Medicare Payment Bundling and Hospitals

Strategies for Surviving and Prospering

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Today's Agenda

1. Medicare Payment Bundling Definition
2. Health Care Reform
   a. Basics
   b. Process
   c. Status as of July 31
3. Paying for Health Care Reform
   a. Medicare Payment Reductions
   b. Bundling Options
4. Bundling Phase 1: Readmissions
   a. H. R. 3200
   b. Senate HELP
5. Bundling Phase 2: Episodic Payment
   a. Fundamentals
   b. H.R. 3200
6. Strategies for Management Under Bundling
   a. Care Transitions
   b. Coaching-Self Management
   c. PAC Network
Medicare Payment Bundling Defined

- Medicare pays a single provider entity an amount intended to cover the costs of providing the full range of care needed over a hospitalization episode.
  - Single provider entity—possibilities are hospital, accountable care organization, integrated delivery system, post-acute coordinating entity.
  - Full range of care—definitely will include acute hospitalization, certain re-hospitalizations, post-acute care (LTACH, rehab hospital/unit, skilled nursing facility, and home health), and possibly physician and outpatient.
  - Hospitalization episode—possibilities are 7–60 days; most likely 30 days.

- Included in Health Care Reform Bills thus far.
  - H. R. 3200.
  - Senate HELP Committee Bill.
Health Care Reform: Basics

Expanding Coverage
- Reduce uninsured, various plans
- Expand Medicaid eligibility
- Limit insurance exclusions

Sustainable Financing
- Pay for uninsured
- Medicare cuts
- Tax surcharge
- Tax on employee benefits

Curve-Bending
- Reduce Medicare payments
- Hospital re-admissions
- Bundling 30 days
- Accountable care organizations

Today’s Topic: Bundling
Health Care Reform: Process

Pundits’ Predicted Timeline

Senate Bill—September?
House and Senate Votes—September-October-November?
Final Vote—11th hour before Christmas break?
H.R. 3200

- Last week, Waxman’s Energy & Commerce Committee resolved differences with Blue Dogs’ concerns about bending the cost curve.
- Pelosi postponed House vote to September.

Senate Bill

- Senate Finance Committee (Baucus) working on bi-partisan bill.
- No Committee vote until September.
Pundits: Regardless of whether or not there is a universal insurance bill, there will be a bill with Medicare reductions.

H.R. 3200 Medicare Part A
- Hospitals, SNFs, LTACHs, rehab hospitals/units, psych hospitals/units, hospice—MB reduced for productivity improvements beginning FY2010.
  - For hospitals, FY2010–2014 = ($19.4B)
  - FY2010–2019 = ($84.7B)
- FY2017, reduction to Medicare DSH if uninsured decrease > 8% between 2012 and 2014.

Medicare Payment Bundling
- Phase 1: Readmissions
- Phase 2: Episodic Payment
H.R. 3200 Total Impact on Hospitals

**Figure 11**

CBO Estimates of the Effects of Medicare Reforms under the Act on Provider Incomes: 2010-2019 (billions)

<table>
<thead>
<tr>
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<td>-1.0</td>
<td>-0.7</td>
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<td>-0.6</td>
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<td>-45.3</td>
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<td>Other Non-Durables</td>
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<td>0.0</td>
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<td>Nursing Home</td>
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<td>-3.2</td>
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<td>All Services</td>
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<td>Sustainable Growth Rate</td>
<td>7.4</td>
<td>13.1</td>
<td>15.3</td>
<td>17.6</td>
<td>20.3</td>
<td>23.5</td>
<td>27.5</td>
<td>31.3</td>
<td>34.4</td>
<td>38.0</td>
<td>228.4</td>
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<td>Medicare Advantage</td>
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<td>-19.7</td>
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<td>Interactions</td>
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<td>1.1</td>
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<td>-34.4</td>
<td>-42.4</td>
<td>-48.3</td>
<td>-219.7</td>
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</table>

Bundling Phase 1: Medicare Hospital Readmissions
MedPAC: Within 30 days of discharge, 17.6% Medicare admissions are readmitted, accounting for $15B in Medicare spending in 2005.

<table>
<thead>
<tr>
<th>Initial condition</th>
<th>Type of hospital admission</th>
<th>Number of potentially preventable 30-day readmissions (in thousands)</th>
<th>Percent readmitted within 30 days</th>
<th>Average Medicare payment for readmissions</th>
<th>Total spending on potentially preventable readmissions (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>Medical</td>
<td>139.2</td>
<td>19.1%</td>
<td>$6,490</td>
<td>$903</td>
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<td>COPD</td>
<td>Medical</td>
<td>85.1</td>
<td>16.5%</td>
<td>6,491</td>
<td>552</td>
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<td>Pneumonia</td>
<td>Medical</td>
<td>86.4</td>
<td>13.3%</td>
<td>6,681</td>
<td>577</td>
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<tr>
<td>AMI</td>
<td>Medical</td>
<td>30.5</td>
<td>18.7%</td>
<td>6,540</td>
<td>199</td>
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<td>CABG</td>
<td>Surgical</td>
<td>26.6</td>
<td>18.1%</td>
<td>8,085</td>
<td>215</td>
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<td>PTCA</td>
<td>Surgical</td>
<td>68.2</td>
<td>14.7%</td>
<td>8,342</td>
<td>569</td>
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<td>Other vascular</td>
<td>Surgical</td>
<td>30.0</td>
<td>18.6%</td>
<td>10,061</td>
<td>302</td>
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<tr>
<td><strong>Total for seven conditions</strong></td>
<td></td>
<td>465.9</td>
<td><strong>27.2%</strong></td>
<td></td>
<td><strong>$3,318</strong></td>
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<tr>
<td><strong>Total for all DRGs</strong></td>
<td></td>
<td>1,715.5</td>
<td></td>
<td></td>
<td><strong>$12,008</strong></td>
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<tr>
<td><strong>Percent of total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>27.6%</strong></td>
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Readmissions: H.R. 3200

- FY2011, reduced payments for readmissions for three conditions.
  - Includes all acute hospitals (CAHs in FY2012).
  - Payment reduction: (1) 1-ratio of aggregate payments for excess readmissions and aggregate payments for all discharges, or (2) floor adjustment factor.
  - Floor adjustment factors:
    - FY2012 = 0.99
    - FY2013 = 0.98
    - FY2014 = 0.97
    - Subsequent FY = 0.95
Readmissions: H.R. 3200 (continued)

- Begin with three conditions (see MedPAC slide); expand to four more in FY2013.
- Exclude planned readmissions or transfers.
- Readmission time period TBD (30 days suggested).
- Hospitals and post-acute providers admissions monitoring to see if avoiding risk; possible sanctions.
- One year after enactment, study how readmissions policy could apply to physicians.
Targeted hospitals (DSH payments > $10M) may receive special assistance payment for:

- Care transitions to other settings.
- Translators and interpreters.
- Increasing discharge planner services.
- Ensuring at discharge summary of care and medication orders.
- QAPI plan for remedying high readmission rates.
- Assigning discharged patients to medical homes.
Payment Reductions to PAC Providers for Hospital Readmissions, H.R. 3200

Table 3-10. Readmissions During Episodes of Post Acute Care, Overall, and for Top 10 DRGs by Volume, 2006

<table>
<thead>
<tr>
<th>Index Acute Admission DRG¹ (Top 10 DRGs for PAC Users)</th>
<th>N PAC Users</th>
<th>Mean Episode Payments</th>
<th>Percent with Readmission</th>
<th>Mean Readmission Payments</th>
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<tr>
<td>Overall Sample of PAC Users</td>
<td>109,236</td>
<td>$30,028</td>
<td>30.5</td>
<td>$15,636</td>
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<tr>
<td>544 Major Joint Replacement or Reattachment of Lower Extremity</td>
<td>15,261</td>
<td>$23,985</td>
<td>14.3</td>
<td>$12,952</td>
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<td>014 Specific Cerebrovascular Disorders Except TIA</td>
<td>4,882</td>
<td>$33,484</td>
<td>32.6</td>
<td>$13,409</td>
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<tr>
<td>089 Simple Pneumonia &amp; Pleurisy Age &gt;17 w CC</td>
<td>4,675</td>
<td>$20,476</td>
<td>31.6</td>
<td>$13,023</td>
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<tr>
<td>127 Heart Failure &amp; Shock</td>
<td>4,096</td>
<td>$26,076</td>
<td>43.1</td>
<td>$17,449</td>
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<tr>
<td>210 Hip &amp; Femur Procedures except Major Joint Age &gt;17 w CC</td>
<td>3,552</td>
<td>$36,882</td>
<td>30.6</td>
<td>$12,919</td>
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<td>088 Chronic Obstructive Pulmonary Disease</td>
<td>2,439</td>
<td>$21,118</td>
<td>36.3</td>
<td>$14,888</td>
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<td>320 Kidney &amp; Urinary Tract Infections Age &gt;17 w CC</td>
<td>2,396</td>
<td>$22,039</td>
<td>31.8</td>
<td>$12,994</td>
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<td>416 Septicemia Age &gt;17</td>
<td>1,996</td>
<td>$30,627</td>
<td>33.1</td>
<td>$16,956</td>
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<td>316 Renal Failure</td>
<td>1,848</td>
<td>$28,729</td>
<td>38.4</td>
<td>$16,999</td>
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<tr>
<td>296 Nutritional &amp; Misc Metabolic Disorders Age &gt;17 w CC</td>
<td>1,757</td>
<td>$22,852</td>
<td>33.1</td>
<td>$15,078</td>
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</table>

Source: Examining Post Acute Care Relationships in an Integrated Hospital System, RTI, 2009

Post Acute Payment Reductions for Readmissions, beginning FY2011
- FY2012 = 0.996
- FY2013 = 0.993
- FY2014 = 0.99

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**Readmissions: Senate HELP Bill**

- FY2010, calculate hospital-specific and national readmission rates for two conditions, later expanding to eight.

- Public reporting two years after enactment, and quality improvement program for hospitals in top 25% for readmissions.

- Develop reimbursement incentives to reduce readmissions.

*Important Note: Readmissions payment reductions are prelude to episodic bundling for hospitals, post-acute providers, and possibly outpatient and physician services.*
Bundling Phase 2: Episodic Payment
Episodic Bundling Background

- Considered to be essential for “bending the Medicare cost curve.”
- Recommended by multiple organizations.
  - MedPAC, June 2008
  - CBO Budget Options Book, December 2008
  - Commonwealth Fund’s Recommendations, March 2009
  - President’s Proposed Budget for 2010
  - Senate Finance Committee’s Policy Options, April 2009
  - H.R. 3200, July 14, 2009
- Goals:
  - Improve coordination, quality, and efficiency of services.
  - Improve outcomes such as reduced readmissions.
Medicare Payment Bundling

Admissions
- Hospital Services
- Physician Services

+30 Days
- Re-hospitalizations
- Post Acute Services
- Physician Services
- Other Services

Options: Single payment for all or separately for hospitals/physicians and for PACs; virtual bundling for all; single payment for hospitals/physicians and virtual for PACs.
Episodic Payment Fundamentals

- Certainties for Inclusion
  - Hospitals
  - Post-acute providers
    - LTACHs
    - Rehab units/hospitals
    - Skilled nursing facilities
    - Home health agencies

- Possibilities for Inclusion
  - Outpatient services
  - Physician services

- Likely to include CAHs
- Most likely episode = 30 days
- Most likely start date: FY2015
- Likelihood of inclusion in Final Bill: High
- Obama budget savings 2015-2019 = $18B
Average Medicare Payment to Post-Acute Venues, MedPAC Report to Congress, March 2009

<table>
<thead>
<tr>
<th>PAC Venue 2007</th>
<th>ALOS - Days</th>
<th>Average Medicare Pymt</th>
<th>Medicare Pymt Basis</th>
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<tr>
<td>LTACHs</td>
<td>26.9</td>
<td>$34,769</td>
<td>Discharge (LTC-M S-DRG)</td>
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<td>Acute Rehab Hospitals &amp; Units</td>
<td>13.2</td>
<td>$16,143</td>
<td>Discharge (CMG)</td>
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<td>Skilled Nursing &amp; Subacute Units</td>
<td>26.7</td>
<td>$9,750</td>
<td>Per Diem</td>
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<tr>
<td>Home Health Agencies*</td>
<td>60.0</td>
<td>$2,705</td>
<td>Per 60 Day Episode</td>
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</table>
Hospitals [Obama budget and Commonwealth Fund].

Hospitals or other entities such as non-profits that include the hospital and/or post-acute care providers [Senate Finance Committee Policy paper].

Accountable Care Organizations (ACOs) [MedPAC and H.R. 3200].

- A combination of a hospital, primary care physicians, and possibly specialists (H.R. 3200 alludes to including other Medicare providers & suppliers).

- May be integrated delivery systems, physician hospital organizations (PHOs), a hospital plus multi-specialty groups, or a hospital plus independent practices.

- Associated with a defined population of patients (5,000 as a minimum) and accountable for total Medicare spending and quality of care for that population.

- H.R. 3200

  - Incentive payments if expenditures for beneficiaries served by ACO less than target spending level or target rate of growth.

  - Pilot program begins January 1, 2012; agreements for 3-5 years.
Bundled Payment Options

- Single Payment Options.
  - Physician + Hospital (ACE demonstration).
  - Hospital + Post-Acute Care (PAC) Providers (may include outpatient services), 30 days.

- Virtual Bundling Options.
  - Continue to pay FFS but adjust providers payment based on providers relative efficiency across an episode of care.

- Hybrid.
  - Single payment for services during hospital stay + virtual bundling for services after discharge within 30 days.
Bundling in H.R. 3200

- Calls for a plan within three years rather than the specifics seen in the Commonwealth and Senate Finance Committee policy papers.

- CBO would not tie a savings to this initiative in H.R. 3200 because no authorization to implement the plan.
  - A key issue in H.R. 3200 for the Blue Dog conservative Democrats.

- In addition to the plan for bundling, the acute care episode demonstration (ACE) project to include post-acute care.
  - ACE demonstration project includes physician/hospital bundled payment for certain cardiovascular and orthopedic surgeries for selected hospitals in four states.
Bundling Plan Considerations Required by H.R. 3200

- Type of provider or entity to whom payment is made; scope of activities and services to be included in the bundle, period covered by bundle?

- Consolidate payment with IPPS payment or separate payment for bundled services? Every discharge or only those to PACs?

- All inpatient and PAC providers or limited to certain categories of providers, services, or discharges?

- How payment rates are established to achieve offsets for efficiencies from bundling, and what adjustments (geographic, CMI, etc)?

- Protections for beneficiaries to ensure right level and amount of services and provider choice?

- Relationships that may be required between hospitals and PACs, e.g., gain-sharing, anti-referral, anti-kickback, and anti-trust laws? Cost sharing viz. current rules?

- How to treat issues such as 3-day prior hospitalization for SNF, post acute transfer payment reductions, coordination of Medicare/Medicaid payments?

- Quality measures for acute and post-acute providers?
Hospitals have time to prepare and pilot strategies to reduce readmissions and to manage single bundled payment for acute and post-acute care, and perhaps physician services.
Strategies for Management Under Bundling
Three Strategies for Managing Under Bundling

- Transitional Care Models.
- Coaching-Self Management Models.
- Preferred Provider Agreements.
Focus on high risk patients with history of readmissions and use APNs.

- Care Transitions (Naylor)
  - 3 months
  - 10.5% readmissions at 1 year
  - Cost = $982 per enrolled patient

- Care Transitions Interventions (Coleman)
  - 4 weeks
  - -5.3% reductions in readmissions in 180 days
  - Cost = $196 per enrolled patient
Care Transitions Intervention

Target Medicare chronic care patients - readmissions

Ensure understanding of discharge orders

Home visit to coach creation of PHR, meds review & readiness for follow-up appointment with PCP

Follow-up telephone calls or visits for 4 weeks post discharge

www.caretransitionsintervention.org
Coaching-Self Management: Readmissions and PAC Stay Monitoring

- Teach/coach highest risk patients to self-manage condition by identifying goals, improving self management, building self-efficiency, assessing skill mastery.
  - Guided Care (Boult)
    - Nurse embedded in 2-4 physician office
    - $1744 per enrollee
    - Results shown next
  - Self-Management (Lorig)
    - 7 weeks—weekly group sessions
    - Medical and non-medical personnel
    - At 6 months, -0.8 fewer nights in hospital
    - $70 per enrollee
- “Medical Home” in H.R. 3200 for high risk patients includes additional payment for care coordination and prevention, begins 2010.
Guided Care

• Nurse/physician team.
• Assesses needs and preferences.
• Creates an evidence-based “care guide” and an “action plan.”
• Monitors patients proactively.
• Supports chronic disease self management.
• Communicates with providers in EDs, hospitals, specialty clinics, rehab facilities, home care agencies, hospice programs, and social service agencies in the community.
• Smoothes transitions between care sites.
• Educates and supports caregivers.
• Facilitates access to community services.
## Annualized Use of Services per Caseload (55 Beneficiaries)

<table>
<thead>
<tr>
<th>Services</th>
<th>Guided Care N = 415</th>
<th>Usual Care N = 394</th>
<th>GC - UC Difference</th>
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</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>223</td>
<td>306</td>
<td>-83</td>
</tr>
<tr>
<td>Hospital admissions</td>
<td>41</td>
<td>50</td>
<td>-9</td>
</tr>
<tr>
<td>SNF days</td>
<td>135</td>
<td>267</td>
<td>-133</td>
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<tr>
<td>SNF admissions</td>
<td>9</td>
<td>15</td>
<td>-6</td>
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</tbody>
</table>

Source: Boult, Chad, The Guided Care Medical Home for High Risk Beneficiaries, presented to CMS, March 13, 2008.
PAC Provider Network

- Partnership between hospitals and those providers of PAC not sponsored by hospital.
  - Criteria for quality and metrics—regularly reported to hospital.
    - Medical management, staffing, nursing skills.
    - Measure changes between admission and discharge from PAC; annual improvements and in top 25% of national measures.
    - Meets readmission targets—or lower.
    - Personal visits by hospital case management to ensure quality.
  - Works with hospital to discharge difficult-to-place patients.
  - Communication linkage with hospital.

- Discharge planners may communicate to patients that these PAC providers are known to meet quality criteria.
In Closing . . .
Why Health Care Reform Is So Difficult

- The Marcus Welby factor.
  Americans maintain a gauzy, almost dreamy image of doctors and nurses.

- The Rube Goldberg Factor.
  The very fact that the current system is like one of those overly complicated machines means Americans have no earthly idea how much they're paying for health care, which is even more costly than most realize.

- The Company-Town Factor.
  It's mostly an accident of history that America has a health-care system in which employers pay most of the cost of insurance.

- The Post Office Factor.
  Americans are deeply cynical about government's ability to do anything right.

- The Job-Machine Factor.
  This is a vastly underappreciated element of the national psyche. The health system isn't just something that provides medical care; it's now also the largest industry in the land.
Thank you

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