



Hilltown Community Health Center

September 11, 2015

David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

Dear Mr. Seltz:

Please find below Hilltown Community Health Centers' required testimony for the Commonwealth's Health Policy Commission's 2015 Health Care Cost Trends hearing. I appreciate the opportunity to provide input into the dialogue on the development of an affordable, effective, and accountable health care system. I would of course welcome any questions or comments that the Commission may have.

As the Executive Director of Hilltown Community Health Centers, Inc., I am legally authorized and empowered by its Board of Directors to represent the organization for the purposes of this testimony. This testimony is signed under the pains and penalties of perjury.

Sincerely,

A handwritten signature in blue ink that reads "Eliza B. Lake".

Eliza B. Lake, MSW
Executive Director

Worthington Health Center • 58 Old North Road • Worthington, MA 01098 • (413) 238-5511 • Fax (413) 238-5570
Huntington Health Center • 73 Russell Road • Huntington, MA 01050 • (413) 667-3009 • Fax (413) 667-8746
Hilltown Community Center • 9 Russell Road • Huntington, MA 01050 • (413) 667-2203 • Fax (413) 667-2225
Gateway School-Based Health Center & Gator Grins • 12 Littleville Road • Huntington, MA 01050 • (413) 667-0142 • Fax (413) 667-0145
www.hhcweb.org

"This institution is an equal opportunity provider."

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

[Remainder of page intentionally left blank]

Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.

a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

Summary: Hilltown Community Health Centers, Inc. (HCHC) is an FQHC with four sites located in the rural Hilltowns of western Hampden and Hampshire Counties of Western Massachusetts. We are the only provider of primary medical, oral health, behavioral health, eye care, and community services in our 600-square-mile service area, and are the second largest employer in the area, after the local regional school district. We serve the entire population of the area, not just the more typical FQHC population of MassHealth and uninsured patients, and therefore have over 50% of some of our towns' residents as our patients. We also draw patients from 74 ZIP codes in Western Massachusetts, in large part due to our oral health program's ability to take individuals enrolled in the Health Safety Net.

HCHC's health care costs over the last year and a half have been most significantly impacted by the difficulty of recruiting medical providers, and in particular MDs in family practice. In 2014, in order to meet the needs of our patients we were forced to use *locum tenens* staff to a significant extent, which increased our costs without increasing our revenue or our patient volume. While we have since been able to hire a number of nurse practitioners, we still see a great need for more family practice MDs, but have difficulty attracting them, given the financial constraints imposed by serving the high-risk, high-cost population that is the focus of our mission.

Response:

Revenue: HCHC's patient revenue payer mix over the last three years has remained relatively constant: 56% public (MassHealth PCC, MassHealth MCO, HSN and Managed Care), 25% Medicare, 17% Commercial Insurance and 2% Self Pay.

Grantor sources of revenue over the last three years as a percentage of total revenue has increased from 5% to 10%. The increased revenue has gone largely to supporting our community services, which while critical to meeting the needs of our patient population, still requires the center to subsidize some of the cost of these type of programs. The ability to bill Community Health Worker services or have their services covered in a more significant way by the rates paid by insurers would be extremely beneficial from both a cost and revenue stabilization basis.

In terms of dental services, HCHC has found HSN as a payer source to be increasingly important (approximating 24% this year) as MassHealth coverages for adult oral dental services is unstable. HSN reimbursement is inadequate, however, and does not in any way keep up with the cost of providing services (provider and program supplies).

Utilization: HCHC's patient volume has not changed appreciably in recent years. While this is largely the result of our declining rural population base, it is also the result of our challenges in finding MDs to join the practice to provide family medicine and therefore not drawing new people to the practice. HCHC is currently exploring the development of new sites in more populous areas where there is unmet need; a new site would enable us to expand our patient base dramatically.

Expenses: HCHC is unable to compete with provider (MD and Dentists) salaries offered in both the private practice or hospital arenas. Fringe Benefit expense, particularly medical and dental insurance costs, have increased or are expected to increase by 7% in the near future. Salary and fringe benefit expenses constitute 81% of total operating expenses. The center size does not offer us any economies of scale in the area and thus little control over this segment of expense.

The cost of program supplies, particularly dental, has increased by about 5% over the past three years without corresponding increase in reimbursement.

- b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
Response: HCHC has undertaken the following activities since January 2014 to meet the needs of its patients in need. These actions likely had minimal impact on the Commonwealth meeting the benchmark:
1. HCHC has hired Nurse Practitioners to serve as Primary Care Providers (PCPs) to both fill the gap created by the difficulty in recruiting family practice MDs, and to provide efficient and effective care to our patients.
 2. As the only provider of medical, oral health, behavioral health, and eye care services in our 600-square-mile region, we are the only source of care for thousands of residents with no easy access to primary care. Our services prevent costly admissions to EDs at the five hospitals that are in surrounding communities. We provide a patient-centered medical home to patients with complex chronic disease to ensure good health outcomes at lower costs.
 3. We provide affordable and accessible services to all individuals, regardless of their ability to pay and do so through: offering extended hours to accommodate a range of patient work schedules; same day access every day to prevent visit to urgent care and EDs; taking Health Safety Net patients who do not have any other access to services, especially for dental patients; and identifying high risk patients to be best addressed by our MD/NP teams.
- c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?
Response: Currently, HCHC is enrolled in two Alternative Quality Contracts through our local Physician/Hospital Organization. These contracts' quality goals, as well as those required by the federal Health Resources and Services Administration of all federally-qualified community health centers, are part of our larger Quality Improvement program. Over the next year, we will continue and complete our current efforts to implement a comprehensive population health management program that identifies and targets high-risk patients, ensuring that their care is comprehensive and coordinated. This will include increasing our collaborative relationships with local hospital and specialists to ensure coordinated care, post-acute care follow-up, and full integration of all of our clinical departments as well as community outreach programs (including Community Health Workers) into our Electronic Medical Record. We are also enrolled in the Senior Care Options dual-eligible program.

HCHC's challenge in adopting APM, however, is that these system require extensive and expensive quality data collection and analysis. Without the investment in such capabilities, it will be difficult for the state to achieve widespread adoption of APM and achieve the attendant cost savings/control.

- d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Response: A number of systemic and policy changes would enable us to operate more efficiently:

- 1) support for developing systems that can respond to increased demands for quality data reporting; the cost is prohibitive for small providers
- 2) a requirement of network adequacy in the contracting with MCOs: currently there is only one hospital system in Western Massachusetts that will accept one of the most popular plans, BMCHHealthNet. This has resulted in PCPs having to refer patients to specialists in Boston, even though there is capacity within the region, because there are no specialists that take the patients insurance. Our Navigators have worked with all clients to make sure that they pick a plan that provides them with the access they need to specialists that they know they need, but this is obviously not a sufficient response to the issue.
- 3) uniform formularies across payers would reduce time and energy in prescribing medication.
- 4) a coordinated EMRs or a well-integrated health information integration system statewide that is shepherded and supported by the state would increase coordination of care and reduce time and effort tracking down information from other providers. HCHC has signed up with the MassHIWay.
- 5) change the state vaccine program so that it can communicate with eClinical Works and other EMRs, as the current lack of communication is inefficient and can affect patient care
- 6) investment in population health development, including CHW and case management support, would enable smaller providers that serve specific and isolated populations create stronger and more efficient infrastructure to provide more cost-effective and efficient, as well as high quality, care
- 7) change in state law so that Medical Assistants can give routine immunizations

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

Response: As noted above, transition to population health management is costly in terms of both personnel and IT infrastructure, and requires an investment of resources that is not readily available. This need, as well as the extremely limited pool of MassHealth PCC patients in our patient population, is the reason that HCHC withdrew from the Patient-Centered Primary Care (PCPR) program; we did not have the capability to generate or track the data required to participate.

HCHC is the only provider in our service area, so if we weren't here to meet the primary care needs, there wouldn't be anyone to serve this rural population with a comprehensive set of services that reduce the overall cost of care. As a small FQHC, we do not capture payment from other services like larger networks with more comprehensive services. Furthermore, since our patients use as many as seven hospitals in the surrounding communities, we cannot control the costs of care (beyond reducing admissions), which makes participation in APM difficult. Finally, community health centers' missions are to serve under-served populations, which tend to be high-risk and therefore higher cost due to higher needs, which results in longer patient visit length, more follow-up visits,

and greater attention to the social determinants of health, including a complete lack of access to public transportation in this region. Recognition of these differences with traditional primary care providers, and investment in the infrastructure needed to maintain this critical safety net system, is important.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
 - a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

Response: HCHC's presence in its community and the services provided are a key piece of addressing the four areas identified. By providing care for high-risk/high-cost patients, we address all four areas with our coordinated care model:

1. After we are informed of a patient having been discharged from acute care, including from the ED (usually within 24 hours), HCHC nursing staff contact the patient to review medication and develop a care plan. HCHC also has Community Health Workers and visiting nurses that can conduct home visits to monitor their recovery and provide support with vital signs, medication management, transportation to follow-up visits, etc. We also offer extended hours to ensure that patients have access to follow-up care with their PCP.
2. With the system described above, we can maintain the patients post-discharge, and reduce the risk of readmissions.
3. As the only provider in our service area of 600 square miles, HCHC reduces the need for patients to make visits to the ED with issues that are more appropriately dealt with in a primary care setting. Our providers offer same day visits to greatly reduce the number of residents who have hospitals as their only other source of care.
4. HCHC has been developing and strengthening its population health management program. This includes integration of all staff into our EMR and increasing the number of Community Health Workers available to support patient disease self-management. Specifically, we have used state funds to collaborate with local Councils on Aging in developing comprehensive outreach plans that identify isolated elders in our rural community, and ensure that they have access to the full range of services needed to maintain their health.

- b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

Response: In the next 12 months, HCHC is going to be increasing our clinical case management capabilities, which enable us to address all four of the areas listed. Specifically, these efforts will enable all of our clinical departments to collaborate on serving individuals with chronic disease, diabetes, hypertension, behavioral health needs, obesity, and those at risk of stroke. We have recently received grant funds to develop an outreach program specifically for high-risk women who have not been screened for breast cancer, which will include developing stronger relationships with local hospitals to ensure that screening results are appropriately shared with PCPs. We will be continuing to increase our integration of the work of our CHWs with that of medical and behavioral health providers. Finally, we are planning to try to increase our capabilities to collect, aggregate, and analyze the data

contained in our EMR to better identify and target high-risk, high-cost patients, but as identified above, this is difficult and very expensive without support from outside funders.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.

a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

As an FQHC, HCHC serves a population that is more likely to be receiving health insurance support from public sources: 56% of our patients receive support from public payers (MassHealth PCC and MCOs, HSN, and Connector Care subsidies), while 25% are Medicare patients. While our payer mix is somewhat different from more traditional FQHCs due to our being the only provider in the region, public payers are still a significant piece of our revenue. This is important, as the Medicaid medical rate is not reviewed annually and has not been rebased to account for loss of DPH funding for CHCs several years ago. In addition, the fee schedule for behavioral health services is too low, and the dental fee schedule for adults is much lower than commercial rates. As we serve a population that is higher-risk, and therefore require more time and more care, recognition of the higher costs associated with these patients is not only acceptable, but must be acknowledged by the payer sources.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

Smaller providers like HCHC, which do not achieve the economies of scale or have the size to negotiate more favorable contracts with payers, cannot compete with large institutions for the providers we need to meet demand. Combined with the limited availability of family practice physicians nationwide, the lower salary we can offer to MDs severely limits our recruitment efforts. As mentioned above, this has forced us to hire costly *locum tenens* providers while we work to achieve full staffing. There is an impact on the overall costs of health care in the state when primary care is not available; paying more for primary care (and therefore for its providers) would, ultimately, be more cost effective than forcing patients to receive care from more costly EDs and specialists.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

Response: As a an FQHC, HCHC is in a unique position from many primary care providers because its behavioral health services are physically co-located in sites with primary medical and dental care, as well as other clinical and enabling services. All providers have access to

the same patient record in the EMR, which greatly increases the coordination of care. Face-to-face discussion and warm hand-off referrals can take place between the multiple disciplines. Also there are monthly Department Head meetings where Department Heads have an opportunity to discuss patients with complex needs and better coordinate patient care. Our organizational structure provides one manager that oversees all clinical departments, and is responsible for the integration and coordination of all clinical care, including medical, dental, behavioral health, eye care, and community services. We are currently integrating our behavior health providers into the medical teams, and we have established an integrated educational program where the oral health, medical, and eye care departments meet with the behavior health clinicians. Finally, in the last year HCHC has initiated a pilot project that assigned a Behavioral Health Clinician to a medical team. That medical team also started a pilot project to support diabetics in their disease management.

These efforts help to avoid the unnecessary utilization of EDs and in-patient care, but HCHC struggles with adequate access to psychiatric services. While our providers have strong relationships with local organizations that provide psychiatry, the waitlists for these services can be very long, and there is not enough capacity in the system. HCHC has not been able to afford the development of a telepsychiatry system, and with the IT infrastructure of our rural region unreliable even in the good weather months of summer, this is not going to be the only solution to the problem. In the long term, we need more support to be able to provide psychiatry services to our patients in need.

- b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

Response: HCHC is undertaking a number of changes in its system of provision of behavioral health services in the next year:

1. Begin planning to expand the Director of Behavioral Health position from a part time position to full time in order to increase capacity for integration
 2. In September 2015, schedule an informational and educational program for patients managing obesity. The meeting will include a PCP, a Nurse and a Behavioral Health Clinician. There will be a discussion of the condition and behavior's that might be contributing to the condition. The BH Clinician will coordinate with the PCP and offers strategies to change behavior to better cope with the medical condition.
 3. Expand its integration pilot project that assigned a behavioral health provider to a medical team and assign at least one clinicians to each medical team.
 4. HCHC has just formulated a policy that will have PCP's, Nursing and Behavioral Health Clinicians coordinating a response for patients who are having a Behavioral Health emergency. The purpose of the policy is to bring together multiple disciplines to correctly identify the patients needed level of care and quickly coordinates a response. One goal of the policy is to decrease the use of emergency room mental health crisis with possible in-patient placement or out-patient services. Being able to offer in-house or tele-psychiatry would be a critical piece of addressing this goal.
6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your

organization developed or does your organization plan to develop to successfully implement these models?

Response: HCHC is proud to have achieved NCQA Level 3 certification for its Worthington Health Center, and Level 2 certification for its Huntington Health Center. We are participating in the University of Chicago's Department of Medicine's study of organizations that have successfully implemented the PCMH into their medical practices. We have restructured our management to create a senior management position specifically to create greater integration between all of our clinical and community departments, and have included patient-centered quality care as one of our primary organizational goals. We are planning to integrate our oral health care providers into our EMR this year, at which point all of our providers, both clinical and those who provide community and social services, will be able to collaborate on patient care through one patient record. These efforts have, however, not been accomplished without the support of grants; they would not have been possible to support out of our operating funds, and the further efforts required to make us able to operate effectively and efficiently in the new health care financing environment will require an outside investment as well, particularly in high-quality analysis and reporting of quality data measures.