Boston Children's Hospital
Until every child is well™

September 2, 2016

Ms. Lois Johnson
General Counsel
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Dear Ms. Johnson,

Attached, please find the testimony of Boston Children's Hospital, signed under pains and penalties of perjury, in response to questions provided by the Health Policy Commission and the Office of the Attorney General.

As the President and Chief Executive Officer of Boston Children's Hospital, I am legally authorized and empowered to represent the organization for the purposes of this testimony.

If you have any questions, please contact Joshua Greenberg, Vice President of Government Relations, at (617) 919-3055.

Sincerely,

Sandra L. Fenwick
President and CEO
Boston Children's Hospital

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, 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 (2) weeks prior to the Hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

- **Data:** Inadequacy of current data and analytics support necessary to manage the health of populations in "real time," including inadequate risk adjustment systems to account for pediatric populations and their unique profiles, especially high cost/outlier cases. For example, there are no currently available "universal" systems that enable a practicing clinician to know in real time whether a patient has visited an emergency department or been hospitalized.

- **Drug Costs:** Escalating drug costs (we have experienced increases in excess of 15% in many years). These are not just for expensive/high cost drugs, but also for legacy (including generic) medications that are used to treat pediatric patients. We would be happy to provide you with specific examples.

- **Social Determinants:** Our inability to identify, target, and treat the social determinants that can so frequently impact costs but lie outside our control. In pediatrics, this can include wider issues in the family (like maternal depression or exposure to family violence), as well as societal challenges (like homelessness).

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

- **Medicaid:** Medicaid underpayment significantly constrains the overall ability to meet cost targets. Boston Children's Hospital and its physicians receives one third of its reimbursement from the Medicaid program, and in FY15 shouldered $120m in combined losses on these patients. We routinely experience rate reductions (as opposed to reasonable inflationary increases) from Medicaid, and this year is no exception. This experience should be factored in to the establishment of cost targets for individual institutions and for the overall system.

- **Behavioral Health:** We must assure that patients with behavioral health needs receive the care they require on a timely basis and in a well-coordinated manner. There is a growing body of evidence that patients with co-morbid behavioral health conditions are some of the least well-managed and most costly patients in terms of their medical (i.e. non-behavioral health) needs. It is

our frequent experience that the children we treat with behavioral health concerns experience by far the most bureaucratic hurdles in accessing the care they need. It is neither a good clinical outcome nor a good use of resources to have a child boarded on our medical floor for two weeks awaiting placement in a behavioral health hospital, yet this occurs all too frequently. We should absolutely ensure that mental health parity protections are fully implemented, that we are closely monitoring the performance of payors in delivering behavioral health services, that we have adequate clinical capacity across all levels of care in the state to serve patients, and that we eliminate as many unnecessary bureaucratic barriers as possible to accessing necessary care. The state and its regulatory agencies must play a lead role in establishing and implementing these services.

- **Health Care Innovation:** The state should recognize that many of its health care statutes and regulations are woefully outdated, and not well suited to evolving health care delivery approaches. For example, we are well behind most of the country in enabling the use of telemedicine services, such as remote patient monitoring, store and forward, virtual visits and mobile health. Payors (including Medicaid) should define clear pathways for utilization approval of its use and adequate reimbursement. Requirements for credentialing providers should be streamlined, including eliminating the requirement that individual hospitals need to separately credential providers offering "remote" services. In this regard, we applaud the Health Policy Commission (HPC) for funding its behavioral health telemedicine pilot but believe there are some basic enabling changes that must occur. Similarly, the state should recognize that intermediate levels of care are frequently important mechanisms for improving patient flow within an inpatient facility and should assess, as part of its Determination of Need (DON) regulatory review, whether existing licensure statutes and regulations enable hospitals to flex beds and/or services at times of highest need.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: Boston Children's Hospital and its patients may be uniquely situated in the Massachusetts health care system. Many drugs are not tested on children (for example, many generic drugs used to treat rare conditions on an off-label basis do not undergo pediatric trials); others are used to treat rare/orphan conditions with few choices in medication. We are fairly rigorous in our development of institutional formularies and protocols, but do emphasize clinical safety and efficacy (e.g. oversight of high risk medications) as the most important criteria (as opposed to cost). We have been aggressive around generic substitution where possible throughout our primary care network, and have begun the process of looking at and using biosimilar substitutes in pediatrics.

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

- **Enhance behavioral health capacity in primary care**

The Pediatric Physicians' Organization at Children's Hospital (PPOC) Behavioral Health Integration Program (BHIP) is a system-wide approach to transforming the delivery of pediatric primary care to include fully-integrated behavioral health services as a core competency. Currently, 60 pediatric primary care practices across the Commonwealth participate in this program, which embeds on-site clinicians (typically LICSWs) to enable timely, co-located delivery of behavioral health services. The program aims to improve a myriad of clinical, quality, and cost outcomes, and has developed substantial enabling infrastructure to support these "distributed" clinicians such as the following:

- Providing access to a rapid-response consultation service to connect primary care providers with child psychiatrists at Boston Children's Hospital (averaging 12 hours of service/month)
- Conducting two major pilot projects to integrate specialized substance abuse services and telepsychiatry services in primary care
- Providing 35+ hours/year of Continuing Medical Education/Continuing Education (CME/CE)-accredited programming focused on integrated care to providers and staff employed by participating practices
- Providing direct operational and clinical consulting to practices as they fully-integrate behavioral health providers into the medical home (approximately 5 hours/month/practice)
- Conducting twice-monthly grand rounds, focused on behavioral health integration, via web-video conferencing. The consulting team includes representatives from the departments/divisions of psychiatry, psychology, social work, and developmental medicine
- Conducting rigorous evaluation to refine and improve the program and enhance engagement

- **Provide integrated care in acute medical/surgical settings and for patients with complex needs**

Boston Children's Hospital provides behavioral health care across all medical/surgical settings. Social work, psychology, and psychiatry clinicians are integrated into specialty care programs which target specific disorders including pain disorders, neurodevelopmental disorders, solid organ transplants, epilepsy, brain disorders, deafness/hearing loss, and pediatric cancers. These collaborations involve longitudinal care across both inpatient and outpatient settings, and focus on early identification and treatment of mental health co-morbidities in order to prevent the need for high-cost services.

- **Improve the availability of intermediate care offerings available to our patients**

Boston Children's Hospital recently opened a 12 bed residential Community Based Accute Treatment (CBAT) unit on our Waltham campus to enable step-down and diversionary settings for children requiring out-of-home treatment but not an inpatient level of care. We have begun the planning process for a partial hospitalization program to supplement these efforts for children that can sleep at home, but need intensive treatment. We have also been working with the state Department of Mental Health, through the Children's Mental Health Campaign, to develop additional residential/inpatient resources for children with co-morbid behavioral and developmental diagnoses (e.g. autism spectrum disorders).

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

- **Lack of reimbursement for behavioral health activities**

Providing family-centered, two generational, integrated care across the hospital requires that Boston Children's Hospital employ a range of behavioral health providers including psychiatrists, psychologists, social workers, child life specialists, and resource specialists/case managers. A majority of these services, considered by many on the care team to be the "glue" that optimizes care and minimizes higher cost activities, are not reimbursed and cannot be captured by a Current Procedural Terminology (CPT) code. It is likely that these sorts of collateral contacts are particularly important to children.

- **Inconsistent or contradictory coverage and reimbursement patterns among payors**

Behavioral health coverage is inconsistent and payor-driven, leading to discrepancies in access among patients with the same needs. They can be exacerbated by the use of carve out companies, whose incentives may run counter to the primary insurer. These discrepancies lead to confusion among other members of the care team, higher administrative expenses, and fragmented care.

- **Insufficient resources for highly complex patients requiring behavioral health specialty care**

Throughout Massachusetts, there is insufficient specialty behavioral health care, leading to delays in accessing care for patients requiring it, which may in turn lead to acute crises and more costly interventions. Patients who require specialized care include those children and adolescents with autism, intellectual delays or disabilities, medical co-occurring disorders, and co-occurring substance use disorders. The inability to access appropriate and timely community based care results in potentially avoidable Emergency Department (ED) visits and patients boarding in the ED and on medical/surgical units for prolonged periods. Notably, over the first six months of 2016, 526 pediatric patients at Boston Children's Hospital spent 1,450 overnights in

inappropriate settings (e.g. the ED or medical beds) due to lack of available community behavioral health resources. The lack of development of specialty care seems to be limited by inadequate reimbursement rates.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Universal iterative screening: For many patients and families, social determinants of health impact patient health outcomes and care efficiency. Active monitoring is crucial for patients and families with emerging risk, who might appear medically stable but for whom social instability could escalate health issues. Children's Hospital Integrated Care Organization (CHICO) has systematically incorporated into its care management portfolio a process to screen, stratify, and address social risks in patients. This process features a three-level questioning process that assesses social, economic, and familial challenges and evaluates the family's level of need for additional supports. Results of the screening are captured in the Electronic Medical Record (EMR) system and incorporated as a component of patient records.

In-depth assessment of high risk patients: Select patients are referred to the CHICO Regional Care Management Team (RCMT) through the iterative process of screening and assessment. The RCMT consists of nurse care managers, social workers, and community health workers who assess patient needs, including social risk factors. Staff engage with patients in in-home visits and comprehensive assessments. They typically uncover various social and medical needs, such as housing insecurity, food insecurity, language barriers, complex psycho-social challenges, transportation, and scheduling/coordination for multiple care services. Staff use this information to provide rapid consultations, collaborate with providers, generate targeted referrals, and deliver gap and transitional care to families (see below).

Targeted care management programs

The care management that follows the identification of social risk takes place on parallel tracks, with care management for many children occurring in the context of the patient-centered medical home and others receiving more intensive support through home-based services.

Medical home care coordination: All primary care practices affiliated with CHICO have a designated medical home care coordinator (MHCC). The MHCC works with the pediatric and behavioral health clinicians, specialists, and the family to coordinate care while improving quality and patient experience. Typical MHCC tasks focus on improving access to care, facilitating communication between the provider and the patient; tracking clinical follow-up; connecting families with community resources; and supporting patient and family education and advocacy.

CHICO regional care management team (RCMT) program: As described previously, the RCMT delivers home and community-centered, culturally-competent care that is intensive and integrated with the care continuum. The RCMT is well-versed in the available community-based resources and can connect families to services such as the medical-legal partnership (MLP). The RCMT is also beginning to accept children via referral from across

the Boston Children's Hospital enterprise, so any Boston Children's Hospital practitioner can engage the RCMT if a child has complex medical or social circumstances that merit comprehensive care management.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

Limited system-wide data collection: There are currently no systematic methods in place to collect data on social determinants of health, placing the burden of data collection on individual clinicians or care managers at the point of care. This approach represents a missed opportunity to standardize data collection and gather population-level data about the factors affecting patients' health, which would help inform market-wide advancement of strategies and tools to tackle these issues. Implementing standardized data collection at the point of application for health insurance—via MassHealth as well as commercial plans—might augment providers' current efforts to identify and address community-level trends among patients and improve policymakers' ability to develop policy solutions to issues affecting health on a large scale.

Complexity and sensitivity of social determinants of health: Patients may be hesitant to share information related to social determinants of health, because of lack of information about the connection to health, stigma, or mistrust or fear of institutions (consider, for example, potential concern about abuse and neglect reporting requirements). The breadth of factors that can affect health and the sensitivity of these factors pose challenges to providers and care managers, who must build trusting relationships with patients and families to learn what influences their health outcomes. This process can take time and be especially complex for vulnerable families. Additional resources to improve information collection and educate patients about the role of social determinants of health could potentially reduce this barrier over time.

Conversely, some patients and families may eagerly welcome support from care managers or other providers, but may not be able to marshal the time or resources to engage in a way that maximizes the effectiveness of care management. The care manager must then activate and empower the family to participate in their care and care management, requiring significant additional time and input from the care team. Market-level initiatives could be useful both in making complex care management sustainable for provider organizations and community-based care managers and in creating an environment that better supports families in need of medical and social services.

Workforce issues: Providing care management for children and families with medical and social complexity is a challenging task requiring multi-faceted skill sets. Currently, Boston Children's Hospital must provide training for in-house staff who perform care management for patients with complex medical or social conditions, as there is a shortage of training and certification standards for this type of professional. This lack of standardized training creates a host of challenges in the employee life cycle, from recruiting, to staff development, to retention. These challenges are further exacerbated by the sometimes specialized skills required to work with children and families.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

The Pediatric Physicians' Organization at Children's Hospital (PPOC) encourages its affiliated practices to refer patients to the specialist or facility that best serves that patient's needs, taking into account clinical factors, cost and convenience. It recognizes that, in many cases, the best referral for the patient is a community or independent provider and encourages its practices to retain these local relationships for appropriate care. As a result, many PPOC practices have relatively high rates of referrals to facilities and providers outside of the Boston Children's Hospital system, with over 70% of specialist visits occurring outside of the Boston Children's Hospital system in 2015.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

The PPOC does not currently have a single shared Electronic Medical Record (EMR) system deployed across the organization, although it does host an eClinicalWorks installation on behalf of a subset of practices. It is currently implementing a single, shared Epic platform for all practices, and expects that project to be completed in early 2018.

In addition, the PPOC is currently unaware of a technically feasible way to incorporate this information into an EMR at the point of referral. If it were to identify a feasible technical solution, the PPOC would consider incorporating cost and quality information in the future, taking into account the relative cost and benefits of doing so.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If no, why not?

Please see response to 5(b)(ii).

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?

Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

The PPOC practices currently maintain laboratory and radiology interfaces with 18 unaffiliated commercial and community hospital trading partners, in addition to Boston Children's Hospital. The PPOC has always supported practice requests to interface with community partners where it was feasible to do so, taking into account cost and resource availability for both the PPOC and trading partner.

The PPOC anticipates that its practices, once live on the Epic platform, will have significantly enhanced connectivity with unaffiliated specialists and hospitals through Epic's interoperability tools.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Through the Children's Hospital Integrated Care Organization (CHICO), Boston Children's Hospital, the Boston Children's Physician's Organization (PO) and the PPOC have undertaken significant work to begin contracting on the basis of alternative payment methodologies (APMs). In 2016, CHICO is responsible for care management for approximately 64,000 children in both commercial and Medicaid plans. Several strategies will allow the enterprise to expand its adoption of APMs:

Scalable infrastructure: In developing care management and quality improvement capacity, CHICO has launched intervention programs with attention to scalability as the population covered through APMs grows. This includes creating standard operating procedures, leveraging technology to automate workflows, and implementing team-based care coordination models.

Development of APM-agnostic value-based care models: The transition from fee-for-service to value-based care has impact far beyond financial management; it requires changes to day-to-day operations at all levels. For the past several years, Boston Children's Hospital has promoted initiatives that apply accountable care principles to all patients (regardless of whether we are currently contracted under an APM), often in the context of chronic disease management. This has pushed the system towards more rigorous management of cost and value.

Internal alignment and shared governance: Across the enterprise, Boston Children's Hospital is increasingly aligned on the strategic value of success with APMs. Leadership in Boston Children's Hospital, the PO, and the PPOC routinely convene with the executive team of CHICO to ensure that all parts of the organization are informed of accountable care work and have input into our overall approach and oversight of our ongoing performance in both quality and Total Medical Expenses (TME). CHICO routinely taps into expertise and resources across the enterprise for clinical, operational and technological guidance.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Lack of market emphasis on pediatric patients: The major APM models have not been developed with pediatric patients as a focus. For example, much market evolution has been driven by Medicare initiatives that do not apply and are unavailable to children. At the same time, the broader health care market lacks essential resources to serve the pediatric population, particularly in the areas of behavioral health capacity, post-acute capacity, and school-based medical care resources. We have extensively commented on these issues and the challenges they pose in previous cost trends hearing responses to the HPC/AGO.

Lack of credible risk adjustment methodologies: Risk adjustment is the underpinning of a market that includes adoption of APMs; a credible, viable risk adjustment methodology is crucial to the function of the market. While risk adjustment methodologies continue to evolve, there is presently not a model in common

use by payors that works well when applied to the pediatric population broadly, and any weaknesses in the methodology are magnified when applied to the complex pediatric population. Given that Boston Children's Hospital cares for a patient population that disproportionately includes children with complex health and social needs, it faces a significant disadvantage in the move toward APMs. Boston Children's Hospital urges the state to continue working to develop appropriate risk adjustment methodologies to meet the needs of the pediatric population and the providers that serve these children.

c. Are behavioral health services included in your APM contracts with payers?

Yes . Behavioral health services are included in Boston Children's Hospital's arrangement with Blue Cross Blue Shield of Massachusetts (BCBSMA) under the Alternative Quality Contract (AQC). In the arrangement with Neighborhood Health Plan (NHP), behavioral health is carved out. However, CHICO's behavioral health integration efforts are payor-agnostic, so all children enrolled in an accountable care arrangement are treated in the same way. That said, we have limited control or insight into the care delivered by behavioral health clinicians on a referral basis/outside our own system.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

State and payer quality measure priorities have historically been and continue to be predominantly adult focused, which leaves pediatrics in a vulnerable position (see, for example, the Center for Health Information and Analysis's (CHIA) recent report in which very few measures are applicable to Boston Children's Hospital). Measure definitions and criteria, e.g. age ranges and stratifications, are often inappropriate for pediatric populations. While the market has made some progress, it remains an issue that quality metrics are not only misaligned across contracts, they are often poor metrics that add limited value to the pediatric sphere and are costly to administer. In addition, payors do not require adult systems with substantial pediatric programs to report quality outcomes at a similar level of detail, making in-state benchmarking more difficult. The following examples present significant challenges:

- Childhood vaccination measures – parents may opt to deny administration of vaccines, contra-indicators prevent administration of vaccines, flu shots in particular may be administered in other settings – for these reasons it is challenging to capture data and the state-wide immunization registry is unreliable.
- Chlamydia screening is a blanket measure that is not appropriate in all instances; it can be clinically appropriate for some young women to be prescribed contraceptives without being sexually active and screening for the sake of meeting a measure is not added value to the patient or provider.

Boston Children's Hospital submits data for three MassHealth quality measures: Care Coordination Measure (CCM), the tobacco treatment measure (TOB), and the Emergency Department stay time measure (ED). The entire process from data collection, to chart review, through electronic submission is time consuming and burdensome to administer, requiring significant allocation of resources among multiple hospital based departments. For example, the Boston Children's Hospital population eligible

for the TOB measure is small compared to the amount of work required to gather and submit data, and in our estimate this limits the return on the resources invested in the measure. Furthermore, the majority of MassHealth measures are adult focused and as a result Boston Children's Hospital is not eligible to earn the Medicaid quality dollars allotted to those metrics. Boston Children's Hospital serves a large proportion of MassHealth members and should be appropriately measured and incentivized for the care delivered to our pediatric population.

Starting in 2012, Boston Children's Hospital and CHICO have made a concerted effort to align our contracted quality portfolios across the major commercial payers in Massachusetts. Our quality portfolios consist of pediatric specific process, outcome, and patient experience measures spanning: (1) primary care, (2) specialty care, and (3) hospital-based care. While there is still variation among the primary care healthcare effectiveness data and information set (HEDIS) measures in our portfolios, there is now nearly 100% alignment among the contracted specialty care and hospital-based measures.

Boston Children's Hospital participates in national pediatric quality projects and registries, and CHICO leverages this participation and the associated measure reporting activities. However, participation in these projects and registries is not without additional burden and resources, including data coordinators and analysts, required on the back end. There is a particular burden on the measure owners related to relevance, e.g. agreeing upon the measures, if it is not a National Quality Foundation (NQF) endorsed or HEDIS measure; this impedes developing the measure and implementing a plan to collect, report on, and improve performance. It is important to have benchmarks amongst comparative pediatric peers. All too often, the payers are not familiar with pediatric measures, tending to try to align with adult populations measures instead. It is particularly difficult to find outcome measures for the Boston Children's Hospital population as patients are complex and many of those seen at Boston Children's Hospital are not seen in other Boston area hospitals. To this end, Boston Children's Hospital has heavily invested in registries - recurring entrance fees, annual maintenance fees, clinician time, and supportive staff. For example, the Cystic Fibrosis (CF) registry requires a single full-time employee to manually submit data, validate for accuracy, and ensure that data is updated on a continuous basis. Lastly, the information is not easily obtained from information systems.

Overall the alignment across commercial payer portfolios has significantly streamlined both the internal data collection and external reporting processes for CHICO; one individual in CHICO is responsible for collecting data from the specialty and hospital measure owners and subsequently compiling the annual and semi-annual quality report deliverables. However, despite the successes made to date, Boston Children's Hospital and CHICO are constantly reiterating to payers the importance of pediatric specific quality measures. It is of little to no value to measure this data against adult metrics, which still remain the priority of the state and the major payers.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

There are opportunities for a collaborative effort that convenes payers and providers market-wide to develop and continuously define an endorsed set of metrics that add the most evidence-based value to a given population. Insurance contracts should focus on selecting measures within the endorsed measure set. The market should consciously align quality measurement with broader movement towards accountable care and system integration.

CHICO's quality portfolios are designed to support and reflect quality improvement priorities across the Children's enterprise. We strive for portfolios that are pediatric specific and balanced across primary care, specialty care, and hospital-based metrics. Our current portfolios range from 18 to 26 measures and are weighted slightly higher towards primary care: 55% primary care measures vs. 45% specialty and hospital measures combined (percentages include respective patient experience measures). CHICO's quality contracts are all based on calendar year measurement periods, which has eased the reporting burden by aligning reporting due dates across payers.

It is important that CHICO's quality contract reporting requirements to the payers are aligned with internal priorities. In the past, it has been challenging when state or payer priorities were predominantly adult focused and not relevant to pediatric populations.

From the perspective of individual primary practices, we do have concerns about the impact of contractual metrics on practices:

1. There are increasing practice-based labor costs to manage data, run registries, and engage patients in the care needed for their children

2. HEDIS metrics for chronic disease management are becoming more problematic due to the growing percentage of families with high cost deductible plans
    a. 19% of commercially insured patients in Massachusetts in 2015
    b. Families are refusing in-person visits / follow-up due to costs

3. In the HEDIS metric for chlamydia screening, we have a measure that drives up total medical expense by requiring screening of patents who are on contraceptives for medical issues like acne, dysmenorrhea, and hirsutism, even when not sexually active

4. When care is delivered outside of the medical home, it can be difficult or impossible for practices to receive results of care needed to deliver that high quality care measured by metrics
    a. Vaccination is a prime example
    b. The absence of a fully functional Massachusetts vaccine registry makes vaccination measures particularly difficult for practices

5. Labor costs and fees to support practices in contract measure performance improvement continue to grow
    a. Networks fund annual (previously bi-annual) Massachusetts health Quality Partners Patient Experience Survey (MHQP PES)
    b. Analytics staffing has increased by more than 50% in the last two years
    c. Performance thresholds rise without clear evidence that higher thresholds are medically appropriate and cost effective

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers,

regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
38T

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
   38T

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

   - 224/Estimate Request is a service that is readily available to patients, where they may utilize the option of requesting self-pay estimate/pricing for health care services. They can access this tool through Boston Children's Hospital's website or by calling Customer Service where they can verbally request an estimate and have a customer service representative submit an online request for them. The online request is submitted to an internal distribution list via email to the finance coordinator, who then is responsible for :
     - obtaining pricing for the services,
     - creating the estimate,
     - documenting the estimate request information in the patient's chart by creating a customer relationship management (CRM),
     - and finally relaying the requested estimate information back to the requestor.

   - Families have an option of how they would like to be contacted and told about the estimate, whether it be by phone, email, through the provider's office, etc.

   - We also have partnered with Blue Cross and Tufts to share information if the family should make contact with them regarding services at Boston Children's Hospital.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

- Boston Children's Hospital monitors the accuracy of the estimate through guarantor feedback post service. Any issue that may arise would be logged into a hospital tracking system for complaints.
- To date, we have had no such feedback.
- All requests have to be responded to within a 24hr period. Most times estimate requests are completed within a couple of hours (unless there is a complication with obtaining the requested info)

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

Having families know the complete array of services needed is challenging for price accuracy. If questionable, Boston Children's Hospital may contact the family for further clarification or contact information for their care provider.

Boston Children's Hospital
Exhibit C: AGO Questions for Written Testimony - Question #1
FY15 (based on Strata) - All Other Clinical & Non-Clinical combined

	FY2012	FY2013	FY2014	FY2015
(A) Commercial Business:				
Operating Margin - Financials	22.2%	24.4%	27.5%	25.4%
% Total Expenses	42.3%	40.7%	38.4%	38.0%
(B) Government Business:				
Operating Margin - Financials	-40.6%	-41.9%	-41.6%	-44.8%
% Total Expenses	21.0%	21.5%	22.0%	22.8%
(C) All Other Business:				
Operating Margin - Financials	-9.9%	-6.5%	-7.8%	-8.7%
% Total Expenses	36.6%	37.8%	39.6%	39.2%
Total Business:				
Operating Margin - Financials	3.4%	5.3%	5.0%	2.6%
% Total Expenses	100.0%	100.0%	100.0%	100.0%

(A) Commercial includes all other payers not listed in (B) and (C) below.
(B) Government includes BMC, HSN, MA Medicaid, Medicaid Out of State, Medicare, MBHP, Network Health, and NHP.
(C) All other includes International, and Self Pay, research, and other operating.
Individual components of each subtotal may have either positive or negative margins.
*Includes one time expenses

Boston Children's Hospital
Exhibit C: AGO Questions for Written Testimony - Question #1
FY15 (based on Strata) - All Other Clinical & Non-Clinical broken out

	FY2012	FY2013	FY2014	FY2015
(A) Commercial Business:				
Operating Margin	22.2%	24.4%	27.5%	25.4%
% Total Expenses	42.3%	40.7%	38.4%	38.0%
(B) Government Business:				
Operating Margin	-40.6%	-41.9%	-41.6%	-44.8%
% Total Expenses	21.0%	21.5%	22.0%	22.8%
(C) All Other Clinical Business:				
Operating Margin	9.4%	-7.2%	10.0%	11.6%
% Total Expenses	2.5%	3.3%	3.6%	4.3%
(D) All Other Non-Clinical Business:				
Operating Margin - Financials	-11.7%	-6.5%	-10.0%	-11.9%
% Total Expenses	34.1%	34.5%	36.0%	34.9%
Total Business:				
Operating Margin - Financials	3.4%	5.3%	5.0%	2.6%
% Total Expenses	100.0%	100.0%	100.0%	100.0%

(A) Commercial includes all other payers not listed in (B) and (C) below.
(B) Government includes BMC, HSN, MA Medicaid, Medicaid Out of State, Medicare, MBHP, Network Health, and NHP.
(C) All other clinical includes International, and Self Pay.
(D) All other non clinical includes research, other operating, etc.

*Includes one time expenses

		FY2012	FY2013	FY2014	FY2015	
AFS	Operating Revenue	1,281,808,000	1,331,483,000	1,399,260,000	1,420,871,000	
AFS	Total Expenses	1,238,429,000	1,260,335,000	1,329,785,000	1,383,220,000	
AFS	Gain (loss) from operations	43,379,000	71,148,000	69,475,000	37,651,000	
AFS	**Operating Margin**	**3.38%**	**5.34%**	**4.97%**	**2.65%**	
	Less: Contribution Revenue	(7,154,000)	(9,972,000)	(12,409,000)	(9,009,000)	
CHIA	Operating Revenue	1,274,654,000	1,321,511,000	1,386,851,000	1,411,862,000	
CHIA	Total Expenses	1,238,429,000	1,260,335,000	1,329,785,000	1,383,220,000	
CHIA	Operating Surplus	36,225,000	61,176,000	57,066,000	28,642,000	Numerator
CHIA	Non-Operating Surplus	22,191,000	96,516,000	(5,883,000)	(34,107,000)	
CHIA	Total Revenue	1,296,845,000	1,418,027,000	1,380,968,000	1,377,755,000	Denominator
CHIA	**Operating Margin**	**2.79%**	**4.31%**	**4.13%**	**2.08%**	
CHIA	**Non-Operating Margin**	**1.71%**	**6.81%**	**-0.43%**	**-2.48%**	
CHIA	**Total Margin**	**4.50%**	**11.12%**	**3.71%**	**-0.40%**	