a patient who leaves the practice involuntarily (dies, moves outside of the provider service area, becomes no longer eligible for Medicare Part A or B, permanently moves into a nursing facility, or has other reasons not listed), the enrollment period will end on the day the patient dies or leaves the practice involuntarily. For example, if a patient moves into a nursing facility on October 6, October 5 will be the last day the patient would be considered enrolled in the practice in determining patient expenditures and quality measure attainment.

Patients who leave the demonstration voluntarily after more than 6 months of enrollment, either by changing practices within the provider service area or enrolling in PACE or an MA plan, will be included in calculations based on the full performance year. However, patients who are voluntarily disenrolled after fewer than 6 months of any given performance year will not be included in the patient population for the entire performance year for purposes of establishing the expenditure target and calculating savings.

For example, a patient who is enrolled for 8 months out of a performance year will be counted as being enrolled for the entire year, and any costs associated with utilization within that year will be used in determining savings calculations—even costs associated with the time when that patient was no longer receiving primary care from the participating practice.

If a patient is enrolled in the demonstration for 5 months out of a performance year, but then decides to change practices, the months of enrollment will not count toward the required minimum average of 200 patients per year, nor will that patient's utilization count toward the quality measures.

Section 4: Quality and Performance Measures

Selection of Quality and Performance Measures

CMS has identified a set of measures for monitoring quality of care and for determining incentive payments. These measures were selected on the basis of an extensive review of the literature, consultation with clinical experts, national quality standards (e.g., National Quality Forum and Agency for Healthcare Research and Quality), and analysis of Medicare claims data. Additionally, some of the measures have been established specifically for the IAH Demonstration. These selected measures are not intended to be a comprehensive set of quality or performance measures for all aspects of clinical management or care coordination.

CMS considered various criteria for measure inclusion. Many of the measures included were mentioned in the legislation (e.g., utilization). CMS also sought to identify measures that are likely to make a difference in the goals of improving quality (e.g., follow-up after hospital discharge) and reducing costs. In particular, the chosen measures can be affected by primary care, either directly or through care coordination (e.g., patient preferences documented).The demonstration Reporting System also includes other performance measures covering a range of other issues, which were not intended to be used for determining incentive payment.

The selected measures will provide a broad range of perspectives in assessing demonstration progress. Many of the selected measures assess patient utilization (i.e., hospitalization rate for ACS conditions, rehospitalization rates, and ED visit rate for ACS conditions) or highlight processes of care (i.e., contact with patients within 48 hours upon admission to or discharge from the hospital or ED, in-home safety assessments). Table 3 provides a brief look at the quality measures that are tied to incentive payments. A more detailed description of how data entered into the Reporting System are used for these measures can be found later in this section.

Table 3. Quality Measures Tied to Incentive Payments

Quality Measures Tied to Incentive Payments
Follow-up within 48 hours after hospital admission, hospital discharge, and ED visits
In-home medication reconciliation within 48 hours of hospital discharge and ED visits
All-cause hospital readmissions
Hospital admission rate for ACS conditions
ED visit rate for ACS conditions
Patient Preferences documented in medical record

Quality Measure Data

IAH practices use the IAH Reporting System to enter data on quality measures for enrolled patients. These data include dates of various utilizations (hospital admissions, hospital discharges, and ED visits), dates when practices followed up with patients (via an in-home visit, telephone call, etc.), and dates when patient preferences were recorded.

The IAH Reporting System is designed to allow practices to enter quality measure data for patients at any time. We recommend that utilization and follow-up data be entered as soon as possible after the occurrence of the activity. Data entered this way will accurately reflect what your practice or consortium has done. However, we know that timely data entry may not always be possible immediately when events occur. Thus, practices have the option to enter utilization and follow-up data (dates, types of follow-ups, etc.) at any point during the performance year. The IAH Reporting System also allows practices to go back and edit previous data entries, if this becomes necessary during the performance year—however, we strongly recommend that data related to the quality measures be entered as close to real-time as possible to ensure that the data reflect the care delivered and that practices get credit for that care. Information entered after the end of the performance year and after the end of the set closing of the Reporting System may not be used for quality measure calculations.

Performance Measure Data

At the start of the demonstration, the Reporting System was constructed to allow practices to enter information for performance measures beyond the six quality measures used for incentive payment calculations. For example, these performance measures included screenings and assessments conducted, including depression, home safety evaluation, risk of falling, and cognitive deficits, and symptom management (e.g., pain, shortness of breath, cognitive deficits, fatigue, sleep disturbances). Although these performance measures were not ultimately included in demonstration analyses, the Reporting System still offers these items, should practices wish to use the Reporting System for documentation. Including these performance measures was intended to support documentation of the range of activities performed by IAH practices, serve as a reminder to provide guideline concordant care, and could have been analyzed in relation to outcomes. However, since practices have not generally completed the performance measures, these data are not analyzed in any way for the IAH Demonstration.

Patient Weighting for Quality Measures

The IAH Demonstration uses patient weighting when analyzing annual quality measure data. Patients who are enrolled in the demonstration after the start of a performance year are weighted in quality measure calculations using the number of months they were enrolled in the demonstration. For example, a patient who enrolls at the start of the demonstration (September 1, 2012, for the first performance year) is included for all 12 months for quality measure weighting that year. A patient who enrolls in the demonstration on December 1, 2012, is weighted for only 9 months of the performance year.

Voluntary and Involuntary Disenrollment

Participation is weighted differently if the patient disenrolls during any given performance year. Patients may leave a practice voluntarily or involuntarily during any performance year. Disenrollment reasons were described in Section 2 that outlined use of the Reporting System.

Involuntary Disenrollment

Participation for patients who involuntarily leave the demonstration is calculated for that portion of the performance year that they were in the demonstration using the weighting method described above.

Voluntary Disenrollment

Patients who leave the demonstration voluntarily *after more than 6 months of enrollment*, either by changing practices within the provider service area or enrolling in PACE or an MA plan, will be included in calculations based on the full performance year. However, patients who disenroll voluntarily *after less than 6 months* of any given performance year will not be included in the patient population for the entire performance year for purposes of establishing the expenditure target and calculating savings. For example, if a patient is enrolled in the demonstration for 5 months of a performance year, but then decides to change practices, his or her months of enrollment will not count toward the required minimum average of 200 patients per year, nor will any utilizations count toward the quality measures.

Voluntary disenrollment of patients who were enrolled for more than 6 months within a performance year will be counted in the patient population for the entire practice performance year for purposes of establishing the expenditure target and calculating savings. For example, a patient who is enrolled for the first 8 months of a performance year and then chooses to leave the practice will be counted as being enrolled for the entire year; any costs associated with utilization within that year will be used in determining savings calculations—even costs associated with the time when that patient was no longer receiving primary care from the participating practice.

Payments Based on Quality Performance

To qualify for incentive payments, each practice must meet or exceed performance requirements on at least three of six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures will not be eligible for incentive payments. Practices are eligible for a proportion of savings depending on whether they meet three, four, five, or six of the quality measures.

Minimum performance values for quality measures that are tied to payment will be determined in one of two ways. Minimum thresholds for process quality measures are based on absolute criteria. Thresholds for utilization quality measures are based on comparison to risk adjusted average utilization for a similar geographic population for each practice. Thresholds levels for each of the six quality measures are presented in Table 4.

Table 4. Quality Measure Threshold Values

Quality Measures	Threshold Value
Contact with patients within 48 hours upon admission to or discharge from the hospital or emergency department	50% of the time
Medication reconciliation in the home within 48 hours of hospital discharge or emergency department visit	50% of the time
Patient preferences documented in medical record annually	80% of the time
Number of inpatient admissions for ACS conditions	Threshold equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments (determined using Medicare claims analysis)
Number of readmissions within 30 days	
Number of ED visits for ACS conditions	

Quality Measures and the Reporting System

The following section includes a brief description for each of the six quality measures tied to the incentive payments. More detail regarding these measures is available in the Technical Specifications for the quality measures.

Each of the quality measures is composed of two parts: a **denominator** and a **numerator**. The **denominator** comprises the total population (patients, hospital utilizations, etc.) from which each quality measure rate will be determined. The **numerator** comprises the number of items from the denominator that meet the requirements set forth for each quality measure. The brief measure description below includes an orientation to the numerator and denominator for each measure. In addition, we include a section that highlights the data sources for each measure, with additional detail if the Reporting System is the data source. Additional information about these quality measures and calculations is available by request via the IAH Help Desk (helpiah@rti.org).

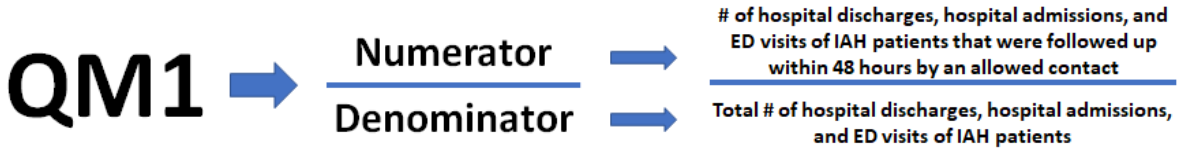
Most pertinent to this training manual, a subset of the IAH quality measures are based on data gathered from the IAH Reporting System. Accurate calculation of the quality measures and credit for the work done by the practice requires complete entry of information into the reporting system. More information regarding these data and how to enter them is detailed below.

Quality Measure 1: Follow-up Contacts Within 48 Hours of Hospital Admissions, Hospital Discharges, and ED Visits

The objective of this quality measure is to capture all hospital admissions, hospital discharges, and ED visits that are followed up by a qualifying ("allowed") contact from a member of the IAH practice's clinical staff within 48 hours.

Numerator Statement: Total number of hospital admissions, hospital discharges, and ED visits for beneficiaries enrolled in each IAH practice with a qualifying follow-up contact from a member of the IAH practice's clinical staff within 48 hours

Denominator Statement: Total number of hospital admissions, hospital discharges, and ED visits for beneficiaries enrolled in each IAH practice.



Data Sources for this Measure

Note that data entered into the Reporting System is used in part to determine whether qualifying follow-up contact occurred. Follow-up contacts that meet the following criteria are used to calculate the numerator for this quality measure:

- Hospital admission follow-ups that will be counted:
  - In-hospital visit to the patient
  - Telephone call to the hospital in which a person from the practice speaks to the patient, the patient's caregiver, or the attending clinical staff
- Hospital discharge allowed follow-up:
  - In-home visit with the patient
- ED-allowed follow-ups:
  - In-home visit with the patient
  - Telephone call in which a person from the practice speaks to either the patient or the patient's caregiver

See the Contact Matrix listed in FAQ E7 for a chart specifying which IAH practice members may complete each of the possible follow-up visits.

Claims data will be used to identify follow-up visits made by physicians, nurse practitioners, and physician assistants in the numerator for this measure, but visits by RNs may not be visible in claims data. The IAH Reporting System is the source for the NPI list used to determine which of the claims can be attributed to any given practice for a follow-up visit.

The IAH Reporting System will serve as the data source for determining whether a follow-up visit occurred for telephone calls and in-home visits by RNs. Although codes for telephone calls currently exist in *Current Procedural Terminology*, Medicare does not reimburse for these services. As a result, this demonstration will be using only data gathered in the IAH Reporting System for telephone calls used by practices and through audit of medical records.

Claims data will be used to determine which hospital admissions, hospital discharges, ED visits should be included in the denominator for this measure.

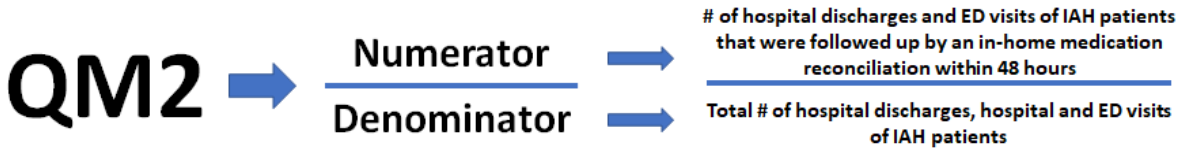
Practices must perform follow-ups within 48 hours for at least 50% of hospital admissions, hospital discharges, and ED visits for Quality Measure 1 to meet the threshold.

Quality Measure 2: Medication Reconciliation in the Home Within 48 Hours of Hospital Discharges and ED Visits

CMS defines *medication reconciliation* as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record with an external list of medications obtained from a patient, hospital, or other provider.[1] The objective of this measure is to capture all hospital discharges and ED visits that are followed by medication reconciliation in the home within 48 hours to ensure that patients have correct information about their medication regimens.

Numerator Statement: Total number of hospital discharges and ED visits for beneficiaries enrolled in each IAH practice with medication reconciliation from a member of the IAH practice's clinical staff within 48 hours.

Denominator Statement: Total number of hospital discharges, and ED visits for beneficiaries enrolled in each IAH practice.



Data Sources for this Measure

A Reporting System entry indicating medication reconciliation is used to determine whether medication reconciliation occurred. This measure does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider. Telephone follow- up is *not* allowed as an option in Quality Measure 2 for fulfilling medication reconciliation after an ED visit. This

[1] CMS.gov, "Eligible Hospital and Critical Access Hospital Meaningful Use Menu Set Measures, Measure 6, Stage 1"

is an intentional difference from Quality Measure 1 put in place for the IAH Demonstration. Practices can fulfill the requirements of both quality measures by completing medication reconciliation during the same in-home visit used as a follow-up contact after all ED visits, though medication reconciliation and visits must be recorded separately in the Reporting System. Clinical pharmacists may also complete in-home medication reconciliations. Visits by clinical pharmacists may count for purposes of medication reconciliation, but not as an in-home follow-up visit for purposes of Quality Measure 1. In-home medication reconciliation documented in the Reporting System also should be indicated in the medical record for each patient. CMS or its designees reserve the right to audit practices to verify this documentation.

The auditing process may include sending pages from a medical record to CMS documenting that the medication reconciliation process occurred and on what date.

Claims data are used to determine which hospital discharges and ED visits should be included in the denominator for this measure

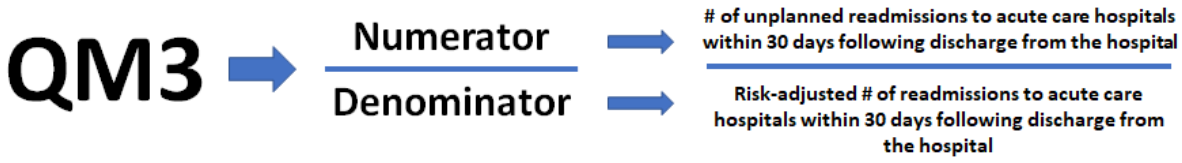
Practices must perform follow-ups within 48 hours for at least 50% of hospital discharges and ED visits to meet the performance threshold for Quality Measure 2.

Quality Measure 3: All-Cause Hospital Readmissions Within 30 Days

The objective of this measure is to assess, among all enrolled IAH patients, the number of hospital inpatient stays during the measurement year that were followed within 30 days by unplanned acute hospital readmissions for any diagnosis. Practices must achieve a readmission rate equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments for Quality Measure 3 to be considered in their incentive payment calculations. Thus, the measure is constructed as a ratio of the observed number of readmissions to a risk adjusted predicted number of readmissions. More information regarding the methodology for risk adjustment is available in the Quality Measure Technical Specifications.

Numerator Statement: Observed unplanned readmissions to acute care hospitals within 30 days following discharge from the hospital for an index admission.

Denominator Statement: Expected (risk adjusted) readmissions to acute care hospitals within 30 days following discharge from the hospital for an index admission.



Data Sources for this Measure

Claims data will be used to determine all hospital discharges and hospital admissions that will be included in the calculations for this quality measure. However, geographic data regarding the

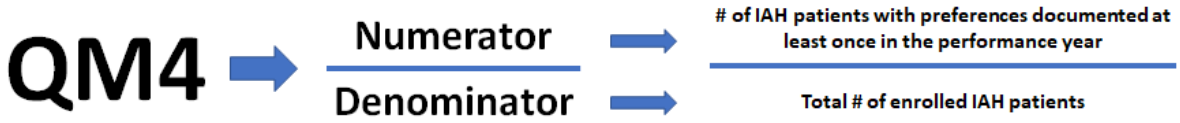
practice's population, used to identify an unmanaged, clinically similar population, will come from the IAH Reporting System.

Quality Measure 4: Annual Documentation of Patient Preferences

High-quality, patient-centered care requires understanding patient preferences, coordinating care according to those expressed preferences, and communicating patient preferences effectively across settings and among patients, family members, and multidisciplinary care team members. Documentation of patient preferences within the medical record is a critical tool to ensure that patient wishes are communicated and acted on across care settings and providers. The objective of this measure is to capture the number of IAH patients with whom IAH practices have discussed preferences and for whom they have documented these preferences in the medical record at least once each performance year. Practices must document patient preferences at least 80% of the time for Quality Measure 4 to meet the threshold for use in their incentive payment calculations.

Numerator Statement: Total number of beneficiaries in each IAH practice with documented patient preferences, weighted by months of enrollment.

Denominator Statement: Total number of beneficiaries enrolled in each IAH practice, weighted by months of enrollment.



Data Sources for this Measure

Data used in calculations for Quality Measure 4 will come from information entered by practices into the IAH Reporting System. IAH practices are requested to enter the date when preferences were discussed with the patient and documented in the medical record.

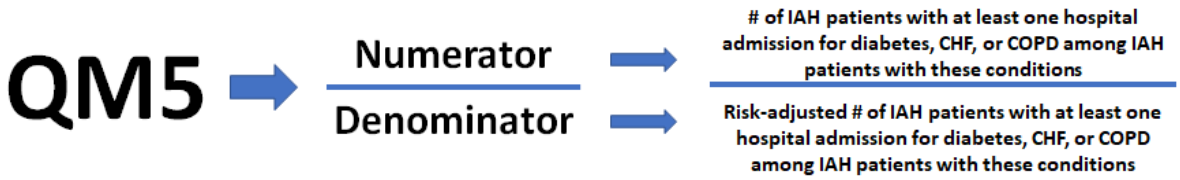
This information should be entered at least once during each performance year.

Quality Measure 5: Number of Hospital Admissions for ACS Conditions

This measure serves to capture the number of hospital admissions associated with specific ACS conditions from IAH patients who are diagnosed with at least one of the following ACS conditions: CHF, diabetes, or COPD. The objective of this quality measure is to assess whether practices perform at least as well as, or better than, other providers in their geographic areas with respect to hospital admissions for these ambulatory sensitive conditions: diabetes, CHF, and COPD. Practices must perform at least as well as predicted, based on analysis of IAH eligible beneficiaries in the same geographic area, to meet the performance threshold. More information regarding the methodology for risk adjustment is available in the Quality Measure Technical Specifications.

Numerator Statement: Observed number of beneficiaries with at least one admission to acute care hospital for diabetes, CHF, or COPD for IAH enrolled beneficiaries identified as having diabetes, CHF, or COPD.

Denominator Statement: Expected (risk adjusted) number of beneficiaries with at least one admission to acute care hospitals for diabetes, CHF, or COPD for beneficiaries identified as having diabetes, CHF, or COPD.



Data Sources for this Measure

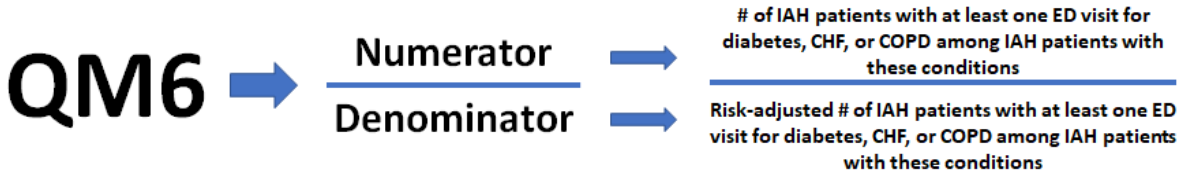
Data used for incentive payment calculations for Quality Measure 5 come from Medicare claims data. However, geographic data (i.e., zip code) regarding the practice's population, used to identify an unmanaged, clinically similar population, come from the IAH Reporting System.

Quality Measure 6: Number of ED Visits for ACS Conditions

This measure serves to capture the number of ED visits associated with specific ACS conditions (CHF, diabetes, and COPD) from IAH patients who have been diagnosed with at least one of the conditions. The objective of this quality measure is to assess whether practices are able to reduce use of emergency departments for diabetes, CHF, and COPD. Practices must perform at least as well as predicted based on analysis of IAH eligible beneficiaries in the same geographic area to meet the performance threshold. The measure is constructed as a ratio of the observed to a risk-adjusted predicted number of IAH enrolled beneficiaries diagnosed with diabetes, CHF, or COPD with at least one emergency department visit for diabetes, CHF, or COPD.

Numerator Statement: Observed number of beneficiaries with at least one ED visit for diabetes, CHF, or COPD for beneficiaries identified as having diabetes, CHF, or COPD.

Denominator Statement: Expected (risk adjusted) number of beneficiaries with at least one ED visit for diabetes, CHF, or COPD for beneficiaries identified as having diabetes, CHF, or COPD.



Data Sources for this Measure

Data for incentive payment calculations for Quality Measure 6 come from Medicare claims data. However, geographic data (i.e., zip code) regarding the practice's population, used to identify an unmanaged, clinically similar population, come from the IAH Reporting System.

Section 5: Methodology for Savings Calculations

The law requires that CMS establish a spending target for Medicare Parts A and B expenditures for each practice participating in the IAH Demonstration. Savings will be measured as the difference between actual expenditures and the spending target for each practice. The spending targets represent the expected Medicare FFS expenditures of enrolled patients in the absence of the demonstration and must include a risk corridor that accounts for variation in expenditures and the number of applicable patients at each practice.

Incentive payments to the IAH practices stem from savings in excess of 5% of the spending targets, but only for those practices that meet at least three of the six quality measures. Such payments will be a percentage of the excess savings.

Participation in this demonstration does not affect a practice's existing Medicare claims submission. The demonstration does not change Medicare coverage or payment policies.

Spending Target

The savings calculation methodology has undergone several revisions since the beginning of the demonstration, at times offering practices a choice of two methodologies for their savings calculations. Effective for performance years 6 and 7, CMS is implementing the methodology described here, referred to as the "revised actuarial approach."

CMS establishes annual practice-specific spending targets derived from claims and based on expected Medicare FFS utilization for each of the patients in the practice in the absence of the demonstration. Annual spending targets are calculated for each participating practice at the end of each performance year. The spending target is derived from a base expenditure amount equal to the average payments under Part A and Part B.

The spending target for each practice will be risk adjusted and frailty adjusted to reflect each practice's patient population using the following formula:

*Average FFS Cost in County of Residence * Trend * (Risk Adjustment Score + Frailty Factor + Utilization Factor)*

The average FFS cost in county of residence (per patient, per month), trend, and frailty adjustment factors are established each year by CMS. We use the most recently available FFS data at the time each year's spending target is determined. The trend applied will represent the expected average increase in the per patient, per month Medicare Part A and B costs from the midpoint of the year of the FFS data to the midpoint of the performance year. Applying a trend factor is necessary because the FFS county costs will have been reported for a time period before the performance year. We will use the Part A and Part B trends published in the most recently available Medicare Trustees Report.

All new enrollees of IAH practices receive a prospective CMS-HCC risk score based on the prior calendar year's diagnoses and demographic factors, plus a frailty factor and a utilization factor. The frailty factor is added to the risk score to reflect a patient's impairments in ADLs, which may increase the costs of care. Information about the number of ADL impairments is collected from the Reporting System. The utilization factor is added to the frailty adjusted risk score to

reflect the level of risk that is not captured by the CMS-HCC model for beneficiaries with a hospitalization and post-acute care in the 12 months prior to their enrollment date in the performance year. The utilization factor for all beneficiaries with a hospitalization and post-acute care in the 12 months prior to their enrollment date in the performance year is 0.245 and will only apply to Aged-Disabled risk scores (not to end-stage renal disease (ESRD) risk scores). For continuing enrollees who did not have a hospitalization and post-acute care in the 12 months prior to the performance year, and for enrollees with ESRD risk scores, the utilization factor is zero. The risk score and frailty factor for continuing enrollees are updated only for changes in demographics (e.g., age and Medicaid status).

An individual practice's spending target equals the average of these per-patient predicted costs, weighted by the number of months of each patient's participation.

Savings Calculation

Savings are calculated annually as the difference between each practice's spending target and actual FFS costs. A *projected* spending target is provided to each practice on the basis of its projected population; CMS calculates the *actual* spending target at the completion of each performance year. Annual expenses per patient are truncated at the 99th percentile of geographically adjusted annual expenditures across all IAH beneficiaries in the entire demonstration. The 99th percentile threshold is calculated separately for ESRD and non-ESRD beneficiaries. Truncation is performed to reduce the effect of an unexpectedly high number of high-cost patients that a practice may treat in any given year. These high-cost patients could negatively affect the calculation of a practice's savings; truncation significantly reduces this impact.

According to the IAH legislation (see Appendix A), spending targets must include a risk corridor that accounts for variation in expenditures and the number of applicable patients at each practice. This inclusion ensures that differences between the target and actual expenditures represent actual savings, rather than differences owing to normal variation in Medicare spending. The more beneficiaries that are in the practice's IAH beneficiary population and the lower the variation in expenditures among those beneficiaries, the more likely that actual savings have occurred.

To determine if the savings qualify a practice for an incentive payment in a given performance year, CMS constructs two, one-sided confidence intervals, one at 80% confidence levels and one at 85% confidence, around the practice's actual expenditures for that year, and compares the practice's spending target to the upper bound of each confidence interval. If the spending target is above the upper bound of one of the confidence intervals, CMS is 80% or 85% confident that the savings were "real" and not due to random variation.

If the practice's spending target exceeds the upper bound of the 85% confidence interval, the practice may receive up to 80% (based on quality performance) of shareable savings; if the practice's spending target exceeds the upper bound of the 80% confidence interval (but not the upper bound of the 85% confidence interval), the practice may receive up to 50% (based on quality performance) of shareable savings. Shareable savings are defined as the savings above the first 5% saved; CMS retains the first 5% saved, which is equal to 5% multiplied by the

spending target and total beneficiary months. If the practice's spending target does not exceed the upper bound of either confidence interval, the practice will not qualify for an incentive payment for the performance year. The 50% or 80% of shareable savings is referred to as the savings that qualify for sharing.

Quality Measures

To qualify for incentive payments, each practice or consortium must meet or exceed performance requirements on at least three of six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures will not be eligible for incentive payments. Please review Section 5 for more information on quality measure calculation.

Savings Calculations for Practices in a Consortium

For practices entering the demonstration as a consortium, savings are determined on the basis of the spending target, actual expenditures, and minimum savings requirement (MSR) for all patients enrolled in the consortium. The calculations will be done using the same methods described above, but using all patients enrolled in the practices that make up your consortium and not just the patients enrolled in your individual practice.

CMS will make a single incentive payment to the entity as a whole. It will be up to each consortium to determine how to distribute the payment among its participating practices.

Section 6: Frequently Asked Questions

A. Background and Eligibility Information

A.1 What is the purpose of the IAH Demonstration?

The IAH Demonstration tests a payment incentive and service delivery model that uses primary care teams led by physicians or nurse practitioners to deliver timely, in-home primary care to Medicare patients with multiple chronic illnesses and functional impairments. These patients experience multiple hospital admissions, ED visits, and high care utilization that are costly for the Medicare program. The demonstration assesses the effects of timely, in-home primary care on health care costs; quality of care; and rates of preventable hospitalizations, hospital readmissions, and ED visits.

A.2 Why would a practice want to participate in the IAH Demonstration?

This is an opportunity for practices to test whether in-home primary care can reduce hospitalizations, hospital readmissions, ED visits, and costs while increasing the quality of care. Practices that achieve cost savings in comparison to target expenditures and also meet the quality standards for the demonstration will receive incentive payments from CMS.

A.3 How do patients benefit from their practices' participation in this demonstration?

Home-based primary care allows patients to receive primary care at home, rather than in an office or facility, thereby increasing access to care. An important goal of at home care is to improve patient satisfaction by reducing hospitalizations and ED visits and promoting care consistent with patient preferences.

A.4 What is meant by "home"?

For the purpose of this demonstration, "home" is simply where the patient resides. A home may be a house, apartment, assisted living facility, or any other *noninstitutional* location. Long-term residence in a nursing facility is not considered living at home for the purpose of this demonstration.

A.5 Can a practice or patient participate in the IAH Demonstration and an Accountable Care Organization (ACO), such as the Medicare Shared Savings Program or testing of the Pioneer ACO model, at the same time?

A practice may participate in another Medicare Shared Savings Program or related effort, but all of the practice's patients attributed to IAH may not participate in any other model. Only the practice's non-IAH patients may participate in another Shared Savings Program (e.g., ACO).

A.6 Can nurse practitioners and physician assistants participate in this demonstration?

Yes. Practices may include physicians, nurse practitioners, and physician assistants. Nurse practitioners and physician assistants must comply with regulations specific to their fields of practice and states regarding their scope of practice. A practice must be led by (1) a physician or (2) nurse practitioners or physicians assistants that meet certain requirements.

A.7 What is the minimum number of patients an IAH practice must enroll per year?

Each participating practice or consortium must provide services to an average of at least 200 applicable patients during each year of the demonstration. A practice's enrollment may vary over a year, but it must reach an average of 200 or more applicable patients each year.

A.8 Will CMS provide a patient caseload or will the practice be responsible for its own caseload?

The practice will be responsible for identifying its eligible caseload and for certifying the eligibility of each applicable patient (an eligible patient must have at least two chronic conditions, two functional impairments, hospitalization in the last 12 months, and use of rehabilitation or other post-acute care in the last 12 months). Practices are required to enroll all eligible patients both at the outset of the demonstration and all additional patients who become eligible in the course of the demonstration. CMS verified patient eligibility by checking Medicare claims data (hospitalization and post-acute care use in the last 12 months) and by auditing medical records for information regarding functional limitations. CMS will also use claims data to identify all potentially eligible patients associated with the individual practices to ensure that the practices enroll all eligible patients. CMS reserves the right to audit a practice's medical records to verify eligibility of patients participating in the demonstration.

A.9 What are the eligibility requirements for patients?

To be counted as part of this demonstration, patients must

- be entitled to Medicare benefits under Part A and be enrolled in benefits under Part B;
- not be enrolled in an MA plan under Part C;
- not be enrolled in a PACE under SSA Title 18 Sec 1894;
- have two or more chronic conditions;
- have had a hospital admission within the past 12 months;
- have received acute or subacute rehabilitation services within the past 12 months (including skilled nursing facility, home health, or inpatient or outpatient rehabilitation services); and
- have two or more functional dependencies requiring the assistance of another person (assistance may include supervision, cueing, or hands-on help).

A.10 How will CMS know that the patients served by the practices meet the eligibility requirements?

Each month, practices will provide CMS with a list of the patients (via the IAH Reporting System) they are serving under the IAH Demonstration, along with information about their patients' chronic conditions and functional impairments. CMS reserves the right to audit the practices' medical records to verify the accuracy of these reports and will check claims records for qualifying hospitalization and rehabilitation or post-acute care utilization in the 12 previous months.

A.11 How are you defining "chronic conditions" for this demonstration?

For the purpose of this demonstration, a chronic disease or condition is a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. CMS will not specify a list of chronic conditions; however, some examples include CHF, diabetes, COPD, ischemic heart disease, stroke, neurodegenerative diseases, and dementias such as Alzheimer's disease.

A.12 Is each patient required to have a hospitalization and subsequent rehabilitation or post-acute care use every year to remain eligible to be counted on a practice's IAH caseload?

No. As part of determining eligibility, patients are required to have a hospitalization and subsequent rehabilitation or post-acute care within 12 months of enrollment. However, CMS hopes that practices will succeed in keeping their patients from returning to the hospital and needing any rehabilitation or post-acute care; it is not necessary to have such care after enrollment. A patient may continue to be counted in a practice's demonstration caseload as long as the patient continues to have two or more chronic conditions and two or more functional impairments requiring human assistance.

A.13 One of our patients walks with a cane but does not need any additional assistance to use it correctly. Does this meet the ADL requirement for this demonstration?

No. The use of assistive devices alone does not count as a functional dependency. For this demonstration, patients must need human assistance, including hands-on assistance, cueing, or supervision, with at least two of the following ADLs: bathing, dressing, transferring, walking, toileting, or eating.

A.14 How will the patient's privacy in the home be protected?

Patients will be guaranteed the same privacy in the home as in a physician's office. All federal and state privacy laws apply to this demonstration.

A.15 Do physicians need informed consent from all of their Medicare patients to participate in this demonstration?

This demonstration does not affect Medicare benefits or payments and does not restrict patients from using other providers or Medicare-covered services. Physician practices are expected to inform patients of their participation, but the demonstration does not require a specific patient consent form or process.

A.16 During the Demonstration, who will provide technical assistance to physician practices if they have questions?

Technical assistance for providing data needed for monitoring patient participation and quality of care is provided by CMS's design and implementation contractor, RTI International.

A.17 Why are you asking if patients are enrolled in Medicaid? Is that part of the eligibility criteria?

The purpose of this question is to determine how many eligible patients are dually eligible for both Medicare and Medicaid in order to understand the potential impact of the IAH Demonstration on dually eligible individuals. Whether or not a patient is currently receiving Medicaid benefits will have no effect on the patient's eligibility for this demonstration.

A.18 One of my patients has partial Medicaid benefits. How should I answer Question 10 on the Patient Enrollment subtab?

Please answer "Yes" if the patient is receiving any benefits from Medicaid at the time of enrollment in the project.

A.19 How do I access information about my patient's recent hospitalizations to determine if they are eligible for the Demonstration?

Practices are expected to obtain this information through conversations with the patient, the patient's caregiver, or any affiliations they may have with local hospitals.

CMS will not be analyzing claims data to alert you to patients who had a hospitalization or to let you know which of your patients may have had a qualifying hospitalization in the last 12 months. We are unaware of a way for you to access claims for that purpose.

Please err on the side of enrolling patients for whom you are uncertain about meeting all the eligibility requirements. We will be able to drop anyone who does not meet the eligibility criteria later. CMS will be analyzing claims retrospectively to ensure that any patients that you enrolled actually did have qualifying hospital admission and acute or subacute rehabilitation service use, have Medicare Parts A & B and are not enrolled in an MA plan or PACE program. CMS will also look at your patient caseload using claims to ensure that you did indeed enroll all those who meet the eligibility criteria (excepting those who you list as having declined participation) and asking you for information about why each potentially eligible patient was not enrolled.

A.20 Can we mail the patient notification letter?

No, the letter must be presented to the patient in person. The intent of this notification is for the primary care provider to discuss this letter with the patient in person or in some cases the with the patient's caregiver. Remember, the date of agreement by the patient does not affect the date of enrollment, which can be retroactive. The primary provider does not have to make a special visit to the home but rather can review this with the patient at the next clinically indicated visit.

A.21 After we give the patient the letter informing them of my practice's participation in the Demonstration, does the patient have to agree in person or can we do a follow-up by phone?

In cases where the patient or caregiver would like additional time to consider agreeing to have their data used, follow-up regarding patient notification may be done by phone, as long as this call is documented in the patient's medical record.

In select cases, where agreement is needed from family living elsewhere (i.e., the patient is cognitively impaired and living alone) phone follow-up is also acceptable.

A.22 Is there any reason that a patient who already has hospice at the time we make our first visit would not be eligible for IAH?

Patients currently receiving hospice services are not eligible for IAH. However, if a patient was already enrolled in IAH and then later receives hospice care, that person is still eligible for IAH as long as an IAH physician is that patient's Physician of Record.

B. Quality Measures

B.1 How were the quality measures targeted for inclusion in the Demonstration chosen?

The quality measures were selected on the basis of an extensive review of the literature, consultation with clinical experts, relevance of national quality standards (e.g., National Quality Forum and Agency for Healthcare Research and Quality), and analysis of Medicare claims data. Some of the measures, which are related to processes of care expected to improve quality and reduce costs, have been established specifically for the IAH Demonstration. Some quality measure information will be self-reported electronically by each practice via the IAH Reporting System. Some quality measures will be calculated using claims data.

B.2 Is there a penalty for not meeting the targets established for the quality measures?

Practices that do not meet at least three of the six quality measures tied to payment will not receive any incentive payments, regardless of any savings they may have achieved.

B.3 What types of hospitalizations will practices be required to report?

Practices will need to provide information on all types of hospitalizations and ED visits, regardless of the condition for which the patient was admitted or seen. However, only hospital admissions and ED visits for ACS conditions will be included in the quality measures related to the number of inpatient admissions and number of ED visits. Conversely, inpatient readmissions will be calculated on the basis of all types of hospitalizations.

B.4 What kind of contact is expected from the practice for Quality Measure 1, "Contact with patients or primary caregivers within 48 hours upon admission to or discharge from the hospital or ED"?

Upon the patient's admission to the hospital, CMS expects the practice to contact the patient, the patient's primary caregiver, or the hospital clinical staff, either via telephone or in person, to discuss the current condition of the patient (see Section 4 for more details). During this contact, the practice should inform the hospital clinical staff that the patient is receiving home-based care, address any questions or concerns that may have arisen regarding the hospitalization, and plan follow-up care. Upon the patient's discharge from the hospital, CMS expects the practice to provide an in-home visit within 48 hours to assess the current condition of the patient and to begin follow-up care. The IAH practice is expected to follow up within 48 hours of admission and discharge from a hospital, regardless of the patient's admission or discharge classification, in

order to fulfill Quality Measure 1. For example, if a patient is admitted to a hospital under observational classification on day 1, then moved to inpatient classification on day 2, and discharged from the hospital under inpatient classification on day 7, the IAH practice would be expected to follow up within 48 hours of the initial hospital admission and within 48 hours of the hospital discharge.

Upon the patient's discharge from the ED, CMS expects the practice to provide either an in-home visit to the patient or telephone call to the patient or the patient's primary caregiver. Telephone call follow-ups are acceptable as determined by the IAH practice. However, telephone call follow-ups are not acceptable for medication reconciliation.

These steps are standard for home-based primary care practices, according to input from clinical experts consulted by CMS.

B.5 Is in-home follow-up within 48 hours of discharge from the hospital required to fulfill Quality Measure 1 if the patient is transferred to another inpatient facility from the hospital?

No. Patients who are discharged from the hospital and transferred to another inpatient facility will be not be included in calculations for Quality Measure 1. However, CMS expects that practices will continue to follow these patients until they are back home to maintain high quality service and to facilitate safe transitions as part of the patient's full plan of care.

B.6 How will CMS know that the IAH practice has conducted follow-up by telephone?

All follow-ups, whether in person or by telephone, need to be reported in the quarterly submissions via the IAH Reporting System. For auditing purposes, CMS is also requiring practices to note information related to telephone follow-ups in the patient's medical record. This information should include the time and date of the call, the name and licensure of the staff member who made the call, and the name or role of the person with whom they spoke (patient, caregiver, etc.)—all information that would normally be recorded by a practice in the course of normal business.

B.7 Regarding ED visits and the 48-hour follow-up required to fulfill Quality Measure 1, is follow-up with a patient required while they are in the ED or only within 48 hours after patients are discharged home?

All hospital admissions, hospital discharges, and ED visits require a follow-up within 48 hours. ED-allowed follow-ups include either (1) an in-home visit with the patient, or (2) a telephone call in which the primary care provider or RN from the practice speaks to either the patient or the patient's caregiver.

B.8 What is meant by Quality Measure 2, "Medication reconciliation in the home"?

Medication reconciliation in the home should occur after a patient returns home from the hospital or ED. The reconciliation should include explaining any newly prescribed medications, as well as reconciling any new medications or dosages with previous ones and making a clinical assessment of the appropriateness of medications prescribed in the hospital or ED. Medication reconciliation also includes ensuring that the patient or caregiver understands and is capable of

following the medication regime and, if not, making arrangements for medication management assistance as needed.

B.9 What is meant by the term "documentation of patient preferences" in Quality Measure 4, and how often is this documentation required for each patient during the Demonstration?

Documentation of patient preferences is one of the six quality measures tied to incentive payment eligibility. The patient—and the patient's caregiver, where applicable—is considered to be an active participant in decision-making surrounding the care planning process. The patient's treatment preferences regarding treatment options, treatment alternatives, and treatment when health care situations arise are obtained from the patient or caregiver. The practice providing primary care in the home incorporates patient preferences into the plan of care, and these statements of preference must be documented in the medical record. These preferences are shared, as appropriate, with the patient's team of caregivers and other service providers.

Examples of patient preferences include general areas such as the preference for receiving primary care in the home, designation of health care proxies, or specific treatment preferences regarding pain management or other types of symptom control.

Practices are expected to discuss and document patient preferences at least once each year and provide the date of this discussion in the IAH Reporting System. Preferences should be documented and updated in the IAH Reporting System more frequently if they change during the performance year.

B.10 If a demonstration patient is admitted and then subsequently discharged from a hospital under observation status in less than 24 hours, is the IAH practice required to provide two follow-up contacts within 48 hours?

No. If a patient is admitted to a hospital under observational status for less than 8 hours, or is admitted to a hospital and discharged in less than 3 days, the IAH practice will be required to make only one follow-up visit within two calendar days of the hospitalization event. Same day hospital admissions and discharges are to be treated as hospital discharges, and an in-home visit to the patient is required of the IAH practice.

B.11 Is in-home medication reconciliation required after hospital discharges from observational status?

Yes, IAH practices are expected to conduct in-home medication reconciliations after all hospital discharges, regardless of the classification of the hospital discharge.

B.12 Is follow-up within 48 hours of an ED visit required to fulfill Quality Measure 1 if the patient is admitted to the hospital or transferred to another inpatient facility from the ED?

No, ED visits that occur on the same day as a hospital admission or a transfer to another inpatient facility are excluded from the denominator of Quality Measure 1.

B.13 Does a Reporting System entry that an in-home visit occurred (following an inpatient discharge or an ED visit) count for Quality Measure 2 as well?

No, the practice must indicate separately that medication reconciliation occurred within 48 hours of hospital discharge or an ED visit. Indicating that a follow-up visit occurred is not sufficient to confirm that medication reconciliation occurred.

C. Data Submission

C.1 What data and communication capabilities are required of a physician practice for participation in the Demonstration?

Practices must have electronic medical records (EMRs), the ability to use remote monitoring, and mobile diagnostic technology or a referral arrangement with providers with this capability who will report findings back to the practice. In addition, practices are required to transmit information about their patients and quality measure data to the IAH Reporting System via the Internet.

C.2 Are we required to use a specific EMR system?

No. Practices are expected to operationalize the use of EMR in a way that best suits the needs of their practice; this includes choosing which system to use.

C.3 What types of feedback will physician practices receive?

CMS will provide feedback reports (Workbooks) on enrolled patients quarterly to the practices. These reports will summarize the information provided by the practices regarding their caseload and utilization. These Workbooks are not case mix or risk adjusted and rely on Medicare claims data available at the time. As a result, these reports only provide an estimate of how each practice is doing and will likely not match the final results for each year.

Practices also will receive annual reports about their performance in respect to meeting the quality standards and financial targets established in the demonstration.

C.4 How and to whom do practices submit data?

Practices will submit data electronically to RTI, CMS' design and implementation and evaluation contractors, via the IAH Reporting System.

C.5 How often should physicians provide information to CMS about their caseload? How often should they report information regarding the quality measures?

Each month, practices must report basic information about their patients; each quarter, they must submit information required for monitoring quality. Most measures will be reported to CMS quarterly, but some, like documenting patient preferences, will be reported yearly. The electronic IAH Reporting System will make it clear which measures need to be reported at what time. The Reporting System is designed to allow practices to submit data on a rolling basis (i.e., as it becomes available for individual patients).

C.6 Does the IAH Reporting System have the capability to receive electronic, bulk uploads for measure specific information and patient enrollment information?

No, the Reporting System currently does not have the capability to receive bulk uploads of quality measure data and patient enrollment information.

C.7 Does the IAH Reporting System have the capability to upload patients in bulk?

Yes, you can upload a batch .csv file with patient names and a few key details (e.g., MBI) using the template in the Rosters tab of the Reporting System. After these patients are uploaded, you can access their records individually to complete enrollment.

C.8 Regarding quarterly workbook submissions, what drop-down should practices use if a patient doesn't qualify for IAH due to insurance reasons, i.e., they recently enrolled in an MA plan?

Generally, people are not included in the potentially eligible list unless CMS has confirmed they were not in a MA plan as of the date identified. However, it's possible that a patient enrolled in a MA plan after the eligibility date. Usually, enrollment initiates at the beginning of the plan year, on January 1. If a patient is otherwise eligible, our recommendation is to select the "patient will be enrolled" option and enter the person into the Reporting System. If they're actually in an MA plan now but weren't earlier this year, CMS will be able to confirm this detail in the data, and the person will be marked as an ineligible enrollment in the next workbook. If the patient is still not in a MA plan according to the Medicare Enrollment Database (EDB), then the patient should be enrolled. If the patient is not eligible for other reasons (e.g., the practice doesn't accept MA patients, regardless of IAH status), then the practice can select "patient not part of our practice" response.

D. Payment

D.1 How will incentive payments to practices be calculated?

Please see Section 5 of this training manual.

D.2 Will participation in this demonstration affect current practice methods of submitting claims or billing Medicare?

No. Current practice methods of submitting claims or billing Medicare will not be affected by participation in this demonstration. The IAH Demonstration does not change Medicare coverage or payment policies.

E. IAH Management

E1. We have hired a new person in our practice. Can I share my IAH name and password so that I can orient him/her until my IAH leader has time to register this new person in the system?

No, providers are not permitted to share access credentials with any other individuals, even if the individual is a member of the same practice and/or it is for training purposes. If your practice has

a new team member, please send a username request e-mail to the IAH Help Desk. Be sure to include the new person's full name and e-mail address in your request.

E2. Does a hospital observation stay count to meet the IAH eligibility criteria requiring that the beneficiary have a nonelective hospital admission within the past 12 months to qualify for the demo?

Yes. An observation stay counts as a hospitalization to meet eligibility criteria.

E3. Do inpatient psychiatric admissions "count"?

Acute psychiatric admissions count as part of the eligibility criteria for nonelective hospital admission within the past 12 months before enrollment in the demonstration. Admissions to long-term psychiatric facilities do not count.

Also, follow-up within 48 hours after a psychiatric hospital admission, discharge and ED visits and in-home medication reconciliation within 48 hours of discharge are required and counted in calculating quality measures tied to incentive payments.

E4. The Demonstration requires follow-up within 48 hours of an IAH patient's discharge from the hospital and within 48 hours of an ED visit. Who can make these follow-up contacts?

The intent of this quality measure is for follow-up to be conducted by clinical staff who are part of the IAH medical practice. The follow-up contacts after an ED visit (in-home visits and telephone calls to the beneficiary or the caregiver) and in-home visits following a hospital discharge must be made by the IAH participating practice. The IAH practice clinician who makes the initial follow-up within 48-hours of the patient's discharge or ED visit should be a skilled professional – an MD, DO, NP, PA, RN, or a master's prepared nurse who is an advanced practice nurse or clinical specialist. The practice will then determine who will provide ongoing oversight whether a member of the IAH practice team or perhaps a home health agency with oversight who will continue to implement a plan of care. The IAH practice brings special competencies to serve this unique frail population and has the opportunity to complete the critical transitional assessment and plan of care for these beneficiaries who have multiple chronic conditions, require human assistance with ADLs, and are at high risk of rehospitalization.

E5. When an IAH beneficiary is admitted to the hospital, follow-up contact within 48 hours of hospital admission is required to meet the quality measure requirements. What is considered a "contact," and who should provide follow-up contacts?

Hospital admission follow-up contacts that meet the quality measure requirements are: 1) an in-hospital visit to the patient or 2) a telephone call to the hospital where the IAH primary care provider speaks to a member of the medical team caring for the patient, the patient or the patient's caregiver. The intent of this quality measure is for admission follow-up to be conducted by clinical staff who are part of the IAH medical practice. The IAH staff who can conduct follow-up contacts within 48-hours of a hospital admission either by phone or via in-hospital visit include an MD, DO, PA, NP or advanced clinical practice nurse, RN or social worker.

This is an opportunity for the IAH practice not only to acquire information about the patient's condition and treatment plan so critical to continuity of care, but potentially for the IAH practice to share important patient information and patient history with the hospital staff.

E6. Who can make in-home follow-up visits for medication reconciliation within 48 hours of hospital discharge or an ED visit?

The actual in-home medication reconciliation and review visit needs to be made by the IAH participating practice. The IAH practice clinician who makes the 48-hour medication reconciliation and review visit should be a skilled professional—an MD, DO, NP, PA or other master's prepared nurse (e.g., clinical specialist or advanced practice nurse), or PA. The IAH practice will determine who will provide ongoing medication oversight subsequent to the follow-up visit and whether it should be a member of the IAH practice team or perhaps a home health agency skilled professional with IAH practice oversight and collaboration to see that this element of the total plan is accomplished effectively and safely.

Medication reconciliation is the process of identifying the most accurate list of all medications that the patient is or should be taking including name dosage, frequency, and route, by comparing the medical record with an external list of medications obtained from the patient, hospital or provider and reviewing the medication list with a clinical understanding of the patient's medical status. The review process not only involves evaluating any medication changes upon discharge to ensure the correct medications are prescribed, and identifying unintended inconsistencies in medication regimens at the point of transition, checking that the patient/caregiver understands which medications and dosages to take but also the medical appropriateness of the medication list received upon discharge. This task requires knowledge of the patient's past experience with medications and the clinical expertise and authority to make changes to the medication regimen.

E7. Is there a matrix that can be used to summarize the allowed follow-up contacts after each of the different utilizations (hospital discharge, hospital admission, and ED visits), including medication reconciliation?

The matrix below summarizes the allowed follow-up contacts after each of the listed utilizations: hospital admission, hospital discharge, and an ED visit. Please note which IAH staff members can conduct these follow-ups, as well as which follow-up types are allowed for each type of utilization in order to meet the quality measure requirements.

Utilization Type	Follow-up Type	Which IAH staff members can conduct the follow-up?						
		MD/DO	Nurse Practitioner	Master's level nurse or nurse clinical specialists	Physician's Assistant	Registered Nurse	Social Worker	Clinical Pharmacist
Hospital Admission	In-Hospital Visit	✓	✓	✓	✓	✓	✓	
	Telephone call to patient, caregiver, or hospital clinical staff	✓	✓	✓	✓	✓	✓	
Hospital Discharge	In-home visit	✓	✓	✓	✓	✓		
	Medication reconciliation	✓	✓	✓	✓	✓		✓
ED Visit	In-home visit	✓	✓	✓	✓	✓		
	Medication reconciliation	✓	✓	✓	✓	✓		✓
	Telephone call to the patient or the caregiver	✓	✓	✓	✓	✓		

E8. Are there criteria for walking that determine someone needs supervision, assistance or are "unable"? Are there any distance requirements such as feet or blocks, and does this include both inside and outside walking?

We do not specify criteria for meeting any of the ADL limitations. Whether a clinician considers the beneficiary to need human assistance with walking is a clinical decision. The walking ADL refers to if a person can manage even short distances within the home without human assistance. The walking ADL does not encompass more general ambulation which might include distance or the ability to walk outside inside the home vs. outside the home.

The solicitation states that "beneficiaries must need human assistance with two or more ADLs" and meet all other eligibility requirements. Human assistance may be required for walking because the beneficiary's walking is unsafe or of poor quality and we make no distinction regarding whether human assistance involves setting up equipment for walking, conducting supervision by verbal cueing or touching/steadying or more assistance like holding or supporting the beneficiary. If a beneficiary can manage an assistive device (cane, walker) on their own completely they would not by definition need "human assistance."

E9. One of our patients agreed to have their information used in the Demonstration, however it was later determined that this patient is ***not*** eligible because their prior hospitalization was greater than 12 months ago. Should this patient become eligible at a later date, do we need to have them agree to have their data used again?

No. The practice does not have to obtain patient agreement again. The agreement will stand in the event that the patient meets eligibility requirements in the future.

E10. We have patients who are not currently eligible for the Demonstration, but we believe they will meet the eligibility requirements before the end of the

Demonstration. Can we give them the patient notification letter and obtain their agreement in anticipation of them becoming eligible?

No, practices may not obtain patient agreement in anticipation of the patient becoming eligible at a later date.

E11. The IAH legislation states that to become eligible to participate in the Demonstration, an individual must have received acute or sub-acute rehabilitation services within the last 12 months. Does that include skilled nursing services?

If the patient has received skilled post-acute care including nursing, physical therapy, occupational therapy and/or speech therapy they do meet the acute or subacute rehabilitation services requirement for purposes of the IAH Demonstration.

E12. Is there is a certain timeframe that practices should disenroll a patient after transferring more permanently to a nursing facility?

No, IAH does not have any requirements about when a patient should be disenrolled if they enter a nursing home. Some practices may wait until 3 months have passed to disenroll, because after that time it is considered a permanent move and shift to being institutionalized as opposed to being there for rehab. However, if a practice knows right away that the patient has gone into the nursing home with the intent of staying there, there is no reason, for the purposes of the demonstration or otherwise, to wait to disenroll. As a rule of thumb, disenrollment timing is left to the practice's discretion.

E13. Can RNs hand out the patient notification letter for IAH?

Yes, a nurse can distribute the letter to a new IAH patient. However, the provider must discuss the demonstration with the patient as well. Patient notification letters should not be handed to patients without an accompanying provider conversation and opportunity for the patient to ask questions.

Appendix A:
Independence at Home Legislation (2010)

Patient Protection and Affordable Care Act Public Law 111-148

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

`INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

`Sec. 1866D. (a) Establishment-

`(1) IN GENERAL- The Secretary shall conduct a demonstration program (in this section referred to as the `demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home- based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

`(2) REQUIREMENT- The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in--

`(A) reducing preventable hospitalizations;

`(B) preventing hospital readmissions;

`(C) reducing emergency room visits;

`(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

`(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

`(F) reducing the cost of health care services covered under this title; and

`(G) achieving beneficiary and family caregiver satisfaction.

`(b) Independence at Home Medical Practice-

`(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED- In this

section:

`(A) IN GENERAL- The term `independence at home medical practice' means a legal entity that-
-

`(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

`(ii) is organized at least in part for the purpose of providing physicians' services;

`(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;
`(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

`(v) has entered into an agreement with the Secretary;

`(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

`(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

`(B) PHYSICIAN- The term `physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

`(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN

ASSISTANTS- Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if--

`(A) all the requirements of this section are met;

`(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

`(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

`(3) INCLUSION OF PROVIDERS AND PRACTITIONERS- Nothing in this

subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

`(4) QUALITY AND PERFORMANCE STANDARDS- The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

`(c) Payment Methodology-

`(1) ESTABLISHMENT OF TARGET SPENDING LEVEL- The Secretary shall

establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

`(2) INCENTIVE PAYMENTS- Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

`(d) Applicable Beneficiaries-

`(1) DEFINITION- In this section, the term `applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined--

`(A) is entitled to benefits under Part A and enrolled for benefits under Part B;

`(B) is not enrolled in a Medicare Advantage plan under Part C or a PACE program under section 1894;

`(C) has two or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

`(D) within the past 12 months has had a nonelective hospital admission;

`(E) within the past 12 months has received acute or subacute rehabilitation services;

`(F) has two or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

`(G) meets such other criteria as the Secretary determines appropriate.

`(2) PATIENT ELECTION TO PARTICIPATE- The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program.

Enrollment in the demonstration program shall be voluntary.

`(3) BENEFICIARY ACCESS TO SERVICES- Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

`(e) Implementation-

`(1) STARTING DATE- The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

`(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION-

The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

`(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION

PARTICIPATION- The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

`(4) PREFERENCE- In approving an independence at home medical practice, the Secretary shall give preference to practices that are--

`(A) located in high-cost areas of the country;

`(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

`(C) use electronic medical records, health information technology, and individualized plans of care.

`(5) LIMITATION ON NUMBER OF PRACTICES- In selecting qualified independence at home medical practices to participate under the demonstration program, 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.

`(6) WAIVER- The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

`(7) ADMINISTRATION- Chapter 35 of title 44, United States Code, shall not apply to this section.

`(f) Evaluation and Monitoring-

`(1) IN GENERAL- The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

`(2) MONITORING APPLICABLE BENEFICIARIES- The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

`(g) Reports to Congress- The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

`(h) Funding- For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

`(i) Termination-

`(1) MANDATORY TERMINATION- The Secretary shall terminate an agreement with an independence at home medical practice if--

`(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

`(B) such practice fails to meet quality standards during any year of the demonstration program.

`(2) PERMISSIVE TERMINATION- The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

Appendix B:
Independence at Home Legislation Extension (2018)

TITLE III--CREATING HIGH QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE

Subtitle A--Receiving High Quality Care in the Home

SEC. 50301. EXTENDING THE INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

(a) In General.--Section 1866E of the Social Security Act (42 U.S.C. 1395cc-5) is amended--
(1) in subsection (e)--
(A) in paragraph (1)--
(i) by striking ``An agreement'' and inserting ``Agreements''; and
(ii) by striking ``5-year'' and inserting ``7-year''; and
(B) in paragraph (5)--
(i) by striking ``10,000'' and inserting ``15,000''; and
(ii) by adding at the end the following new sentence: ``An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program.'';
(2) in subsection (g), in the first sentence, by inserting ``, including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)'' after ``under the demonstration program''; and
(3) in subsection (i)(1)(A), by striking ``will not receive an incentive payment for the second of 2'' and inserting ``did not achieve savings for the third of 3''.

(b) <<NOTE: 42 USC 1395cc-5 note.>> Effective Date.--The amendment made by subsection (a)(3) shall take effect as if included in the enactment of Public Law 111-148.

Appendix C:
Independence at Home Solicitation (2012)

Independence at Home Demonstration Solicitation

Background

Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), directs the Centers for Medicare & Medicaid Services (CMS) to conduct the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses. Home-based primary care is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need patients and to coordinate health care across all treatment settings. Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's natural environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

Medicare beneficiaries with multiple chronic conditions have extremely high health care costs and may experience difficulty in independently performing many of life's daily activities, such as bathing, toileting, and getting in and out of bed. These beneficiaries are often very frail, have trouble managing their numerous health issues, and may find getting to the doctor extremely difficult. As a result, this population may lack a routine source of care or may often postpone routine follow-up care until an acute exacerbation of their condition leads to an emergency department (ED) visit or an inpatient hospital admission. Timely home-based primary care can prevent such ED visits and inpatient hospitalizations by bringing clinical expertise and mobile technology into the home when clinical instability is first developing. Treating people at home also allows primary care practitioners to provide more holistic care by observing how patients actually function in their day-to-day environment and identifying unmet needs for services that can help their patients to remain independent, such as home health, social supports, and other community-based services.

Individuals who are eligible for both the Medicare and Medicaid programs (Medicare-Medicaid enrollees) are likely to comprise a sizeable portion of the population eligible for IAH. Medicare-Medicaid enrollees are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, with many having multiple chronic conditions and significant health care needs. This group must navigate separate health care programs: Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. Greater care coordination, such as through IAH's home-based primary care model, has the potential to improve quality and lower health care costs for these beneficiaries. For Medicare-Medicaid enrollees participating in IAH, CMS would expect that IAH medical practices will coordinate care across Medicare and Medicaid to the greatest extent possible. CMS also encourages IAH medical practices to partner with States, particularly in better coordinating care for Medicare-Medicaid enrollees. While the IAH savings calculation is based upon Medicare spending for Medicare-Medicaid enrollees participating in IAH, CMS is also interested in and will evaluate

the impact of IAH on Medicaid costs apart from any determination of potential shared savings for IAH medical practices.

Eligibility Requirements for Participation

The statute establishes standards for participating primary care practices and patients for the IAH Demonstration.

Provider Eligibility Requirements

To be involved in the demonstration, practices must be individual physicians or nurse practitioners or multidisciplinary teams composed of various members such as physicians, nurse practitioners, physician assistants, pharmacists, social workers, and other supporting staff. Such practices must be led by physicians or nurse practitioners and must have experience providing home-based primary care to patients with multiple chronic illnesses. These practices will be organized at least in part for the purpose of providing physician services. Providers of service or practitioners affiliated with the practice may share in any savings. Practices participating in section 1899, the Medicare Shared Savings Program, may not also participate in the IAH Demonstration. In addition, practices and their beneficiaries participating in the demonstration cannot participate in any other program or demonstration that uses shared savings because savings related to a beneficiary with more than one organization cannot be determined without confounding the IAH model of care with the effects of other interventions or models.

Each participating practice or entity must provide services to at least an average of 200 applicable beneficiaries during each year of the demonstration. A practice's (or consortium's) enrollment may vary over the course of a year but must reach at least an average of 200 applicable beneficiaries during the first year and not drop below this yearly average for the remainder of the Demonstration. Because the size of the minimum savings requirement (MSR) is inversely related to the size of the IAH practice and could present a challenge to small practices, CMS will provide three options for demonstration participation.

- Option 1: Any practice meeting the eligibility criteria may apply as a sole legal entity.
- Option 2: Multiple primary care practices within a geographic area may join as a consortium to participate. Any practices joining in this way must establish a legal entity and will be treated by CMS as one IAH practice for the purpose of establishing expenditure targets, evaluating quality, and determining incentive payments. A consortium of practices that applies must provide the Taxpayer Identification Numbers (TINs) of all the applying practices and must designate a single TIN that will act as the agent for the consortium and be responsible for distributing any incentive payments to all the individual practices that comprise the consortium.
- Option 3: Practices with a beneficiary case load of between 200 – 500 beneficiaries may select an option to become a part of a national pool of providers. Providers participating in a national pool will waive the right to have savings evaluated as a single practice and all financial targets will be calculated based on the pooled practices. Savings will then be distributed according to 1) practice level, risk and frailty adjusted beneficiary months of enrollment and 2) number of quality measures met at the individual practice level (see percentage of incentive payments under Payment Methodology: Quality Measures).

Once a practice elects to participate in a selected option, the practice will remain in that option for the entirety of the demonstration.

From this point forward, references to practices or individual practices will encompass the above chosen option. Practices will enroll existing patients meeting beneficiary eligibility criteria.

Participating practices must make in-home visits tailored to an individual patient's needs. Each practice must be available 24 hours per day, 7 days a week to carry out plans of care. Practices must use electronic health information systems, remote monitoring, and mobile diagnostic technology.

Practices are required to report information about their patients and the health care services provided. In addition, practices will be required to report data on the quality measures required for the demonstration.

Beneficiary Eligibility Requirements

Eligibility criteria are designed to target the most costly beneficiaries with advanced chronic illnesses and substantial disabilities. Beneficiaries must be entitled to Part A and enrolled in Part B, not enrolled in a Medicare Advantage plan or a Program for All-Inclusive Care for the Elderly, and cannot be enrolled in a practice that is part of the Medicare Shared Savings Program or other shared savings demonstrations. Applicable beneficiaries are defined as Medicare FFS patients who have at least two chronic illnesses, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke, dementias such as Alzheimer's disease, neurodegenerative diseases, and other diseases and conditions designated by the Secretary that result in high costs. Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. Beneficiaries must also need human assistance with two or more activities of daily living (ADLs), have had a nonelective hospital admission within the last 12 months, and have used acute or subacute rehabilitation services within the last 12 months. Although practices will report chronic conditions and ADL limitations, chronic conditions and ADLs are subject to medical record audit.

Note that this demonstration focuses on beneficiaries treated at home. Therefore, the demonstration will not enroll beneficiaries who are long-term residents of nursing facilities. Beneficiaries who receive skilled nursing facility (SNF) services as a current Medicare benefit remain in the demonstration. However, if the beneficiary remains in the facility and is not expected to return home when the SNF stay has ended, then the beneficiary will no longer be considered part of the demonstration. Beneficiaries will continue to be enrolled in the demonstration if they transition to hospice while under the care of an IAH practice.

Physicians or nurse practitioners whose practices are participating in this demonstration will be required to certify beneficiary eligibility and to enroll all eligible beneficiaries both at the onset of the demonstration and throughout the demonstration. As existing beneficiaries become eligible or new patients enter their practice, they will be considered a part of the practice's caseload. Eligible beneficiaries will remain enrolled throughout the demonstration, unless their eligibility status changes, e.g., death, joining an MA plan, or loss of Part A or Part B.

Participating providers will be required to notify their patients of the practice's participation in the demonstration. Beneficiary participation in the demonstration is automatic when eligible beneficiaries agree to be seen in their homes by a provider in the participating practice. Practices are required to submit a list of their eligible patient caseload to CMS. CMS will verify the Medicare home visits in the claims data by accessing the practice's designated TIN and National Provider Identification number and will verify patient eligibility, e.g., by utilizing the Medicare Enrollment Database, claims to verify hospitalizations and post-acute care. To ensure that IAH practices are enrolling all eligible beneficiaries, CMS will analyze Medicare claims of patients associated with the practices to identify those who have had a hospitalization and post-acute care use in the previous 12 months.

Applicable beneficiaries enrolled in one year of the demonstration do not have to have another hospitalization or use post-acute care to remain in the demonstration in the following years. Providers will not be required to re-certify in subsequent years, although the beneficiary must continue to have two or more chronic conditions and two or more human assisted ADL impairments.

Data to be Provided by Participating Practices

Participating practices must agree to provide data on quality and other measures for the purposes of monitoring, evaluation, and determining eligibility for any incentive payment under the demonstration. Additional measures may be included in the demonstration if it is found to be necessary for achieving the demonstration goals. Data on these measures are to be submitted on an ongoing basis throughout the demonstration using an electronic data collection mechanism to be administered by CMS for this purpose.

Quality Measures

The CMS has identified a set of quality measures for performance monitoring and, in part, for determining incentive payments. These measures were selected based on an extensive review of the literature, consultation with clinical experts, national quality standards (e.g., National Quality Forum and Agency for Healthcare Research and Quality), and analysis of Medicare claims data. Additionally, some of the measures have been established specifically for the IAH Demonstration (Table C-1).

CMS considered various criteria for inclusion of quality measures. Many of the measures included were mentioned in the legislation (e.g., utilization). CMS also sought to identify measures that are likely to make a difference in the goals of improving quality (e.g., follow-up after hospital discharge) and reducing costs. In particular, measures were chosen that can be impacted by primary care, either directly or through care coordination. Finally, CMS sought items that can be measured on a timely basis and used to provide feedback, technical assistance, and payment during the implementation of the demonstration instead of items that would require a longer period for the availability of data for analysis.

The selected quality measures will provide a broad range of perspectives in assessing demonstration progress. Many of the selected quality measures assess patient utilization (hospitalization rate for ACS conditions, rehospitalization rate, and ED visit rate for ACS conditions), indicate aspects of health status (pain control, depression screening), or highlight

processes of care (contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED, in-home safety assessments). Quality measures tied to the incentive payment include hospital admission for ACS conditions, readmission, and ED visit rates for ACS conditions; contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED; medication reconciliation in the home; and whether patient preferences were documented.

In addition to the measures to be used for determining the incentive payments, quality measures will be required for performance monitoring in order to identify assessment, planning, implementation, and monitoring/evaluation priorities and activities for the demonstration. This information will include, but are not limited to, identification of goals for the patient and family caregiver; screenings/ assessments conducted including depression, home safety evaluation, risk of falling, cognitive deficits; symptom management (e.g., pain, shortness of breath, cognitive deficits, fatigue, sleep disturbances); medication management; caregiver stress; voluntary disenrollment rate; and referrals made to home health, community/social services, and hospice. Satisfaction will be measured as a part of the evaluation of the demonstration and these data will be collected by a third party. Practices may be required to provide additional information to CMS during the demonstration.

Table C-1: Quality Measures

Quality measure	Measure tied to incentive payments
Number of inpatient admissions for ACS conditions per 100 patient enrollment months	Yes
Number of readmissions within 30 days per 100 inpatient discharges	
Number of ED visits for ACS conditions per 100 patient enrollment months	
Contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED	
Medication reconciliation in the home	
Patient preferences documented	
Beneficiary/caregiver goals	No
Screenings/assessments	
Symptom management	
Medication management	
Caregiver stress	
Voluntary disenrollment rate	
Referrals	
Patient satisfaction	

Payment Methodology

Under this 3-year demonstration, IAH providers will continue to bill and be paid standard Medicare FFS reimbursement, subject to beneficiary deductibles and coinsurance, and balance billing rules.

Spending Target

CMS will establish a practice-specific spending target derived from claims, based on expected Medicare FFS utilization for each of the beneficiaries in the practices in the absence of the demonstration. Annual spending targets will be calculated for each participating practice at the end of each performance year. The spending target will be derived from a base expenditure amount equal to the average payments under Part A and Part B.

The spending target for each practice will be risk adjusted and frailty adjusted to reflect each practice's patient population using the following formula:

Average FFS Cost in County of Residence * Trend * (Risk Adjustment Score + Frailty Factor)

The average FFS cost in county of residence (per beneficiary per month), trend, and frailty adjustment factors are established each year by CMS. The trend applied will represent the expected average increase in the per beneficiary per month Medicare Part A and B costs. Applying a trend factor is necessary because the FFS county costs will have been reported for a time period prior to the performance year.

Risk scores will be derived using the CMS Hierarchical Chronic Condition (CMS-HCC) model. The frailty factor is added to the risk score to reflect a beneficiary's impairments with ADLs that may increase the costs of care. All new enrollees of IAH providers will receive a prospective CMS-HCC risk score based on the prior calendar year's diagnoses and demographic factors, plus a frailty factor. The risk score and frailty factor for continuing enrollees will be updated only for changes in demographics (such as age and Medicaid status).

An individual practice's spending target will equal the average of these per beneficiary predicted costs, weighted by the number of months of each beneficiary's participation.

Savings Calculation

Savings will be calculated as the difference between each practice's spending target and actual FFS costs. A projected spending target will be provided to each practice based upon its projected population and CMS will calculate a spending target at the completion of each demonstration performance year. Annual expenses per beneficiary will be truncated at the 99th percentile of all demonstration beneficiaries prior to calculating savings. Truncation is performed to reduce the effect of an unexpectedly high number of high-cost patients that a practice may treat in any given year.

These high-cost patients could negatively impact the calculation of a practice's savings and truncation significantly reduces this impact.

Per the IAH legislation, each participating practice must meet an MSR to be eligible to share in savings. The use of an MSR is to ensure that differences between the target and actual spending represent actual savings rather than differences owing to normal variation in Medicare spending. The size of this MSR is inversely related to the size of the IAH practice. Table C-2 provides examples of MSRs for practices of different sizes based on simulations for beneficiaries determined to be eligible for IAH based on claims and assessment data analysis. The MSRs in Table C-2 represent an estimate of the MSRs that will be used in the demonstration. This table presents MSRs calculated at both the 5 percent significance and the 10 percent significance levels. These different levels of significance factor into the incentive payments as described below.

Table C-2: MSR for sample practice sizes

	Minimum Savings Requirement	
Practice Size*	5% significance level	10% significance level
200	14.1%	11.4%
500	9.3%	7.5%
800	7.4%	5.7%
1000	6.4%	5.0%
2000	4.4%	3.5%
5000	2.8%	2.2%

*CMS will count all beneficiary months of enrollment in a practice divided by 12 to arrive at an estimate of the number of beneficiaries in the practice for the year.

If a practice's difference between actual FFS spending and its target is greater than the MSR, then we are confident that the difference represents actual savings that may be shared with the practice if the practice achieves performance on a set of quality measures tied to payment. Note that CMS will retain the first 5 percent of savings, consistent with statute.

Practices that meet the MSR at the 5 percent significance level and that meet the quality requirements (See Quality Measure section) may receive up to 80 percent of any savings beyond the first 5 percent retained by CMS. Practices that meet the MSR at the 10 percent significance level and that meet quality requirements may receive up to 50 percent of any savings beyond the first 5 percent retained by CMS. Incentive payments will be proportional to the level of savings and proportional to the number of quality measures achieved. Examples of these savings calculations follow:

- Practice A, with 500 applicable beneficiaries, achieves a spending reduction of 12 percent relative to the calculated spending target. This 12 percent reduction exceeds the 9.3 percent MSR at the 5 percent significance level. This practice qualifies to share in savings. CMS will retain the first 5 percent of the savings and the remaining 7 percent (12 percent total savings minus the first 5 percent retained by CMS) of the savings will be shared with CMS based on quality performance as described below.

- Practice B, also with 500 applicable beneficiaries, achieves a spending reduction of 8 percent, which is less than the 9.3 percent MSR at the 5 percent significance level but greater than the 7.5 percent MSR at the 10 percent significance level. This practice qualifies to share the 3 percent of the savings with CMS (8 percent total savings minus the first 5 percent retained by CMS). Savings will be shared with CMS based on quality performance as described below.
- Practice C, with 500 applicable beneficiaries, achieves a spending reduction of 5 percent relative to the calculated spending target. This does not meet the MSR to qualify for an incentive payment at either the 5 percent significance level or the 10 percent significance level for a practice of this size and, therefore, the practice does not qualify for any incentive payment.

Patients who are currently enrolled in a practice as eligible beneficiaries for more than 6 months within a performance year and voluntarily disenroll will be included in the patient population of the practice for the entire practice performance year for purposes of establishing the expenditure target and calculating savings. Patients who are currently enrolled in a practice as eligible beneficiaries for fewer than 6 months within a performance year and voluntarily disenroll will be excluded from the patient population of the practice for the entire practice performance year for purposes of establishing the expenditure target and calculating savings. Voluntary disenrollment refers to disenrollment for reasons other than a change in Medicare status, death, transition to long-term care placement in a nursing facility, or relocation of residence outside of a practice's service area.

Quality Measures

To qualify for incentive payments, each practice must meet or exceed performance requirements on at least three of six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures will not be eligible for incentive payments. Below are the percentages of incentive payments a practice will receive if it meets or exceeds the performance requirements of the specified quality measures.

- A practice that meets all six of the quality measures that are tied to payment will receive 100 percent of savings that qualify for sharing (i.e., 100 percent of maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets five of the six quality measures that are tied to payment will receive 83 percent of savings that qualify for sharing (i.e., 83 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets four of the six quality measures that are tied to payment will receive 67 percent of savings that qualify for sharing (i.e., 67 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).
- A practice that meets three of the six quality measures that are tied to payment will receive 50 percent of savings that qualify for sharing (i.e., 50 percent of the maximum 80 percent possible for practices exceeding the MSR at the 5 percent significance level).

Minimum performance values for quality measures that are tied to payment will be determined in one of two ways (Table C-3). Minimum thresholds for quality measures will be measured either

at an individual 80 percent threshold, or will be based on average mean utilization for a similar comparison population calculated from CMS data prior to the demonstration. This comparison population will meet the same eligibility criteria as the IAH beneficiary population, and it will be matched by metropolitan statistical area; its utilization rates will be adjusted for CMS-HCC scores.

Table C-3. Quality Measure Threshold Values

Quality Measures	Threshold Value
Number of inpatient admissions for ambulatory care sensitive conditions	Threshold equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments
Number of readmissions within 30 days	
Number of ED visits for ACS conditions	
Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED	80% of the time
Medication reconciliation in the home	80% of the time
Patient preferences documented in medical record	80% of the time

Monitoring and Evaluation

CMS will conduct program monitoring throughout the demonstration. Monitoring will include review of quarterly submissions of required data. Data submitted will be used to determine incentive payments, adequate provision of care to applicable beneficiaries, and provider performance. Practices that do not meet quality standards during any year of the demonstration or consistently fail to achieve savings over two consecutive years will be terminated from the demonstration.

An independent evaluation will be conducted for this demonstration. Demonstration practices are required to provide full cooperation to the implementation and evaluation contractors and associated CMS Contracting Officer Representatives. In addition to the evaluation, CMS will prepare a report to Congress, including, but not limited to, an assessment of best practices, coordination of care, expenditures, applicable beneficiary access to services, and quality of health care services provided to applicable beneficiaries.

Application Process

Applicants must submit completed applications following the format outlined in the demonstration application instructions in order to be considered for review by CMS. Pursuant to section 1866E (e)(7) of the Social Security Act, this information collection requirement is not subject to the Paperwork Reduction Act of 1995. The application is available online at http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf.

All questions regarding the application must be submitted in writing to the IAH Demonstration e-mail box at IndependenceAtHomeDemo@cms.hhs.gov.

Applicants must submit at least one electronic copy on CD-ROM of the application and are required to submit a paper version of the application with an original signature. Because of staffing and resource limitations, we cannot accept applications by facsimile (FAX) transmission. Hard copies and electronic copies must be identical.

Applications will be reviewed by CMS only if they are received on or before 5:00 p.m. EST Monday, February 6, 2012. For practices applying as a consortium, the application date will be extended until Friday, May 4, 2012, to allow adequate time to form the legal entity as required above. However, potential consortium practices must submit a letter of intent to participate in the demonstration by Monday, February 6, 2012, unless the consortium is able to submit a completed application by the original date. At a minimum, applicants should ensure that their applications and supplemental materials include the information requested in the application section.

IAH Practice Application

Please fill out all sections of the application. The application will capture the IAH practice characteristics, practitioner information, and applicable beneficiary eligibility characteristics. If any part is left unanswered, the application will be deemed an incomplete application and will not be reviewed by CMS.

Selection of organizations for the IAH Demonstration will be from among the most highly qualified applicants and will take into consideration a number of factors, including, but not limited to, operational feasibility, geographic location, and Medicare program priorities (e.g., testing a variety of provider-directed approaches for delivering services). This process will focus only on meeting the overall balance to adequately measure the impact of the demonstration and the practice selection will be from only those applicants that meet all of the criteria.

If the eligible applicant pool exceeds the 10,000 applicable beneficiary maximum, CMS will select a subset of eligible practices to participate in the demonstration. Should this occur, practices will be selected to ensure balance among participants for evaluation purposes using the following criteria: location (high-cost area, State and region, urban and rural), size of the practice's patient population (variation will be based upon actual applicant pool), and practice readiness (all criteria met at the time of application submission). CMS may also limit the number of beneficiaries per practice to ensure that the demonstration does not exceed the statutory maximum size of 10,000 beneficiaries.

CMS reserves the right to conduct one or more site visits before making awards.