Boston Children's Hospital
Until every child is well™

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

To: Executive Office of Health and Human Services, the Health Policy Commission, the Division of Insurance and the Center for Health Information and Analysis
Attn: Amy Bianco
From: Josh Greenberg, Vice President of Government Relations, Boston Children's Hospital
Candace Reddy, Senior Director of Payor Relations, Boston Children's Hospital
Dr. Richard Bachur, President of Boston Children's Hospitals Physician's Organization, Chief of Emergency Medicine
Date: June 30, 2021
RE: Boston Children's Hospital response to Out of Network Rate Rates Study – Section 71 of Chapter 260 of the Acts of 2021

Boston Children's Hospital (Boston Children's) and its Physicians Organization (PO) support the state and federal laws that were put in place to protect patients from surprise billing. We appreciate the opportunity to respond to the study on Out of Network default commercial rates being conducted by the Executive Office of Health and Human Services (EOHHS), the Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA) and the Division of Insurance (DOI). Boston Children's and the PO oppose setting the default rates for non-contracted or non-participating providers at a percent of Medicare rates.

1. Background on Boston Children's Hospital and the Physician's Organization.

   As the only freestanding acute care children's hospital in Massachusetts, Boston Children's and its physicians treat a patient population that includes the sickest pediatric patients in the Commonwealth. We maintain services for children unavailable even at other Academic Medical Centers and receive transfers from them and numerous community hospitals. Using case mix index (CMI) greater than 3.5 as one standard for high level of inpatient medical complexity, Boston Children's handles 75 percent of highly complex pediatric inpatient cases in Massachusetts. As a result, we seek to be in network and maintain contracts with all major Massachusetts payors.

   Boston Children's is also the major safety net provider for children covered by Medicaid/CHIP, and heavily cross-subsidizes the losses incurred as a result. Nearly 40 percent of our Massachusetts patients are publicly insured. Last year, Boston Children's and the PO lost over $250 million providing care for these children. Similar to our overall patient population, our MassHealth patients include many children with critical or complex medical needs. In the MassHealth ACO context, the risk scores for patients in the Boston Children's ACO identified in the RCII (disabled) child rating category are 25 percent higher than the average for the RCII child population program-wide. Unlike our adult system counterparts, we see only a very small percentage (1-1.5%) of Medicare patients (many of these specially covered for End-Stage Renal Disease).

   Lastly, Boston Children's treats many children (about 30% of our payor mix) who reside in other states or other countries. These patients typically travel for the unique care offered by the hospital and its physicians. They tend to be complex patients, requiring expensive procedures and medical care, and can require lengthy stays and extensive resources. Much of this care is arranged and paid for under specific agreements with other governments (if international), through national payor referral networks, or under single case agreements.

2. The establishment of artificially low default rates will incent payors to have inadequate networks for children.

   Regulators must balance the need to protect consumers from surprise bills with the need to protect consumers from inadequate provider networks. In doing so, they should seek to avoid creating financial incentives for payors to exclude key safety net providers from networks. Because many adult providers do not care for and are not trained to care for children, regulators must also specifically ensure that pediatric networks are sufficient for children and adolescents.

Pediatric specialty care has become highly regionalized and pediatric capacity in Massachusetts and nationally has declined steadily over the last several years. Pediatric inpatient units decreased by 19.1% from 1753 in 2008 (38.2% of all open hospitals) to 1418 (32.1%) in 2018, a decline of 34.2 units per year. Pediatric inpatient unit beds decreased by 11.8%, from 31,171 in 2008 to 27,496 in 2018, a decrease of 407 beds per year[1].This must be considered when health plans develop their health benefit plan networks.
While Massachusetts does have network adequacy requirements set by the DOI, they are only applied to fully insured products and a majority of the commercial health insurance market is self-insured. Setting an artificially low default commercial rate will encourage plans to limit their networks while pediatric capacity is already limited and Boston Children's and the PO are the only providers that can deliver many of these specialized services.

3. Regulators should explicitly exclude out of state and international patients that are not covered by Massachusetts insurance products from the application of these regulations.

   As noted, Boston Children's and its physicians treat a very large number of patients that do not reside in Massachusetts. These patients frequently have complex and unique care needs. It is not uncommon for these patients to need to be transferred on an urgent or emergent basis, and for the hospital and its clinicians to have to negotiate an agreement with the patient's payor. In other cases, care is arranged via a national network (e.g. currently our contract with Blue Cross Blue Shield Massachusetts covers Blue Cross Blue Shield patients from other states.)

   Application of this surprise billing framework to out-of-state patients would highly incentivize national and international payors to NOT negotiate appropriate rates, and would result in increased cross-subsidization of this care by Massachusetts residents and employers. Out of state patients should also be excluded from noticing requirements that are to be determined by the Department of Public Health through regulatory guidance. The notion that a provider would be able to keep up with thousands of national health benefit plans would be extremely confusing and not a cost effective use of provider administrative resources. This will result in higher administrative costs for providers adding to the overall costs of health care services. Massachusetts regulators should expressly exclude out of state and international residents from application of this law (recognizing in addition that DOI likely does not have authority to regulate plans licensed in other states).

4. Benchmarking to Medicare is inappropriate for freestanding children's hospitals and their pediatric providers.

   The implementation of a commercial out of network default rate at 135% of Medicare should not be applied to pediatric specialty care. Medicare rates are a poor proxy to cover costs for pediatric specialty care. The Medicare program is designed to serve an elderly population, whose health care needs differ significantly from the pediatric population. When the Medicare prospective payment system (PPS) was introduced in 1983, children's hospitals were excluded from immediate participation in the system. The exclusion of children's hospitals was primarily because of concerns that the diagnosis-related group (DRG) case-mix system and the payment weights used in PPS did not adequately reflect pediatric hospital utilization and that PPS might adversely affect children's hospitals if adopted without modification[2].

   As a result, most state Medicaid programs have adopted a more appropriate DRG case-mix system for reimbursing all hospitals including pediatric providers. In addition, many Medicaid programs have enhanced rates for freestanding pediatric hospitals and/or substantial supplemental funding for these provider types. Massachusetts is somewhat of an outlier in that they do not have specific rates for freestanding pediatric hospitals or supplemental payments but they do make adjustments to base rates for highly complex pediatric care.

[1] https://pediatrics.aappublications.org/content/early/2021/06/21/peds.2020-041723
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192890/

5. Benchmarking to existing contracted rates of payment by the same payor is the most appropriate and easily implemented standard;

   The proposed out of network default rate, if implemented, would have a significant negative effect on the ability of Boston Children's to provide care to some of its most critically ill and complex patients. While we are contracted with most commercial and Medicaid health plans in Massachusetts the hospital and the PO are not in every product that these health plans offer. The commercial health plan does have set contracted rates with Boston Children's Hospital and the PO for many products and those rates should be applicable when the hospital and the PO are non-participating in certain circumstances. This would simplify the process and make that rate applicable in situations in which patient comes emergently or if the patient is referred to Boston Children's Hospital and the PO for complex care that cannot be provided elsewhere.

6. The state should consider deferring to the federal surprise billing law which allows payors and providers to negotiate rates for services provided and an independent dispute resolution (IDR), if an agreement can't be reached

   In situations in which Boston Children's and the PO are not contracted it is recommended that the state align with the federal government's process. The federal surprise billing law allows the payor and provider to negotiate rates for services provided and an independent dispute resolution (IDR), if an agreement can't be reached. The IDR process takes into consideration a number of factors including: median in-network rates, provider training and quality of outcomes, market share of parties, patient acuity or complexity of services, teaching status, case mix, and scope of services of the facility, demonstrations of previous good faith efforts to negotiate in-network rates and the contract history between the two parties over the previous four years. This federal process takes into consideration the unique situation of each provider and plan. Setting a standard out of network rate at a percent of Medicare is a one size fits all approach that does not work for the unique health care needs of children in the Commonwealth.

Thank you for your consideration on this matter.