

Massachusetts Community Health Centers — Get the Facts

Patients

Massachusetts community health centers care for 988,000 patients of all ages and racial and ethnic backgrounds, and represent a major source of care for medically underserved women and children. In 2016, 24% of the state's health center patients were women of child-bearing age (15-44), 23% were children under 18 years of age and 11% were over 65. Forty-four percent were insured through Medicaid, 31% had subsidized and private coverage, another 10% were Medicare beneficiaries and nearly 14% remained uninsured. Forty-two percent were better served in a language other than English.

Value

Health centers' locally-accessible, comprehensive and patient-centered approach helps to keep high-need patients engaged in primary care and less reliant on expensive emergency and hospital care. In addition, Massachusetts health centers support 12,000 jobs across the state, and contribute nearly \$2 billion in statewide economic output every year. What's more, because of the impact they have in reducing emergency room visits, hospital stays and the need for higher-cost specialty care among their patients, health centers help generate close to \$1 billion in annual savings for Massachusetts.

Comprehensive Focus

As early pioneers of the patient-centered care model, health centers remain the most integrated of primary health care providers, offering medical, dental, vision, pharmacy, behavioral health and addiction services to anyone in need — regardless of their health coverage status. Health centers work to eliminate the increased risk of serious illness, chronic disease, and mortality experienced among the state's many ethnic and racial groups by hiring multilingual and multicultural staff at every level of their organizations; deploying outreach workers to help patients navigate our complex health system; and assisting residents in enrolling — and staying enrolled — in critical health care coverage.

Quality

Staffed by board-certified physicians, nurse practitioners, physician assistants, registered nurses, nutritionists, dentists and a range of other of medical and social service providers, community health centers excel at providing preventive care and chronic disease management in lower-cost community settings. Based on recent data from the U.S. Health Resources and Services Administration, Massachusetts health centers continue to exceed national benchmarks on federal measures related to timely prenatal care and healthy birthweights for newborns.



Health Centers Outside of Boston

Baystate Medical Center Health Centers, Springfield
 Brockton Neighborhood Health Center
 Cambridge Health Alliance Health Centers,
 Cambridge, Somerville, Malden and Revere
 Caring Health Center, Springfield
 Charles River Community Health, Waltham
 Community Healthlink
 Community Health Center of Cape Cod,
 Falmouth, Mashpee and Bourne
 Community Health Center of Franklin County,
 Turners Falls, Orange and Greenfield
 Community Health Connections Family Health Centers,
 Fitchburg, Gardner and Leominster
 Community Health Programs, Adams, Great Barrington,
 North Adams, Pittsfield and Lee
 Duffy Health Center, Hyannis
 Edward M. Kennedy Community Health Center,
 Worcester, Framingham, Clinton and Milford
 Family HealthCare Center at SSTAR, Fall River
 Family Health Center of Worcester, Worcester and Southbridge
 Greater Lawrence Family Health Center, Lawrence and Methuen
 Greater New Bedford Community Health Center,
 New Bedford and Wareham
 Harbor Community Health Center,
 Hyannis, Harwich and Plymouth
 HealthFirst Family Care Center, Fall River
 Hilltown Community Health Centers,
 Huntington and Worthington
 Holyoke Health Center, Holyoke and Chicopee
 Island Health Care, Edgartown, Martha's Vineyard
 Lowell Community Health Center
 Lynn Community Health Center
 Manet Community Health Center, Quincy, Hull and Taunton
 MGH Community Health Associates,
 Chelsea and Revere

North Shore Community Health, Peabody, Salem
 and Gloucester
 Outer Cape Health Services, Harwich, Provincetown
 and Wellfleet
 South Cove Community Health Center, Quincy
 Springfield Health Services for the Homeless Health Center

Health Centers in Boston

Boston Health Care for the Homeless Program
 Bowdoin Street Health Center, Dorchester
 Brookside Community Health Center, Jamaica Plain
 Charles River Community Health, Allston-Brighton
 Codman Square Health Center, Dorchester
 Dimock Community Health Center, Roxbury
 DotHouse Health, Dorchester
 East Boston Neighborhood Health Center
 Fenway Community Health Center
 Geiger Gibson Community Health Center, Dorchester
 Greater Roslindale Medical & Dental Center
 Harvard Street Neighborhood Health Center, Dorchester
 Mattapan Community Health Center
 MGH Community Health Associates, Charlestown
 Neponset Health Center, Dorchester
 North End Waterfront Health, North End and Charlestown
 South Boston Community Health Center
 South Cove Community Health Center, Chinatown
 South End Community Health Center
 Southern Jamaica Plain Health Center
 Upham's Corner Health Center, Dorchester
 Whittier Street Health Center, Roxbury

**FY18 Budget Request
DPH Funding for Community Health Centers
(Line 4510-0110)**

Massachusetts League
of Community Health Centers

Background

This Department of Public Health (DPH) Funding for Community Health Centers program, recognized by the Commonwealth since 1981, is an essential part of health center funding, as it provides a flexible source of funding that enables health centers to meet current challenges and locally-based priorities for which other funding is unavailable. Prior to the significant cut to this line in FY10, the funding helped support a wide range of patient care services (e.g., eligibility assistance, patient navigation, violence prevention, paraprofessional support, interpreter services)—often programs and activities that are critical to meeting the needs of our patients. In addition, the line included \$1 million in funding for the Chronic Disease Management program, linked to state and federal Chronic Disease initiatives. This enabled health centers to provide intensive care management for high-risk asthma and diabetes patients, frequently provided by bi-lingual or tri-lingual professional and paraprofessional staff. As a result of the \$6.3 million in cuts to this line and other vital DPH lines, many of these programs have been eliminated or seriously curtailed, and resulted in a loss of savings to the Commonwealth. It is critically important to increase the amount of dollars provided so that a meaningful program can be sustained, or in some cases restored.

The line also includes \$250,000 in critically needed technical assistance funding, used by the Massachusetts League of Community Health Centers for training and education, as well as specific health center technical assistance in the clinical and financial areas. The FY17 budget included \$1,598,773, along with the requested technical assistance, but was reduced to \$1,323,773 after 9C cuts. The Governor's H.1 FY18 budget includes \$692,354, without the technical assistance language. The House Ways and Means budget, which fails to restore any funding to the line, also provides \$692,354, but does include the requested technical assistance language.

FY18 Budget Request

Restore Department of Public Health Funding for Community Health Centers. We ask that the House and Senate budgets include \$2.5 million in funding in line 4510-0110 in order to restore vital programs and services that ultimately save lives and lower cost for the Commonwealth. In addition, we request the Senate Ways and Means budget maintain the Health Center Technical Assistance funding by including the following language:

Provided further that not less than \$250,000 shall be expended on a statewide program of technical assistance to community health centers to be provided by a state primary care association qualified under Section 330(f)(1) of the United States Public Health Service Act at 42 USC 254c(f)(1).

Or, alternatively the final FY17 budget language:

For community health center services; provided, that not less than the amount appropriated in item 4510-0110 of section 2 of chapter 38 of the acts of 2013 shall be expended on a statewide program of technical assistance to community health centers to be provided by a statewide primary care association qualified under Section 330A (f)(1) of the Public Health Service Act, as codified at 42 USC 254c(f)(1).

Advocacy

Contact your State Representative by Thursday, April 13, 2017 and urge them to support the Amendment to include \$2.5 million in line 4510-0110. Then, contact your State Senator and ask them to request this amount in the Senate Ways and Means FY18 budget, to be released in May.

Background

The **Infrastructure and Capacity Building (ICB) Grant Program** historically allowed acute hospitals, critical access hospitals, and community health centers (CHCs) to access funding in order to develop and implement infrastructure and capacity building projects with the stated goal of improving or continuing health care services that benefit the uninsured, underinsured, MassHealth, demonstration, and Safety Net Care Pool (SNCP) populations. With this funding, participating providers were able to better keep pace with the rapidly-evolving healthcare landscape and serve MassHealth members, as well as the state's remaining uninsured, with high quality care. More recently, the **ICB program has become critical to advancing the state's health and payment reform efforts**; funding delivery system integration, team-based models of care, cross-continuum information exchange, as well as readiness initiatives aimed at population management and shifts to Alternative Payment Methodologies (APMs) for the MassHealth population.

This *Infrastructure and Capacity Building* (ICB) funding is **authorized through the MassHealth federal waiver and supports efforts to help transition health care providers into MassHealth Accountable Care Organizations (ACO) payment models**. On October 30, 2014 the Centers for Medicare & Medicaid Services (CMS) approved the Commonwealth's request to extend the Massachusetts' section 1115 demonstration project through June 30, 2019. The approval included \$90 million for the ICB Program with \$30 million available in state fiscal years 15, 16 and 17. The Medicaid Waiver was renegotiated in 2016 and approved in November with no stated funding for ICB. Therefore, without reauthorization of funding in FY18, the ICB grants will be eliminated.

ICB Investments in Community Health Centers Key to Reform

In February 2017, the Baker Administration announced **\$8 million in grant funding to nine healthcare provider organizations, including more than 25 community health centers, which are participating in MassHealth payment reform efforts**. These organizations were identified as taking significant steps in **implementing a new health care model for MassHealth members that should result in integrated, outcome-based care** for the 1.9 million members, including better coordination of both behavioral and physical health care. Lowell Community Health Center received a grant to increase the time clinicians spend with patients who have chronic medical conditions in an effort to reduce the need for hospitalization, while others are expanding their population health analytics and reporting capabilities, improving their ability to identify members who could benefit from more frequent or involved outreach. With the roll-out of ACOs, funding is also being used to build the infrastructure to improve care, considering the complex behavioral health and physical health needs of health center patients.

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Fiscal Year (FY) 2018 Budget

The **Governor's FY18 budget does not include funding for Infrastructure and Capacity Building** in line 4000-0500 or -0700. However, the Committee on **House Ways and Means' proposed FY18 budget includes the following language:**

provided further, that funds may be expended for infrastructure and capacity building grants to promote delivery system reform, achieve federal financial participation and serve populations in need more efficiently and effectively; provided further, that of said funds, funds may be expended for community health centers;

It is unclear whether this language allows for the continued distribution of previously approved funds under the Medicaid Waiver into FY18 or includes additional ICB funding into the next fiscal year. Therefore, it is important that we advocate for continued ICB funding to community health centers, as the payment reform transition continues with some uncertainty around the shift to ACOs and the reliability of federal funds.

Advocacy Request

While the FY18 Budget is being debated in the House, **request your State Representative support the amendment to continue ICB funding in FY18 with an allocation of \$10 million for community health centers.** Also, In advance of the release of the Committee on Senate Ways and Means' FY18 Budget, contact your State Senator and request they communicate their support for ICB funding in the Senate Budget. Tell your legislator that **these targeted investments in community health centers help to mitigate the risks faced during the transition to an accountable care system in Massachusetts while, most importantly, supporting services and initiatives that lead to better access, quality and lower costs.**

Background

The state of our nation's health care delivery system continues to be a pressing issue. In addition to rising costs and waning quality, **shortages exist for a range of medical professionals, including primary care physicians, nurses, dentists, pharmacists and technicians.** Ongoing shortages in the health care workforce present a unique set of challenges for the state's health centers, many of which are treating large numbers of new and recently insured patients while **competing with higher paying hospitals for physicians, nurse practitioners and other health care personnel.**

The rising demand for health center services over the last several years has led to some **new approaches for recruiting and retaining primary care workforce professionals at the community level.** Established in 2007, the **Community Health Center Primary Care Workforce Development and Loan Forgiveness Grant Program is managed by the Massachusetts League of Community Health Centers** (the "Mass League") and was funded by donations from Bank of America, the Commonwealth of Massachusetts, Neighborhood Health Plan, Blue Cross and Blue Shield Foundation of Massachusetts and Partners HealthCare. The program offers school loan repayment to primary care physicians, nurse practitioners (NPs), and physician assistants (PAs) who make a two-year commitment to practice at one of the state's 52 health centers. To date, 187 primary care clinicians have been awarded loan repayment at 50 health center sites, creating capacity for more than 280,500 patients.

The Community Health Center Primary Care Workforce Development and Loan Forgiveness Grant Program was funded in part by a 3-year commitment of \$1.7 million from the Commonwealth of Massachusetts. In FY10, the Legislature funded the program at 850,000, and the Governor reduced the line by 400,000. In October, the Governor then used his 9C authority to eliminate the remaining \$450,000 from the 2010 appropriation. In FY11, the final House and Senate budget included \$500,000 for the loan repayment program, but tied 100% of the funding to the anticipated receipt of Enhanced FMAP funding. Congress failed to pass the enhanced payment to states and Governor Patrick vetoed the line item. The final FY12 budget included \$1 million in the line for four community health center residency programs, but no funding for loan repayment. Unfortunately, the funding was eliminated in subsequent budgets.

The Legislature included some investments in workforce development initiatives at community health centers in Chapter 224. Through the Health Care Workforce Trust Fund, Chapter 224 provides \$2 million over 4 years (through 2017) or \$500,000 per year. The Mass League was contracted by the Commonwealth to distribute these funds through our existing infrastructure. To date, we provided loan repayment to 30 primary care providers (20 physicians, 9 NPs and 1 PA). In FY17, the final year of the contract, we will provide up to 12 additional loans and likely 6 physicians and 5 nurse practitioners.

Although Chapter 224 provided some much needed investments in Primary Care Provider Loan Repayment at Community Health Centers, the capacity of the Massachusetts League of Community Health Centers' program has been severely diminished with the loss of private investments. At the high point of the program in 2009, we were able to provide loan repayment to 36 primary care providers in a 12-month period between July 1, 2008 and June 30, 2009. The awards were made to 27 physicians and 9 nurse practitioners, providing care to an estimated 64,000 patients. Restoration of funds will allow the Mass League to restore the pipeline of primary care providers receiving loan repayment to 2009 levels.

The **recently approved MassHealth 1115 Demonstration Waiver also includes \$114.8 million over five years under DSRIP Funding for statewide investments, including investments in workforce development at community health centers.** The **Waiver provides funding for a loan repayment program** that "repays a portion of a student's loan in exchange for a two year commitment (or equivalent in part-time service) as a (1) primary care provider at a community health center; or (2) behavioral health professional or licensed clinical social worker at a community health center, community mental health center, or an Emergency Service Program (ESP)."

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FY18 Budget Request

We ask that line 4000-0265 be restored in the FY18 Budget with \$500,000 for the State's Investment in the Community Health Center Primary Care Workforce Development and Loan Forgiveness Grant Program. Funding from the MassHealth 1115 Demonstration Waiver can be used to restore the line.

2017-2018 Legislative Request

Senate Bill 608, filed by Sen. Sonia Chang-Diaz, entitled *An Act establishing a primary care loan repayment program at community health centers* has been filed for the 2017-2018 legislative session. The bill reads:

Section 1. Notwithstanding any general or special law to the contrary, there shall be established a Primary Care Workforce Development and Loan Repayment Grant Program at Community Health Centers to enhance recruitment and retention of primary care physicians and other clinicians at community health centers throughout the commonwealth for a period beginning January 1, 2018 and ending December 31, 2021. The grant program shall be administered by the department of public health; provided, that the department may contract with an organization to administer the grant program. The program established under this act shall be a continuation of the program established under Chapter 224 of the Acts of 2012 and M.G.L Chapter 111, Section 25N3/4, and shall seek to continue its successes.

Advocacy

Contact your State Representative by Thursday, April 13, 2017 and urge them to support the Amendment to include \$500,000 in line 4000-0265. Then, **contact your State Senator and ask them to request this amount in the Senate Ways and Means FY18 budget**, to be released in May. In the event that this language is not included in the FY18 budget, urge members to support the legislative proposal and to ensure this language is included in any health care legislation that renews funding under Chapter 224.

Background

Medical residency is a period of formal clinical training provided by accredited programs to physicians who have completed medical school. Accredited residency programs have historically been sponsored by teaching hospitals, although it is common for **a significant portion of training to occur in health centers, which often act as the continuity sites for residents**. In 1994, Greater Lawrence Family Health Center became the nation's first fully accredited community **health center-sponsored** family medicine residency program.

Surveys and research have demonstrated that providers trained in health center settings are **more likely** to end up practicing at a health center or in an underserved area. Medical residents also benefit from the opportunity to train in a **community setting, utilizing a team based model of care**. Simultaneously, adopting a teaching mission improves health centers' ability to **recruit and retain** providers who are attracted to practicing in a setting that also allows them to teach. Residents can also significantly expand health centers' **care delivery capacity**. Despite the clear benefits of taking on this mission, doing so poses significant challenges for health centers as it comes at a **high financial cost** to their organizations.

In 2011, the Affordable Care Act (ACA) acknowledged both the **value of health center-based (and led) residencies** and the challenges health centers faced in accessing Medicare Graduate Medical Education (GME) directly by creating a new Teaching Health Center GME program (THCGME). The THCGME program provided \$230 million over a five-year period to support an increased number of primary care residents and dentists training in health center-led residencies. Results have been promising, demonstrating that almost all **(91%) of THC graduates remain in primary care**. Due to the limited scope and funding available through that program, however, only one Massachusetts health center to date has been able to access THCGME resources. There remains a considerable need to **stabilize and expand** medical residency programs at Massachusetts health centers.

Medicaid GME – A Flexible Tool for Shaping and Growing the Massachusetts Clinical Workforce

Because Medicaid GME is an allowable, federally-“matchable” expense, **many states use Medicaid funding to supplement their states' GME needs**. In addition to creating additional training capacity, Medicaid GME offers states the **flexibility** to tailor and direct resources; for example, states have funded primary care and behavioral residencies preferentially or exclusively, incentivized community-based or rural residencies, or allowed funding for providers such as nurses and dentists in underserved areas. Currently, **42 states support residency programs** with Medicaid Graduate Medical Education (GME) payments, and **Massachusetts is one of only eight states that do not**. Massachusetts previously funded Medicaid GME, but **eliminated these payments in 2008** due to the recession. Prior to 2008, Massachusetts provided **Medicaid GME funding totaling \$44 million**—with half generated by federal matching funds.

Chapter 224 of the Acts of 2012 established a special commission to “examine the economic, social and educational value of graduate medical education in the Commonwealth and to recommend a fair and sustainable model for the future funding of graduate medical education in the Commonwealth.” The **Commission recommended additional funding for GME** tied to performance benchmarks and urged that these benchmarks **include training physicians in community health centers**, following the model of the federal Teaching Health Center Graduate Medical Education Program or programs which **improve the supply of physicians in shortage areas and care for vulnerable populations**.

Health centers are eager to continue and expand their work in training the next generation of clinical providers who will stay and practice in Massachusetts' underserved communities, but **reliable funding is essential**. Restoring **Medicaid GME** offers a unique opportunity to provide this investment.

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Legislative Proposal

Senate Bill (SB) 626, entitled ***“An Act to Promote Graduate Medical Education”*** filed by **Senator Linda Darcena Forry** (co-sponsored by Rep Provost, Sens. DiDomenico and Lewis), calls for the restoration of Medicaid GME for payments for primary care, behavioral health, and other physician shortage professions residency training. Eligible recipients include community health centers and hospitals licensed in the Commonwealth.

Advocacy Request

Here is how you can help to make this the law in Massachusetts. **Contact your state Senator and Representative** and **urge them to support SB626** as a ***vitaly important investment in building tomorrow’s clinical workforce, today***. Ask them to sign on as a co-sponsor and to engage their colleagues in building support for this proposal.

Health Center-Based Nurse Practitioner Residency
A Pioneering Workforce Development Approach for the Care Model

Background

Community health centers are able to deliver on its promise of high-quality, affordable, accessible and culturally competent care only by relying on their most valuable resource: their workforce. High-quality patient care, especially in the underserved areas health centers serve throughout the Commonwealth, demands an integrated, multidisciplinary team, drawing on a range of clinical disciplines and administrative expertise. However, because of a persistent national shortage of clinicians, most health centers currently **struggle to recruit and retain the clinical workforce necessary** to meet patient needs. In addition, health centers face **competition from higher paying hospitals for physicians, nurse practitioners (NPs) and other health care personnel**. However, health centers have historically found innovative ways to address these workforce challenges with the necessary investments in loan repayment and physician residency programs, which have proven to result in greater provider retention. With the **expanding role of NPs** in today's team-based models and the unique training that is required beyond graduation to serve health center patients, **health center-based NP residency is another innovative approach to growing our primary care workforce**.

Setting NPs Up for Success: Post-Graduate Training in a Health Center Setting

In advancing the Commonwealth's goals of providing high quality, low-cost, team-based care, **health centers have been at the forefront of implementing models that emphasize NPs**. However, community health centers are unique, dynamic, and challenging organizations in which to practice. Health centers care for racially, ethnically, and culturally diverse populations who are largely low income and have complex physical and behavioral care needs. Primary care providers in these settings are pushed to high quality and productivity standards, while earning significantly less than their peers who care for higher income, less complex patients.

Health center physicians benefit from a minimum of three post-graduate years of residency in which they receive additional didactics, support, and mentorship before they are required to assume the full caseload of a primary care provider. However, newly graduated NPs, who perform many of the same duties, are not. Because of this, several Massachusetts **health centers have been at the forefront of a national movement to start year-long health center NP residency programs in which NPs work closely with mentors, receive didactics similar to physician residents, and operate with a reduced patient panel**. They have found that these programs act as both recruitment and retention tools, as they attract newly graduated NPs and reduce burnout while these new providers adjust to the complex demands of the health center's population.

Unfortunately, such **programs are currently unfunded**. Only two health centers in Massachusetts have been able to implement them under existing cost structures, and even these are at risk. More health centers have expressed interest in being able to offer NP residency were resources made available. In 2014, the **Department of Public Health created a pilot program for NP residency, but funding for the program was cut under 9C authority before it was able to be implemented**. In the most recent **1115 Medicaid Demonstration Waiver, the Commonwealth asked for and received approval for statewide workforce investments** that direct resources for primary care residency training to "*help offset the costs of community health center residency slots for both community health centers and hospitals*" and workforce development grants to "*support health care workforce development and training to more effectively operate in a new health care system.*" NP residency would support both these goals. Medicaid Graduate Medical Education (GME) also offers a potential sustainable budget path for these programs.

Health Center-Based Nurse Practitioner Residency
A Pioneering Workforce Development Approach for the Care Model

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Legislative Proposal

Senate Bill (SB) 633, entitled “An Act promoting Workforce Development and Provider Retention at Community Health Centers,” filed by Senator John Keenan, establishes a community health center NP residency program to train newly certified NPs who elect to practice in community health centers. The 12-month, post-graduate residency program will be available to community health center certified NPs who have graduated from an accredited nursing school within the past three years. Residents will be provided with patient panels under the supervision and mentorship of a physician or advance practice nurse at a health center. The program will seek to encourage certified NPs to commit to careers in the primary care or family medicine fields at community health centers. The legislation calls for the state to fund the program through the Medicaid Waiver, approved in 2016, and to seek federal Medicaid reimbursement for the program as graduate medical education.

Advocacy Request

Here is how you can help to make this the law in Massachusetts. **Contact your state Senator and Representative and urge them to support SB633 as a *pioneering workforce development approach for the care model of tomorrow*.** Ask them to sign on as a co-sponsor and to engage their colleagues in building support for this proposal.