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Provider Alert

May 3, 2021

Care N' Care Partners with Landmark Health

Care N' Care (HMO/PPO) has engaged Landmark Health and its affiliated medical groups (Landmark) to deliver in-home medical services for members with multiple chronic conditions. Some of your Care N' Care covered patients now qualify for a house-call program through Landmark, in addition to the care that you provide.

Who Qualifies:

- Patients with Care N' Care Medicare Advantage HMO and PPO plans
- Patients with multiple chronic health conditions

Value to Providers:

- Does not affect primary care billing, member's copay or additional cost to members, your billing and patient interaction remain the same.
- Landmark acts as an experienced complex care resource, supporting your care plan.
- Landmark keeps you informed, updating you on patient status changes, disease progression, and medications.
- Helps close quality care gaps.
- Does not replace the PCP and encourages members to follow up with their providers.

Landmark FAQ's - Learn More

Have Questions? Contact your Provider Concierge:
817-687-4004 | providerconcierge@cnchealthplan.com

Sent by Care N' Care Insurance Company, Inc. 1701 River Run, Suite 402, Fort Worth, TX 76107

Care N' Care is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal. Care N' Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Care N' Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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Southwestern Health Resources and Landmark:

Answers to your questions about our exciting partnership

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Southwestern Health Resources + Landmark = Improved Care for Medicare Advantage Patients
Southwestern Health Resources is dedicated to enhancing the value of healthcare delivered to our members through our premier network of contracted physicians. Our goal is to provide patients the best possible care in the most appropriate setting. The challenges of today's environment to your practice – pivoting care delivery to accommodate COVID-19, effectively listening to patients and their families about their individual needs and maximizing your time and resources by providing the right care at the right time in the right place – underscore the value of our model rooted in collaboration.

Our ongoing analysis of our members' medical needs reveals the greatest potential to improve well-being and reduce costs lies with our Medicare Advantage (MA) members. A subset of this population – those with complex diagnoses (6 attribution points defined by Landmark – see appendix) – often require a higher volume of services, more face-to-face time, and frequently require a higher number of costly inpatient stays. Landmark can help get patients the right care at the right time - assisting in preventing avoidable inpatient stays. That's why SWHR has formed a strategic partnership with Landmark, the nation's leading provider of in-home care to older adults. Extending your ability to improve care for these members.

SWHR is nationally recognized for effective care management and is the regional leader in reducing unnecessary hospitalizations and emergency room visits. We believe this collaboration with Landmark will only further that success. Landmark's mobile, physician-led teams will work collaboratively with network physicians to amplify access to care and ensure better outcomes and experience for thousands of complex patients in Medicare Advantage plans. Patient participation is voluntary and home visits are offered at no cost to the patient.

By focusing on the long-term needs of patients living with multiple chronic conditions, there is greater emphasis on routine preventive care and on-demand urgent care, delivered by doctors and nurses in the home, to reduce avoidable hospital visits. Landmark providers are a safety net to PCPs and eligible patients when the provider's office is closed. Landmark follows patients across the healthcare delivery system to ensure adherence to the patient's care plan devised by the patient and their PCP.

Landmark's services target at-risk, complex patients who will benefit from in-home care.

- **Multidisciplinary care teams**
  Landmark's mobile care team includes doctors, nurse practitioners, physician assistants, behavioral health specialists, social workers, pharmacists, dietitians, nurse care managers and healthcare ambassadors.

- **In-home urgent care services**
  Landmark helps to reduce avoidable emergency room visits, hospital admissions and readmissions.

- **Social, lifestyle and behavioral health support**
  Social needs often affect those with multiple chronic conditions. Landmark's care team addresses a wide range of needs, thereby treating the whole patient.

- **PCP collaboration and following the PCP's care plan**
  After each home visit, Landmark updates the PCP by phone, direct message, or secure fax, and provides the PCP with additional insight into the patient's needs. Landmark encourages patients to follow up with their PCP and specialists for continued care.

- **Help closing quality care gaps**
  Landmark works with PCPs to address gaps in care such as comprehensive diabetic care, colorectal cancer screening, and behavioral health screening.

"Landmark will reach those patients who need greater support with in-home medical visits – these can augment the already excellent care our community of physicians provide. This kind

of innovative care delivery extends our mission to ensure that people living with chronic conditions have an opportunity to receive the best medical care in the comfort of their homes." - Sanjay Doddamani, MD, Chief Physician Executive and COO of SWHR

Key takeaways:

- Landmark is a national leader in comprehensive, in-home medical care, with a geriatric-specialist team providing care to more than 100,000 patients across fifteen states.
- Patients who are eligible for this program represent a small percentage of a PCP's patient panel, as this is limited to the most complex patients. Landmark's home-based geriatric care model is tailored to these patients' unique medical and social needs.
- Patients in this program are often high utilizers of the emergency department (ED) or inpatient (IP) setting. In the home, Landmark can stabilize these patients, helping patients avoid time in the ED and IP - getting patients back into the PCP's office.
- 97% of patients actively engaged in Landmark's program have reported that Landmark has helped them stay out of the hospital or emergency room.
- Hospitalizations decreased 28% in the portion of Landmark's patient cohort that had actively engaged with Landmark in addition to their PCP.

Answers to Physicians' and Providers' Questions

Background on the Partnership Between SWHR and Landmark

1. **Why is SWHR launching this partnership? What is the clinical rationale?**
   SWHR is expanding the network's capabilities in home-based geriatrics model care. Patients who enroll and engage with Landmark's program are less likely to need admission to the hospital, and benefit from augmented care to manage chronic conditions, coordination of care, and management of cost and resources. This program extends a PCP's care plan into the homes of their seniors who are medically complex (see appendix) and often require additional care.

2. **Why Landmark and what is their value proposition?**
   Landmark Health and its affiliated medical groups (Landmark) are a healthcare company designed to support patients with complex, multimorbid conditions. Landmark partners with health plans and care delivery systems to bring high-touch, longitudinal care to their frailest members, in coordination with community providers and resources.

   Through the Landmark program, members receive provider house call visits, routine, urgent and post-discharge visits, and 24/7 phone availability and care coordination.

   Landmark's business model emphasizes coordination and collaboration. Its clinical teams communicate findings back to the PCP and reinforce their care plan in the home. This collaborative care model helps treat patients at home, address behavioral and social determinants of health. It also integrates palliative care and end-of-life planning into the longitudinal care of high-risk patients.

3. **How does Landmark's care model benefit you and your patients?**
   The Landmark medical team augments your office-based care as a local interdisciplinary team that comprises physicians, advanced practice providers (APPs), behavioral health specialists, social workers, nurse care managers, dietitians, pharmacists, care coordinators and healthcare ambassadors. While not all patients may need assistance from available team services at all times, having such services available at any time is important in managing the changing needs of a complex patient's care.

   In addition to addressing patient needs at home, Landmark's team is committed to updating the PCP on clinical changes that may change the PCP's recommended care plan. This timely and efficient coordination of care is designed to assist PCPs close quality gaps and amplify PCP care through urgent acute interventions, routine visits, and thorough documentation – while giving patients maximum access to quality care.

4. **What is Landmark's experience with this patient population? What are the results of their efforts?**
   Landmark is in its seventh year of operations in 46 markets across the United States. Landmark serves more than 100K lives. Landmark's engagement with SWHR will be its first in the Texas market. Please reach out to Landmark's Community Outreach Specialists at 1-833-874-2581 or Care N' Care's Provider Concierge team for more details.

Landmark's Care Model

1. **What is Landmark's patient eligibility criteria?**
   The eligibility criteria is that a patient must be part of a participating plans, meet the Landmark eligibility requirements, and live within the service area. Please see appendix for more details.

2. **What SWHR Medicare Advantage members are eligible for this program?**
   Members of Care N' Care HMO, and Care N' Care PPO plans who meet Landmark participation criteria will be eligible for program launch in April 2021.

3. **Can a patient be enrolled in a SWHR Care Management program and also be eligible for care from the Landmark team? How will Landmark report to (and occasionally message back and forth with) the SWHR Care Managers regarding patient care updates?**
   Yes. However, the Landmark program is a standalone SWHR Care Management program. If a patient is enrolled in the Landmark service, other SWHR Care Management programs will give Landmark preference in service delivery. If additional assistance for a patient is needed, Landmark will coordinate with SWHR Care Management.

4. **What is the division of patient care responsibilities between Landmark, a PCP, and a SWHR Care Manager?**
   Landmark does not replace or exclude a patient's PCP. The relationship and responsibility of a PCP and their patient does not change. Rather, this program helps support the great work of primary care physicians by extending their expertise in the home- bringing awareness to root causes and failure points that are not always visible in an office setting. Landmark providers are a safety net to PCPs and patients when their office is closed. Landmark follows patients across the healthcare delivery system to ensure adherence to their care plan. SWHR CM will provide further support as determined between Landmark and SWHR.

5. **How will PCPs identify which patients among their panel are enrolled and/or eligible in Landmark?**
   At the launch of the program, PCPs will receive a report listing their patients who are enrolled and/or eligible in Landmark from the Landmark team and Provider Concierge team. After the launch, PCPs will receive a monthly list of their enrolled and/or eligible patients.

   Landmark members will be flagged in Acuity. SWHR will provide an update when this feature becomes available.

6. **What routine support services will SWHR continue to provide to PCPs for patients enrolled in the Landmark program? What routine support services will SWHR NOT provide for these patients?**
   Routine services will continue to be available to PCPs in the SWHR network. SWHR Care Management will coordinate services with Landmark and will provide support for any services out of Landmark's scope such as prior authorization. If you have any further questions on routine support services, please reach out to the SWHR team.

7. **Will Landmark always utilize SWHR's network of post-acute providers and facilities for these patients?**
   Yes, unless patient choose a post-acute providers/facility outside of the SWHR network. Landmark will work closely with our case management and utilization management teams on the utilization of post-acute providers.

8. **Once a patient is enrolled in the Landmark program does his or her PCP have any ongoing patient care responsibility?**
   Yes, the PCP still creates or directs the care plan for the patient. Landmark will augment care for the patient in coordination of the PCP.

9. **If a Landmark physician sees my patients in their home, does that mean that patient will not be attributed to me?**
   The services of a Landmark physician do not change the attribution between the physician and the patient. Landmark services will augment the physician's plan of care for the patient.

10. **What will the impact of Landmark Health home visits be on our ability to perform Chronic Care Management (CCM) for our patients and bill for it?**
    There would be no impact on the physician and billing to provide CCM. Landmark is not a fee-for-service provider. Because Landmark services are complementary to the physician, Landmark will consult with the physician on any changes and recommendations for the patient.

11. **If a PCP opts out of the Landmark program, will the physician's patients be eligible for the Landmark program?**
    No, the physician's patients will not be eligible for the program. If an opt-out physician re-enrolls (during the re-enrollment period) in the Landmark Program, then the physician's patients will be eligible for Landmark services.

12. **How can an PCP opt out of the Landmark Program?**
    There are two opportunities to opt out of the Landmark program. Both opportunities are available for the program year 2021 only. After program year 2021, there will be no other opportunity to opt out for the term of the program.

    Any physicians who have opted out and later wish to participate in the Landmark program, will need to opt in through a separate form. The opt-in opportunity is available for the entirety of the Landmark program.

    Care N' Care and SWHR encourages all physicians who are considering opting out of the Landmark program to please allow Care N' Care and SWHR to discuss and answer any questions regarding the Landmark program.

Communication Between Landmark and PCPs

1. **What can PCPs expect in the engagements, such as meetings?**
   At the launch of the program and afterwards, the Landmark Community Outreach team and the Provider Concierge team will meet with physicians and practices to discuss meeting and communication preferences. The Landmark team will work toward accommodating the physicians' meeting preferences, such as meeting cadence and times.

2. **What is the communication and escalation path if a PCP has a question/concern about care Landmark is providing to their patients?**
   If you have any questions or concerns regarding Landmark, please contact SWHR's Care Management team or Provider Concierge team.

3. **How will a patient's Landmark Care team communicate with PCPs regarding care being provided to their patients?**
   Landmark will communicate with physicians via a variety of channels-- e-mail, telephone, e-fax, in-person. Clinical documentation will be exported from Landmark's EMR. During the initial meeting between Landmark and the PCP, preferred communication methods will be determined. Landmark will request records from the assigned PCP for each patient.

Enrollment/Disenrollment/Graduation

1. **Will PCPs be given the opportunity to review an initial list of their Landmark-eligible patients and prioritize patient outreach?**
   Yes, the PCP will be asked to review their initial list of Landmark eligible patients. Landmark will coordinate with the PCP on patient engagement prioritization.

2. **Can a PCP nominate a patient who is not on Landmark's original list? How?**
   Yes. This will be considered a referred Landmark member. Since Landmark is a SWHR Care Management program, SWHR will help the PCP with the appropriate Care Management program for the patient. PCPs should utilize the current referral process to make a Landmark referral to SWHR.

3. **After receiving PCP approval, how will Landmark notify the PCP which patients have agreed to participate or declined?**
   Landmark will communicate directly to the physician and SWHR Care Management about the decision. Landmark will work with the physician and SWHR to promote participation.

4. **If a patient is determined to be eligible for Landmark, is the patient enrolled automatically or does the patient have to agree to participate in Landmark's program?**
   If a patient is eligible for the Landmark program, it is REQUIRED that they give consent to Landmark to receive services. Patients will never be forced to work with Landmark.

5. **How/when will Landmark notify the PCP when a patient is no longer eligible for the program?**
   Landmark will provide a patient eligibility report once a month to PCPs and SWHR.

6. **How often will the Landmark eligibility list be refreshed?**
   The Landmark eligibility list will be updated monthly. The first list will be published in late March 2021 for the launch of the program.

Appendix

Landmark Eligibility Criteria:

1. Members of Care N' Care HMO, Care N' Care PPO plans.

2. Have at least six (6) attribution points that are either chronic condition-based or age-based (see Table: Age-Based & Chronic Condition-Based Attribution).

Age-Based & Chronic Conditions
Age 85 and older
Atrial Fibrillation
Cancer
Cerebral Vascular Disease
Chronic Kidney Disease
Coronary Heart Disease / Myocardial Infarction
Diabetes
Fluid and Electrolyte Disorders
Heart Failure
Peripheral Vascular Disease
Pulmonary Disease
Rheumatoid Arthritis/Osteoarthritis
Severe Chronic Liver Disease
Disabling Condition
Frailty: Protein-Calorie Malnutrition
End Stage Renal Disease (ESRD)
Pressure Ulcers with Necrosis (Stage 4)

3. Live within the Target Service Area (see Table: Texas Zip Codes)

4. Not be subject to the following condition or status:
   a. Members who have hemophilia
   b. Members already on hospice
   c. Members who move out of the Target Service Area
   d. Members under the age of eighteen (18)

Service Area Zip Codes											
75001	75050	75088	75143	75182	75227	75315	76008	76048	76092	76124	76208
75002	75051	75089	75144	75187	75228	75336	76009	76049	76093	76126	76209
75006	75052	75093	75146	75189	75229	75355	76010	76050	76095	76127	76210
75007	75054	75094	75147	75201	75230	75370	76011	76051	76096	76131	76225
75009	75056	75098	75148	75203	75231	75376	76012	76052	76097	76132	76226
75010	75057	75101	75149	75204	75232	75379	76013	76053	76098	76133	76227
75013	75060	75103	75150	75205	75233	75380	76014	76054	76102	76134	76234
75019	75061	75104	75152	75206	75234	75381	76015	76055	76103	76135	76244
75022	75062	75105	75154	75207	75235	75390	76016	76058	76104	76137	76247
75023	75063	75106	75155	75208	75236	75401	76017	76059	76105	76140	76248
75024	75065	75114	75156	75209	75237	75402	76018	76060	76106	76147	76249
75025	75067	75115	75157	75210	75238	75407	76019	76061	76107	76148	76258
75028	75068	75116	75158	75211	75240	75409	76020	76063	76108	76155	76259
75032	75069	75118	75159	75212	75241	75440	76021	76064	76109	76161	76262
75033	75070	75119	75160	75214	75243	75442	76022	76065	76110	76162	76266
75034	75071	75121	75161	75215	75244	75453	76023	76066	76111	76163	76426
75035	75072	75123	75163	75216	75246	75454	76028	76067	76112	76164	76462
75036	75074	75124	75164	75217	75247	75472	76031	76071	76114	76177	76476
75038	75075	75125	75165	75218	75248	75474	76033	76073	76115	76179	76627
75039	75077	75126	75166	75219	75249	75751	76034	76078	76116	76180	76651
75040	75078	75132	75167	75220	75251	75752	76035	76082	76117	76182	
75041	75080	75134	75169	75222	75252	76001	76036	76084	76118	76185	
75042	75081	75135	75172	75223	75253	76002	76039	76085	76119	76201	
75043	75082	75137	75173	75224	75254	76003	76040	76086	76120	76205	
75044	75085	75141	75180	75225	75275	76005	76041	76087	76121	76206	
75048	75087	75142	75181	75226	75287	76006	76044	76088	76123	76207	