Bluestone Physician Services℠

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Building
Washington, D.C. 20510

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

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

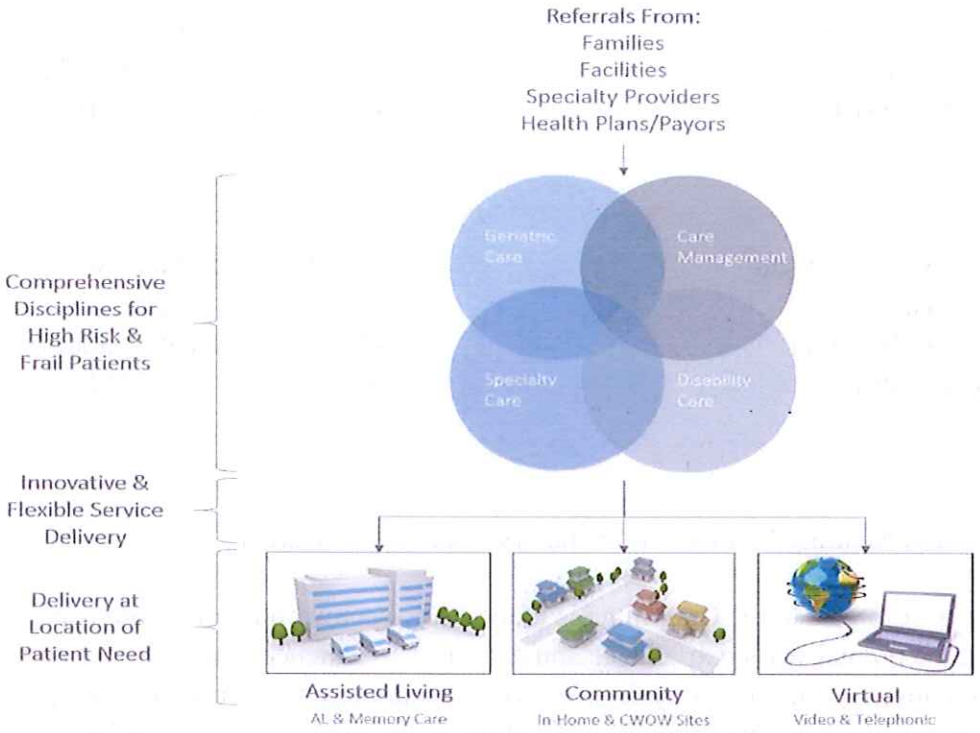
Dear Chairman and Ranking Member and Senators Isakson and Warner:

We are writing in response to the Committee's request for recommendations from health care stakeholders based on real world experience and data-driven evidence that will improve care for vulnerable populations. Bluestone Physician Services, is an innovative, primary care practice delivering on-site care to patients living in assisted living and people with disabilities in both residential and community settings. Advancing a care model consisting of a team approach, regular visits and proactive care, their care delivery model reduces medical costs and patient stress. Providing care since 2006 for chronically ill, frail, elderly and disabled individuals, Bluestone has evidence that personal engagement, quality of care and exceptional service results in high patient and staff satisfaction while improving the impact of care. Applying Bluestone Physician Services to Medicare beneficiaries broadly would address your core goals to address those with chronic conditions and achieve your objectives for the Medicare program overall.

Bluestone's care coordination services are designed to facilitate the patient, family and clinician partnerships needed to support high-risk patients and deliver care to those not served well through traditional channels of care. By going into the facility or home setting on a regular basis, once a month, our care teams are able to detect needs and address deficiencies upfront instead waiting until the patient is admitted to the hospital. In addition, by serving as a single entry point for labs, prescriptions, doctor appointments, and ongoing communication, caregivers and the

patient can both feel confident the necessary follow-up for their care will occur and they can comply with their care plan.

To further enhance the level of coordination and information sharing between all parties such as the patient, caregiver, care facility and other providers, Bluestone created the Bluestone Bridge. The Bluestone Bridge is a 24/7 web-based communications portal that allows provider teams, residential care staff, and service agencies to access patient information, message with providers, and receive orders for medications, lab work, and follow up. In a nutshell, Bluestone found that a bucket focused on coordinated care needed to be added to the already traditional buckets of geriatric, specialty, and disability care. There needs to be a full view of the patient, a



determination of their risk profile and a customized care plan informed by those factors.

This care delivery model employs the operational efficiencies necessary to make it financial sustainable while available at a lower cost to payors. Reimbursement through Medicare for these services would serve the Committee's goal of implementing policies to deliver high quality care, improve care transitions, produce stronger patient outcomes, increase program efficiency, and contribute to an overall effort that will reduce the growth in Medicare spending. In particular, the Committee indicated a desire to find solutions addressing eight (8) core areas. Applying Bluestone Physician Services to Medicare beneficiaries would address **all** of them.

Bluestone began providing on-site care in BI and Psychiatric group home settings and has expanded to Assisted Living and Memory Care settings. As the largest provider of residential

based care in the Twin Cities area, primary care is provided to nearly 4,000 high risk patients through on-site medical teams. Bluestone was certified as a Health Care Home, Minnesota's Patient Centered Medical Home program in 2010 and has incorporated PCMH principles into our model of care. In addition to primary care, Bluestone has a highly developed care coordination model for seniors and people with disabilities throughout Minnesota, serving nearly 2000 people with disabilities in the community. In 2013 Bluestone expanded primary care services to Wisconsin and in 2015 has begun service in Florida. Bluestone is serving over 1600 high risk patient in those areas. Bluestone has served well over 15,000 patients since 2006.

Year	2008	2009	2010	2011	2012	2013	2014
Unique Primary Care Patients	615	1,116	1,871	2,862	3,802	4,314	6,844

Over the last almost 10 years, the company continues to achieve its mission to bring the highest-quality health care directly to residents in assisted living communities, memory care, and group home communities. The recent addition of primary care visit in individual homes is only possible through Minnesota's current alternative payment models, both within FFS and managed care. By using the latest medical advances, technology, and collaboration with community/facility staff, patients, and their families, we have developed an unsurpassed care model for residential patients. We treat our patients with kindness and respect, recognizing their individuality, and working with them and all involved care givers to provide optimal health care, supporting their independence. Leveraging the EHR system, people, clinical expertise, telehealth tools, digital assessments, and our in-house analytics engine, we can create the right recipe for care management. A system initially designed to efficiently deliver care to residents not served well in traditional health systems has proved an effective testing ground to aggregate high risk Medicare beneficiaries in both the senior and disability populations.

With services available in three states, Minnesota, Florida and Wisconsin, Bluestone Physician Services employs over 170 staff, serve over 250 assisted-living and group home facilities, and provides both virtual and on-site psychiatric care. Bluestone launched services in Florida in April of 2015 and have successfully grown to over 900 patients. With data collected and results being modeled, Bluestone's services are ready to deploy in many more states and immediate impact on both quality and cost will be seen in particular in states with high Medicare costs. As you noted, those with chronic conditions such as heart disease, diabetes, and cancer account for almost 93% of the Medicare spend and the prevalence of Medicare beneficiaries with one or more chronic disease continues to grow. In addition, an important factor to note is that over 80% of an individual's medical is spend in the final two years of life.

Evaluation of performance and outcomes are key to the sustainability of the Bluestone model and in patient satisfaction. With constant collection of data, we track whether the patient has an advance care or end of life plan completed on file, the rate of Emergency Department and hospital visits and utilization, termination rates, patient and family experience and satisfaction and overall cost of care. As a result, Bluestone's primary care solution has decreased hospital

days by 83%, emergency department utilization by 74% among patients that are dually eligible. Bluestone's integrated care model has reduced Emergency Department and hospital utilization by 45%. These health outcomes are created while simultaneously satisfying patients and their families. Families have given our services a satisfaction rate of 96.3% and facility partners have given us 100% satisfaction results.

In addition to advance care planning, emergency plans, and transition of care management the model focuses on medication management through high risk medication reduction, including antipsychotic management. Over 80% of Bluestone's assisted living population has a diagnosis of Alzheimer's or related dementia. The model has resulted in over 97% of those individuals to die in their homes per their wishes, as opposed to SNFs or acute care settings. This results in increased quality of life and cost reductions.

In order to integrate the delivery of Bluestone services with the Medicare program, we recommend providing a baseline payment rate for the fee for service work completed and a PMPM reimbursement for care coordination services. This model should incorporate a shared-savings approach that is adequately risk adjusted for the population being served. We believe the new Chronic Care Management code goes a long way in recognition of the need for "non face to face" reimbursement, however it is currently not sufficient for the frail population we serve. Our services could be applied to distinct care populations or a demonstration could even be created to test out the model in the various regions.

Expansion of our model to other geographies and the Medicare population can have a meaningful impact on the Medicare program. Our vision and outcomes are 100% aligned with the goals of the Committee and we applaud your efforts to take best practices from the private sector to achieve results in public programs. We would welcome the opportunity to sit down with your staff in-person to go through in detail how our company can be of service to individuals and companies covered by public programs and with regard to your mission at hand. We appreciate the Committee's ongoing work to find innovative delivery system reforms to address access, quality and cost and look forward to working with you in the future.

Sincerely,

Sarah Keenan, President
Bluestone Physician Services