



January 26, 2016

The Honorable Orrin G. Hatch  
Chairman  
Senate Finance Committee  
United States Senate

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee  
United States Senate

The Honorable Johnny Isakson  
Co-Chairman  
Chronic Care Working Group  
Senate Finance Committee  
United States Senate

The Honorable Mark Warner  
Co-Chairman  
Chronic Care Working Group  
Senate Finance Committee  
United States Senate

*Delivered via email: [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)*

Dear Chairman Hatch, Senators Wyden, Isakson and Warner:

Landmark Health (“Landmark”) is pleased to provide feedback on the Senate Finance Committee’s Chronic Care Working Group (“Working Group”) Policy Options Document. We are very encouraged by the Working Group’s commitment to bipartisan and stakeholder developed solutions to chronic care, and believe many of the policies proposed will significantly improve the care of Medicare beneficiaries suffering from chronic conditions. Our recommendations provide additional input on the policy options outlined, and reflect our experience in managing and delivering care for Medicare beneficiaries with multiple chronic conditions.

The following provides a brief background on Landmark and our experience successfully serving complex chronic patient populations, and comments identifying areas of support as well as additional suggestions for the proposed policy options.

**Section I: Background on Landmark**

Landmark is unique in that we are a medical group that delivers in-home, team-based primary care to highly medically vulnerable Medicare beneficiaries, and we take on risk in our payment model. Our patients are high-risk dual eligibles, polychronic seniors, bedbound and homebound individuals, and the disabled. In addition to addressing our patients’ medical issues, we also focus on their behavioral and social issues. Our patients often have at least six or more co-morbid chronic conditions.

Our company was founded by a team of passionate leaders with substantial expertise in managing these clinically complex populations. Our company’s executive management team has more eighty years of collective experience, obtained at leading healthcare companies such as CareMore, Inspiris, Optum, XL



Health and HealthCare Partners. Dr. Arnie Milstein, Professor of Medicine at Stanford University and former Medicare Payment Advisory Commission (MedPAC) Commissioner, serves as Chairman of Landmark’s Clinical Advisory Board.

Landmark was formed because the traditional, office-based healthcare delivery system does not adequately address the needs of patients with complex chronic conditions. The current healthcare system is one-size-fits-all and often limited to 15-minute visits several times per year, and does not engage families of patients nor provide behavioral and social resources in a primary care visit. Further, a physician’s office is often open only 30% of the hours in a week, forcing many polychronic patients to go to the emergency room when a problem arises in off-hours or on weekends.

By bringing longitudinal care to the home, we dramatically expand access for these clinically high-risk patients with multiple chronic conditions, many of whom are homebound. Our fully employed providers visit patients up to 20-30 times per year in their place of residence, and we respond to off-hours calls by sending a provider to a patient’s home immediately if clinically appropriate. We are 24x7 and deliver medical, behavioral, and social care to our patients, which allows them to age independently at home and avoid unnecessary ER visits. Importantly, Landmark does not require our patients to drop or change their existing primary care or other provider relationships in any way. Rather, we become the 24x7 “eyes and ears” in the home and are additive to the patient’s existing in-office relationships—filling the above-mentioned gaps in the existing healthcare system.

We currently partner with health insurance plans, including plans with Medicare Advantage (MA) populations, and assume financial risk based on total cost of care, quality and member satisfaction (of the populations under our management). We have financial risk for nearly 25,000 of our nation’s sickest patients in five major metropolitan markets in across the country: Albany, NY; Buffalo, NY; Portland, OR; Seattle, WA; and Southern California’s Inland Empire (opening soon).

## **Section II: Supported Policies and Recommendations**

Given our sole focus on complex patients with multiple chronic conditions, we hope our feedback on the proposed policy options is helpful.

### **1. Expansion of the Independence at Home Demonstration**

We are strongly supportive of the Working Group’s proposal to modify and expand the Independence at Home (IAH) demonstration. We recommend some additional modifications to expand the footprint of this successful initiative.



First, the program is currently limited to beneficiaries who meet stringent eligibility requirements<sup>1</sup> – only a small portion of beneficiaries who could benefit from such a program. We believe that patients should be allowed to affirmatively enroll in IAH. We are confident that with our high rates of patient satisfaction beneficiaries will choose to be part of our program. This would enable more patients’ access to the kind of care coordination that can improve their quality of life and reduce costs in Medicare.

We are supportive of the Working Group’s proposal to modify the identification process for eligible beneficiaries through the use of hierarchical condition categories (HCC) risk scores to better identify patients. We believe removing the requirement of a non-elective hospitalization within 12 months for a beneficiary to be eligible would help participating organizations identify and treat currently underserved chronic patient populations. In addition, the IAH program requires provider participants to be serving a minimum of 200 eligible beneficiaries, a high threshold given the stringent eligibility requirements. Therefore, we propose the Working Group consider modifying this requirement to reflect a more flexible threshold under the HCC identification process in order to incentivize participation of interested and capable provider organizations, including organizations not currently serving beneficiaries in a market but highly capable of doing so.

Second, we propose the Working Group consider making provider eligibility contingent on their ability to accept financial responsibility. The program is currently a one-sided incentive model, with providers receiving bonus payments for meeting their benchmarks, but with no symmetrical penalty applied to providers that fail to meet those benchmarks. As a provider taking two-sided risk, we strongly believe that risk sharing provides the most effective motivation to take improving quality and total cost of care into account in the planning and delivery of care.

### **Reforms to Medicare Advantage (MA)**

*Coverage for hospice and End-Stage Renal Disease (ESRD)* – We are very pleased that the Committee is supportive of re-integrating hospice into the Medicare Advantage benefit. It will be administratively and clinically simpler to appropriately refer seriously ill patients to hospice with this change. Landmark is also supportive of the proposal to increase access and choice for beneficiaries with ESRD by allowing their enrollment in MA plans. Both hospice and specific treatment related to ESRD are core cost categories in our populations, and including these services in MA will create a more seamless care continuum for patients. Landmark and other providers focusing on total care for patients believe that including these options in MA will allow for less onerous decision making and care transitions. We urge the Working Group to include the expanded MA coverage for hospice and ESRD in the final language.

*Modifications to the MA Risk Adjustment model* – We are supportive of the Working Group’s interest in providing MA plans with flexibility to establish a varied benefit structure for certain chronic conditions.

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<sup>1</sup> To participate in the Independence at Home Demonstration, beneficiaries must: 1) Have two or more chronic conditions; 2) Have coverage from original, fee-for-service (FFS) Medicare; 3) Need assistance with two or more functional dependencies (e.g., walking or feeding); 4) Have had a non-elective hospital admission within the last 12 months; and 5) Have received acute or sub-acute rehabilitation services in the last 12 months.



We believe providing flexibility for MA plans to offer additional supplemental benefits designed to improve the treatment, prevention or progression of chronic disease will help providers and chronically ill beneficiaries. We need to accurately reflect the acuity of the patient in order to commit the necessary resources to appropriately and comprehensively caring for the patient. Sometimes there are particular benefits MA plans can invest in that will have particularly good effects for certain patients, and MA plans need the flexibility and resources to make these choices.

*Special Needs Plan (SNP) program* – In addition, we are supportive of the Working Group’s proposal to permanently authorize the SNP program. SNPs are an important mechanism for integrating care for chronically ill patients.

## **2. Improving Care Management**

We are encouraged by the Working Group’s proposal to include high-severity chronic care management codes in Medicare FFS to provide increased support for clinicians coordinating care for beneficiaries with multiple chronic conditions. The need for reimbursement that is greater than current chronic care management codes will help providers like Landmark with the costs associated with coordinated care of complex patient populations. We are eager as a company to provide services under FFS model in addition to MA, but this requires a structure in which Landmark can take financial risk under FFS but also receive adequate resources for addressing complex care that will ultimately lead to greater reductions in unnecessary admissions and increased quality of care.

We also believe the final proposal should include patient criteria that accurately reflect the chronically ill patient populations, and flexible provider eligibility that incentivizes participation from organizations experienced in caring for complex chronic populations.

## **3. Adjustment to Attribution Methodology for Current ACOs**

We are very supportive of the Working Group’s proposal to require the Centers for Medicare & Medicaid Services (CMS) to change its current ACO attribution model. Under the current attribution model for CMS’ ACO programs, CMS identifies the patients that are attributed, or assigned, to an ACO by determining those that receive a plurality of primary care services from a provider or supplier participating in the ACO. There is some additional flexibility in the Next Generation ACO Model, where a beneficiary may “opt in” to the ACO by identifying an ACO provider as his or her primary care provider. However, this “opt in” option is only available to the ACO starting in performance year two. Patients are still assigned to the ACO in the traditional manner in year one, which is a barrier to program entry for innovative medical practice groups like Landmark.

Expanding “opt in” options for all ACOs that take risk will eliminate the barrier to program entry for forward-thinking medical groups already able to take risk in other programs, such as Landmark. Our advanced capability enables us to analyze claims data, identify patients with multiple chronic conditions who could benefit from our care model, and directly reach out to them to bring them into our program.



Allowing us to reach out to these patients directly will help us expand our model to more people in need and ensure longitudinal care for more patients. We support the preservation of beneficiaries' ability to choose not to participate, but believe allowing voluntary assignment will enhance Medicare FFS providers' ability to better longitudinally care for patients.

#### **4. Addressing Behavioral Health and Social Needs**

As the Committee acknowledged in the options paper, there are many important needs of patients with behavioral health issues that are not addressed by Medicare. Landmark believes it is imperative that payments for behavioral health and social services be included as a part of any chronic care model. There have been a few collaborative care models that include behavioral health services that have demonstrated improvements in quality, outcomes, and cost that may serve as examples for the Committee to consider. The University of Washington's Collaborative Care is a Medicaid home health pay-for-performance model that incentivizes integration of primary care and psychiatric consultants to provide screenings, effective care plans, and regular monitoring of a patient's progress. It is estimated that the Collaborative Care model's cost-effective approach saves approximately six dollars for every one dollar spent on collaborative behavioral health services.<sup>2</sup>

In the Calendar Year 2016 Medicare Physician Fee Schedule final rule with comment period, CMS acknowledged the extensive discussion and planning required by primary care physicians and specialists to effectively manage common behavioral health conditions. In addition, CMS requested additional stakeholder input, during the final comment period, around the development of a collaborative care code that accurately accounts for the cost to provide collaborative behavioral health care services.<sup>3</sup> We urge the Working Group's final legislation require CMS to include separate collaborative care payments for primary care provider teams and psychiatric consultants that accurately reflects the investment providers make to improve the overall mental health of Medicare beneficiaries.

#### **5. Creation of a Polychronic ACO**

Although the Working Group is considering numerous solutions to improve the design and implementation of ACOs, we believe more improvement is necessary for the coordination of care for polychronic beneficiaries. We urge the Working Group to consider including policy solutions for ACOs that specifically focus on care delivery for these highly complex patient populations.

The current CMS ACO models are designed for provider groups that manage patients across the spectrum, which has the unintended consequence of discouraging participation from provider groups with medical

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<sup>2</sup> University of Washington. Advancing Integrated Mental Health Solutions. "Collaborative Care: Dollars & Sense." Retrieved: <http://bit.ly/1U9YaqS>

<sup>3</sup> 80 FR 70920



models designed explicitly to serve patients with multiple chronic conditions. We do not find it surprising that these demonstration programs have shown “mixed results” for patients with chronic conditions.

There are several improvements that would increase the likelihood of successful management of chronic disease in Medicare FFS, including through the Medicare ACO programs. First, we recommend that Congress require CMS to create a polychronic ACO tailored specifically to the high-acuity Medicare population. In this ACO, CMS should amend its attribution mechanism for ACO or other risk-based demonstrations to focus on those patients that are polychronic as eligible rather than their existing provider relationships. CMS should consider number of chronic comorbidities as an attribution methodology (for example, six or greater chronic conditions). Patients that fit this methodology would be eligible to be enrolled in a polychronic ACO. Patients would not be forced to change or abandon existing provider relationships; rather, services would be provided above and beyond existing in-office primary care or hospital services. CMS would be setting its attribution methodology based on patient needs and characteristics instead of where they receive their existing services (practices and hospitals that are often at physical locations). As mentioned above, we believe patients should be able to affirmatively enroll in polychronic ACOs.

While Landmark is comfortable taking risk on polychronic patients, other medical providers may need a glide path to full risk. We recommend consideration of temporary risk corridors to provide a transition period.

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Thank you again for your consideration of these comments, and the Working Group’s continued commitment to engaging with stakeholders to improve chronic care delivery. Please do not hesitate to reach out to us if we can be a resource to you or your staff on issues related to chronic care. We are happy to share information and insights with you as medical group focused exclusively on taking financial risk and delivering home-based care to polychronic patients.

Sincerely,

A handwritten signature in blue ink, appearing to read "A. Boehler".

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