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:
   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.
      ANSWER: The Community Health Center of Franklin County experienced declines in both operating revenue and expenses, primarily due to the difficulty in recruiting both primary care and dental providers even with National and State loan repayment incentives.
   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?
      ANSWER: To reduce expenses, CHCFC hired mid-level providers, including nurse practitioners and limited license dentists. In addition, CHCFC transferred to an electronic medical record (EMR), resulting in a decreased medical records workforce. This electronic medical record system allowed CHCFC to enhance the tracking of patient care, which increased quality of care and decreased Emergency Department ("ED") utilization. These cost savings were offset by decreased producitivity as it takes additional time for providers to use the EMR to enter all the necessary quality indicator information for meaningful use, patient centered medical home and the federal government as required by our federal grant. All of these agencies have different quality indicators, which is very cumbersome, costly and labor intensive to complete.
   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?
      ANSWER: CHCFC joined the MassHIway to enhance data collection. CHCFC was recently awarded grant funds to accomplish the following: become a Level 3 PCMH (currently a Level 2), improve patient care management and triage to further reduce ED utilization. In addition, CHCFC is in process of joining the Pioneer Valley Information Exchange ("PVIX") to enhance patient health care data collection and sharing across the local network of community providers.
   d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
      ANSWER: CHCFC is currently restructuring its call center to ensure appriopriate triage and more timely visits. CHCFC reserves several urgent visits per day to allow for increased triage capacity. CHCFC is utilizing nurses to assist providers

in urgent visits. The purpose of these efforts is to increase quality and continuity of care while decreasing ED utilization.

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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:
   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?
      ANSWER: CHCFC receieves some pay-for performance incentives from various insurers. CHCFC's incentive payments increase year-over-year due to our continuous effort to improve our quality measurement documentation, tracking and reporting. These incentive payments are not accompanied by fee-for-service payments.
   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).
      ANSWER: During the spring of 2013, CHCFC considered the State's alternative payment model and decided not to move forward due to the risk and lower reimbursement. A previous initiative by the State to pay for performance of PCMH achievements was not successful for our peer Community Health Centers.
   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.
      ANSWER: The Community Health Center of Franklin County does not have any patients that are 100% paid for under an APM.

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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:
   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?
      ANSWER: Risk adjustments are a concern as CHCFC has a relatively high volume of sick patients due to our mission to care for everyone regardless of ability to pay. CHCFC tends to see patients that have gone years without care due to lack of health insurance.
   b. How do the health status risk adjustment measures used by different payers compare?

ANSWER: CHCFC has only seen one APM proposal by Medicaid. No other payers have offered this solution to CHCFC.

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?
ANSWER: CHCFC is a small multi-specialty practice; therefore, risk sharing could be beneficial if the pool is performing above expectations. However, CHCFC cannot financially afford to take on this risk knowing there is a possibility of lower reimbursement if the pool is not able to meet goals.

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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:
ANSWER: Real-time data would be most helpful as our patient population is always changing. In 2013 during the RFP process, CHCFC was presented with 2-year old data, which was no longer relevant to our current population.

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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?
   ANSWER: Medicaid and Medicaid Managed Care auto-assign patients to a PCP. Medicare allows patients to self-select. Commercial insurance plans require CHCFC to complete contracting and credentialing before patients can be assigned. For patients without insurance, CHCFC is the only option in the area since we see patients regardless of their ability to pay.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
   ANSWER: CHCFC would like to see Community Health Centers have priority of assignment for Medicaid patients as it our mission to serve the underserved. In addition, we would appreciate enhanced communication when patients are auto-assigned to us as we ran into difficulties with the ACA conversion on 1/1/14 when patients were assigned to us without us having a contract with a Medicaid Managed Care insurer. The MCO refused to pay us for services rendered without a contract. This took nearly five months to resolve. We would also like to see the prohibition on self-referrals enforced to reduce health care costs as the patient's health condition may have been able to be treated by their lower-cost PCP.

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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:
   ANSWER: The impact of the wide-range of quality measures by payers requires an extensive amount of CHCFC's resources, including costs related to employing a quality nurse, time expended by our Chief Information Officer to create templates in our EMR, time spent by providers both during and after patient vists. We experience longer patient visits, which decreases reimbursement since we are still paid on a FFS model. Providers are complaining that the data collection process they have to undertake through use of the EMR is a distraction to patient care. CHCFC would like to see one set of quality indicators become the standard across all payers operating in MA, PCMH organizations and regulatory agencies, including Meaningful Use.

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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.
      ANSWER: CHCFC has limited resources and does not have the capacity to analyize inpatient utilization trends.
   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.
      ANSWER: CHCFC is currently restructuring its call center to ensure appriopriate triage and more timely visits. CHCFC reserves several urgent visits per day to allow for increased triage capacity. In addition, CHCFC is training its nurses on effective care management strategies. The purpose of these efforts is to increase quality of care and decrease ED utilization.

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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.
      ANSWER: CHCFC has limited resources and does not have the capacity to analyize post-acute care trends.
   b. How does your organization ensure optimal use of post-acute care?
      ANSWER: CHCFC has implemented transition to care procedures, which include a nurse calling the patient within 48 hours of receiving a hospital discharge notice.

The nurse will call the patient a third time if contact is not achieved after the first two calls. The nurse will determine if the patient needs a follow up visit with their PCP.

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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			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: CHCFC has not received any requests regarding the price of its services. The community realizes we are the lowest cost provider because we are a Community Health Center.

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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:
ANSWER: CHCFC has not been notified of any tiering by commercial payers.

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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.
   ANSWER:CHCFC intergrated behavioral health into its primary care practices. CHCFC partnered with a behavioral health company to provide services to our patients onsite at CHCFC medical offices.
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.
   ANSWER: CHCFC providers 24/7 on-call services to our patients. Patients can call the clinician on-call as a resource to discuss appropriate triage, which may include calling a crisis hotline or referral to a local hospital ED.
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.
   ANSWER: There is a lack of Psychiatrists, inpatient beds and detox beds in our area. In addition, PCP's are writing behavioral health scripts, but are not paid for basic behavorial health diagnoses such as depression & anxiety even though the PCP is treating the patient.
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.
   ANSWER: State laws do not permit the release of behavioral health information to third parties without additional consents for speficic diagnoses. It is very time consuming for providers to sift through medical records to determine what information can and cannot be shared in order to protect the patient and be in compliance with laws.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY:
    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?
       ANSWER:100% of medical providers.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       ANSWER:100% of medical patients
    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.
       ANSWER: CHCFC is currently recognized as a Level 2 NCQA PCMH at both of our medical sites. Although the procedures we implemented to earn this status have improved patient outcomes, it has been a costly process. We had to employ more nurses to meet care coordination standards. In addition and as mentioned

above, the effort to collect data for PCMH quality indicators results in decreased provider productivity. Medicare, Medicaid and commercial payers are not paying us any incentives for our stature as a PCMH. We are unaware of any impact this may have on our tiering.

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:
    ANSWER: