January 26, 2016

The Honorable Orrin Hatch
Finance Committee, Chairman
SD-219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Finance Committee, Ranking Member
SD-219 Dirksen Senate Office Building
Washington, DC 2510-6200

The Honorable Johnny Isakson
Finance Committee, Member
SR-131 Russell Senate Office Building
Washington, DC 20510-1008

The Honorable Mark Warner
Finance Committee, Member
SR-475 Russell Senate Office Building
Washington, DC 20510-4605

Dear Senators:

On behalf of Kindred Healthcare and our more than 100,000 dedicated teammates, thank you for engaging a national dialogue on the need to improve care and coordination for Medicare beneficiaries living with chronic health conditions.

We appreciate the opportunity to specifically comment on the workgroup's Policy Options and look forward to working with you and your staffs to advance effective reforms that have real and lasting impact on the lives of Medicare beneficiaries with multiple, complex chronic illnesses.

Through Kindred's experience in settings across the full continuum of post-acute services, we have targeted our abilities to deliver care and services where and when patients need it most, and coordinate patient care throughout an entire episode. In addition to responding to specific Policy Options as presented by the working group, our comments also detail a series of approaches that we have been testing in the field that have produced promising outcomes and improvement – particularly for patients suffering from multiple chronic illnesses. We believe that our first-hand experiences may help inform the workgroup's pursuit of new policies and solutions for improved care management for Medicare beneficiaries with chronic conditions.

As we have publicly commented in the past, based upon our experience in delivering care to patients with multiple chronic illnesses, Kindred strongly supports:

- Expansion of the Independence at Home initiative,
- Additional physician payment codes to encourage enhanced chronic care management,

- New policies that encourage beneficiary use of chronic care management services,
- Greater regulatory flexibility, which remove some of the barriers that limit providers' abilities to pursue innovative care models, and most importantly
- A comprehensive and coordinated approach with proposals that work together – not at odds with one another – and are implemented in a sequential order.

On behalf of our patients, many of whom have multiple chronic conditions in addition to an acute illness/injury, we are dedicated to helping develop policy solutions for some of our nation's most costly and complex to treat patients.

We look forward to working with the chronic care working group along with all stakeholders in order to advance progressive post-acute care reform to ensure the delivery of high quality and efficient care that Medicare beneficiaries deserve. By working together, we will make healthcare better for everyone.

Sincerely,

William M. Altman
Executive Vice President
Strategy, Policy & Integrated Care
Kindred Healthcare, Inc.

It is said that, "A nation's greatness is measured by how it treats its weakest members." Therefore, it is imperative that we take important steps today in order to ensure appropriate and effective care options are available and accessible to individuals of all ages with multiple chronic illnesses.

With a rapidly growing elderly population, who are more prone to suffer from several chronic conditions, the United States faces an epidemic of chronic illness that requires real-time and actionable solutions today. In fact, more than two-thirds of the current 54 million Medicare beneficiaries have two or more chronic conditions, and 14 percent have six or more chronic conditions. Those beneficiaries with six or more illnesses accounted for 46 percent of all Medicare spending in 2010. Additionally, the Centers for Disease Control and Prevention (CDC) reports that individuals aged 45-64 are increasingly living with multiple chronic conditions.

The aging population and rapid increase in the number of chronically ill and medically complex beneficiaries present significant challenges for caregivers, care managers and payors alike. Of the 1.9 million Medicare hospital readmissions in 2010, beneficiaries with two or more chronic conditions accounted for 98 percent of these readmissions. This trend underscores the need for reforms in our healthcare system in order to treat the entire patient, rather than focus on each disease in a vacuum.

KINDRED'S COMMITMENT TO COORDINATED CARE ACROSS THE CONTINUUM

Over the course of the past several years, Kindred has transformed our operations and capabilities in order to deliver care and services where and when patients need it most. We have developed a care platform that spans the continuum of post-acute services with the goal of coordinating patient care interventions throughout an entire episode.

Kindred is the largest provider of integrated care for people with chronic care needs in the nation, with 102,600 dedicated employees providing care for over one million patients annually across 47 states. Our care settings include 95 long-term acute care (LTAC) hospitals, 18 freestanding inpatient rehabilitation facilities (IRF), 101 hospital-based IRFs, 20 sub-acute units, 90 skilled nursing and rehabilitation centers, 626 Kindred at Home home health, hospice and non-medical home care sites of service. Additionally, our more than 30,000 rehabilitation therapists provide medically-necessary restorative care in nearly 1,800 non-affiliated contract sites of service.

Our goal is to deliver population health management through our continuum of care from hospital to home – we strive to provide patient-centered coordinated services to improve clinical outcomes, improve the patient experience, and reduce costs. Through our continuum of services, we have a unique experience in caring for aging patients suffering from chronic illnesses.

Consistent with national demographics, physicians and clinicians in Kindred care settings are increasingly caring for patients living with multiple chronic conditions. Because they suffer from several ongoing illnesses, these patients present additional challenges in treating their complex – and sometimes conflicting – care needs. In order to best meet patient need and deliver medical and rehabilitative care that best supports recovery and return home, Kindred has significantly expanded our care management capabilities as we test innovative approaches to care such as

bundled payments and shared savings. We believe that our experience in testing new approaches – both what has worked well and the unique challenges we faced – may help inform the Senate Finance Chronic Care working group as it seeks to pursue policy solutions.

THE KINDRED EXPERIENCE

Over the past several years, we have pursued new patient-centered care models that encourage collaboration among providers, feature care management expertise, and ensure patients access the right level of care for the shortest length of stay to meet their needs and support wellness. This has included testing programs initiated by the Centers for Medicare and Medicaid Services (CMS), such as assuming ownership of an Accountable Care Organization, and testing bundling as a Model 3 convener within the Bundled Payment for Care Improvement (BPCI) Initiative.

Kindred's specific BPCI experience demonstrates that under a retrospective bundled payment, the financial incentives are such that it is very difficult to reduce costs and share in savings for a small patient population with significant high care spending. The retrospective payment design combined with insufficient risk adjustment, creates a strong financial disincentive for utilization of higher intensity, and higher cost, settings such as LTAC hospitals and IRFs, even for the small number of patients that need access to these settings. These settings of care with per-discharge diagnosis based payments lack the ability to modify their practice or utilization patterns by reducing length of stay or intensity of services to produce lower Medicare expenditures for patient care.

As CMS pursues clinical redesign and payment innovation, it is imperative that the environment is driven by a patient's clinical need rather than primarily or exclusively by cost savings. Of particular concern are the most medically-complex patients that may be prevented from accessing the intensive and comprehensive care with additional physician oversight at an IRF or LTAC hospital. Therefore, we encourage regulatory relief in terms of payment flexibility for continued access to these sites of service.

While worthy of testing, Kindred's experience to date with the BPCI demonstration suggests that this approach may not be designed to produce the optimal clinical results for the chronically ill population. As we note later in our comments, we believe that ACOs have a better potential for providing chronic care management and we support broad application of regulatory waivers to the ACO program in order to allow providers to treat patients in the most clinically appropriate and cost-effective setting for the appropriate length of time.

Additionally, we have seen promising outcomes and improvement – particularly for patients suffering from multiple chronic illnesses – in a series of other approaches Kindred has been applying and testing in the field. We appreciate the opportunity to highlight some of these efforts outside of government-sponsored demonstrations to help inform the discussion regarding chronic care management.

Home-based Primary Care

Kindred established Kindred House Calls in order to provide high-quality physician-based house call services for patients who are at high risk for hospitalization and cannot easily access traditional outpatient services – enabling patients to stay at home. Through

our tailored medical care, we are delivering improved clinical outcomes, preventing emergency room visits and hospital stays, and creating positive patient experiences.

In 2014, Kindred House Calls served a high-risk population, typically about 86 years of age, with an average of 20 diagnoses, and seven chronic conditions. A Medicare cost data pilot project found that the group's care was associated with significant cost savings over traditional care models, and for the **seventh year in a row achieved a 30-day readmission rate below 7%**. These outcomes are consistent with the strong results from the first performance year of the Independence at Home Demonstration. CMS recently announced that the participants **saved more than $25 million to the Medicare program in that first year**, while also providing higher quality care for chronically ill patients.

Kindred House Calls currently operates in four states – Colorado, Ohio, Texas, and Washington – with 70 physicians and nurse practitioners.

Care Transitions Program
Kindred's Care Transitions Program focuses on patients with complex medical conditions and are identified as high risk – often those suffering from chronic conditions. The Care Transitions Manager works collaboratively with our provider teams and serves as an additional educational resource to engage patients and caregivers and help them understand disease processes, care plans, medications and follow up care. The program begins when a patient is admitted to a Kindred site of care and continues throughout their stay across Kindred locations and their return to community – concluding 35 days post discharge from Kindred's services.

To date, Kindred has piloted the Transitions Program in five of our regionally-diverse Integrated Care Markets, with strong clinical outcomes that contribute to reduced Medicare spending, and improved patient experience. High-level 2015 results:

Boston Integrated Market –
Program helped **reduce readmission rates to 3% within 30 days** of hospital discharge, and 97% of patients kept scheduled follow-up appointments with their primary care physician (PCP).

Dallas/Fort Worth Integrated Market –
All participants are high risk, with an active CMS readmission penalty diagnosis, with a **4% unplanned return to acute**.

Cleveland Integrated Care Market –
As part of Kindred's participation in CMS' BPCI, the program contributed to a **significant reduction – 10 percentage points – in hospital readmission** rates.

Las Vegas Integrated Care Market –
90% of patients kept their PCP appointment within 7 days of discharge, with a 7% hospital readmission rate within 30 days of discharge or less.

Indianapolis Integrated Care Market –
Participants very satisfied with care – **more than 95% "would recommend," with a low 5.5% 30-day hospital readmission** rate.

After Care Program
Kindred's After Care Program is designed to maintain personal, consistent, and compassionate communication with patients after they are discharged from formal home health care services. Trained nurses call patients 30, 60 and 90 days after discharge (with an additional call at 14 days for patients with high-risk diagnoses) to assess their progress, answer ongoing questions, identify any unmet or new needs, and ensure a positive patient experience. This personal touch is particularly valuable in preventing decline in patient condition – thus helping to eliminate the need for a costly rehospitalization. For patients with multiple chronic conditions, the follow-up calls with trained clinical professionals familiar with their personal situation are invaluable to their ongoing condition management and well-being.

24/7 Direct Consumer Assistance
Recognizing the difficulties that patients, families, and loved ones face in navigating the complex and confusing healthcare system when dealing with tough medical decisions, Kindred offers a toll-free resource (1.866.KINDRED) and dedicated online site for consumers to talk with Registered Nurses to facilitate informed care decisions. These dedicated clinicians can help identify the best and most convenient care options to meet a patient's need after a hospital stay – which may, or may not, include a Kindred option. Our goal is to be a trusted consumer resource as our nurses answer tough questions about insurance or Medicare coverage, discuss medical conditions, and detail the care options available to consumers in their local community.

We highlight these Kindred-specific initiatives, not just for their role in assisting and supporting patients with chronic conditions, but for the fact that several of these are not covered by the current Medicare Fee-For-Service payment structure. We will continue to test other innovative approaches in order to better manage care for our patients as we seek to deliver population health. However, we believe that policies that increase flexibility in Medicare's program design and remove some of the barriers that limit providers' abilities to pursue innovative care models are essential to any effort to address chronic care management.

In order to more effectively incentivize providers to pursue new models of care and support effective chronic care management, policymakers should also consider waiving additional regulatory restrictions such as:

- the Skilled Nursing Facility 3-day qualifying stay,
- co-location of post-acute care provider types,
- the Long-term Acute Care Hospital 25-day length of stay requirement,
- the Inpatient Rehabilitation Facility 60 percent rule,
- the Home Health Agency homebound status requirement,
- restrictions for referring beneficiaries to post-acute care settings, and
- restrictions on information sharing between institutional post-acute and home health providers.

We appreciate the opportunity to specifically comment on the workgroup's Policy Options and look forward to working with the Senators and their staffs to advance effective reforms that have real and lasting impact on the lives of Medicare beneficiaries with multiple, complex chronic illnesses. As we have publicly commented in the past, Kindred strongly supports expansion of

the Independence at Home initiative, an expansion in physician payment codes to encourage enhanced chronic care management and greater regulatory flexibility that would encourage stakeholders and providers to innovate and more effectively deliver coordinated care management for chronically ill patients.

While we support many of the policy options detailed in the workgroup's Policy Options Document of which we comment below, we are concerned that the initiatives do not provide a comprehensive or coordinated approach. These one-off proposals do not work together, and in some instances may actually compete with one another. With all the great work done by the workgroup and staff, we urge caution in implementing piece-meal policy options that complicate an already complex system, rather than pursuing a more comprehensive policy solution that ensures coordinated care management for some of our nation's most costly and complex patients.

KINDRED COMMENTS ON "CCWG POLICY OPTIONS PAPER"

I. Expanding the Independence at Home (IAH) Model of Care

Kindred Healthcare supports expanding Independence at Home Model of Care into a permanent, nationwide program. This recommendation is largely informed based on our first-hand experience with the Kindred House Calls program. A Medicare cost data pilot project found that the Kindred House Calls program was associated with significant cost savings over traditional care models and for the seventh year in a row achieved a 30-day readmission rate below seven percent. These outcomes are consistent with the strong results from the first performance year of the IAH Demonstration, which saved more than $25 million to the Medicare program in that first year, an average of $3,070 per participating beneficiary, while also providing higher quality care to chronically ill patients.

To promote additional participation in the program, Kindred recommends furnishing providers with increased flexibility in the program requirements and using hierarchical condition categories (HCC) risk scores as a method to identify participants.

Increased Flexibility. To encourage additional participation, Kindred encourages furnishing providers with additional flexibility in the program design including: the team structure, frequency of visits, ancillary services utilized, and waiver of regulatory restrictions (such as SNF 3-day stay rule). Kindred also recommends expanding the definition of "home" to ensure non-institutional settings such as congregate housing are included.

HCC Scores. Kindred supports IAH providers using HCC risk scores as a way to identify complex chronic care beneficiaries for inclusion in IAH. This would allow for better alignment between IAH providers and managed care entities, which outweighs the increased administrative burden on IAH providers.

II. Expanding Access to Hemodialysis Therapy

Kindred supports the widespread use of telehealth services to deliver the necessary medical services to patients who are in facilities without access to necessary specialists or during times

with limited access to specialists (i.e., nights and weekends). Kindred Healthcare supports expanding Medicare's qualified originating site definition for beneficiaries' receiving hemodialysis therapy to expand the use of telehealth services for the beneficiaries' monthly visit with their clinician. Kindred recommends expanding the qualified originating site definition to non-hospital healthcare facilities with the necessary clinical services for oversight (i.e., RNs, CNAs, social workers, etc.) such as skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. Kindred supports one in-person visit per six months as an appropriate safeguard to ensure that these services are being used appropriately.

III. Providing Medicare Advantage Enrollees with Hospice Benefits

Kindred at Home's hospice professionals provide compassionate care, support, and comfort for beneficiaries and their families facing terminal illness or severe pain. Kindred's hospice priority is to create the most dignified possible end of life experience through a culture of compassion that meets the emotional, physical, and spiritual needs of patients and their families during a difficult time. Kindred Healthcare is concerned that requiring MA plans to cover hospice without specifying that all hospice benefits be covered would adversely impact the beneficiaries' hospice experience by limiting beneficiaries' choice of hospice provider, increasing the administrative burden of hospice providers and compromising the hospice benefit.

Network Adequacy Concerns. Network adequacy requirements call for plans to contract with a minimum number of providers based on statistical formulas and geography. Unlike some other MA enrollees, hospice patients are unable to wait several months for an open-enrollment period to change plans – more than one-third of hospice patients die within a week of electing hospice. The limited networks with potential pre-authorization requirements of managed care are poorly aligned with the needs of hospice beneficiaries and may result in limiting beneficiaries' choice in hospice providers.

Increased Administrative Burden. The proposal to require MA plans to cover hospice services would significantly increase hospices' administrative burden. Rather than a single claims process, hospices would be required to negotiate, manage and process claims from all the MA plans with whom they contract. This would divert essential resources from necessary patient care to administrative tasks to process claims.

Compromised Benefit. Past experience has shown that some commercial insurers and Medicaid managed care plans have asked hospice organizations to offer a subset of services, such as pain management or in-home care, but at a reduced fee-for-service rate. Kindred is concerned that a compromised hospice benefit may undermine the integrity of the hospice benefit, incentivizing plans to offer only a diluted and less effective set of services for dying patients and their families.

Essential Safeguards. If the working group does continue to pursue requiring MA plans to cover hospice services, Kindred encourages the working group to include safeguards to ensure beneficiary access to the hospice of their choice, ease administrative burdens, and preserve the integrity of the hospice benefit. For example, MA plan coverage must be commensurate with FFS Medicare coverage of hospice services. Plans must demonstrate that providers can (and do) provide all four levels of hospice care (routine home care, respite inpatient care, general inpatient care, and continuous home care). Plans must also demonstrate involvement of all core services

by an interdisciplinary team at least every 15 days in developing and updating the patient's hospice plan of care. Involvement of non-core services when indicated must also be demonstrated. Ensuring beneficiary choice in electing hospice services must be monitored, including the ability of the beneficiary/representative to revoke hospice services without reason and without repercussion. Additionally, live discharges would need to be monitored to ensure hospice services are being used appropriately.

Recommended Performance Measures. The measures currently required for Medicare hospice providers to report (including the Hospice Item Set (HIS) and Hospice CAHPS measures) should be incorporated into the plan-level measures to ensure quality of care being provided. Additionally, performance metrics should be incorporated to address the safeguards listed above including monitoring live discharges, ensuring plans are providing all four levels of care, and maintaining beneficiary choice.

IV. Providing Continued Access to Medicare Advantage Special Needs Plans (SNP) for Vulnerable Populations

The aging population and rapid increase in the number of chronically ill and medically complex people presents a significant challenge for caregivers, care managers and payors alike. Of the 1.9 million Medicare hospital readmissions in 2010, beneficiaries with two or more chronic conditions accounted for 98 percent of these readmissions. This trend underscores the need in healthcare to focus on the entire patient rather than individual disease interventions. Special Needs Plans serve an important role in providing patient-centered services to the most complex chronically ill beneficiaries. These plans include benefits and providers targeted to the special needs of this highly complex and costly patient population that frequently suffers from poorly coordinated care. It is also essential that care management (including dedicated care managers) is an integral part of these SNPs to ensure sufficient care coordination. Kindred Healthcare supports either a long-term extension, or permanent authorization, of the SNP programs.

V. Improving Care Management Services for Individuals with Multiple Chronic Conditions

Kindred supports establishing a new high severity Chronic Care Management code that clinicians could bill under the Physician Fee Schedule. This recommendation builds off Kindred's support of the current Chronic Care Management codes in responses to recent Physician Fee Schedule regulations and our positive experience with our Care Transitions Program as detailed above. As a patient-advocate, the Transitions Manager helps beneficiaries understand disease processes, care plans, medications and follow up care. The ongoing support significantly reduced hospital readmission rates, improved clinical outcomes, and better coordinated care and communication across separate sites of care and with the beneficiary's primary care physician.

Eligible Beneficiaries. Kindred recommends that patient criteria for the new high severity Chronic Care Management code should take into consideration functional impairment, cognitive status (such as diagnosis of dementia or delirium), beneficiaries' living arrangements (such as living alone) and support system as well as social and economic criteria. The number of chronic diseases required should be less than five when considered in combination with functional

impairment, severity of illness, and cognitive status. If possible, patient criteria could be further strengthened by considering recent declines in functional status.

Eligible Providers. Kindred recommends that providers eligible for the new high severity Chronic Care Management code include family medicine, geriatricians, palliative care specialists, and geriatric psychiatrist. These clinicians offer comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time and therefore should be eligible for these payments.

Performance Measures. Kindred recommends the following performance measures to assess the impact, effectiveness, and compliance of the new high severity Chronic Care Management code: reduced emergency room and acute inpatient hospital utilization, fewer falls with injury, increased medication adherence, and increased utilization of hospice services earlier in the course of treatment (i.e., not in the last 3-5 days of life), and utilization of Palliative Care and Home health services as the patient's illness progresses.

VI. Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Kindred Healthcare supports proposals which promote the use of telehealth services, including permitting MA plans to incorporate certain telehealth services in the annual bid amounts. Kindred recommends that any such proposals furnish sufficient flexibility in originating site requirements to allow non-hospital healthcare facilities with the necessary clinical services for oversight (i.e., RNs, CNAs, social workers, etc.) to be considered originating sites.

VII. Providing ACOs the Ability to Expand the Use of Telehealth

Kindred Healthcare supports waiving the originating site requirement for telehealth services in ACOs participating in both the Medicare Shared Savings Program one-sided and two-sided risk models. This will promote cost effective care by encouraging ACOs to use telehealth services. Potential safeguards could include adopting an on-site face-to-face visit every six months to certify that telehealth services are appropriate for the next six months and ensure that there is some clinical oversight of the appropriateness of telehealth services.

VIII. Ensuring Accurate Payment for Chronically Ill Individuals

Kindred Healthcare supports changes to the HCC risk adjustment model to take into account functional and cognitive status. The role of functional status as a predictor of outcomes (such as hospitalizations, rehospitalizations, and mortality) has been well documented. For example, research has demonstrated that the best performing readmission risk prediction models used data on comorbidity, prior use of medical services along with functional status to predict a composite outcome of hospital readmissions.[1] Similarly, cognitive status leads to adverse outcomes, which is exacerbated by sociodemographic factors such as living alone.[2]

IX. Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization (ACO)

[1] Kansagara D, Englander H, Salanitro A, et al. Risk Prediction Models for Hospital Readmission: A Systematic Review. *JAMA*.2011;306(15):1688-1698.

[2]Daiello L, Gardner, R, et al. Association of Dementia with Early Rehospitalization Among Medicare Beneficiaries. DOI: http://dx.doi.org/10.1016/j.archger.2014.02.010

Kindred Healthcare supports efforts to test different payment delivery models, particularly models which integrate care and payment, and will serve as important building blocks for future post-acute care reform. In May 2014, Kindred announced its strategic partnership and ownership in the Silver State Medicare Shared Savings Program ACO, which serves Medicare fee-for-service beneficiaries in Las Vegas, Nevada. Within this ACO, Kindred Healthcare is responsible for managing clinical outcomes and care utilization for nearly 18,000 covered Medicare lives in partnership with approximately 150 primary care physicians based in Las Vegas. Kindred also has partnered with other ACOs, such as Steward Promise, a Next Generation ACO in MA.

Kindred Healthcare encourages CMS to more broadly apply regulatory waivers to the ACO program to allow providers to treat patients in the most clinically appropriate and cost-effective setting for the appropriate length of time. Kindred recommends that CMS more broadly apply the waiver authority to ACO participants particularly in Track 1 and 2; and also consider waiving restrictions on co-location of post-acute care provider types, the LTAC 25-day length of stay requirement, IRF 60 percent rule, and restrictions on information sharing between institutional post-acute and home health providers. With the appropriate reporting requirements and financial incentives in place to ensure high quality clinically appropriate care, these regulatory restrictions are unnecessary and impede the ability of providers to fully innovate or reform health delivery systems.

Kindred supports flexibility in the design of the ACO program, including allowing all ACOs to choose between prospective and retrospective beneficiary assignment. Kindred also believes that a beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO, because not all ACOs are able to offer a full array of services and in some instances beneficiaries will need to receive specialized services from providers outside the ACO. Kindred supports further consideration of a prospective payment under the ACO model, but believes that more experience with the ACO program is required prior to allowing providers to receive an upfront collective payment for all services furnished to the beneficiaries that are prospectively assigned to the ACO.

Our experience with Steward has also highlighted the impact that taxpayer identification rules have in limiting provider participation in Medicare Shared Savings Programs (MSSP) ACOs – a taxpayer identification number (TIN) can only be in one MSSP ACO. Because Kindred, as an organization, has tried to simplify our list of TINs for ease of administration, we are unable to participate in another ACO in New England because of the Kindred TIN being used in the Steward ACO.

X. Encouraging Beneficiary Use of Chronic Care Management Services

Kindred supports waiving beneficiary co-payments associated with the current chronic care management code as well as the proposed high severity chronic care management code discussed above. More than two-thirds of the current 54 million beneficiaries have two or more chronic conditions, and 14 percent have six or more chronic conditions. Those beneficiaries with six or more illnesses accounted for 46 percent of all Medicare spending in 2010. Care coordination is an integral step in appropriately managing the care for these complex chronically ill beneficiaries and addressing their disproportionate share of Medicare spending. Waiving the co-payments will

improve beneficiary access to the care coordination and care management services so essential to this patient population.

XI. Increasing Transparency at the Center for Medicare & Medicaid Innovation

As we pursue strategies to address patient-centered care management for the highest risk consumers, we must test models and multi-dimensional opportunities to provide effective care management that improves quality outcomes while reducing the overall cost of care. The CMS' Center for Medicare and Medicaid Innovation (CMMI) continues to test programs that strive to encourage care coordination with the goal of producing improved outcomes and Medicare savings. ACOs, Medical Homes, and the Bundled Payment for Care Improvement (BPCI) Initiative are some of the innovative approaches that are intended to coordinate care for Medicare's most at risk patients – including those with several chronic conditions. Kindred is currently participating in some of the CMMI supported models, including Model Three of the CMS BPCI Demonstration and the Medicare Shared Savings Program ACO.

Kindred supports requiring CMMI to issue notice and comment rulemaking (with at least a 30-day comment period) for all alternate payment models. This would allow stakeholders to engage in the model development process earlier and to assist CMMI in highlighting implementation challenges earlier in the process. At a minimum, CMMI should be required to issue notice and comment rulemaking for models that require mandatory participation.

Conclusion

Kindred applauds the Senate Finance Committee's Chronic Care Working Group for their pursuit of strong end effective policies that would contribute to more effective care management and an improved care delivery system for beneficiaries suffering from multiple chronic illnesses. We appreciate the opportunity to publicly comment on several of the proposed Policy Options that we believe would be beneficial, and to highlight – based on Kindred's experience – where some policies may be improved for the future. We encourage the work group to continue efforts in order to achieve a comprehensive and coordinated solution to the challenges of delivering effective chronic care management. On behalf of our patients, many of whom have multiple chronic conditions in addition to an acute illness/injury, we are dedicated to helping develop policy solutions for some of our nation's most costly and complex to treat patients.