June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, D.C. 20510

Delivered via email: *chronic_care@finance.senate.gov*

Dear Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

Landmark Health ("Landmark") is pleased to provide recommendations in response to your call for stakeholder input on chronic care solutions. Our recommendations are rooted in practical experience in taking financial risk and delivering care for Medicare beneficiaries with multiple chronic conditions.

The Medicare Advantage Program has incubated multiple medical models that are have been successful in delivering higher quality care at a sustainably lower expense for polychronic beneficiaries. We believe that these medical models can be applied at scale and with equal success in the Medicare fee-for-service ("FFS") population, so long as certain policies are adopted that enable medical groups to aggregate and assume financial and clinical responsibility for this population.

We have described these policies below in Section II. Section I provides a brief background on Landmark.

Section I: Background on Landmark

Landmark is a risk-based medical group that delivers in-home, team-based primary care to the most medically vulnerable, including high-risk dual eligible, polychronic seniors, bedbound and homebound individuals, and the disabled. We address our patients' medical issues as well as their behavioral and social issues. Our patients often have six or more chronic conditions. The company was founded by a team of passionate leaders with substantial expertise in managing these clinically complex populations. The company's executive management team has over eighty years of collective experience, obtained at leading healthcare companies such as CareMore, Inspiris, Optum, Amerigroup and

HealthCare Partners. Dr. Arnie Milstein, Professor, Medicine at Stanford University and former 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 needs. The existing healthcare system is one-size-fits-all and often limited to 15 minute visits with physicians several times per year, and does not engage patient families, and does not adequately address behavioral and social resources in the doctor's office. Further, a physician's office is only open 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. An alternative and complementary medical delivery model is needed for patients with complex medical conditions.

At Landmark, our providers work tirelessly to deliver compassionate care for highly frail, chronically ill populations. 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 bedbound and homebound. Our fully employed providers visit patients and average of 20-30 times per year in their place of residence and respond to off-hours call by sending a provider to a patients 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 their 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 their existing in-office relationships—filling the above mentioned gaps in the existing office-based system.

We currently partner with health insurance plans, including plans with those with Medicare Advantage 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 20,000 of our nation's sickest patients in four major metropolitan markets in across the country: Albany, NY; Buffalo, NY; Portland, OR; and Seattle, WA (opening soon).

Section II: Specific Recommendations

Given our focus solely on taking financial risk and delivering medical care to complex patients with multiple chronic conditions, we believe that can be of service to the Senate Finance Committee in helping to craft a FFS model that accomplishes your bipartisan goals of increased care coordination across providers, streamlines current payment systems to incentivize appropriate levels of care, and improves care transitions. Three specific recommendations are below. We have tried to link these recommendations to the specific questions posed in your letter to stakeholders, where possible.

1. Creation of a Polychronic ACO and Adjustment to Attribution Methodology for Current ACOs

Many providers focused on high-risk populations seek to deliver care to polychronic beneficiaries in both the Medicare Advantage and Medicare FFS programs. However, the current FFS payment structure does not adequately compensate for the higher intensity of services a higher acuity

population requires, not does create sufficient incentives to reward a long-term and sustainable reduction in total cost of care.

The current CMS ACO models are designed for provider groups that manage patients across the chronicity spectrum, which has the unintended consequence of discouraging participation from those providers with medical models designed explicitly to serve patients with multiple chronic conditions. As a result, we do not find it surprising that these demonstration programs have shown "mixed results" for patients with chronic conditions. Currently, CMS identifies the patients that are attributed, or assigned, to an ACO by determining where he/she receives a plurality of primary care services from a provider or supplier participating in the ACO. This may be adequate for patients on the healthier spectrum but does not do service to those patients with multiple 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 the Centers for Medicare & Medicaid Services (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 a "patient-centered" attribution methodology (for example, 6 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).

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.

Second, we recommend that Congress require the Centers for Medicare & Medicaid Services (CMS) to change its current ACO attribution model to allow more patients to realize the benefits of accountable care. Under the current attribution model for CMS' ACO programs, CMS identifies the patients that are attributed, or assigned, to an ACO by determining that he/she receives a plurality of primary care services from a provider or supplier participating in the ACO. There is some additional flexibility in the recently-announced Next Generation ACO Model, where beneficiaries 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.

Recognizing that some guardrails may be needed to protect beneficiaries, we recommend that Congress direct CMS to expand "opt in" options for all ACOs that take risk. This will eliminate the barrier to program entry experienced by more advanced medical groups like Landmark. We have the ability 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 directly patients will ensure longitudinal care for more patients, while preserving their option to choose not to participate. It will also empower Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

2. Create and/or Modify Other CMS Programs to Allow for Broader Participation : PACE and Independence at Home (IAH)

As you know, CMS is piloting many programs designed to improve care for Medicare and Medicaid beneficiaries. Some of these programs are targeted at testing value-based delivery and payment arrangements, and others aim to improve FFS for Medicare patients. While we briefly touched on our recommendations for CMS' ACO programs above, there are several other programs that could be expanded or reformed to specifically target patients with chronic disease.

First, we recommend that Congress mandate a Program of All-Inclusive Care for the Elderly (PACE) "without walls" demonstration project. PACE is a unique program in Medicare that provides comprehensive services to frail elderly patients within the framework of a community-based medical home model. Under the PACE program, seniors receive all services covered by Medicare and Medicaid, including primary care, medical specialties, adult day health centers, home care, prescription and over-the-counter medications, social work, dietitians, and any other services. PACE has many elements that have been proven effective in managing patients with chronic disease: 1) care by an interdisciplinary team; 2) centralized, coordinated medical care with integrated benefits around community-based and social needs; 3) PACE sites bear full financial risk.

While the evidence around PACE clearly demonstrates improved outcomes, one significant challenge for the program is the resource intensity required to become certified. Significant physical infrastructure is also necessary to establish a program. While the PACE Innovation Act (S. 1362) is a step in the right direction, we believe Congress should go further and mandate a "PACE without walls," which patients are cared for by a home-based, fully integrated medical and social service team. We believe that this type of program would produce results comparable to or better than the traditional program.

Second, we urge Congress to modify and expand the Independence at Home (IAH) demonstration. As you know, the IAH program is testing home-based primary care approaches to chronic disease care: initial evidence suggests that the Program has been effective in reducing total of care while improving access and quality. We endorse the IAH demonstration and recommend additional modifications to expand the footprint of this successful initiative. First, provider participants should be required to demonstrate a path to financial responsibility. The program is currently a one-sided incentive program, with providers who meet benchmarks receiving a bonus payment for doing so, but with no symmetrical penalty applied to providers should they fail to meet those benchmarks. Second, the scope of the program should be expanded to include a larger percentage of the population. The

program is currently limited to beneficiaries that meet stringent eligibility requirements[1] – only a small portion of those beneficiaries who could benefit from such a program can be enrolled. Third, additional practices should be allowed to apply for the newly modified demonstration. There are currently only 12 participants. We believe that this number would increase if program requirements were revisited, resulting in home-based care for a greater number of Medicare beneficiaries with chronic conditions.

3. Include Hospice as Part of the Base MA Benefit.

Hospice is an important part of the continuum of care for patients with chronic disease. This benefit is currently "carved out" of the base Medicare Advantage benefit. The lack of coverage for hospice by Medicare Advantage results in fewer referrals to hospice among MA plan beneficiaries. The "carve-in" of hospice back into the base Medicare Advantage benefit will enhance longitudinal management for patients with chronic disease, and will make it administratively and clinically simpler to appropriately refer members into hospice. We urge CMS to consider and implement MedPAC's recent recommendation to re-integrate hospice as part of the Medicare Advantage benefit.

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Thank you again for your consideration of these comments. 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,

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[1] 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.