EDWARD M. KENNEDY
Community Health Center

September 23, 2013

David Seltz, Executive Director
The Commonwealth of Massachusetts Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

I am pleased to submit testimony regarding health care costs and cost trends in the Commonwealth and the experiences of Edward M. Kennedy Community Center (EMKCHC). Thank you for this opportunity to provide evidence from the community health center perspective during this time of transformative work on both the delivery side of health care as well as the cost and financing aspect as set forth by new regulation in the Commonwealth of Massachusetts.

Edward M. Kennedy Community Health Center Background:
Edward M. Kennedy Community Health Center has been providing primary care services for over 40 years. Established first in the City of Worcester in public housing, we are now located in several Central Massachusetts towns, including Framingham, Clinton and soon in Milford. We are a federally qualified community health center (FQHC) which provides primary care, oral health care, and mental health care to over 24,000 individual patients annually and employs over 350 staff members. And as a community health center we engage not only individual and families, but we connect with the community as is evidenced by the five school based health center sites, and by the site we operate at Spectrum Health in Worcester in order to deliver the right primary care at the right place, at the right time.

At Edward M. Kennedy Community Health Center we welcome everyone, regardless of their ability to pay. Our family practice primary care model welcomes children, adults, and families in a patient centered medical home setting. We offer a welcoming environment where our providers and staff reflect the diversity of our patient population in language, culture, race, sexual orientation, and physical ability. Many of our clinical staff members are bilingual or trilingual. We provide medical interpreters to meet our patient's needs. Some of our patients arrive as part of the Commonwealth Office of Refugee Resettlement (ORR), making our language and cultural responsiveness one of our most outstanding tools. Our patients speak over 94 languages (Spanish, Portuguese, English and Arabic are the top four), and our staff speak over 30 languages and come from 39 countries. In fact, 73% of

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our staff are at least bilingual, in order to communicate in the best way possible with our patients.

Many of our patients are insured by pubic insurance programs: Medicaid (38%), Medicare (5%) or other public insurances (9%). The uninsured continue to represent 48% of our patient population as community health centers continue to represent the safety net for primary care in our communities.

We participate in the Commonwealth Medicine Patient Centered Medical Homes Initiative as a technical assistance only grantee, which means we receive no additional payment for additional patient navigation, but do receive the technical assistance and participate in learning forums.

One of our primary areas of focus is community-based programming. We work with Family Health Center of Worcester on HRSA/HAB Ryan White grant to care for those with HIV-related illness in the Worcester community and we also share a WIC program. EMKCHC has a contract with Worcester County Corrections for the Corrections to Community (CTC) Program, which connects recently discharged persons with primary care. We support several youth programs, such as the Strong Girls, Healthy Choices, and Get Up and Dance projects. These programs are the basis for our outreach, prevention, and community education presence in the communities we serve.

We work toward growing our own team of professionals in this era of ever declining numbers of students who want to become primary care clinicians. We host a Dental Residency program as a method of growing our own dental clinicians. We participate with Massachusetts College of Pharmacy to train pharmacists on site. We also work with the University of Massachusetts Medical School to train Nurse Practitioners; we have hired ten clinicians from this training program alone and we sponsor medical students who want to learn more about community medicine through various clerkships and rotations. We are grateful for loan repayment and scholar programs because they may be our single biggest recruitment tool in primary care community medicine in the Commonwealth.

It is important to recognize in my response that Community Health Centers (CHCs) do not drive health care costs; we provide a lower-cost alternative to hospital care, emergency room visits, and specialty care. The EMKCHC sites serve city neighborhoods and towns alike in central Massachusetts. We provide access to primary care, oral health, and mental health in a market that has little primary care availability for the uninsured or underinsured. The demand for our services shows no sign of decreasing in the near future, in fact the demand far exceeds the supply, which has driven our strategy to grow additional delivery sites in Central MA when we can find the grant support to expand the reach into other communities in need.

1. *Chapter 224 of the Acts of 2012 (c.224) sets a health care cost growth benchmark for the Commonwealth based on long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.*

a. *What are the actions your organization has undertaken to reduce the total cost of care for your patients*

In our strategic plan three years ago, we acknowledged that as a multi-site Community Health Center, we would need to centralize some of our operational functions and we would need to carve out operational units that were high cost/low return. To that end, we formed a collaboration with UHealth Solutions, a University of Massachusetts Medical School/Commonwealth Medicine entity. This newly formed corporation now answers ALL of our patient calls in a formal call center. As we prepared for health reform, we acknowledged that our on-time answering of the telephone was one of our single biggest challenges given our multi-site operation. We also acknowledged the cost problem to be twofold: the cost of duplicity of service at twelve sites, and the "cost" to our customers when we were not as phone responsive as they needed us to be. We are currently serving as the beta site for other CHCs to evaluate this method. Functionally, when patients call this central telephone number, the work is seamless and they can book appointments, get reminder calls, or receive calls to encourage health management.

Another line function which we carved out was our internal laboratory services. We were losing approximately $350,000 annually in our laboratory services because we did not have the volume to support a full service clinical laboratory that had been created over time. We outsourced to University of Massachusetts Memorial Healthcare at not only a cost savings, but a cost gain as they rented space from us in which they provided the service to our patients. Again, to patients this is seamless because the labs are located in the CHC space. Since then, the University of Massachusetts Memorial sold this venture to QUEST Labs. As such, we will watch the lab expense closely to be certain our patients continue to get the appropriate level of laboratory service.

b. *What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?*

We have expanded our sites for greater market penetration in Central MA to meet an ever growing safety-net need. Our market expansions and our newly enhanced information technology will allow us to improve both quality and efficiency. Our limiting factor continues to be the recruitment and retention of primary care providers. We cannot seem to keep pace with the market growth in wages and benefits, and we cannot offer the kinds of sabbaticals to long-term clinicians that they need to stay fresh in the field. This work is difficult and challenging. As an organization, we continually seek new methods of recruitment and retention.

c. *What systemic or policy changes would encourage to help organizations like yours to operate more efficiently without reducing quality?*

Primary care rates need to be more valued in the system as a whole. If in fact, primary care drives the system, then primary care clinicians' work needs to be reimbursed at rates that cover costs. Until this is driven by policy, this will not happen.

d. *What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses*

Most of our clientele/patients are on publicly assisted programs, so that the quality of care that we deliver and the cost of the care that we deliver have an immediate impact on consumer costs. As stated previously, CHCs are the less expensive primary care alternative to expensive visits at emergency rooms or hospitals. It is our job to keep

people in the community engaged in health care as partners in their care, so that they do not need the higher cost alternatives. We accomplish this in several ways, beginning with our Patient Centered Medical Home model, which utilizes our outreach, enrollment, and education staff, as well as our patient education staff and community health workers.

2. *The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's office found that growth in prices for medical care continues to drive the overall increases in medical spending. What are the actions that your organization has undertaken to address the impact of growth in prices on medical trend or what have been the results of these actions?*

The work of our health center and other health centers across the Commonwealth reflects that we work to contain costs at several levels. We provide health care to populations that are subject to major health disparities; we provide health care to populations that are often turned down for care at private provider offices; and we employ staff that reflect our communities in order to encourage people who live in our communities to enter into care early when a diagnosis is most treatable and less costly. We have been the recipient of several grants that have allowed us to staff a coordinator/patient navigator who's job it is to work with local emergency rooms and hospital discharge planners. In fact, one reason we are expanding in the town of Milford is an ever-growing over-utilization of the emergency room for primary care.

3. *C224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?*

We have several mental health models in our organization. At our Worcester site, we have mental health and social services onsite and work closely to integrate the model. In Framingham, we have continued to work with the three local mental health organizations over the last six years to address complicated site licensing, build organizational relationships, and establish payment methodologies in a manner acceptable to all the organizations and to the Commonwealth. If there is one single obstacle, it is around the payment of mental health services and the ability to bill BOTH mental health provider and primary care clinician services on the SAME DAY. The purpose of integration is to give the patient the most comprehensive visit possible. Policy has not reflected integration delivery or payment needs.

a. *What potential opportunities have you identified in implementing such integration?*
   Working relationships with mental health providers, who are willing to come onsite to integrate primary health care. For our patients, this is a win/win! We have also been working with Spectrum Health (a substance abuse facility) and have established a small CHC satellite site on their grounds to determine if this would be a way to not only integrate substance abuse, mental health, and primary care treatment, but also as a way to engage the patient while they are receiving treatment. We have only begun this work and evaluation is still incomplete.
b. *What challenges have you identified in implementing such integration?*
   The single biggest challenge has been around payment methodologies and to break even financially on the provision of integrated care. Current policy does not support

the payment of integration; as a result, we often provide these services at a loss to our bottom line.

c. *What systemic or policy changes would further promote such integration?*
Because Community Health Centers offer lines of service that promote integration, we have had to become experts in two very different financing worlds. Payment methodologies need to be more uniform in order to streamline health center billing and financial analysis.

4. *C224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.*

a. *Describe your organization's efforts to promote these goals.*
As stated, our primary payors are public payors. We received our data books from the Commonwealth and determined that there were too many discrepancies between the data presented in our data books and our ability to manage the actuarial science needed to be conversant in this new market trend. We chose not to apply to the initial alternative payment model set forth by the state, but rather to focus on some of our high need populations with our other insurers. We participate in some high risk/high manage contracts and are just beginning the work in October to truly look at utilization trends among dual eligibles.

b. *What current factors limit your ability to promote these goals?*
We lack depth in our traditional billing/financial departments to conduct the level of fiscal analysis necessary for managing payment reform. Some of our peers have engaged actuaries in order to accomplish this work. CHCs pride themselves in keeping administrative costs down. Enhancing our bench strength in this area will require significant investment in our finance infrastructure and serve to increase our administrative costs.

c. *What systemic or policy changes would support your ability to promote more efficient and accountable care?*
Based on our strategic vision, EMKCHC staff have spent the last five years developing systems that promote greater efficiencies in care delivery. As we march toward the implementation of ICD-10, we are aware that we must continually improve and reinvent our health systems to accommodate change. Some of our preparation includes the implementation of a new electronic health record (that replaced our ten-year-old electronic health record) to meet meaningful use approval, application to NCQA for our patient centered medical home certification, readiness for the Joint Commission Accreditation renewal, building a new facility in Framingham and establishing a new site in Milford. In addition, we are joining a collaboration with the Massachusetts League of Community Health Centers on the DRVS project to measure and compare our work to that of our peer health centers. All of these projects require resources -- both human potential and financial -- and are necessary to positioning us for the future. But the resources to do this work as a Health Safety Net provider are not readily available. In fact, making our work more difficult is the often 90-180 day lag in Health Safety Net reimbursement, which is primarily the result of that agency's efforts to implement its own new billing system. This has had an impact on our cash flow at a time when we have had to make unprecedented investments in technology and operations to meet systemic change.

5. *What metrics does your organization use to track trends in your organizational operational costs?*

We have implemented many metrics in the organization. A daily "flash report" tracks our visits by provider, site, and cost center. We have restructured our cost centers in the past year to reflect not only each site but every service line, and we track our programs through a patient access committee that looks at market opportunities and market threats. With our quality team, we have developed a monthly organizational report card with the top five or six 'hot issues' that everyone in the organization can work to improve.

a. *What unit(s) of analysis do you use to track cost structure (e.g. at organization, practice, and/or provider level)?*
   With our Board of Directors' Finance Committee, we track and review costs at the organizational level monthly, which we share with our entire leadership team. At the practice level, we review income and expense by site and service line, and we review monthly reports with all leadership and clinical staff. Daily flash reports provide our leadership, team managers, and clinicians with a snap shot comparison of the day before that looks at productivity and service delivery.
b. *How does your organization benchmark its performance on operational cost structure against peer organizations?*
   The Massachusetts League of Community Health Centers prepares a blinded report annually that measures participants against peer organizations. We have used this report to track ourselves against some of our CHC peers. Additionally, when our audit firm presents our annual data to the Board of Directors, they provide us with a peer comparison performance sheet.
c. *How does your organization manage performance on these metrics?*
   Our leadership team currently manages using fee-for-service performance metrics and acknowledges that we need to reshape our paradigm to move toward pay-for-performance, quality, and patient diagnosis outcome measures. Until the payment systems match the delivery system, managing to two differing methodologies is difficult at best, because it often requires two lenses when looking at the same picture.

6. *Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.*

Earlier this year (2013) the organization developed a new sliding fee schedule. This was the first step in the process of developing a new chart of accounts for all of our health care services and procedures. Once completed and approved by our Board of Directors and its Finance Committee, the fee schedule will be made available as required by c.224. Our ultimate goal is to align transparency of price with transparency of quality to better demonstrate patient outcomes. Of note, EMKCHC does not charge a facility fee.

7. *After reviewing the reports issued by the Attorney General (April2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.*

According to the Center for Health Information and Analysis, the majority of MA commercial payments went to higher priced providers. Clearly, this does not include community health centers, especially those such as EMKCHC which are stand-alone and not

affiliated with an academic hospital system. In fact, there was no mention of the community health center primary and preventive health delivery model in the 47 pages of the August 2013 Annual Report on the MA Health Care Market. As is our (EMKCHC) experience, fee-for-service remains the dominant method of payment today. We see global payment and/or enhanced rates offered variably by insurer and typically only for our high utilizing patients.

Based on the Attorney General's report of April 24, 2013, I have three observations:

1. As an employer, our premium growth was kept to a minimum with strong negotiation; but we did have to drop the "choice" of multiple insurers and had to offer one product exclusively to get the best rate. Additionally, we kept our prices low by increasing deductibles to keep health insurance affordable for the employee and organization alike.
2. Risk Arrangements: We are contacted by plans almost weekly asking us to "share" risk under varying models. Just yesterday we were asked to sign a "full risk" contract for a plan in which we have a total population of five (5) enrollees. Clearly, most plans do not meet any industry threshold for EMKCHC to risk share.
3. Again, CHCs have an ever-increasing number of presenting patients that represent significant health disparities in our communities. Maintaining access to care for that population requires significant resources.

On behalf of the Board of Directors and the entire staff of EMKCHC, we thank you this opportunity to provide testimony on health care provider and insurer costs as it relates to our health center marketplace.

Respectfully Submitted By:

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As voted and directed by the Board of Directors of Edward M. Kennedy Community Health Center, Antonia G. McGuire is legally authorized and empowered to represent Edward M. Kennedy Community Health Center for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.