Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 Tuesday, October 7. 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 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, 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.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk 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 Kelly.A.Mercer@state.ma.us a minimum of two 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. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses 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 begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

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.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 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 between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: HealthFirst Family Care Center, Inc. has been serving the Greater Fall River community since 1972. As an FQHC since 2004, we operate in compliance with the Bureau of Primary Health Care's 19 Program Requirements related to required services, staffing, hours of operation, quality improvement, financial management and control, and Board authority and Board composition. Each year we are required to file a Uniform Data System (UDS) Report which captures clinical, financial and demographic information. The data help to identify trends over time and also allow HealthFirst to compare our measures to regional and national data. It is for these reasons that FQHC's remain a low-cost alternative to high-quality, comprehensive care.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      Attached is a summary of our utilization, expenses and revenue for the Calendar Years 2010 through June of 2014. Utilization has pretty much remained stable. We moved into our new state-of-the-art facility in July of 2012 increasing depreciation expense and facility operating costs. In an effort to mitigate the impact of these costs we had to layoff 12 employees and reduce Administrative staff hours indefinitely. We are actively recruiting new provider staff and are considering additional revenue streams from specialty care services for our patients. Additionally, we recently contracted with a company to review our billing and collection processes to ensure that we are maximizing revenue and not leaving any dollars on the table. The results of this review are currently under discussion and could have a significant positive impact on operations.
   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Example: a few months ago we received notification that our request for funding to expand our current care management program to include a Complex Care Management (CCM) component was approved by the Commonwealth of Masschusetts Executive Office of Health and Human Services. The $402,151 in funding allows HealthFirst to hire an RN, Community Health Worker, Social Worker, and supports the recruiting fee and partial salary of a staff physician. CCM is aimed at patients diagnosed with chronic illness that require a higher level of case management. This sub-population of high risk patients have been difficult to engage in care. We have noted that they often do not follow-up with their care regimen and need to be monitored more closely to prevent

hospitalization. In order to engage these patients, we shall provide care management services in their homes.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?
We have successfully secured aWorkforce Training Fund grant award for the period June 16, 2014 through June 15, 2016. In order for us to better meet the demands of a changing market and increased competition from private, for-profit healthcare providers in our area, our training modules include: Management Development, Marketing and Business Development, Effective Communication & Cultural Competency for Patient/Customer Service, and Lean Sigma/Process Improvement for Healthcare. The combined impact will be to improve our efficiency and service allowing us to grow our patient base.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
We record an average 27% No-Show rate. Therefore, it is always important to provide our patients with the most necessary services possible when they do show and are in our grasp. We would truly appreciate it if payers would reimburse us for two or more services on the same day (i.e., primary care visit with a care management vist). This would be in the best interest of our patients.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY: We agree that high-quality, efficient care provides a reimbursement platform that makes sense. However, a fee-for-service model is more practical and predictable and if used in conjuncton with quality-based incentives is more acceptable.
    a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
    Our limited experience with APM's does not provide us with enough information to respond adequately to this question.
    b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
    N/A
    c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
    N/A

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY: HealthFist has recently signed on with NHP's Shared Services Program. Feedback indicates that our risk scores are higher than some similar sites, noting that we do a good job of populating multiple diagnosis codes on claims, better than NHP's network average. However, we have other areas that need improvement.
   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
      It is still too early for us to make an informed decision.
   b. How do the health status risk adjustment measures used by different payers compare?
      It is still too early for us to make an informed decision.
   c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
      It is still too early for us to make an informed decision.

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
   SUMMARY: Internally, we will be implementing an EHR system (EClinicalWorks) by the end of the calendar year. This will obviously improve efficiency and streamline data collection allowing us to respond to our patients' needs on a more timely basis.
   ANSWER: From external souces the provision of real-time data which would allow us to enhance and expand services to our patients would be most beneficial

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?
      It is unclear which attribution methods account for patients we care for.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      We have experienced issues with patients being assigned to different PCP's outside of HealthFirst. For example, if patients don't select their PCP's annually, they often get auto-assigned to another PCP even though they have been established with us for multiple years.

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY: As previously indicated, we are currently without an EHR system, therefore, our manual system of extracting data from patients' charts is obviously time-consuming and draining on staff.
   ANSWER: We plan to implement an EHR by the end of the calendar year.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
   SUMMARY:
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      This questions seems geared towards hospitals/health systems.
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      Our new Complex Care Management Program should help minimize our patients/ use of the ER. In addition, we continually educate patients about appropriate ER usage. Once the number of providers we have stabilizes, and through our Marketing & Development training, we will most likely increase our availability by increasing our hours of operation. Our new facility can accommodate the addition of additional specialty services and an Urgent Care Center.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY:
   a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
      N/A
   b. How does your organization ensure optimal use of post-acute care?
      Once our patient is discharged from the hospital, we receive a discharge summary report. Upon doctor's order, we contact the patient to make a follow up appointment here at HealthFirst.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that

seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY:

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	0	0	0
	Q2	0	0	0
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: To the best of our knowledge, no individuals have requested this information.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: As a community health center, greater than 50% of our patients are members of publicly-sponsored plans
ANSWER: N/A

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 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.
SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
    We do not provide behavioral health care services at HealthFirst. Often we have considered pursuing a mental health license, however, reimbursements are low, and lack of BH specialists in our service area is alarming.
    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

We follow up with our patients after hospital discharge and educate all patients about appropriate ER usage. In addition, we have a new Medical Director starting in December who will provide a new perspective and direction in this area.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
Limited number of BH specialists creates a barrier due to wait times.
d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.
Once we transition from a paper system to an electronic one, we would most likely be willing to participate in data reporting.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: Without an EHR system, we have been unable to pursue the PCMH model.
a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
N/A
b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
N/A
c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
N/A

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY: We respect the mission of the Health Policy Commission and appreciate being invited to sit at the table and provide feedback, as limited as it may be in some instances.
ANSWER: Across the board, community health centers provide high-quality, low-cost services to the underserved of communities.Our experience allows us to be flexible in an ever-changing health care environment. We are guided by our powerful mission. Therefore, it is a bit concerning that the Cost Trends Report to not make reference to CHC's.

Respectfully submitted,

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Gene P. Alves, President
HealthFirst Family Care Center, Inc.