January 26, 2016

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
Unites States Senate
475 Russell Senate Building
Washington, D.C. 20510

Dear Chairman and Ranking Member and Senators Isakson and Warner:

Bluestone Physician Services is a primary care model serving high risk, chronic care patients who reside in residential care and community settings. All care is provided on-site and is highly coordinated with community resources. Our service area includes Minnesota, Wisconsin, and Florida. Care is provided to over 6000 frail senior and people with disabilities. Bluestone also provides on-site and tele-health psychiatry services.

We appreciated the opportunity to provide initial comments to you as leaders and members of the Senate Finance Committee on how to address the care needs of those with multiple chronic conditions. We were pleased to see the inclusion of some of the recommendations included in the Bipartisan Chronic Care Working Group Policy Options document. We applaud your efforts to incent alternative and innovative models of care and avoid a one size fits all approach. Providers should be active participants in the process and technology should be leveraged to enhance patient outcomes and the caregiver's experience. Bluestone also commends the working group on the thoughtful process to improve the delivery of chronic care.

Based on our experiences, we have provided comments on the following areas:

1. Receiving High Quality Care in the Home
    a. Expanding the Independence at Home Model of Care
2. Advancing Team Based Care
    a. Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations
    b. Improving Care Management Services for Individuals with Multiple Chronic Conditions.
    c. Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries
3. Expanding Innovation and Technology
    a. Increasing Convenience for Medicare Advantage Enrollees through Telehealth

   b. Providing ACO the Ability to Expand the Use of Telehealth
4. Identifying the Chronically Ill Population and Ways to Improve Quality
   a. Ensuring Accurate Payment for Chronically Ill Individuals
   b. Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization
   c. Developing Quality Measures for Chronic Conditions
5. Empowering Individuals & Caregivers in Care Delivery
   a. Encouraging Beneficiary Use of Chronic Care Management Services
   b. Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious of Life-Threatening Illness.

Expanding the Independence at Home Model (IAH) of Care

Our practice supports the expansion of the IAH model into a permanent, nationwide program. We agree that the current patient inclusion criteria should be modified. The non-elective hospitalization criteria should be eliminated. This criteria limits the inclusion of innovative methods that identify high risk patients prior to acute care encounters.

HCC risk scores should be used as one component of the patient inclusion criteria. Providers should have the opportunity to identify patients using social factors in partnership with community based settings, such as residential care communities. This will facilitate the inclusion of high risk beneficiaries not yet identified through claims or encounters.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

While our practice serves high risk patients across all payer types, Special Needs Plans have enabled the development of an integrated care coordination-primary care model that would have not been possible under traditional fee for service or traditional Medicare Advantage plans. The lessons learned through these innovative partnerships have benefited all patients in our practice. In particular, we commend the D-SNP in Minnesota for innovation and flexibility, and encourage the replication of similar programs.
If general Medicare Advantage Plans gain greater flexibility in their benefit design C-SNP requirement should lead to greater accountability for high severity chronic care patients. C-SNPs should lead to increased accountability and innovation in the Model of Care for health plans and care systems participating in C-SNP plans.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

As a primary care provider of services to high severity chronic care patients with an average of 7.25 chronic conditions and multiple functional deficiencies, Bluestone supports the

establishment of a high-severity chronic care code. By definition, patients in this category require and benefit greatly from the coordination of care activities that happen "outside the exam room". Patient criteria should be five or more chronic conditions OR one care defining condition, including Alzheimer's or a related condition or Developmental Disability combined with impaired functional status. Nearly all patients currently served through the Bluestone model fit this profile with measureable positive cost and quality impact of a high intensity care model.

Key to success of this policy is identification and engagement of qualified providers. Eligible providers should be primary care and able to meet the criteria of Patient Centered Medical Home. Providers must demonstrate the ability to coordinate with community based services, including residential care and home care providers. In addition, providers must be able to provide services where people live, working with formal, informal, and quasi-formal care givers. High severity chronic care patients have or could benefit from a strong base of community services. Providers must integrate into that system to truly impact care.

The impact of a high severity chronic care code should be measured through process and outcome measures. Process measures should include evidence of; non-face to face contact, care plan development, community service coordination, care giver support, and home based assessment and evaluation. Outcome measures should include appropriate quality of life measures, and care coordination measures including advance care planning and transition management.
Providers should also be required to use technology to coordinate services across systems, including referral management and information exchange with community based providers.

Alignment of Incentives should be established through community-clinic coordination relevant to the population served. Agreements may include best practice coordination up to and including incentives for quality metrics.

With these guardrails and quality measures in place, fraudulent billing practices will be minimized and outcomes will drive cost savings. Although many disease areas may be seeking service related payments, keeping this code focused on serving the populations with multiple chronic conditions impacting activities of daily living will allow federal funds to make the greatest impact on health outcomes and costs.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Bluestone Physician Services supports and encourages the integration of primary care and behavioral health. Currently, for chronically ill beneficiaries, this is among the least coordinated areas of care delivery. A key group of patients are those who behavioral health needs are expressed through behaviors and often lack the ability to communicate. This may include patients with Alzheimer's or related dementias and people with Developmental Disabilities such as Down's Syndrome. The lack of coordination of care between primary

and behavioral health providers results in increased and inappropriate use of antipsychotics. All care delivery systems being considered should have the capacity to provide or coordinate with behavioral health services.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth and ACO use of Telehealth Services

Bluestone Physician Services supports the use of telehealth services throughout the healthcare delivery system. Telehealth services that integrate with community providers are an effective delivery method for chronic care patients. In a multi-payer environment, it is critical to support key services such as telehealth across payers. Providers are less likely to invest in building the infrastructure of a telehealth program if payment across MA and ACO systems are not assured.

We have the Bluestone Bridge which is a very useful technology tool to allow all providers, the patient and their caregivers to communicate with each on the care and services being provided. Telemedicine and technology can significantly enhance patient outcomes and experiences. We support policies that encourage the use of tools like the bridge and telehealth. Incorporating the use of these technologies into alternative payment models and quality measures will increase adoption of these tools.

Ensuring Accurate Payment for Chronically Ill Individuals

Bluestone Physician Services encourages the use of functional status to improve the accuracy of risk-adjusted payments. Care defining conditions such as Alzheimer's and Developmental Disabilities vary greatly over the course of the disease process. Providers should not be discouraged from caring for the frailest and most complex patients due to inadequate risk adjustment based on the entire population.

Developing Quality Measures for Chronic Conditions

Bluestone Physician Services supports the quality measures outlined in the document in their entirety. All are effective measures for chronic care patients. We would add an appropriate quality of life measure and encourage standardized data and reporting systems and formats. In addition, CMS should consider including appropriate chronic care measures into PQRS and allow system wide use of domiciliary coding in submission criteria.

Encouraging Beneficiary Use of Chronic Care Management Services

Bluestone Physician Services strongly encourages waiving the beneficiary co-payment associated with CCM codes. In addition to the financial disincentive for patients the c-payment has caused confusion for patients and responsible parties. In our experience, many clinics are absorbing the co-payment due to this confusion. This increases the

importance of a clearly stated consent process to ensure patients have a full understanding of the program.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious of Life-Threatening Illness

Bluestone Physician Services supports the establishment of a covered planning visits. The scope of Dementia diagnosis, Parkinson's, and Traumatic Brain Injuries should be considered. We also believe the planning should be a one-time service, but not necessarily tied to initial diagnosis as the provider of the initial diagnosis may not be qualified to provide the planning visits. Bluestone also supports the use of an Interdisciplinary Care Team in the provision of these services, as RN and social workers-services are highly beneficial in community based planning.

As a care management services, this code should not be billed during the same month as CCM or TCM.

To be patient-focused and increase access to quality care models will benefit all stakeholders involved. We appreciate the Committee's efforts and look forward to working with you as you enact legislation to alleviate the burdens those with chronic conditions face today.

Sincerely,

T. Stivland MD

Dr. Todd Stivland
Founder and CEO