MASSACHUSETTS
HEALTH POLICY COMMISSION

2021 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2021 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, November 5, 2021**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed 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 pre-filed testimony responses from 2013 to 2019, if applicable. If a question is not applicable to your organization, please indicate that 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.

You are receiving questions from both the HPC and the Attorney General's Office (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO Contact Information

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

HPC QUESTIONS

1. UNDERSTANDING THE IMPACT OF COVID-19:

Please briefly describe how you believe the COVID-19 pandemic has impacted each of the following:

a. Your organization, including but not limited to the impact on your providers and other staff, and any impacts on your ability to recruit and retain staff:

Boston Children's Hospital and the COVID-19 Pandemic

The wide-ranging impacts of COVID-19 continue to place tremendous strain on the state's entire health care system, as the entire way of doing business and caring for our patients and families changed virtually overnight. Boston Children's is unique in that we strive to be a community hospital for local children, the academic pediatric specialty hospital for the New England region and a quaternary care provider for the most complex pediatric patients nationally. This role has attracted children from across the Commonwealth, the region and the nation that need access a variety of different services at Boston Children's Hospital. At the height of the pandemic, and now coming out of the pandemic the patient needs have weighed heavily toward behavioral health, delayed seasonal viruses leading to ED visits, and extremely complex medical procedures and surgeries that cannot be provided elsewhere. In addition to these needs the payor mix continued to shift more toward the Medicaid population.

This dynamic has and continues to strain the pediatric capacity locally, regionally and nationally. According to a study published by the Journal of the American Academic of Pediatrics, definitive pediatric hospital care is less available than adult care and is increasingly dependent on referral centers[*]. This should be accounted for in public health plans, disaster preparedness, and determinations of network adequacy. Coverage does not translate into access to care for children unless the state and federal governments play active roles in evaluating capacity, network adequacy and ensuring adequate rates of payment for services.

Impacts on Staff Retention and Recruitment

Our dedicated health care professionals have been asked to undertake a tremendous amount of responsibility, grief, workload, and the challenges can at times seem insurmountable. Our leadership is doing all we can to uphold to the health and well-being of our team while prioritizing the safety and quality of the care we deliver to patients and families.

[*] http://pediatrics.aappublications.org/content/141/1/e20171940

While we are doing our best to offer supports and respite to our dedicated employees, the current volume of patients has strained our staff and systems and is not sustainable. We all have been working extremely hard to care for each patient who comes to Boston Children's. We've seen that the volume of patients has been growing substantially and is straining our staff and our systems. While our COVID inpatient numbers have remained steady and low, the increase in volume is driven by three key factors: a sharp increase in behavioral health patients, coupled with slightly higher levels of seasonal illness and trauma than before COVID, and an increased demand for urgent and elective care that may have been delayed at the height of the pandemic.

These challenges are not exclusive to Boston Children's. From the evening news to our hometown papers, we see persistent coverage of extremely busy and stressed emergency departments, inpatient beds, intensive care units, and unprecedented volume of patients with behavioral health needs.

While staff are strained at all levels of the organization, one of the most challenging areas has been staffing our behavioral health workforce. The difficulty of working in a COVID environment has made it all the more challenging to attract and retain providers, especially those who are knowledgeable in treating some of the most acute and complex behavioral health cases in the state. For example, it can take up to a year to hire child psychiatrists or to staff our inpatient units, and we are competing with other hospitals and the private pay market to recruit and retain a limited pool of experts and clinical staff. Investments in workforce should include strategies to attract individuals from diverse backgrounds and strategies to retain and support the workforce that we do have, including psychiatrists, psychologists, psychiatric nurses, social workers trained in behavioral health, ABA specialists, night nurses, and sitters. Focusing strategies on increased payment for providers, loan-forgiveness expansion, and enhanced training and educational opportunities, provides a comprehensive approach to a longstanding problem.

Financial Impacts of the Pandemic

Pediatric hospitals have been differently impacted by the COVID-19 pandemic due to the patient profile of kids during the pandemic, a shift in payer mix from private insurance to Medicaid, and the early failure of the federal government to provide financial assistance to pediatric health care providers at the start of the crisis. As an initial statement, in the early days of the pandemic, the combination of state requirements to cancel elective procedures, the decline in outpatient care, limitations on national and international travel, and the need to implement reduced capacity protocols (eg single bedded environments where possible), etc. led to significant operational losses. This has been well documented in recent CHIA and MHA reports; of note, Boston Children's was one of the most impacted hospitals in the state in terms of operating margin.

At the same time, we have witnessed a payor mix shift to Medicaid. Serving **all** patients, including those children covered by the Medicaid program is critical to Boston Children's Hospital's mission and values. Boston Children's Hospital Medicaid patient mix is one of the highest in the state only behind Cambridge Health Alliance, Boston Medical Center

and Steward Carney Hospital. This is driven by the number of children that rely on Medicaid for primary and secondary health coverage nationally. Children's hospitals are major safety net institutions, providing more than half of their inpatient care for children covered by Medicaid[†]. As some of the highest Medicaid hospitals in the nation, children's hospitals serve the most economically challenged and diverse communities and are still awaiting additional provider relief funding (PRF) to remediate their losses and stabilize their finances[‡].

On average, Medicaid reimburses children's hospitals only 80% of the cost of care provided — even including all supplemental payments[§]. Boston Children's Hospital experienced losses of over $250M across the enterprise in fiscal year 2019. Although there is room for improvement, continued investment in Medicaid is critical to children's health and our nation's future. The Executive Office of Health and Human Services (EOHHS) has continued to make investments in the Medicaid payments through the pandemic including medical and behavioral supplemental payments, advanced payments and rate increases for certain respiratory conditions. Boston Children's Hospital with the Massachusetts Health and Hospital Association (MHA) is working with EOHHS to develop an 1115 Waiver extension that supports the hospital community through investments in health equity, clinical quality outcomes and rate enhancements for safety net providers including those serving the pediatric population. The ability to come closer to covering costs in the Medicaid program will minimize the cross subsidization that is currently needed to sustain the business.

Lastly, early federal provider relief efforts, which focused on distribution to Medicare providers, almost entirely missed pediatric providers and children's hospitals. While some of this has been corrected more recently, Boston Children's still has not received support from the third phase of provider relief funding that many other hospitals in the state received months ago.

Going forward, as the only freestanding pediatric acute care hospital in the state, we have been especially impacted by all three trends above. Currently, we are being impacted by the overwhelming behavioral health crisis more fully described below. As a point of reference, Boston Children's Hospital makes up 31% of total pediatric bed availability in Massachusetts which is almost three times more than any other academic medical center providing pediatric services. When you factor in the community hospitals that Boston Children's Hospital staffs it is closer to 40% of total bed availability. On some days, we have 50-60 children boarded in our medical-surgical beds awaiting psychiatric placement. This is important because over the last several weeks Boston Children's Hospital has had to issue capacity alerts and delay elective medical procedures as a result.

[†] https://www.childrenshospitals.org/issues-and-advocacy/medicaid/fact-sheets/2014/medicaid-dsh-payments-are-critical-to-childrens-hospitals

[‡] https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/General/surge/president_biden_pediatric_capacity_challenges_letter_082621.pdf?la=en&hash=EF45AD4A04C476CD2FDCF190598B19B898AD49AE

[§] https://www.childrenshospitals.org/Issues-and-Advocacy/Medicaid/Fact-Sheets/2020/Medicaid-101-Fact-Sheet

This data and experience is evidence that the pediatric system of care needs to be enhanced in order to meet supply and demand needs of health care for children.

b. Your patients, including but not limited to the direct health effects of COVID-19 as well as indirect health effects, such as the effects of deferred or cancelled care, exacerbation of behavioral health and substance use conditions, and effects from economic disruption and social distancing (e.g., evictions, food security):

Pandemic-Era Care at Boston Children's Hospital

COVID-19 radically altered how we think about care at Boston Children's Hospital. During the forced closure of deferred care, non-essential hospital services, our staff did the best they could to maintain services for our most chronic, complex kids who could not afford to wait for care. Children who are rapidly growing and changing cannot afford to have deferred services in most cases and there was an ongoing need for our staff to maintain services via virtual visits or at our satellite facilities, where we were able to spread out and divert care from our main campus, where acuity has increased on the fronts of behavioral health.

As the sole Emergency Department in the state dedicated to children, we are the front door for acute behavioral health emergencies that have been exacerbated by the conditions of children isolated at home for lengths of time and the statewide lack of beds for children with psychiatric conditions and co-occurring disorders. Our main campus is triaging children from the ED into inpatient beds that we had not intended for behavioral health patients. Even before the pandemic, we were hearing from our patients and families that they were seeking options closer to home, and we are now shifting less acute patients back to communities closer to home to receive care.

Prior to the pandemic, we saw a greater need for care at our satellite facilities. Now our patients and families are asking for options to stay out of our busy main campus. Our pre-pandemic plan to better utilize our existing satellite facilities is now more needed than before, and we have officially filed a Determination of Need with the state's Department of Public Health to better serve children throughout the state, to enhance the coordination of care and health outcomes, and to minimize patient and family stress. As a party of record to this filing, the HPC will be reviewing the full application and its supporting information.

In addition to providing ambulatory and outpatient services at our satellite offices, patients were able to continue making primary care visits through our Pediatric Physicians' Organization (PPOC) practices in more than 90 locations throughout Massachusetts, collectively caring for more than 350,000 children. Our integrated primary care network struggled in the early part of the pandemic. Shortages of personal protective equipment were even worse in primary care and patient volume put them in significant financial peril.

Telemedicine and paycheck protection programs enabled our primary care practices to survive financially and provided necessary access to the clinicians especially, for behavioral health care needs, which have continued to have significant remote utilization. Our primary care practices provide over 40K integrated behavioral health visits each year and have been able to sustain this during the pandemic. In addition, through dedicated adjustments with regard to space and staffing they were able to follow and immunize young children at rates comparable to pre-COVID benchmarks. Currently, between COVID and return to school they are now overwhelmed by volume and many have fewer office staff than prior to the pandemic. Demand and utilization is higher than at the peak severe flu season of 2019. The PPOC has added in wellness resources for their clinicians and staff.

Telehealth, in particular video visits, have been a key component to continue care for our patients and ensure continuity. At the peak of the pandemic, 80-90% of total visit volume was completed virtually which has stabilized to 20-30% over the last six months. In order to properly sustain the needs of offering video visits and other telehealth and digital health offerings, we have doubled the size of the team as well as created a centralized support team to help both patient and provider needs, questions and assistance. Virtual visits have been an alternative option when medically appropriate for patients to be able to access care, resulting in fewer deferred or cancelled visits during the pandemic.

Children's Behavioral Health and Substance Use Disorder Treatment

Children have been in a behavioral health pandemic long before the COVID-19 pandemic, which has exacerbated the need. Prior to COVID, the data demonstrated that one in five children experience a psychiatric disorder within a given year and one-half of psychiatric disorders begin by age 14. However, less than one-half of children with psychiatric disorders receive treatment, and for those receiving treatment, 10 years is the average delay between symptom onset and treatment.

We are seeing a significant rise in demand for pediatric behavioral health care and the behavioral health care system is not equipped to meet the demand due to inadequate capacity and longstanding workforce shortages across the continuum of care. These shortages expressly derive from insufficient reimbursement rates for behavioral health services.

In this context, acute care has become the default safety net, leading to increased rates of psychiatric boarding among children in emergency departments and in medical/surgical units. Children's hospitals nationwide are seeing rising encounters of suicidal ideation and suicide attempts. In the four years leading up to the COVID-19 pandemic, Boston Children's experienced a 61% increase in psychiatric boarding. Currently, between 50-60 children are boarding in our emergency department or on a medical/surgical unit awaiting psychiatric care. Needless to say, the current crisis is causing significant strain on children, their families and the health care workforce.

In order to address this influx of children in our emergency department, we have been utilizing approximately 40 of our general inpatient med/surg beds to move patients out of the ED and hired 50 new staffers to support these cases. We have also been able to add 12 new inpatient psychiatric beds at our Waltham Facility due to flexibilities in the determination of need process during COVID to allow us to quickly address this growing population.

Also thanks to COVID flexibilities, no show rates in select clinics have also decreased when patients have an option to complete through telehealth. At BCH, we have seen increased participation among adolescents in group substance use disorder treatment; for the first time, we have seen 100-percent attendance in these critically important group sessions. Due to the greater telehealth access, there have been lower "no-show" rates for patients who require frequent visits as part of their complex care plan. BCH will continue to utilize telehealth for behavioral health and substance use treatment in the longer-term future even after the pandemic, given the rapid adoption of telehealth and the dramatic impact it has had on children.

Family Homelessness and Food Insecurity

At Boston Children's Hospital, approximately 40-percent of our Massachusetts patients are clients of MassHealth and many were in tenuous housing situations prior to the start of the pandemic. We have seen an alarming number of families coming to our emergency room doors and clinic offices in situations where they have nowhere safe to stay for the night. The majority of these children are younger than kindergarten age, with over 350 infants seen in our emergency department for homelessness, as young as two days old.

These visits had been steadily rising since a 2012 Department of Housing and Community Development regulation requiring families to spend a night in a place "not meant for human habitation" prior to being eligible for the emergency assistance shelter system. In the two and half years before this policy we saw 15 children in our emergency department for homelessness, and even before the pandemic we frequently saw that many children in 2.5 weeks. And while we experienced a drop off in visits for homelessness early on in the pandemic, which mirrored our drop in medical visits as well, these visits have surged in 2021, including 48 visits in September 2021 alone. The vast majority of these children have no medical complaints and are only seeking shelter, receiving no medical services while in our emergency department. Additionally, nearly 90% of these visits are paid for by MassHealth or other state-based insurance programs and cost significantly more than the cost of a night in emergency assistance shelter.

Families arriving in our emergency department due to homelessness are waiting several hours to meet with caseworkers as our overburdened emergency staff triages patients in medical crisis as well as children experiencing acute mental health crises. This comes as we are heading into another cold and flu season on top of potential COVID-19 cases in

our crowded emergency room, compounding the threat of spreading multiple respiratory illnesses in a small space.

At Boston Children's Hospital, we also concerned with the increasing number of families who are reporting hunger and seeking food assistance in our clinics, primary care offices, and emergency department. Children who are hungry are at greater risk for developmental delays, may struggle to concentrate in school, and may experience poorer overall health outcomes. Due to our screening protocols for social and health needs at our clinic, we know that food insecurity continues to be a prevalent issue among our patients. Boston Children's Hospital has partnered with the Boston Housing Authority to create a community food pantry. The pantry will be open to both BCH patients and residents and is currently being constructed in a large public housing development. This unique partnership will provide low to no barrier access to healthy food, nutritious tips, and recipes to families. We also will continue to follow pre-existing protocols to refer families to supports and to our community partners, which provide invaluable resources to our patient families.

c. The health care system as a whole, including but not limited to how you think the health care system will change going forward, and any policies or innovations undertaken during the pandemic that you hope will continue (e.g., telehealth policies, licensure and scope of practice changes):

The impacts that COVID-19 has imposed on our children and health care system will be significant and long-lasting. The Governor and the Executive Office of Health and Human Services executed a number of emergency rules and regulations that have been invaluable to Boston Children's Hospital during the COVID-19 pandemic. The key policies in place that have helped to ensure appropriate care delivery to our patients includes, but is not limited to, the following:

- Equal reimbursement across payers for in-person and virtual visits during the pandemic and with certain parity extensions from the legislature and MassHealth.
- Consistent and predictable requirements for documentation, coding/modifiers and scope of practice standards (e.g., eligible originating sites and provider types)
- Relaxed licensing waivers for interstate telehealth
- Expedited licensure for health care workers coming into the state

Telehealth

A significant change that enabled Boston Children's to maintain world class care during the pandemic came through telehealth flexibilities and reimbursement parity. Telehealth has been a critical tool in our kit over the past year and a half in providing care to kids in their homes. When the Governor's executive orders closed all in-person, non-essential hospital services, our telehealth team stepped up to switch all clinically appropriate care to be completed virtually while guiding patients through the new telehealth landscape.

Since March, BCH has increased its telehealth visits from 1-percent of all outpatient visits to 85-percent during the height of COVID. In the recent months, outpatient visits continue to be between 10- and 95-percent virtual depending on the specialty while maintaining high patient and practitioner satisfaction ratings. Virtual care will be a foundational to way Boston Children's continue to see care. In a recent survey to all departments, predicted to continue offering at 20-30% if reimbursement continues at the rates authorized during the pandemic.

Infrastructure improvements and telehealth protocols have been put to place to ensure consistency in care from virtual to in-person as well as between specialties. Key guidelines that have contributed to successful telehealth implementation include:

- Patient consent protocols and communications about telehealth visits
- Uniform coding and documentation requirements across payers
- HIPAA compliant technology used across programs and patient types throughout the health care system
- Flexibility in available technology types to best meet the need of the organization

Through the use of telehealth, we have seen increased appointment compliance, especially for adolescents/teens and patients, families, and providers have expressed positive experiences using telehealth. Telehealth allows for more convenient follow-up visits, including to review developmental progress, provide strategies for positive behavior reinforcement, counsel children and parents in distress, and adjust prescribed medication.

Telehealth utilization has kept patients from missing school and learning time, resulting in better education outcomes; decreased caretaker burden for parents who would have had to take time off work; reduced time travelling long distances, saving resources on transportation; eased appointment compliance for patients with mobility challenges, including due to the difficulties associated with transporting cumbersome medical equipment; and has kept medically fragile children out of high-traffic areas, where they may be exposed to contagious infection.

Continued expanded telehealth policies must provide flexibilities for patients whose only access to telehealth is through audio-only technology and accommodate the varying platforms that patients may have access to and be supported in a variety of languages and be culturally sensitive.

Behavioral Health

As noted above, the unmet behavioral health needs of children in Massachusetts is largely related to the behavioral health labor pool. It takes significant resources for an individual to acquire the education and training necessary to become a mental health professional, especially one with pediatric focus. We are heartened the Governor and his health and human services administration's focus on outlining a behavioral health roadmap to lay the groundwork forward for mental and behavioral health. We also applaud the

legislature's efforts to include behavioral health funding for employee training and loan repayment programs in the federal spending debate. The state should continue working with stakeholders to enact a comprehensive behavioral and mental health plan to address the gaps in services that have been identified by the state.

Expedited Licensure and Paperwork

The state took several emergency steps to make sure that hospitals were able to fulfill staffing needs and to maintain the appropriate number and types of beds during the pandemic. We have immensely benefited from the expedited time during the pandemic for doctors and nurses to have their licenses process by the respective professional boards upon graduation or when moving from out of state. We also greatly appreciated the flexibility of the determination of need bed review process in quickly opening additional behavioral health beds at our Waltham facility in response to growing needs. Continued flexibilities in licensure approval for both professional licenses and bed licenses would be greatly beneficial to staffing and patient needs even beyond the pandemic.

Health Care Systems Redesign

As we come out of the immediate crisis and move into long-term planning for life with COVID, we must continue to press forward with caring for the most vulnerable children in our state. We applaud the state's continued efforts toward health care redesign to better serve kids through the MassHealth program and Medicaid waiver. We are greatly appreciative of the work being done to address health needs and social determinants of health through the acute hospital Requests for Application (RFA) and look forward to continued work with the Baker administration on this matter.

2. EFFORTS TO COLLECT DATA TO ADVANCE HEALTH EQUITY:

Comprehensive data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity is foundational to advancing health equity in the Commonwealth. Please describe your current efforts to collect these data on your patients. Please also describe specific barriers your organization faces in collecting such data and what policy changes or support has your organization identified as necessary to overcome such barriers.

.

Boston Children's Hospital attempts to collect patient/parent-reported race, ethnicity and language on all patients at the time of scheduling, registration, check in and through the MyChildren's portal. REaL data are collected via several electronic, confidential, self-service options in English and Spanish: 1. Pre check-in via MyChildren's Portal before coming to visit, 2. Self check-in via Kiosk upon arriving to hospital, and 3. Self check-in option via iPad upon arriving to clinic (launching November 2021). If unable to collect electronically or if patient prefers, front desk staff collect REaL data during in-person check-in using scripting and support materials. In addition, REaL data can be added or changed at any time through the MyChildren's Portal.

We do not regularly collect disability status or sexual orientation/gender identity. With respect to disability status, we do collect extensive information on chronic and congenital medical conditions experienced by our patients, analyze that information in multiple ways, and plan for care delivery and access requirements accordingly. With respect to gender identity issues, our medical records capture this information and we use various mechanisms to collect. We would note that there are some very complicated practical and ethical issues involved in collecting this information from children and adolescents when parents or other caregivers may have access to information that the child may therefore not wish to disclose. We would be happy to sit down with HPC staff to more fully describe.

Barriers to collecting REaL data include staff hesitation to collecting and parent reluctance to provide this information. To address this, we expanded our use of electronic, self-service data capture and implemented training of front desk staff to provide them with skills and tools for collecting this sensitive information. We have also provided patients and families with more explanation about why we collect this data and its importance to ensuring we provide high quality, equitable care.

Lastly, we would point out specific barriers around coleection of data related to child mental health needs across the delivery system. While we know the number of children psychiatrically boarding at our own institution, the fact remains that accurate, comprehensive, and publicly available data on the number of children boarding across the Commonwealth, paired with information on which acute psychiatric beds are in operation in real-time does not exist. Without this information, it is impossible to fully understand the scope of the problem, assess needs overtime, and adequately allocate resources to address the need. Moreover, without this information, stakeholders cannot effectively address the racial and socio-economic disparities that exist in the acute behavioral health care setting. The state should invest in publicly available dashboard in order to cut down on the human resource spent engaging in bed search and also to enable evidenced-based planning to address the escalating need, particularly for the most underserved populations.

AGO QUESTION

Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request. In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2019	**Q1**	239	138
	Q2	235	197
	Q3	245	136
	Q4	154	153
CY2020	**Q1**	409	26
	Q2	231	
	Q3	385	
	Q4	387	
CY2021	**Q1**	323	
	Q2	398	1
	TOTAL:	3006	651

Note: telephone and in-person inquiries dropped off significantly in a timeframe that corresponds to the onset of the Covid crisis and accompanying travel restrictions. The majority of telephone inquiries have historically been for international patients who would have been affected by limitations on international travel.