September 27, 2013

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

The following written testimony is submitted in response to the questions posed in your letters dated August 26, 2013 and August 28, 2013. I am the legally authorized representative to submit this testimony on behalf of Boston Children's Hospital and am signing under pains and penalties of perjury.

Should you have further questions, please contact Joshua Greenberg, Vice President, Government Relations at 617-919-3063 or Joshua.greenberg@childrens.harvard.edu.

Signed,

Sandra L. Fenwick
President and Chief Executive Officer

Introduction: Child Health and the Structure of the Pediatric Delivery System in Massachusetts

Summary: This section provides an overview of child health needs, the structure of the pediatric delivery system in Massachusetts, and some of the broad policy issues that arise from the differences inherent in delivering pediatric care versus adult/elder care.

There are an estimated 1.6 million children in Massachusetts, representing approximately 24% of all residents. They have health care needs that differ substantially from those of adults and elders. Children are developmentally changing at a rapid pace from infancy through their adolescence. Fundamental developmental processes from physical growth to brain development occur in rapid succession, and are often inter-related.

Most children depend upon adults to make health care decisions for them. Younger children have limited language skills and are frequently unable to describe symptoms or health status comprehensively.[1] They also suffer from different kinds of diseases or have different medical needs. For example, adult providers focus on diseases/procedures (knee replacement, hip replacement, bariatric surgery, myocardial infarction) or conditions (Type 1 diabetes[2], congestive heart failure, chronic obstructive pulmonary disease, hypertension, coronary artery disease) that rarely occur in children. In contrast, pediatricians and pediatric subspecialists routinely correct congenital conditions like structural heart defects, identify and begin to treat chronic conditions like cystic fibrosis, seizure disorders and depression, and address a range of developmental concerns like attention deficit hyperactivity disorder (ADHD). As a result, it can be difficult at times to reduce variability in care delivery processes due to the heterogeneous nature of the medical conditions affecting children.

Child health services are not the major cost-driver in the delivery system. Child health accounts for approximately 13% of health spending nationally. Hospital services are about 37% of total child health spending, equivalent to 5% of national health spending.[3] At the same time, there are compelling reasons to invest in child health. At birth, children account for the total amount of future lifetime health spending. Many chronic

[1] At Boston Children's Hospital, 37% of our patients are age 5 or under. In Massachusetts hospitals, about 2.9% of non-newborn admissions are age 5 or under.

[2] The vast majority of diabetes care provided to children is for Type 1 (congenital) diabetes resulting from defects in insulin production. The RAND data includes Type 2 diabetes resulting from obesity. While a growing problem in children, Type 2 diabetes accounts for a very small fraction of care provided to children.

[3] Hartman, et al, U.S. Health Spending by Age, Selected Years Through 2004, Health Affairs – Web Exclusive, DOI 10.1377/hlthaff.27.1.wl

conditions associated with higher health costs and poorer health outcomes are identifiable in childhood, including obesity and mental health disorders. The opportunity to alter the trajectory of lifetime health spending (or more accurately to produce additional years of healthy life) begins in childhood when small changes can lead to compounded impacts.[4]

While children are generally healthy, they require special services when sick. Children are, on average, twice as sick as adults when hospitalized as measured by casemix intensity. Because of their health status and general physiologic vulnerability, they require more careful monitoring and nursing care, specialized equipment, and different safety protocols. On average, hospitalized children use 31-45% more nursing care than adults.[5] At Boston Children's Hospital (Children's), our patients range from 1 pound premature infants to 300 pound obese adolescents. We must stock multiple sizes of equipment and specially formulate and monitor medication doses to treat this range of patients. A medication error that might make an adult feel dizzy can kill an infant.

Children also use a different set of medical providers than adults. Overall, the pediatric delivery system is much more concentrated and regionalized for a number of reasons. First, pediatric subspecialty providers are relatively rare. Many pediatric specialists must complete several additional years of training beyond residency in order to meet subspecialty certification requirements. In addition, the need to aggregate different types of subspecialists and services (for example pediatric anesthesiologists and intensive care specialists to support pediatric surgeons) results in more concentrated delivery systems. The technology, supplies and support systems (like pharmacy) required to safely care for sick children are not widely available throughout the health care system.

The discussion and reports to date have all pointed to the lack of primary care capacity as a primary rationale for payment reform in Massachusetts. In fact, there are generally speaking a sufficient number of primary care pediatricians both in Massachusetts and nationally.[6] The 2011 report on access from the Division of Healthcare Finance and Policy/Center for Health Information and Analytics routinely find that 97% of children have a usual source of care, 94% had seen a physician in the past year, and 89% had a preventive care visit during the same period.[7] These are not figures that reflect significant

[4] For a good discussion including the significant links between childhood socio-economic status and adult health conditions, see "Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New framework for Health Promotion and Disease Prevention", Jack Shonkoff, W. Thomas Boyce, and Bruce McEwen, JAMA v. 301, No.21, June 3, 2009.

[5] The lower figure is for all children; the higher figure is for children under the age of 2 years. "Children's Health Care Needs Are Different: Why One Size Won't Fit All", National Association of Children's Hospitals, Alexandria, VA (1993).

[6] "The General Pediatrician: Projecting Future Workforce Supply and Requirements", Shipman, Lurie and Goodman. Pediatrics 2004, v113, pps 435-442.

[7] "Access to Health Care in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey", Sharon K. Long, Allison Cook, and Karen Stockley, Urban Institute (March 2009).

access barriers for primary care services for children. In contrast, there is a significant undersupply of subspecialists in a growing number of pediatric subspecialties both in Massachusetts and nationally.[8]

In Massachusetts, only 50% of all hospitals maintain any pediatric beds, and the vast majority of these are concentrated in academic settings. In the decade between 1997 and 2007, 40% of all Massachusetts hospitals closed completely or reduced the number of pediatric beds at their facilities.[9] In some cases, beds remain open because physicians from the academic centers staff them. For example, Boston Children's Hospital currently staffs pediatric units (inpatient or NICU) in 7 community hospitals throughout the Commonwealth.[10] As a result, approximately 1/3 of all beds and 42% of all pediatric discharges in the state are delivered by Children's or its physicians.

The system is even more concentrated for complex pediatric care. There are only 6 hospitals in Massachusetts that maintain any pediatric ICU beds. Over 60% of all pediatric intensive care unit[11] beds are at Boston Children's Hospital or staffed by Children's physicians. Boston Children's Hospital discharges over 90% of the sickest children, as defined by having a casemix intensity of 5.0 or greater, in the Commonwealth.[12] This pattern contrasts dramatically from the adult system where virtually every hospital maintains ICU beds, and even the most complex care is distributed across a number of academic centers. The level of expertise, technology and safety support systems required to care for critically ill children results in regionalized delivery systems in New England and in all major health care markets nationally because it is the safest, most cost effective means of organizing care delivery.

Finally, children are disproportionately poor and disproportionately reliant on the Medicaid and CHIP programs. In Massachusetts, Medicare pays for 49% of total adult and elder discharges, private insurance pays for 34% of care, and Medicaid pays for 12%. For newborns and children, MassHealth is responsible for 30% of the care provided.[13] Only a tiny number of children are covered through the Medicare program, and most of

[8] See results of a national survey of 69 major children's hospitals at http://www.childrenshospitals.net/AM/Template.cfm?Section=Surveys&Template=/CM/ContentDisplay.cfm&ContentID=63293

[9] Data provided by the Massachusetts Department of Public Health.

[10] Beverly Hospital, Caritas Good Samaritan Medical Ctr (Brockton), Caritas Holy Family Hospital (Methuen), Caritas Norwood Hospital, Caritas St. Elizabeth's Medical Center (Brighton), South Shore Hospital (Weymouth), Winchester Hospital.

[11] Data provided by the Department of Public Health. Throughout this document we distinguish ICU beds from Neonatal ICU beds. Children's Hospital is not a birthing facility. Our NICU only serves infants that have been transferred in from other hospitals including other academic medical centers. Any hospital with a significant obstetrics service will maintain a NICU.

[12] Analysis of Massachusetts discharge data utilizing APR-DRG grouper and excluding neonatal cases.

[13] Source: State statistics from HCUP State Inpatient Database 2006, Agency for Healthcare Research and Quality (AHRQ), based on data collected by the Massachusetts Division of Health Care Finance and Policy and provided to AHRQ.

these have end stage renal disease. Any payment or system reform that does not include MassHealth will fail to account for the needs of children.

Exhibit B Written Testimony

1. Chapter 224 of the Acts of 2012 (c.224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

   a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?

Summary: Boston Children's Hospital has met this benchmark annually since 2009 through aggressive cost reduction efforts internally that have focused on redesign of care while maintaining and/or improving quality. We have utilized a wide range of strategies including prevention initiatives, use of lower cost settings, and implementation of new care protocols (Standardized Clinical Assessment and Management Protocols). We have done our best to assure that these reductions are returned to payors, employers and consumers but don't have ultimate control over prices charges by insurers in the marketplace.

We think about the answer to this question from three perspectives: 1) how have we reduced our internal costs; 2) how have we attempted to reduce costs to the overall healthcare system through prevention-based strategies; 3) how have we attempted to ensure that these reductions are passed along to employers and consumers through price reductions?

Boston Children's Hospital has been working on efforts to reduce costs from every angle, including unit price, efficiency and utilization. The hospital has decreased our overall per unit cost, volume adjusted, each year for the last five years. We have taken over $125M of expenses out of our system. In FY2013 we implemented $76M in clinical cost savings and have identified an additional $24M in cost savings to be implemented in FY2014. If successful, we will surpass reductions in costs of over $200m over the last several years. Attachment 1 provides a depiction in our unit costs relative to CPI and CPI-M benchmarks since 2009.

In addition to cost reductions the institution has done a lot of work in other ways to reduce the total cost of care to the health care system, including: reducing lengths of stay, reducing utilization, reducing admissions altogether and transitioning care to lower-priced settings. Some examples include:

- Reducing ED utilization – our community asthma initiative has reduced asthma ED rates by 68% for children with uncontrolled asthma through intense patient education and environmental mitigation efforts and is more fully described in a journal article from Pediatrics (See Abstract as Attachment 2).[14]
- Reducing admissions – our home ventilation program for technology-dependent children sends teams comprised of ICU physicians, nurses and respiratory therapists on home visits to prevent admissions to the ICU through better at-home management of these very complex patients.
- Lower-priced settings – our physicians staff the pediatric services in a number of lower cost community hospitals in eastern Massachusetts. Our general experience is that these staffing arrangements result in fewer admissions overall and fewer transfers of low complexity care to our Longwood campus.

b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

One of our major initiatives is the development and implementation of Standardized Clinical Assessment and Management Protocols (SCAMPs) throughout the organization. Originally developed by our Cardiology Department, this process and associated tools creates and rapidly refines evidence-based decision support systems in a clinically flexible and iterative manner. The system actively solicits information about unexpected outcomes and clinically-based deviations from the suggested protocol in order to gather relevant information that allows refinement of the clinical algorithms. SCAMPs specifically target the elimination of unnecessary resource utilization as a desired outcome (for example tests determined to not provide actionable clinical information). Our experience to date is that mature SCAMPs have reduced costs by 26% on average with high provider satisfaction and no adverse impact on quality. The SCAMPs approach is rapidly spreading to other providers in and outside Massachusetts in hospitals, specialist and primary care settings; as a result Boston Children's Hospital has supported the development of a free-standing non-profit organization to manage the continued evolution of this innovative approach to care deliver and cost reduction. For more information, please see the Health Affairs article (see abstract as Attachment 3).

[14] There were also dramatic reductions in recurrent admissions, missed school days for children, and missed work days for parents.

In these cost reduction efforts, we are sometimes challenged by the lack of data available for care management, evaluation and benchmarking purposes. We have also been challenged at times by the inability of payors to implement payment methodologies or cover services that we believe would support the delivery of care in lower costs settings. A good example of the latter is the relatively immature deployment of and payment for telemedicine services in Massachusetts relative to many other states. At the same time, benefits and product design often work at cross purposes with high-value care, introducing co-pays, limiting access to pediatric care, and other barriers to cost-effective longitudinal care.

In addition, we collectively need to pay more attention to the Medicaid program. Medicaid represents 30% of Children's payor mix (third highest among hospitals in the state) and serves some of the most vulnerable patients in Massachusetts. We would very much like to see funding and support that enables Medicaid to scale promising demonstration projects more rapidly. For example, Medicaid was directed by the state legislature to expand our asthma program to other parts of the state in 2010. Asthma is the single most common reason for hospitalization for children and is largely preventable. This expansion has yet to occur.

Lastly, we should 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 not a good clinical outcome or a good use of resources to have a child boarded on our medical floor for two weeks awaiting placement in a behavioral health hospital; this occurs all too frequently. We should absolutely assure 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 assuring this occurs.

> d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?

Payors, not providers, are in general the entities able to assure that savings achieved within the healthcare system are passed along to consumers and businesses. As a hospital, we do not control the premiums charged by payors to their customers, and have not historically played a role in the development of products marketed to them. We

understand one of the functions of the Payment Reform Commission to be careful monitoring of payor premium rates, administrative expenses, and the like to assure that the cost reductions we are working so hard to achieve benefit Massachusetts residents.

As a result of all the efforts described above, we have decreased our net revenues over the past two years by 8.7%, as compared to the average increase of 5.7% for Boston area teaching hospitals. We are the only Boston area teaching hospital to reduce our net revenues over that time period, the very time that Government, payors and consumers have been demanding cost containment. We have achieved this result despite maintaining our overall volume, and witnessing an increase in the complexity of care delivered at our institution.

Our reductions have largely been returned to payors and the public in the form of rate and price reductions. In the early phases of our efforts, we voluntarily reopened contracts with the major private payors and Medicaid Managed Care Organizations (MCOs) and lowered our contracted rates. In subsequent years, we have made concerted efforts to better align our prices with internal assessment of our costs. For example, we are able to deliver less complex care in our satellite locations at a lower cost than on our Longwood campus. We have worked with the Center for Medicare and Medicaid Services (CMS) and with the private payors to reduce our prices at these satellites accordingly. Lastly, with respect to the reductions in utilization described above, these by their nature reduce costs for both consumers and employers.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?

Summary: Boston Children's Hospital does not believe that our prices are a major component of medical spending increases. Our costs have declined on a per-unit basis and children are a very small part of overall health spending. However, there are many input costs (labor, pharmaceuticals, medical supplies) that lie outside our control and limit our ability to reduce internal costs further.

Our unit costs have decreased yearly by 0.2% to 5.9% since 2009, a result that is inconsistent with the Attorney General's findings (Attachment 1). See the answer to question B.1 for specific examples of activities and strategies.

We are frequently challenged by costs that lie outside our control. For example, a large percentage of our clinical operating budget is for pharmaceuticals, where we can

experience cost increases of 5 to 10% per year. The state and federal governments could consider any and all mechanisms to reduce the price of pharmaceuticals.

Similarly, the largest component of our internal costs is salaries and benefits. We are one of the Commonwealth's largest employers. We are a non-profit organization. Because 30% of our revenue comes from non-Massachusetts residents and we are a major recipient of National Institutes of Health (NIH) and other external funding, we are able to bring about $500M into the Massachusetts economy each year. In order to achieve this, we need to employ a workforce able to provide extraordinary clinical care and to lead the nation in pediatric research. As such, our labor costs are relatively inflexible. We are frequently competing with regional and national providers for a relatively small pool of highly skilled clinicians and researchers. We are also committed as an organization to assuring a living wage for all our employees that keeps pace with inflation. Absent dramatic shifts in volume, most of our labor savings will be tied to increased efficiencies/decreased utilization; we do not have the ability to significantly reduce the price we pay for labor, particularly given the high cost of living in the metropolitan Boston region.

Staffing needs are also affected by federal, state local and non-governmental regulatory and compliance regimes, e.g. each new or duplicative administrative or reporting requirement creates additional staffing burdens. As a small example, we currently employ three people to submit bills to the health safety net trust (HSN). We have not received a payment from the HSN for several years, due to the way the state allocates HSN shortfalls. The net impact to patients of this requirement is non-existent from an access perspective, but certainly adds costs to the system. At a minimum, the state should make every effort to assure that new health care regulatory requirements provide a demonstrable benefit and add substantial value above and beyond existing federal requirements.

On a more global level, our administrative staffing has been impacted by the proliferation of insurance products with differential cost sharing, coverage and network designs. For example, we have many, many staff members whose entire job is seeking authorization from payors for services delivered here. These services are almost always approved; when they are not, we typically discover the fact after the service has been provided. As a result, the entire authorization process yields little to no benefit from a utilization management perspective and adds administrative costs for providers and payors.

3. C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?
    a. What potential opportunities have you identified for such integration?
    b. What challenges have you identified in implementing such integration?

c. What systematic or policy changes would further promote such integration?

Summary: We agree that there should be a serious focus on this issue. We have made very significant efforts in this regard, have contributed actively to both improving the child mental health delivery system and improving the policy/regulatory climate for child mental health. We have made extensive recommendations to the Behavioral Health Integration Task Force in this regard which are attached.

We have a longstanding commitment to the delivery of integrated behavioral health services. Our Department of Psychiatry, working with our affiliated primary care network of 260 pediatricians, is actively engaged in the co-location of behavioral health specialists. We have presented this initiative in some detail to the Behavioral Health Task Force.

We have also helped develop and participated in the Massachusetts Child Psychiatry Access Project (MCPAP) which provides consultative supports, clinical assessment and referral services to pediatric primary care providers and is operated through the Massachusetts Behavioral Health Partnership.

We believe that more efforts should be devoted to the early identification and treatment of mental health concerns in childhood in order to prevent or mitigate lifetime consequences. One of the obvious places to do this is through early childhood and school-based interventions. In general, this work should attempt to enhance the capacity of the education system to address behavioral health needs directly. We have worked comprehensively to outline potential approaches including the extension of MCPAP-like services to the school setting.

Through the Department of Mental Health's Children's Behavioral Health Advisory Council and the Children's Mental Health Campaign, we have provided extensive recommendations on improving the behavioral health system and the services it provides to the Behavioral Health Integration Task Force. (Attachment 4).

4. C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

   a. Describe your organization's efforts to promote these goals.
   b. What current factors limit your ability to promote these goals?
   c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

Summary: Boston Children's Hospital has put increasing emphasis and resources into developing accountable care capacity. We have created an innovative oversight and financing model for projects designed to assure impact and alignment with payor objectives and interests. We have also entered into the first pediatric-only AQC contract which required development of performance standards for child health. We do experience significant challenges with the ability of the Medicaid program to improve care delivery. We also note that specialty hospitals that serve a discrete population (children) from all over the state do not fit neatly into traditional ACO constructs.

Our integrated care organization is the entity responsible for developing and implementing alternative payment models within our enterprise (hospital, specialists and primary care network). We have described a number of our hospital-based care models above (see answer to question B.1).

We have also been working proactively with our major payors to design, test and deploy care delivery programs that improve quality while reducing costs. In 2009, we created a pool of funds for our Payor-Provider Quality Initiative (PPQI). We appointed an oversight committee that includes 5 representatives from our system and five representatives from the payor community including Medicaid. We tasked the committee with the review and selection of promising initiatives that would result in better care at lower cost, that would be deemed credible and relevant by the payors, and that had a strong potential for "spread" to other hospitals and physician organizations.

This structure has proven itself to be very successful; it has served as our own internal version of CMS' Innovation Grants program. Several of the initiatives described above, as well as many others, have received start up funding from the PPQI.

The main challenge to longevity of these high-value programs is sustainable funding. In many cases, these programs are not reimbursed by payors, reduce the revenues of our enterprise, and benefits accrue to payors and risk-based providers who refer patients to BCH. Over time, payment models will need to allow for flexibility in distributing benefits and supporting services that are low-reimbursement or no-reimbursement offerings.

More generally, we have attempted to embrace alternative payment model opportunities in a thoughtful and proactive manner, recognizing that many of these structures are initially designed for adult populations and that one of our roles is to translate and/or optimize these strategies for use in pediatrics. For example, we were the first pediatric organization to sign an alternative quality contract (AQC) with Blue Cross Blue Shield. This required reaching agreement on a relevant quality measurement portfolio and set of

benchmarks for a freestanding pediatric hospital. We are now in our second year under the AQC and have undertaken many system changes to enhance quality and lower costs.

Likewise, we are in the process of developing bundles for common surgical procedures through our contract with Harvard Pilgrim Health Care. In this area, we are challenged by the fact that many of the common procedures are "low cost" relative to some of the adult-care opportunities like hip replacements.

While we can, through contract negotiations, reach agreement with private payors on initiatives of common interest, we are unable to do so with the Medicaid Program. In our opinion, this occurs because of several inter-connected issues: 1) Medicaid lacks the staff resources to implement promising projects; 2) Medicaid is overly bound to procurement rules that tend to stifle innovation; 3) Medicaid data systems are inaccessible to providers in a meaningful way that allows them to develop and evaluate promising approaches; and 4) Medicaid in general tends to focus on disabled and elderly patients due to their high cost (the Children's Behavioral Health Initiative being a significant exception). Medicaid has also perpetuated a series of outdated payment methodologies in effect since the late 1980s for inpatient and outpatients care that do not align well with delivery system reform. This is very problematic given the issues confronting the state including the increasing share of state budget resources devoted to Medicaid and the increasing percentage of state residents that rely on Medicaid for their health coverage.

As a referral center, we serve patients from across the Commonwealth. Traditional models of risk and accountability center around the primary care provider. While this is generally appropriate and offers the potential to improve quality while managing costs, many of the most costly patients receive substantial care in sub-specialty settings. Under many of the payment models currently in place, the ability for Children's to access information that would be supportive of managing health care costs is limited in the specialty-provider role. With limited access to data, insights required to address costs are challenged. Further, the lack of information about patients receiving longitudinal care at Children's limits our ability to identify systematic opportunities for increasing cost-effectiveness. While we are able to identify overarching opportunities for quality improvement relying on our clinical data, our financial data provides only part of the picture.

In addition to these challenges of data, we also face a real hurdle due to limited risk adjustment capabilities specific to pediatrics in general, and complex pediatric patients in particular. As is widely known, the accuracy and sustainability of many alternative payments models hinges on the ability to accurately assess the inherent risks of specific populations. Existing risk adjustors, including those relied on by major payors in our market, emphasize adult populations and are less accurate for specific sub-populations such as complex pediatric patients.

A major barrier to MassHealth's proposed Primary Care Payment Reform Initiative (PCPRI), which will likely be relevant more broadly, is the ability to gain share. If primary care providers take on increased risk, the role of the referral center, and its ability to participate in the management of the highest-cost patients, must be sustainable. In addition, guidance and consideration around reserves required for risk-bearing providers should be given. Over time, there is potential for duplicate reserves and expenditure on reinsurance across a transitioning insurance and delivery system.

5. What metrics does your organization use to track trends in your organization's operational costs?

    a. What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?

Summary: Boston Children's Hospital has focused on cost management across the organization with strong oversight provided by senior leadership of the hospital. We benchmark comprehensively against other freestanding children's hospitals for both costs and quality/safety. Through iterative cost savings processes, we have achieved a significant degree of success.

We monitor expenses monthly by Vice President utilizing budget performance reports. Individual Vice Presidents drill down into responsible reporting units within their areas of responsibility. We review costs per unit by department and discuss results monthly at our internal Operations committee meeting, including reasons for variances which may include changes in volume, payor mix or referral patterns.

In order to assure ongoing management of labor costs, we implemented a selective hiring committee staffed by Vice President's to assure that all new or replacement hires were deemed necessary to our operations and that work could not be redistributed or eliminated. Over the past two years, we have had a workforce reduction of about 375 FTEs.

Overall oversight is provided by our Board Committee on Finance and our internal Executive Committee. Each routinely review financial results and changes to both budget and variation from prior year results across several key parameters (service line, location of care, department, etc.)

    b. How does your organization benchmark its performance on operational cost structure against peer organizations?

We benchmark our costs and operations against other freestanding children's hospitals across the country. Our patient population and the services we deliver are atypical in the Massachusetts market (we treat children, frequently with rare or complex conditions). The children's hospitals have collaborated to develop a rich set of data and benchmarking resources for this purpose. In general, on a wage adjusted basis, services delivered at Boston Children's Hospital are delivered at below median cost and below median price relative to our peer institutions.

We likewise benchmark the quality and safety of the care we deliver. We have been similarly comprehensive and focused in this regard and are consistently recognized for our local and national leadership in the development of pediatric quality measures and our commitment to improved safety and quality practices. Results are reported to our Board of Trustees on a quarterly basis. Our approach to cost savings has required that we be able to demonstrate to our clinicians and our governance committees that cost reductions are not negatively impacting the quality or safety of the care we deliver. We believe this is a fundamental aspect of making change in a healthcare environment and should not be overlooked as the Commission conducts its work.

c. How does your organization manage performance on these metrics?

We identify a performance improvement plan at the beginning of each year with express cost-reduction targets. Specific cost reduction initiatives are built up to meet targets within each area. In the last five years, our performance improvement plans have reduced costs by $181M (FY09-13).

Throughout the year we track the run rate of specific initiatives and implement a corrective action plan if run rate does not meet budget expectations. The action plans would tend to be service-specific.

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.

Summary: Boston Children's Hospital is working hard to comply with this requirement but believes that state guidance would be helpful so that consumers are provided with consistent and intelligible information.

We have convened an internal workgroup to address this requirement and will make our best effort to provide accurate estimates for common services for typically well children. However, we find this an incredibly difficult undertaking for many of the relatively rare

procedures and admissions that occur at a specialty hospital.[15] It is frequently our experience that clinical decisions about treatment are made in real time, and that prospective utilization is difficult to predict. For example, for congenital heart patients, costs can vary dramatically depending on whether we need to use extracorporeal membrane oxygenation (ECMO) during an inpatient admission. We do not know this in advance. Even for lower complexity services, costs can vary significantly due to the underlying medical condition of the child. A teenager with significant developmental delays may require sedation and use of the operating room for "routine" dental care.

As a corollary, we question whether the estimates provided will be consistently calculated across providers. Providing estimates is an inexact science that leaves much to the discretion of the person providing the information and may be very dependent on the internal information sources available to that person, how costs are calculated and apportioned within the organization, etc

We are also concerned that there not be inconsistent information provided by payors versus providers, and recognize that the payor is likely to have better and more accurate information about the structure of the patients benefit plan and relevant cost-sharing obligations. For example, patients may have a high-deductible plan and services delivered against that deductible may need to be accumulated across provider organizations. As such, we think that the best approach is for the payor to answer these questions in the first instance and that we as providers should be available to attempt to answer residual questions to the best of our ability.

We also think it would be helpful if the state provided recommended contextual language, like it does for charity care policies, that indicates that costs have been estimated to the extent possible but may vary due to the aforementioned factors. Likewise, it would be very helpful if the state limited the scope of the provider obligation under this provision to a delimited number of procedures or admissions (for example, the top 50 procedures performed).

7. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Summary: The reports compare Boston Children's Hospital to all other acute care hospitals in the state, despite the fact that our pediatric patient population, service

[15] We have some experience in this regard with our international patients where we can see significant variability in costs based on the clinical presentation of the patient and the course of treatment.

mix, and payor mix are significantly different. The reports fail to account for Medicaid underpayment in any serious way.

We have three major concerns with the reports that have been published to date. First, Boston Children's Hospital is atypical in the Massachusetts market as outlined in the introductory comments above. Comparison to a pool of hospitals, many of which do not even serve children and few of which maintain any level of pediatric intensive care capacity, is misleading.

Second, the physician views of the data comingle primary care and subspecialty physicians. This distorts the findings for an organization weighted so substantially to highly specialized care delivery.

Finally, the report fails to include Medicaid or analyze the impact of Medicaid underpayment in any serious way. We have the third highest Medicaid payor mix in the Commonwealth, are tremendously underpaid by the Medicaid program (especially our physicians), and have sustained dramatic reductions in payment during the period in question. Nearly 1 in 4 non-elderly residents of the state are covered by the Medicaid program. Its impact on individual providers and the cost shifting required to address its underpayments should not be excluded from this analysis. In addition, Medicaid should not continue to be conflated with Medicare in terms of its programmatic and financial impacts. Medicare pays better, has nationally-vetted and better standardized payment methods, is not subject to the variability of year-by-year state budget decision-making, and makes some attempt to cover teaching and other related costs of safety net hospitals.

Exhibit C Written Testimony

1. For each year 2009 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.

Summary: The requested table is attached and ties to the hospital's audited financial statements; given the substantial percentage of our business derived from out of state payors, we have separately broken that out. Medicaid underpayment results in the need for substantial cost shifting to other payors.

See attached table (Attachment 5). We have separately broken out "Medicaid" from "Government" as the margins are substantially different. We have also broken out in-state vs. out-of-state business as a very substantial portion of our revenue is derived from out-of-state payors and patients and the margins vary significantly. We do not separately track margins by type of business PPO vs HMO vs. Per Member Per Month budgeted.

2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully - insured v. self - insured) on your opportunities for surpluses.

Summary: Boston Children's Hospital is very interested in pursuing a broad range of accountable care opportunities and have made some significant investments but are still in the early stages of this work. We are at times challenged by the fact that many of the alternative payment models have been developed for adult patients (e.g. Medicare ACOs and shared savings programs).

As noted above, we are the first pediatric hospital to enter into an AQC contract with Blue Cross Blue Shield. These contracts have been well described elsewhere in terms of their general structure. There are approximately 40,000 patients enrolled in the AQC out of a total primary care patient population of 300,000 within our integrated care organization. Overall management of performance on the AQC contract is housed in Children's Hospital Integrated Care Organization (CHICO) which comprises the hospital, specialist physicians and our affiliated primary care network.

This contract is a relatively small part of our overall revenue. It has not fundamentally altered our care delivery or operational structure. We are still in the early stages of understanding how to manage accountable-care risk in the context of a pediatric specialty hospital and are in the process of building some of our capacities. We have not made significant changes to physician recruitment or patient referral practices, e.g. by significantly tightening our network. Indeed, a significant percentage of primary care patients in our affiliated primary care network are referred to hospitals other than Boston Children's for less complicated care.

We have altered to some degree the governance structure of CHICO and provided some additional funding to support its quality improvement and care management capacities. This change was the subject of a material change filing with the Health Policy Commission, which chose not to investigate it further.

3. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop - loss coverage), solvency standards, and projections and plans for deficit scenarios . Include in your response any analysis of how your costs or risk - capital needs would change due to changes in the risk you bear on your commercial or government business.

Summary: Boston Children's Hospital manages our risk contract (the AQC) through the integrated care organization of which we are a member.

The hospital's participation in the AQC risk contract is via CHICO, which provides key administrative and management functions to the Hospital and its other member organizations. The hospital's share of gains or losses through the risk contract is allocated based on a formula agreed to within CHICO. Each quarter, CHICO provides the hospital an estimate of financial impact based on risk contract performance. To date, specific reserves have not been established beyond estimates due to/from third parties. Stop-loss coverage has been obtained through the payor with whom we have our risk agreement. Costs of administering the contract is by and large accounted for in the dues paid to CHICO. It is not possible to calculate the per member per month costs since CHICO's efforts to improve quality, reduce fragmentation, and assure access to cost-

effective care are applied in a payor-blind manner. To the extent that we entered into agreements that include substantial exposure to downside risk, we would need to revisit our current approach and would work through CHICO to develop a policy across all members. We await guidance on the requirements of risk-bearing provider organizations to inform such a policy. Similarly, additional risk agreements would likely require further investments in analytical, IT, care management and contract management functions commensurate with access to additional data and likely additional performance measures.

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).

Summary: Boston Children's Hospital does not track health status globally beyond information provided by payors. We do track health status for patients with individual clinical conditions. We also maintain a comprehensive quality and safety measurement and improvement infrastructure (but do not understand that infrastructure to be measuring "health status" as commonly defined).

We do not track "health status" on a global level and are unaware of strong validated mechanisms in the pediatric population for doing so beyond some of the risk adjustment tools used by payors. We have concerns about the predictive use of these tools in pediatrics, as well as their accuracy in adequately adjusting for high cost outliers. We do track health status for specific conditions/disease processes (e.g. is a child with cystic fibrosis doing better or worse longitudinally). This is very particular to the condition. Lastly, individual providers with their individual patients (especially those with chronic conditions) pay a great deal of attention to health status while delivering care.

As noted above, we have a very substantial infrastructure for measuring and reporting on patient safety and quality at the hospital, but this would not be viewed as measurement of "health status" per se.

5. Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for an y category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

Summary: Boston Children's Hospital does not collect or report on this information in the manner outlined. We have attempted to provide a high level view of the types of contracts we have by payor and how we are reimbursed.

We do not collect or report on information in this manner. We are concerned about the time it would take and the accuracy of what we would be reporting. For example, the differentiation made between the PPO and HMO throughout this table is dependent on patient registration functions that accurately capture and update this information on an ongoing basis. We are extremely hesitant to submit a response to this question signed under "pains and penalties of perjury" given that we do not analyze or aggregate information in this fashion.

In general, for the time period in question, we would note the following:

- We have pay for performance (P4P) contracts with Blue Cross Blue Shield, Harvard Pilgrim Health Care and Medicaid.
- We participate in the BCBS AQC as a risk contract.
- As a pediatric hospital, our Medicare business is negligible (approximately 1% gross patient service revenue) and does not permit us to participate in alternative payment models.
- For all other payors, the hospital is paid on a fee for service basis, typically using diagnosis related groups (DRGs) or a percent of charges for inpatient care, and typically utilizes a percent of charges approach for outpatient care. As noted in answers above, we have been actively reducing our charges over the past several years as a mechanism to assure that our cost-reductions are returned to payors and consumers.
- We have witnessed the following trends: a) an increasing shift from fully insured to self-insured products; b) a shift from commercial to Medicaid and other government products; c) the HMO population within the BCBS AQC has fallen; and d) a substantial increase in cost-sharing obligations for consumers.

6. Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010 to 2012. Please explain and submit supporting documents that show your understanding as to the factors underlying any such growth.

Summary: See below.

During the period in question:

- Pharmacy spending has increased 14%.
- Medical/surgical supplies spending has increased 8.6%
- Health insurance expenses for our employees have increased 7.2%.
- FICA tax for employees has increased by 8.1%

- Rent has increased 8.8%.
- We have made investments in the development of our accountable care capabilities and integrated care organization that exceeds 10%; these investments are difficult to break out as they may vary by department.

With respect to the first two items, we have very little control over the pricing of these items. We are a member of a preferred purchasing organization that specializes in pediatric care and have relied on that organization to negotiate the best prices.

With respect to health insurance, we experience the same increases in costs that all other employers in the state experience.

With respect to FICA tax increases, expiration of the ARRA stimulus funding tax reduction drove this result.

With respect to rent, this derives from the opening of satellite facilities in Peabody and Weymouth. This is part of our conscious strategy to try to create lower cost (and hence lower priced) specialty care outpatient facilities while enhancing patient access.

With respect to accountable care investments, these have been made in order to be able to better respond to rapidly evolving care delivery and alternative payment model reforms in the market place. It should be noted that many of these types of reforms are developed or implemented for adult populations and need to be modified to work well for a pediatric population and/or a pediatric specialty hospital.

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees . Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

Summary: Pediatrics, by nature, has a wellness focus. We have provided extensive and innovative community benefits as reported to the Attorney General on a yearly basis to children that are not our primary care patients. We are in the early stages of taking a more comprehensive approach to employee wellness.

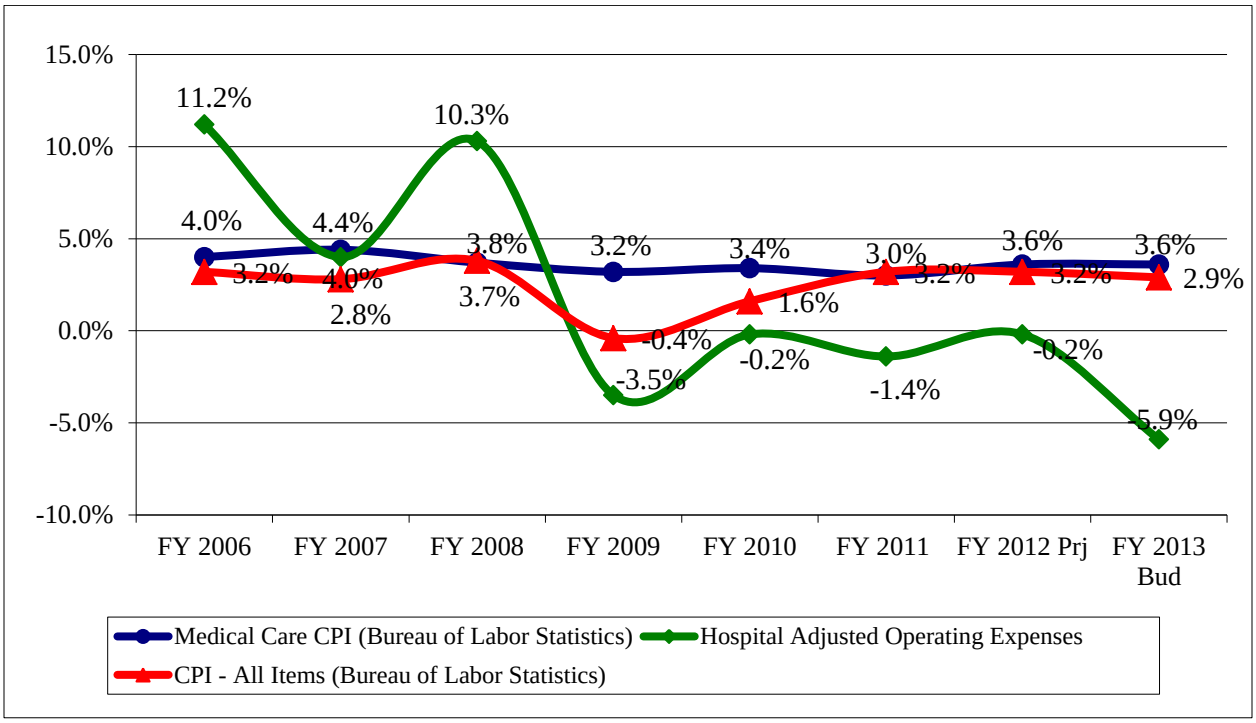
Pediatrics, for most children, is all about promoting health and wellness. Most children are healthy and the pediatrician's role is to assure that the child is meeting developmental milestones and best positioned to lead a healthy life. Pediatrics tends to emphasize early screening for conditions that lead to long-term health impacts and to provide a substantial

amount of anticipatory guidance to parents and children. We have described a number of our prevention oriented programs including their cost-benefit above in our answer to question B.1.

Our community benefits report to the Attorney General describes the majority of programming we offer to children "beyond our four walls" and may be found on the Attorney General's website at: http://www.cbsys.ago.state.ma.us/cbpublic/public/hccmainpage.aspx?org_id=19&report_year=2012.

With respect to our employees, we are in the process of rolling out a more comprehensive employee wellness program. Over the past several months, we completed a biometric screening and assessment of nearly two-thirds of our employees which will be used at the aggregate level to develop more comprehensive and targeted wellness programming. The hospital and its third party administrator are still in the process of evaluating and synthesizing the raw data.

Attachment 1: Unit cost vs. CPI and CPI-M



Attachment 2: Woods, E et al, "Community Asthma Initiative: Evaluation of a Quality Improvement Program for Comprehensive Asthma Care", Pediatrics, 129, No. 3, March, 2012.

Abstract

OBJECTIVES:

The objective of this study was to assess the cost-effectiveness of a quality improvement (QI) program in reducing asthma emergency department (ED) visits, hospitalizations, limitation of physical activity, patient missed school, and parent missed work.

METHODS:

Urban, low-income patients with asthma from 4 zip codes were identified through logs of ED visits or hospitalizations, and offered enhanced care including nurse case management and home visits. QI evaluation focused on parent-completed interviews at enrollment, and at 6- and 12-month contacts. Hospital administrative data were used to assess ED visits and hospitalizations at enrollment, and 1 and 2 years after enrollment. Hospital costs of the program were compared with the hospital costs of a neighboring community with similar demographics.

RESULTS:

The program provided services to 283 children. Participants were 55.1% male; 39.6% African American, 52.3% Latino; 72.7% had Medicaid; 70.8% had a household income <$25 000. Twelve-month data show a significant decrease in any (≥1) asthma ED visits (68.0%) and hospitalizations (84.8%), and any days of limitation of physical activity (42.6%), patient missed school (41.0%), and parent missed work (49.7%) (all $P < .0001$). Patients with greatest functional impairment from ED visits, limitation of activity, and missed school were more likely to have any nurse home visit and greater number of home visits. There was a significant reduction in hospital costs compared with the comparison community ($P < .0001$), and a return on investment of 1.46.

CONCLUSIONS:

The program showed improved health outcomes and cost-effectiveness and generated information to guide advocacy efforts to finance comprehensive asthma care.

Attachment 3: Farias, M. et al, "Standardized Clinical Assessment and Management Plans (SCAMPs) Provide a Better Alternative to Clinical Practice Guidelines", Health Affairs, 32, no. 5 (2013) 911-920.

Abstract

Variability in medical practice in the United States leads to higher costs without achieving better patient outcomes. Clinical practice guidelines, which are intended to reduce variation and improve care, have several drawbacks that limit the extent of buy-in by clinicians. In contrast, standardized clinical assessment and management plans (SCAMPs) offer a clinician-designed approach to promoting care standardization that accommodates patients' individual differences, respects providers' clinical acumen, and keeps pace with the rapid growth of medical knowledge. Since early 2009 more than 12,000 patients have been enrolled in forty-nine SCAMPs in nine states and Washington, D.C. In one example, a SCAMP was credited with increasing clinicians' rate of compliance with a recommended specialist referral for children from 19.6 percent to 75 percent. In another example, SCAMPs were associated with an 11-51 percent decrease in total medical expenses for six conditions when compared with a historical cohort. Innovative tools such as SCAMPs should be carefully examined by policy makers searching for methods to promote the delivery of high-quality, cost-effective care.

Attachment 4: Recommendations of the Children's Behavioral Health Advisory Council to the Behavioral Health Integration Task Force.

Children's Behavioral Health Advisory Council
Recommendations to the Behavioral Health Integration Task Force

The Children's Behavioral Health Advisory Council is pleased to provide the Behavioral Health Integration Task Force with advice and recommendations on the issues identified in Section 275 of Chapter 24 as they affect behavioral health care for children.

The Council was established by *Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental Health* as part of a comprehensive set of reforms in the children's behavioral health system. The Council is a unique public-private partnership representing child-serving agencies, parents, and professionals with knowledge and with expertise in the field of children's behavioral health. Council activities have ranged from viewing initial data on service utilization and penetration, including In-home Therapy, Intensive Care Coordination and Family Support and Training, to a detailed and thorough review of commercial insurance practices; from examining the challenges of workforce development to the research and development of culturally-informed best and promising practices, and the reduction and elimination of racial and ethnic disparities. We take a broad view of child health as encompassing healthy development over time, not just the amelioration of problems. Although much of our work has focused on reforms in the public children's behavioral health system, our purview encompasses the entire children's behavioral health system, both public and private payers.

We welcome the opportunity to assist the Behavioral Health Integration Task Force (BHTF) in completing its charge as outlined in *Section 275 of Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*. We view Chapter 224 as the next critical phase in the ongoing improvement in the children's behavioral healthcare system. Over the past few years, significant effort and investment have been made to improve the MassHealth children's behavioral health system, which serves approximately one-third of the children in the Commonwealth. Some of that investment has extended into the privately insured healthcare system, e.g. the Massachusetts Child Psychiatry Access Program.

Our recommendations are informed by our work together over the past five years as a Council. In addition, we invited leaders from MassHealth's Patient-Centered Medical Home Initiative, the

Child Health Quality Coalition, and Boston Children's Hospital to share their expertise with us. Some Council members also attended the Task Force's early meetings in order to learn from its expert guests. Several Council members have shared their professional organizations' (e.g., AACAP, AAP) white papers on primary and behavioral health integration. We are excited to see an emerging consensus about the key principles and strategies for improving healthcare quality and cost through primary and behavioral health care integration. We hope our advice helps to move the conversation from conceptual to operational.

CHILDREN AND HEALTHCARE REFORM

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience "significant impairment" and 5 percent experience "extreme functional impairment."[16]
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.[17]
- About 36% of youth with any lifetime mental health disorder receive services, and only half of these youth who were severely impaired by their condition received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime.[18]

It would be easy, but a mistake, to overlook the needs of children in the context of the healthcare reform efforts required by Chapter 224. Children are not "cost drivers" when compared to some groups of adults, e.g. adults eligible for both Medicaid and Medicare. However, without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults.[19] Moreover, the Adverse Childhood Events literature (discussed below in Section V) underscores the impact of the consequences of adverse childhood events on adult physical and behavioral health morbidity, mortality and costs.[20] There is clear and expanding scientific evidence that toxic stress, associated with adverse child events, can permanently alter brain maturation broadly and particularly in the prefrontal cortex, hippocampus and amygdala, as well as the nerve interconnections between them. These brain changes may be permanent

[16] Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999

[17] NIMH, Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.

[18] NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011

[19] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

[20] http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html

and may not change easily, once established, underscoring the importance of prevention and early intervention. [21]

GUIDING PRINCIPLES

In addition to an abiding commitment to children's health and well-being, our recommendations are guided by the following beliefs.

- Children's development to become healthy adults should be supported through prevention and early intervention services and supports. Families with risk factors for distress and impairment in the child should have access to, as well as support for engagement with, helpful resources that are community-based and culturally competent.
- Healthcare services should be organized and delivered in a manner that helps families and youth become better health consumers and builds their self-efficacy skills and independence. Healthcare providers must partner with families and transition age youth at all levels in the behavioral health care system.
- No one size fits all. Pediatric and family medicine practices vary in size, communities vary in available resources, and families, youth, and children have different strengths, needs, and cultures. Integration strategies must be sufficiently robust and flexible to address racial and ethnic disparities in access, treatment, and outcomes.
- Current investments and initiatives should be leveraged for their operational capacity and emerging promising practices. These initiatives include the Children's Behavioral Health Initiative (CBHI) [22], the Massachusetts Child Psychiatry Access Program (MCPAP) [23], the Patient Centered Medical Home Initiative (PCMHI)[24], and the Child Health Quality Coalition (CHQC)[25].
- The move to integrated care will and should be an evolution. Moving from fee-for-service to alternative payment methods might require some short-term bridging strategies. Extending the empirical evidence base to support innovations and refinement of current

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[21] Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. Shonkoff JP et al. *JAMA* 2009: 301(21): 2252-2259

[22] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/

[23] Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatry Access Project. B. Sarvet et al. *Pediatrics* published online Nov 8, 2010; DOI: 10.1542/peds.2009-1340

[24] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/

[25] http://www.mhqp.org/collaboration/chqc.asp?nav=063700

precedents such as CBHI and MCPAP will take time and require systems that can adapt to emerging evidence about what works with the populations served.

- Pediatric behavioral healthcare costs and return on investment (ROI) are dispersed into other systems (e.g., schools, child welfare, juvenile justice) and into the future (e.g. physical health, substance abuse, prison, employment, parenting competence). However, the inability to fully capture that ROI to fund healthcare reforms today should not deter us from investing in improving the quality of children's healthcare. While the ROI within healthcare over the short term might be minimal, ROI to society as a whole over time and across generations will be substantial.

RECOMMENDATIONS

In order to facilitate the BHTF's work, our recommendations are organized according to the six questions posed by the Legislature in Section 275 of Chapter 224. In some cases, we have taken the liberty of addressing the general issues raised, rather than specifics, in a manner that best applies to children and their families.

I. The most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care.

Integrating behavioral health services with primary care requires several structural mechanisms to bridge these two care delivery systems. We view the patient-centered medical home (PCMH) model and System of Care (SOC) [26] models as compatible with each other and as strong platforms on which to build these integrating mechanisms.

We acknowledge that these mechanisms have not yet been established through empirical research as "effective and appropriate." However, there is expanding evidence and consensus from a variety of sources, including references cited in this document as well as innovators' experiences and the professional experiences of Council members, which has informed our deliberations. Implementation of these integrating mechanisms should include a strong research / evaluation component in order to assess their cost-effectiveness and to promote continuous quality improvement.

[26] The System of Care Handbook: Transforming Mental Health Services for Children, Youth and Families. Stroul BA and Blau GM. Paul H. Brookes Publishing Co., Baltimore, 2008.

Care Integration Recommendations

1. Behavioral health screening, using evidence-based standardized tools, at every well child visit should be required and reimbursed for all primary care providers for all children up to age 21. When a PCP deems necessary, both a mental health screening and a substance abuse screening should be allowed in a single visit. Post-partum depression screening should be included in well-child visits for parents of children under six months in age. Primary care providers in the adult system should provide age appropriate behavioral health screening to their transition age youth patients.
2. Behavioral health consultation should be readily accessible to primary care providers. A range of arrangements supporting strong working relationships between behavioral health providers and primary care providers should be allowed. These arrangements include, but are not limited to, co-location.
3. Peer supports, including family partners with "lived experience" raising a child with behavioral health challenges and youth mentors, should be a standard service that is readily available. Peer supports are critical for initial and on-going engagement of families and youth who might be reluctant to or lack knowledge about and/or skills for engaging with behavioral health care. Reimbursement should be sufficient to allow for ongoing coaching and support for the emerging workforce.
4. Care coordination should be a standard of care and reimbursed for all children receiving both primary and behavioral health care. For most children, the PCP's on-going relationship means that they will be best able to provide care coordination. However, behavioral health providers might be better able to coordinate care for children with significant behavioral health conditions.

1. Behavioral Health Screening

The first step in integrating behavioral health care is identifying the need for it. Nationally, the average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years – critical developmental years in the life of a child.[27] Behavioral health screening using validated tools provides an effective, evidence-based approach for increasing early identification and intervention, which can both improve outcomes and reduce the costs of mental illness.[28]

[27] Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, American Academy of Child and Adolescent Psychiatry

[28] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

Since 2008, MassHealth has required and reimbursed PCPs to conduct behavioral health screening at well child visits (up to age 21) as required by Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) provision. MassHealth established a list of clinically appropriate standardized screening tools from which providers select, based on the age of the child. The data below illustrate that it takes time to make significant progress and that, even with reimbursement available, screening does not occur at all visits for all children, as it should. Frequent public reporting and monitoring are important and should be expanded beyond MassHealth.

	Jan-March 2008		Jan – March 2011	
	% visits with BH screens	% BH need identified	% visits with BH screens	% BH need identified
< 6 months	8%	6%	43%	2%
6 mo to 2 years	17%	6%	73%	5%
3 years to 6 years	18%	9%	76%	9%
7 years to 12 years	20%	11%	77%	11%
13 years to 17 years	18.5%	12%	71%	11%
18 years to 20 years	7%	24%	34%	11%
ALL	15%	11%	67%	8%

Source: CBHI website

For children under six months in age, the low screening rate has been explained by some as due to the lack of an appropriate screening tool. Primary care providers have advocated for the substitution of postpartum depression screening for a child mental health screen.[29] The Council

[29] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

recommends requiring and reimbursing post partum depression screening, in addition to developmentally appropriate screens, at well-child visits for parents of children under six months in age. Identifying and treating post-partum depression is critical. Postpartum depression has a significant adverse effect on young children's cognitive and emotional development in the preschool years. Treating maternal depression improves the cognitive and social emotional development of young children even in the absence of any direct intervention with the child.[30]

At the other end of the age spectrum, screening rates are likely lower among 18 to 20 year-olds because they are frequently seen in adult care, rather than pediatric settings, where providers are more often unfamiliar with the screening requirement.[31] The Council recommends educating primary care providers in the adult practices about the importance of behavioral health screening. In addition, reimbursement should be allowed for both a mental health screening and a substance abuse screening in a single visit. Currently, providers are limited to one screening and must choose between screening tools that do not cover both mental health and substance abuse.

2. Behavioral Health Consultation

One quarter of pediatric primary care visits address behavioral issues.[32] When a behavioral health concern is identified, the primary care provider must have access to a behavioral health provider for (1) clinical consultation, if needed, and (2) connecting a child / family either for a brief intervention or longer term services. A licensed behavioral health provider should, ideally, be on site to provide "curbside" consultation to the primary care provider. These consultations might take as little as ten minutes. Access to psychiatric consults will likely be through a

[30] Children of affectively ill parents: A review of the past 12 years. Beardslee WR, Gladstone TRG, and O'Connor E. Jl of Am Academy of Child and Adol Psychiatry, 50, 1098-1109, 2011

[31] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

[32] Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

combination of on-site and virtual, since most primary care practices will not generate enough need to support a full-time psychiatrist on site.

Based on the consult, a referral might be needed for direct services. Some children will need only a brief intervention, which could be provided by the on-site behavioral health provider using a brief solution-oriented treatment approach. Other children will need longer-term care provided by a community-based organization. The on-site behavioral health provider or a care coordinator could locate an appropriate community-based provider and make the referral. The MCPAP teams include care coordinators for this purpose. [MCPAP is described below under "Telemedicine".]

3. Peer Support: Family Partners and Youth Peer Mentors

Every healthcare professional has a responsibility to engage families and children in the care delivery process. However, engaging with families and children presents unique challenges. Unlike adults where engagement is with the identified patient, for children (the identified patient) engagement is primarily with the parents. Engaging parents around family behavior change and use of community supports can be challenging. Some parents don't think their young children could have a behavioral health problem, so they see no reason to consult a behavioral health provider. Some may view other needs in the family, such as employment, housing, childcare or transportation, as requiring priority attention before or concurrent with mental health treatment for their child and family. Others may be wary of involvement with the "system" based on previous negative experiences with providers. Others are burdened with their own medical, behavioral health and/or substance use disorders.

A variety of engagement strategies are necessary, with choices available to families. Some families may prefer to engage with professionals with expertise in subject matter and exceptional family engagement skills. Evidence-based strategies for family engagement by clinicians and behavioral health settings have shown excellent results.[33] However, some families will benefit from and want the support of a person, a Family Partner, who has lived experience caring for a child with behavioral health needs. For older adolescents and young adults, young adult peer support, analogous to parent to parent support for parents, may be critical to promote the youth/young adult's engagement in care coordination and treatment.

[33] Integrating Evidence-Based Engagement Interventions Into Real World Mental Health Settings. McKay, M. et al. Brief Treatment and Crisis Intervention, Oxford University, 4, 2, 177-186, 2004.

A Family Partner service (called "Family Support and Training" services) and workforce has been built in the MassHealth system over the past five years. Family Partners are individuals who have raised children with special health care needs (usually behavioral health needs) and who have been specially trained to work with other caregivers. Initially, this service was available only to families whose children received intensive care coordination (ICC). Approximately three-quarters of the ICC users also accessed Family Partner services in FY2011. Based on numerous requests by families, this service has been expanded to cover families whose children receive in-home therapy or outpatient services without receiving ICC. Anecdotal evidence from MassHealth services shows extremely high family satisfaction with Family Partners and good success in engaging families who might otherwise not follow though with care.

On a smaller scale, MassHealth has funded "Therapeutic Mentor" services to support skill building and effective use of treatment by youth served within Intensive Care Coordination. As noted above, half of all lifetime mental illness develops by age 14 and three-quarters by age 24. Good behavioral and primary care at this age can change the trajectory of their adult well-being. Yet, as youth transition to adulthood, the safety net of family is receding leaving them to manage health risks on their own with limited experience with self-care (e.g., making or keeping appointments). Reaching out to and supporting transition age youth in accessing and engaging in behavioral health care is critical and deserves dedicated resources.

Peer supports have value even beyond their work with families and youth. They can be critical in promoting engagement by supporting cultural competence, by helping the workforce reflect the population served, as well as by serving as cultural "bridges" to other providers working with the family and youth. They can also help educate their healthcare colleagues and de-stigmatize behavioral health conditions by sharing their lived experiences.

The Council also endorses engaging families and youth beyond just the receipt of services for their children. Patient and family engagement should include patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, evaluation, and policy-making – to improve health and healthcare.[34]

The Council lauds the Chapter 224 requirement that Accountable Care Organizations include a consumer representative in their governing structure. We recommend that ACOs appoint more

[34] Patient and Family Engagement: A Framework For Understanding The Elements and Developing Interventions and Policies, K. L. Carman, P. Dardess, M. Maurer, S. Sofaer, K. Adams, C. Bechtel, and J. Sweeney. *Health Affairs* 32. No. 2 (2013): 223-23.

than one consumer representative. At least one should represent families whose children receive both primary and behavioral health care and one should represent transition age youth. Examples worth noting include the Pediatric Primary Care Organization at Children's (PPOC), which is working with several of its practices to establish family advisory councils, and the PCMHI Workgroup on Behavioral Health Integration and the CHQC Task Force on Care Coordination whose members include parents of youth with physical and behavioral health chronic conditions.

4. Care Coordination

Care coordination should be a standard of care for all children. We have benefited from the significant effort of our colleagues on the Child Health Quality Coalition in defining how care coordination functions as a key integrating mechanism. The Council endorses the definition of care coordination put forth by Dr. Richard Antonelli and his colleagues[35]:

> Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

The MA Child Health Quality Coalition's Care Coordination Task Force's Care Coordination Framework identifies a structure for implementing care coordination as a standard of care. The Framework was developed by a multi-stakeholder task force with strong family representation and builds on implementation experiences nationwide. It offers a foundational set of care coordination services that is broadly applicable independent of condition, severity/acuity, or age, including adults, with the obvious additions of references to schools and transitions from pediatric to adult care.

> *Key Elements of High-Performing Care Coordination Linked to Process, Structure, and Outcome Measures to Monitor Their Adoption*
> 1. Needs assessment for care coordination and continuing care coordination engagement
> 2. Care planning and communication
> 3. Facilitating care transitions (inpatient, ambulatory)
> 4. Connecting with community resources and schools
> 5. Transitioning to adult care

[35] Making Care Coordination A Critical Component of the Pediatric Health System: A Multi-disciplinary Framework. R. Antonelli, J. McAllister, and J. Popp. Commonwealth Fund pub no. 1277. May 2009

Antonelli and colleagues delineate the following functions incorporated into care coordination. They also note that these functions are applicable across all ages (i.e., children and adults).

1. Provides separate visits and care coordination interactions
2. Manages continuous communications
3. Completes / analyzes assessments
4. Develops care plans with families
5. Manages / tracks tests, referrals, and outcomes
6. Coaches patients / families and promotes family engagement in treatment
7. Integrates critical care information
8. Supports/ facilitates care transitions across both settings and ages
9. Facilitates team meetings
10. Uses health information technology to organize care coordination activities

These functions could be performed by any member of a care team. Some (likely larger) practices might establish a dedicated care coordinator position. Others will distribute these functions among members of the care team. The competencies that are needed by whomever provides care coordination are:

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Approach is adaptable and flexible
8. Desires continuous learning
9. Applies solid team building skills
10. Adept with information technology

Instruments to assess the need for care coordination for behavioral health needs as well as the need to enhance patient or provider engagement ("activation") are needed. Examples of the former are the AACAP Child and Adolescent Service Intensity Instrument (CASII)[36] and the Patient Activation Measure.[37]

Locus of Care Coordination

For most children, it is the primary care provider who has an on-going connection and, thus, will be best able to serve as their medical home. However, there may be periods of time during

[36] www.AACAP.org

[37] www.insigniahealth.com/solutions/**patient-activation**-measure

which children with more intensive and chronic behavioral health needs could be better served by their behavioral health provider as their medical home. In fact, MassHealth is exploring how its 32 Community Service Agencies (CSAs) could serve as a health home (a special kind of medical home) for children with intensive behavioral health needs. A recent publication, "Customizing Health Homes for Children with Serious Behavioral Health Challenges", provides some helpful guidance on this, making the following points about how and why health homes are different from medical homes[38]:

- Health homes are intended for populations with chronic conditions, including those with serious behavioral health conditions, while medical homes are intended for every individual.
- Medical homes historically have focused on the coordination of medical care, while health homes are intended to build linkages to community and social supports and coordinate medical, behavioral and long-term care.
- Medical homes tend to use physician-led primary care practices as the coordinating entity or team. Health homes may use other types of entities, such as behavioral health provider organizations.
- General estimates are that two-thirds of the children served in intensive care coordination models like the CSAs are involved in child welfare and/or juvenile justice and sixty percent are involved with special education. The coordination among these systems along with behavioral health services consumes most of the care coordinators' time rather than the interface with primary care.
- This extensive systems involvement as well as the need to work closely with caregivers creates a complexity that has implications for care coordinator staffing ratios and qualifications as well as reimbursement rates.

Design and Operational Flexibility

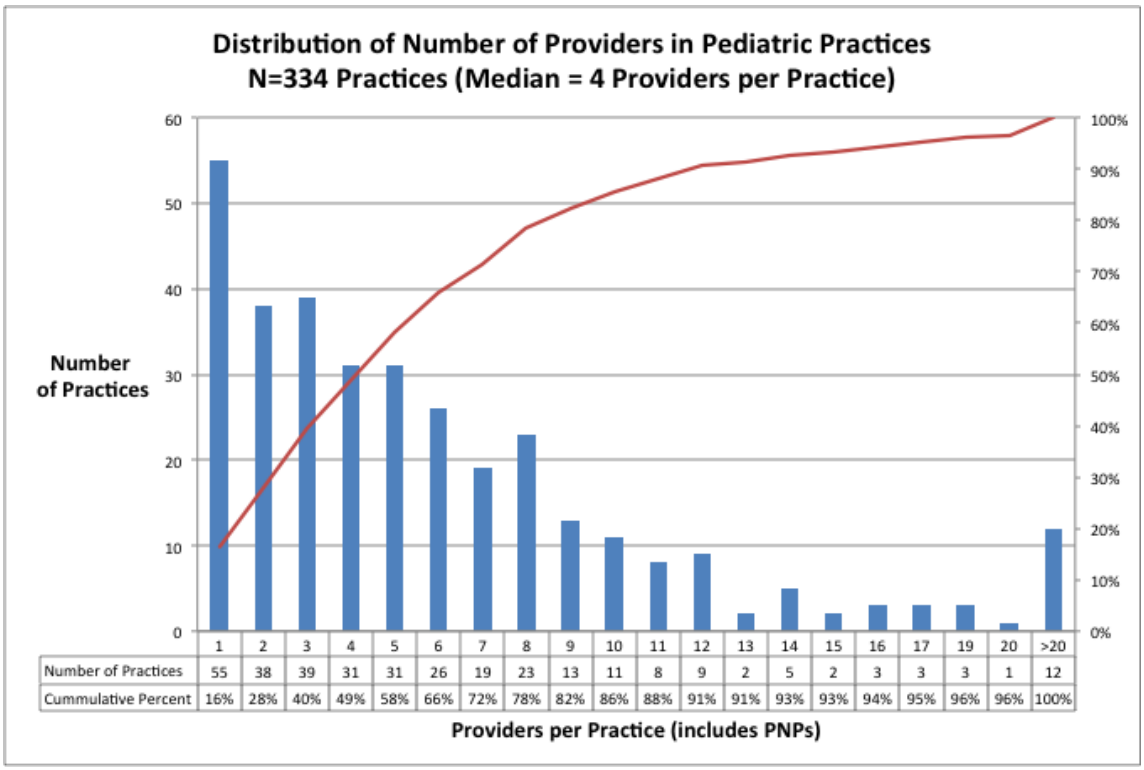
It is difficult to predict how many behavioral health providers, care coordinators, and peer partners would be needed at a PCP practice, an ACO, or system-wide. We asked our guest experts about the ratio of these staff to a primary care pediatrician's caseload within their practices. They generally estimated five primary care pediatricians would generate a full time workload for one care coordinator, but cautioned that testing and refinement of processes and relationships is needed. The demographics of the population served by each practice or ACO will have significant impact on the care coordinator and peer partner capacity needed. For minority populations and/or families living in poverty, there will likely be a relatively greater need in order to reduce disparities in access, treatment, and outcomes.

[38] Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

The varying size of primary care practices indicated in the chart below means that a number of arrangements will be necessary. These arrangements include: coordinated but not co-located, co-located and coordinated, and co-located and fully integrated. Small group practices and solo practitioners will likely need to develop arrangements to share capacity. Even a medium-sized group practice might not be able to afford a dedicated care coordinator but rather have a behavioral health specialist and peer partner share care coordination responsibilities. MCPAP is a good model for sharing capacity virtually. The CSAs could provide a base of support for Family Partners and Youth Peer Mentors, as they currently do for CBHI Family Partners.

Several experts shared with us the benefit of co-location in allowing a primary care provider to introduce the family/child to a behavioral health specialist, noting that a referral from a trusted provider increased comfort level with a behavioral health provider. They also noted the strong working relationships that develop because of co-location. They were careful to note that care coordination and co-location do not necessarily mean that care is integrated. Co-location eases integration, making it more likely, but doesn't guarantee it.

There is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. Care coordination, which is the key process for integrating care, should not be defined solely by its physical location. Primary care providers will need to be able to develop effective relationships with family therapy teams and with care management entities to support a significant portion of their patient populations. **Attachment A** provides vignettes of three children, their families, and their healthcare needs that illustrate the range of integration arrangements that will be needed in a well-functioning system.



Data from the MCPAP database. Provided courtesy of the Massachusetts Chapter of the American Academy of Pediatricians

Telemedicine

Given the varying sizes of pediatric practices, telemedicine will be an important mechanism to support integration. Small PCPs will likely need to access behavioral health consultation, peer supports, and care coordinators virtually.

The Massachusetts Child Psychiatry Access Project (MCPAP) solves this problem by providing primary care clinicians with virtual access, via telephone, to child psychiatry consultation. Funded by the Department of Mental Health and managed by the Massachusetts Behavioral Health Partnership, MCPAP is comprised of six regional teams of 1 FTE of a child psychiatrist, 1.5 FTE of a licensed social worker, and 1 FTE of a care coordinator. The regional focus helps foster relationships between PCP practices and their MCPAP team and promotes a teaching orientation. The program is designed to give primary care providers consultative support to manage children with less complex behavioral health needs, freeing the limited child psychiatry workforce to manage children with more complex needs. Services include: answering a PCP's diagnostic or therapeutic question, assistance in accessing behavioral health services,

transitional care until those services begin, and acute psychopharmacologic or diagnostic consultation. PCPs may access MCPAP for any child regardless of insurance type; more than half of the encounters are for privately insured children. [39] Commercial insurers have resisted requests to pay their fair share for MCPAP; we recommend that they be required to do so.

Workforce Development

Our Council membership represents a range of disciplines, each one committed to working through the challenges of primary and behavioral health care integration. We recognize that each of our disciplines has its own language, practice culture, professional licensure, and professional development resources.

Whether working on an integrated team, co-locating, or coordinating care between two provider sites, all primary care and behavioral health providers will need to become "bi-lingual", able to speak the language of both the primary and behavioral health care systems. Behavioral health specialists who work in primary care practice will likely be the solo practitioner and thus need to be a seasoned and skilled professional. Primary care practices will need to be welcoming and supportive of behavioral health providers.

We encourage the training programs and credentialing bodies of each discipline to take a leadership role in preparing and supporting professionals to collaborate with colleagues in order to deliver integrated care. Training programs to produce skilled behavioral health specialists to work in primary care settings are needed, as are training programs for pediatricians in working with behavioral health specialists. An example is the AACAP "Toolkit in Training for Systems-Based Practice" developed to support training of child and adolescent psychiatrists in these areas.[40] Licensing boards for the behavioral health professions should review licensure statutes and regulations to ensure that they do not create obstacles for training and supervised practice in innovative settings and practice models.

Ongoing professional development and learning opportunities will be needed to help health care providers continue to develop their abilities to work in an evolving integrated healthcare system. Continuing education requirements (e.g., CEUs) must reflect the specific knowledge and competencies needed to be an effective practitioner. In addition to formal training, real-time learning opportunities and communities of practice will be important. Payment methods and productivity expectations must allow for the time to participate in these opportunities.

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[39] The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care. Wendy Holt. Commonwealth Fund pub. 1378, Vol. 41. March 2010.

[40] http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

Peer supports need specific training and ongoing coaching and supervision, as well as a "home" where they can support each other. Accreditation for peer support specialists is supported the National Federation of Families for Children's Mental Health.[41] Resources are needed to develop this new workforce.

Performance Measurement

The Council believes strongly in the importance of outcomes. Ultimately, the significant effort and investment in integrating primary and behavioral health care is worthwhile only if it results in better health and wellbeing outcomes for children. We believe that the integration mechanisms that we recommend will do so; however, we acknowledge that they have not been rigorously studied and should be. Thus, we recommend that initial efforts focus on measuring and studying the quality and cost effectiveness of any integration mechanisms used. We need to know how these mechanisms are operating in order to understand their impact on quality, cost, and outcomes. The Council points to work of the Child Health Quality Coalition in inventorying measurement domains as a useful starting place for developing and testing measures of care coordination. Since care coordination measurement is in its earliest stages of development, we recommend that measures be promoted for usability and feasibility testing prior to requirements for pay-for-performance.

We also recommend measuring key process milestones towards good clinical outcomes (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction). Payers should invest in creating a culture of reporting by providing incentive payments to providers for collecting and using data to improve their performance. Reporting should allow providers to demonstrate their quality, especially those in new areas of performance, as well as to identify areas needing improvement.

Linking Pediatric Care with Care for Parents

Parents of children with a behavioral health condition are often under great stress and /or burdened with their own physical and/or psychological disorders. This can impede their ability to fully care for and to manage care for their children. Care coordinators and family partners can help the parent become more aware of how their unmet healthcare needs may adversely impact their best efforts to care for their children. Care coordination for children's health care should be prepared to develop linkages with the parents' medical care, in conjunction with the parent and the child's PCP, as needed.

[41] http://certification.ffcmh.org/resources

II. How current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes.

Our advice and recommendations come at a time of significant transition in healthcare payment methods. Some health insurers have already or are in the process of implementing alternatives to the traditional fee-for-service payment methods. We see great potential in using payment methods as a means to facilitating integration and achieving higher quality. We caution against using payment methods simply as a means to drive down costs. Investing in quality will be cost-effective over the long term. That said, we anticipate that fee-for-service payment will exist for a while longer, whether at the provider organization level or at the individual practitioner level. Therefore, our recommendations are intended to address both traditional and emerging payment methods.

Whether by supplementing fee-for-service rate schedules or by incorporating an alternative payment method, the integration mechanisms described above must be reimbursed / funded in order to achieve cost effective, quality care for children. In addition, reimbursement barriers to primary and behavioral care integration must be reduced so that we can learn what the service need really is and what it will take to deliver it. The real cost of behavioral health services is not currently known since behavioral health services have historically been under-utilized and underfunded. We caution against developing alternative payment methods that include behavioral health in a comprehensive rate until there is sufficient data available to inform utilization and pricing targets. Aligning billing requirements with the routines of integrated care, rather than with separated primary and behavioral health care as they are now, will help reveal actual need and cost.[42]

- Care integration services should be reimbursed as a bundle that incorporates the ten functions and the CHQC care coordination framework elements listed above. PCP practices will need leeway to determine the best way to staff those functions, given the size of their practice and the potential partners and resources available in their communities.

- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of behavioral health screening at every

[42] The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

well child visit. Providers should not be limited to one screening per visit, as is the case currently. If they deem necessary for assessing a youth's health, they should be reimbursed for conducting both a mental health and a substance abuse screening. In particular, reimbursement for behavioral health screening should be mandatory for any adolescent who screens positively for substance use disorder (SUD), given the very high rate of co-morbidity of a mental health diagnosis in the context of a SUD.

- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of post partum screening in pediatric well child visits for parents of children under six months in age.

- Several other changes are needed to make it possible to support and refine the integration of primary and behavioral health care.[43] [44]
    - Eliminate any restrictions on same-day billing between behavioral health and primary care providers.
    - Allow both primary care and behavioral health providers to bill for overlapping time.
    - Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day.
    - Allow for brief intervention services to be billed before a full assessment is completed.
    - Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
    - Set rates for consultation time to a PCP commensurate with rate for psychotherapy direct service.
    - Pay primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without their child present when the focus of the visit is the child's healthcare needs.

- Reimbursement methods should support the adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care. Parent training programs have a particularly strong evidence base and we call attention to two: the Family Talk Preventive

[43] The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

[44] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

Intervention and the Positive Parenting Program (Triple P). Developed by our colleague and Council member Dr. Beardslee, Family Talk is designed to help families identify the effects of parental depression, share individual experiences with parental depression, build on family strengths, improve family communication about depression, build coping skills and develop strategies to promote resilience in parents and children. [45] Triple P gives parents simple and practical strategies to help them confidently manage their children's behaviors, prevent problems from developing, and build strong, healthy relationships.[46]

- We recommend measuring structure and process (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction) before paying for outcomes. Managing any alternate payment method will require good measurement of process and proximal outcomes. It also requires fully defining care coordination and measuring when it is occurring as appropriate in order to assess its contribution to improved outcomes.

- Children will vary greatly in the amount of care coordination they require. Payment mechanisms need to accommodate this variation and must be structured so that payers and providers share risk for the cost of care, particularly for children with complex health needs and costs. Care coordination for children with modest needs for care coordination might be paid through a PMPM rate to the PCP, for example, while children with intensive needs requiring dedicated, low-caseload care coordination might receive this through a per diem rate.

- Establishing rates for a new service model, without a payment or utilization history, is hard to get right the first time. There must be sustained commitment and effort to review and adjust rates to ensure that they support both the service standards and the organizational supports required to manage the services (e.g., information technology). Insurers and providers must work together to review and adjust payment rates and/or methods to ensure high quality care is provided in a cost-effective manner.

- In addition to alternative payment methods for healthcare, it might be fruitful to explore alternative financing methods across child-serving systems. There are two points of access for children to receive behavioral health care services: pediatric primary care and schools. However, funding is siloed and healthcare reform doesn't impact some of the financing sources for school-based care. Some school-based care is provided by community-based agencies and reimbursed by insurance, while some services are provided directly by school personnel and financed by the school (e.g. municipal Medicaid, Federal grants). Methods that integrate healthcare financing across child-serving systems might allow for even more effective healthcare delivery integration and reduced healthcare costs.

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[45] http://fampod.org

[46] http://www.triplep-america.com/index.html

III. The extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols.

Parity

Ensuring that behavioral health treatment is covered in the same way as treatment for physical health conditions, as legally mandated, is a critical foundation for the integration of behavioral health and primary care. Clear guidance for both providers and consumers and enforcement regarding parity will remain necessary as new health care delivery arrangements are developed. We support the numerous recommendations that our colleagues leading the Children's Mental Health Campaign have provided to the Division of Insurance.

Achieving Chapter 224's quality and cost goals requires a broader view of what it means to treat behavioral health and physical health conditions on par with each other. Focusing solely on the amount of services will not be sufficient as primary care providers become dependent on the quality of and access to behavioral health services. Quality behavioral health services can help improve primary care outcomes and costs if they are broadly available as well as reimbursed sufficiently and in a manner that allows them to be delivered as we have recommended in this document.

First, there must be a full array of community-based behavioral health services available to children and families regardless of where they live and what health insurance they have. Currently, MassHealth offers a richer array than do private insurers. Commercial insurers will need to offer an equally rich array in order to achieve quality and cost outcomes for children.

Second, parity also needs to include support for behavioral health interventions (e.g. talking to the patient or family) at a rate based on time and complexity commensurate with rates that support physical health interventions. For example, PCPs should not continue to be reimbursed more for the few minutes required to freeze off a wart than a half hour talking with the child or parents about a behavioral health issue such as the impact on the child of parental divorce when parents are putting the child in the middle of their conflict with each other. Reasonable rates will help ensure a sufficient number and range of behavioral health providers and services.

Choice

The Council believes strongly that families should be able to choose their healthcare providers. However, we recognize the tension between the value of according broad choice to families and the strategy of co-locating primary care and behavioral health.

Allowing families to choose to receive behavioral health from a provider that does not have a relationship with their PCP undermines the integration mechanisms that we recommend above. In an integrated system, when families choose a primary care provider, they will increasingly also be choosing a behavioral health provider.

Therefore, they should have access to information about how primary care providers integrate behavioral health services, how this might impact their children's care, and the expected benefits of coordinated or integrated care. Our hope is providers will offer primary care and behavioral health care services that are so responsive to and effective in meeting families' needs and concerns that families will choose these new integrated arrangements. Peer supports can help families understand their options, and make well-informed choices, and be educated consumers of these new health arrangements.

IV. How best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services.

We believe that the functions and positions described in our response to Question I are key strategies for helping primary care providers recognize behavioral health conditions and to make appropriate referral decisions. Using standard screening tools to identify behavioral health concerns, consulting with behavioral health providers, and working with peer supports and care coordinators to access appropriate services are important patient-level strategies.

There are strategies at the macro level as well. First, professional development and licensure /credentialing bodies must reflect the knowledge and competencies required to be effective in a more integrated healthcare system. Experts in integrated care delivery could identify specific topics and competencies. Second, primary care providers will need to establish clear referral pathways and relationships with community providers. PCPs will need knowledge about and confidence in the organizations to which referrals could be made. Primary care and behavioral health care providers must work together to ensure that the right service capacity exists to meet the needs of children and their families. This means that the behavioral health service array should be equally robust as physical health services.

V. How best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness.

The co-morbidity issues for children are different from those of adults with serious mental illness. Children with serious behavioral health challenges do have high rates of expensive co-morbid physical health conditions. Recent estimates suggest that about one-third of Medicaid-enrolled children who use behavioral health care have serious medical conditions, principally asthma. However, Medicaid expenditures for children who use behavioral health care – even the most expensive of these children – are driven more by behavioral health service use than by use of physical health care – in contrast to the adult population.[47]

For children, the issues of concern are more often in reverse: it is the effect of emotional or psychological trauma, or toxic stress, on their physical health over their lifespan into adulthood about which healthcare providers need to be educated. There is ever- expanding basic science research demonstrating how ongoing stress of sufficient intensity can cause enduring changes in brain maturation across childhood into young adulthood. The most compelling evidence of this impact has been produced by the landmark Adverse Childhood Experiences (ACE) study. The ACE Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC).

Adverse Childhood Experiences (ACEs) include 10 types of adverse childhood experiences: childhood abuse (emotional, physical, and sexual abuse), neglect (physical and emotional), and family dysfunction (growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, a parental separation/divorce, or a family member incarcerated). Over 20% of respondents experienced three or more categories of trauma, or ACEs. The ACE Study examined the relationship between these experiences during childhood and reduced health and well-being later in life. It showed dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of death.

[47] Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

As the ACE Study gains traction across the nation, some states have collected statewide, population level ACE data gathered through the Behavioral Risk Factor Surveillance System (BRFSS). The MA Department of Public Health should explore the feasibility of incorporating the ACE questions in its annual BRFSS survey.

Investing in Wellness

According to the National Academy of Sciences, several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral disorders are greatest by focusing on young people. Interventions before the disorder occurs offer the greatest opportunity to avoid the substantial costs to individuals, families, and society that these disorders entail. [48]

Chapter 224 created a Prevention and Wellness Trust Fund, administered by DPH in collaboration with the Prevention and Wellness Advisory Board. All activities paid for by the fund must support Massachusetts's goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming. The Commissioner of DPH must award at least 75% of the fund each year through a competitive grant process to community-based organizations, health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need. [49]

DPH should take a strategically long-term approach to managing this Wellness Fund by investing, in part, in children's well-being. The Council recognizes that responding to ACEs and childhood trauma is not solely the purview of the healthcare system but also of the broader social services and public health systems. This Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care

[48] Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

[49] Summary of Chapter 224 of the Acts of 2012. Anna Gosline and Elisabeth Rodman, *Blue Cross Blue Shield of Massachusetts Foundation*. September 2012

organizations. It could utilize ACE data, along with other sources, to guide its grant-making and leverage existing initiatives that incorporate a trauma-focus into service delivery. Wellness Fund investments should be studied for their ROI.

VI. The unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

The Council recognizes that all of the above strategies for integrating care will have little impact if health information cannot be shared among all providers on a care team (regardless of physical location). We fully acknowledge the tension that exists between promoting communication among all members of a child's care team and ensuring that confidentiality and privacy protections are in place. Our colleagues on the Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues. The Council supports their emerging recommendations, provided in Attachment B.

One of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, DCF, and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to the sharing of information by parents and/or young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances.

ATTACHMENT A: Three Vignettes Illustrating Primary Care and Behavioral Health Integration

The following three vignettes illustrate pediatric primary care and behavioral health integration at different levels of intensity of care coordination. We believe that family-driven care coordination, at all levels of intensity, is they key element of service integration as experienced by the youth and family. These vignettes are fictitious and are not based upon any specific child or family.

These vignettes are meant to demonstrate how a well-functioning system might respond to various levels of family need for care coordination. The system should meet whatever level of need the family experiences. We do not mean to suggest that there should be three fixed models or that families should be assigned to fixed tiers of service intensity.

Sara

Sara is an 11 year old fifth-grade girl seen in a group pediatric practice. Her mother brings Sara to see her PCP with a chief complaint of recurrent headache of recent onset. Sara has always shown signs of shyness, and recently has been complaining of headaches, often on school mornings. On these mornings she refuses to go to school. Sara has also been coming home from school in tears saying the other kids make fun of her; this is not altogether new but is happening more often this year. Sara is highly verbal and historically has been very successful academically, but sometimes appears to be "off" in her social interactions. She's also beginning to have difficulty in some of her academic subjects. Sara is medically well and appears to have no notable family or neighborhood stressors. Her 8 year old sister is doing fine.

Sara's mother is worried about Sara's headaches as she herself has a history of debilitating migraines (for which psychotherapy was prescribed but was not perceived as helpful). She is also concerned about Sara's social frustration and newly emerging academic problems.

Sara's mother brings her to her PCP with the complaint of recurrent headache and stresses at school. The PCP suspects that Sara's recent headaches and school refusal are related and after conducting a physical exam defers further medical workup. The PCP practice is large enough, with 7 FTE primary care clinicians, to support a full time on-site psychologist who has a policy of being interruptible for PCPs "warm hand-offs". The psychologist provides training, curbside consults with PCPs, and offers assessment and brief treatment for patients like Sara with relatively simple and mild to moderate behavioral health conditions. He also makes referrals to community BH providers for children with more complex or acute conditions, and coordinates care of those children with those providers. In this case, the psychologist meets briefly with Sara and her mom and arranges a return appointment later in the week. Although Sara's mom is concerned about a possibly serious headache syndrome that might require further medical evaluation, she finds it easier to accept a psychological consultation with a provider to whom she has been already introduced by Sara's PCP, and who offers a quick follow-up consultation in PCP office.

The psychologist meets with Sara and her mother the following week. He, Sara, and Sara's mother are quickly able to agree that fifth grade is proving a stressful year for Sara and that she might benefit from

learning some new skills to manage stressful moments. Over the next four months he meets six times with Sara and with Sara's mom or dad, teaching relaxation skills to Sara and the parents. He also suspects that Sara has some deficits in cognitive processing of social cues, and helps her parents request an evaluation of Sara for special education services. They are eager consumers of medical information and gladly read materials he provides on non-verbal learning disorders. He has time for several phone calls with Sara's school to assist in setting up her evaluation, and phone calls to her parents to coach them through the process of having Sara testing and IEP process. He also suggests to her parents that they explore some social skills groups in the community and he provides reference materials for two programs. With the parents, he is also able to explore with the school whether Sara is being bullied at school.

School testing reveals that Sara does has some cognitive deficits that affect her reading of social cues, and of her own emotions, and that could affect her developing awareness of her own psychological functioning. The school offers special educational support with organizational tasks, and a social skills group. The school adjustment counselor also works with the Sara, Sara's parents and the school nurse to develop and support strategies that Sara can use when feeling "stressed out" by peer issues or academic challenges. The school acknowledges that some bullying has occurred and includes a component in Sara's IEP to provide greater supervision and intervention if bullying occurs.

Commentary on integration with Sara:

Sara has a mild / moderate level of behavioral health acuity, and some complexity evident in the involvement of a non-medical service sector (education). It is clear that her difficulties could quickly escalate without the help provided in this scenario. The care Sara receives is timely and appropriate, and receiving counseling in the PCP setting may also reassure Sara's mother that the medical aspect of Sara's headaches is not being ignored. Sara's parents are willing consumers of the education offered by the co-located psychologist.

The co-located practice model in this illustration is drawn from Dr. Glenn Focht's description of a very promising model being piloted at PPOC. This model is designed to work for practices with at least 6 PCPs; if Sara's PCP belonged to a smaller practice, full co-location would not be practicable. Also, if evidence arose that Sara would work better with a female therapist, or if cultural or linguistic factors favored a behavioral health clinician with different competencies, her behavioral health care would need to be referred out. This model is based on behavioral health services lasting for a short duration and not requiring a high level of care coordination as the behavioral health clinician is expected to see 15 (out of a total caseload of 30) new cases per week. Fortunately, Sara's need for treatment and care coordination in this illustration fit within these requirements. In general this model for integration appears to work best with children and families with relatively low acuity and complexity, and might be especially helpful when behavioral health problems have a strong somatic component. While medication was not considered for Sara, the co-location of the psychologist and the PCP could have helped to facilitate communication with a consulting psychiatrist if this had been needed.

- **Kalina**

Kalina is an 11-year old girl attending sixth grade at a suburban middle school. She lives with her mother and younger brother and sister and has weekend visits to her father in another town, which she usually enjoys. Kalina is medically well, has routine PCP well child visits, and no behavioral health services. Her mother, to whom Kalina has historically been very close, is undergoing treatment for cancer and Kalina's two maternal aunts are frequently in the home to help out and to supervise the kids when Kalina's mother needs rest. Kalina's mother is worried she will lose her full-time job due to medical absence and has shared this with Kalina. Kalina is bright and has always been successful in school. She often tries to dominate her younger sisters and seems to compete with her aunts for control when they try to help out. Kalina's mother is more angry than usual with Kalina's father and when Kalina visits her father she rebuffs his attempts to cheer her up, and increasingly feels cut off from him. She also feels worried because her father has been sober for two years and she fears he will relapse if she upsets him.

Kalina's teacher has become concerned about changes in Kalina's behavior: she seems increasingly irritable in class, has gotten into feuds with other girls, which in one case erupted into a physical fight, and her journals and poetry contain explicit suicidal imagery. She has also gotten into confrontations with a couple of teachers and is not turning in her work consistently. Last week she confided to her teacher that one of her aunts had repeatedly slapped her; the school nurse filed a 51A. A DCF worker contacted the PCP seeking information and trying to determine how to help Kalina and her family. Later the PCP learns that DCF has screened out the report of abuse.

Commentary on integration with Kalina:

Kalina's situation is not unusual: a child with no recent history of behavioral health care but with fulminating behavioral health problems. Although the child and family have many strengths, things seem to be falling apart. Clearly Kalina has need for psychological support, but there are also family needs that must be addressed. The mother's medical crisis has realigned the family hierarchy resulting in disruption of Kalina's relations with her aunts, her father, her peers, and teachers. Initiating individual therapy would not address the family needs that are precipitating Kalina's behavior changes.

The well-targeted intervention of limited intensity and duration that works for Sara (behavioral health clinician co-located within the PCP practice) will probably be insufficient for Kalina. Kalina needs resources mobilized quickly and intensively to assess the family situation, address concrete needs, and provide rapid treatment to de-escalate and stabilize the developing crisis. Someone needs to open a conversation immediately with Kalina's mom and Kalina, leading to subsequent conversations with Kalina's aunts, father, and siblings. In-home visits may be the best way to accomplish this. They must also get consent to talk with the PCP, DCF, and Kalina's school to understand her support system. Then they must be able to develop a plan with Kalina's mother that can unite various stakeholders in working to support the family through the crisis.

Unlike Jacob (the vignette below), with his long history of problems and his need for long-term planning and coordination, Kalina and her family need a rapid mobilization of resources including both treatment and care coordination. This type of resource is typically provided by a family therapy team with the capacity to do intensive outreach. Currently, MassHealth provides this resource through the In-home Therapy service. Some commercial plans pay for similar

services, particularly on an individually-negotiated basis. Usually such teams are located in organizations that provide other behavioral health services.

A co-located clinician in a PCP practice will probably not have the time needed to meet Kalina's needs. However, PCPs could contract with behavioral health teams to provide treatment and coordination for their clients with high-intensity treatment need. The behavioral health team would maintain close contact with the clinician in the PCP practice throughout Kalina's treatment and while stepping her down, eventually, to less intensive treatment.

- **Jacob**

Jacob is an 11-year old boy, attending fourth grade at his local public school, adopted at age 8 through the Department of Children and Families. His adoptive family was previously his foster family; he has two adoptive siblings who are in their late teens and functioning well. Jacob has a long history of special educational services and behavioral health services including six stays in institutional settings (inpatient hospitalization twice, CBAT three times, and a DCF STARR program once). Jacob has a full-scale IQ of 85, is believed to have had significant fetal alcohol exposure, is of very short stature for his age, and is about two years behind grade level in reading and math. He is an affable and outgoing boy who is somewhat impulsive and inattentive and has difficulty following complex verbal instructions. He loves sports and with some support has been able to participate with great enthusiasm, despite being small, in his town's youth football program. He has occasional contact with his birth mother, which is regulated by his adoptive parents, and which often results in some behavioral decompensation. Jacob's adoptive parents and therapist agree that these contacts, while stressful to Jacob, are also very important to him and should be facilitated when possible.

Historically Jacob has responded to stress and loss by running away, exploding with rage, and fabricating stories (confirmed untrue) of being abused. Since becoming adopted his behavior has stabilized considerably but his parents worry about his transition into adolescence and his ability to maintain a place in a pro-social peer group. After a CBAT admission last year, following particularly disruptive contacts with his birth mother, Jacob began boasting in school about drug use and sexual exploits, narratives that he apparently acquired from peers at the CBAT.

Jacob is medically well and has had extensive medical workups for his short stature in the past, as well as neuropsychological assessment and psychiatric evaluations for medication. Despite concerns about his growth, he is currently on a regime of Adderal managed by his pediatrician. He has a counselor at a local clinic who has known him for two years and also consults frequently with his parents. During the past three years he has also had In-home Therapy, Intensive Care Coordination (ICC), and Therapeutic Mentoring at various points through his MassHealth plan. While in ICC, Jacob's family was connected with a Family Partner who has continued to work with them even since graduating from ICC eight months ago. ICC helped to bring together all the known information from Jacob's complex history, to prioritize the family's goals for treatment, and to organize a plan of care that coordinates multiple services and supports (including medical services, Crisis Intervention, and CBAT discharge planning), putting the family in the driver's seat as much as possible. The family continues to work on the goals although no longer actively involved in ICC. The goals include: repeating Jacob's neuropsychological

evaluation and meeting with the school to consider plans to help him catch up on critical academic skills; finding positive social and peer supports through sports, church and extended family; reevaluation of his medication on a regular basis. The family considers their Family Partner to have been one of the most significant components of the CBHI system in helping them learn to be empowered consumers who understand how to communicate effectively with other system partners, becoming as a result more independent and self-sufficient in managing Jacob's care.

Commentary on integration with Jacob:

Jacob is a boy with moderate acuity, high complexity, and a fairly strong support system. He is likely to have significant emotional / behavioral challenges during every major life transition or period of loss. Although he has had some medical concerns relating to his short stature, most of his medical services have been behavioral health services, and his care has been coordinated primarily by behavioral health providers (previously ICC and Family Partner, currently outpatient therapist and Family Partner).

The care coordination that integrates medical and behavioral care for Jacob is based on the model of CBHI services for MassHealth members (age birth to 21). Intensive Care Coordination provides a high level of care planning and care coordination, referring to other services for treatment. When the child's need for intensive planning and coordination declines, this function can shift to another level of care (such as outpatient, in Jacob's case). In this model the PCP is an important partner in the process, while the locus of planning and coordination lies outside the PCP. Strengths of this model include the ability to deal with children and families with very complex needs (cultural and linguistic competence, crisis management, extensive efforts to engage the family and natural supports, liaison with state agencies and schools), and a very strong emphasis on culturally-informed family-driven care. The use of an external organization which is dedicated to care coordination and provider Family Partners gives the PCP an enormous resource for supporting and following the most complex and high risk children and their families. Challenges inherent in this model include the fact that it is not currently supported by commercial payers, the systemic need to train more behavioral health workers in the novel and demanding model of Intensive Care Coordination, and the need for primary care to develop relationships and role understanding to work effectively with external care management entities.

- **Summary comments**

These vignettes suggest that there is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. A co-located behavioral health clinician in a primary care practice is convenient for the PCP and can help with the large number of PCP clients who need a relatively light level of behavioral health intervention and coordination. Depending on the population served by the practice, however, there will be a segment whose needs are not fully met by this model. This includes children and families who need services mobilized intensively and quickly, and children with long-term needs for coordination of care for complex needs. Cultural complexity and caregiver impairment also create needs that are not easily met by brief intervention.

As a result, care coordination, which is the key process for integrating care, cannot be defined by its physical location. PCPs will need to be able to develop effective relationships with family

therapy teams and with care management entities to support a significant portion of their patient populations. Internally located behavioral health clinicians can facilitate those relationships but cannot take their place. External care management resources will help PCPs with family engagement, with mobilization of appropriate levels of treatment and care coordination resources, and with community engagement to meet families' non-medical needs.

ATTACHMENT B:

MA Child Health Quality Coalition

Communication and Confidentiality Task Force

Suggestions for the Behavioral Health Integration Task Force Recommendations

on Confidentiality/Privacy Issues

(3-18-13)

The MA Child Health Quality Coalition has an active Communication and Confidentiality Task Force created to support its work promoting improved care coordination for children in Massachusetts, including addressing special issues for children with behavioral health needs.

Task Force Objective: Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.

This Task Force has been identifying issues impacting communications and confidentiality across the Coalition's different stakeholder groups and identifying resources that can help in addressing those issues. Based on the task force work to date, the following recommendations for confidentiality and privacy considerations should be considered:

(1) Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

(2) Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages.
- Provide guidance on the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.).

- Strategies that encourage information sharing (e.g. "opt out") still need safe guards that ensure informed consent.
- Special issues of confidentially must be considered for adolescents
- Peer networks offer important opportunities to support youth in understanding privacy protections and promote **strategic sharing**

(3) Sharing behavioral health information with families/youth can improve accuracy and patient safety.

(4) Look at privacy as a whole, not just within electronic health records.

Recommendations on Confidentiality/Privacy Issues for Behavioral Health Integration

Expanded Detail on CHQC Task Force Input from Child/Adolescent Perspectives

Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

- Leverage work already done that identifies the communication needs in a way that will transfer just enough information. See for example:
  - *Combined MCE Behavioral Health Provider/Primary Care Provider Two-Way Communication Form* in use for children receiving services under the Children's Behavioral Health Initiative.
  - *Re-entry planning for students returning to school following hospitalization for a behavioral health crisis* developed by the MetroWest Foundation/Framingham Public Schools and the Brookline Resilient Youth Team.
  - *Boston Public Schools Superintendent's Circular on Sharing Student Health Information* that offers guidance including expressing all diagnoses, especially those related to mental health, as a functional diagnosis.
- Provide specific training/guidance around what types of information pediatricians/MDs want and/or need from behavioral health providers and what types of information behavioral health providers need/want from MDs.
  - The Task Force puts special importance on improving information sharing when a child is getting psychotropic meds prescribed by a BH provider, but the pediatrician is providing ongoing monitoring of the medication. Sharing best practices in this area would be especially useful.

Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages. This is especially true for behavioral health care where there is often an evolutionary process in settling on the correct diagnosis.
- Providers need training on how to explain the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.). Best practices including scripts and checklists should be disseminated widely.
- Strategies that encourage information sharing such as having sharing as the default with families signing only if they want to "opt out" need important safe guards that ensure enough context is shared that the families know what they are agreeing to.

- Special issues of confidentially must be considered for adolescents, including how and when to transition from having their parent/proxy as the signer and also addressing the sensitivity in putting a diagnosis or confidential services delivered to a teen into the medical record to avoid being seen by the teen's family. Suggestions for how to document that, so that payers can have a record, and other providers can become aware, without risking release of confidential information would be helpful.
    - See for example issues raised in the MCPAP/DPH BSAS alcohol and substance abuse screening toolkit www.mcpap.com/pdf/CRAFFT%20Screening%20Tool.pdf, p. 15-16.
- Peer networks offer important opportunities to support youth in understanding privacy protections that exist in different settings and promote **strategic sharing** that identifies what is appropriate information to share

Sharing behavioral health information with families/youth can improve accuracy and patient safety.

- Adolescents and families often do not see a lot of the information that is in their behavioral health records as well as information that is shared among staff at the primary care provider's office and with the medical care team. Having providers consistently share information with the youth/family should be viewed as a fundament component to protecting patient safety and preventing sharing of incorrect information.
- Share best practices where youth have been empowered to review their medical records.

Look at privacy as a whole, not just within electronic health records.

- New modes of communication (remote servers, email, the cloud…) offer important opportunities to improve communication among disparate members of a child's care team. Strategies for promoting effective use of these technologies should be part of the recommendations.
- Still, it is important to recognize that electronic medical records make it so easy to share without thinking, so suggestions for how to ensure that only minimally necessary information is generated from an EHR, that still allows providers to take advantage of the ease of electronically generating records/forms, are crucial.

References available on request.

Please contact Val Konar, staff lead for the MA Child Health Quality Coalition Communication and Confidentiality Task Force: valerie.konar@state.ma.us

ATTACHMENT C: SOURCES

Presentations to the Advisory Council

Karen Hacker, MD MPH, Institute for Community Health, Cambridge Health Alliance *Overview of Behavioral Health Integration Models and Examples*, February 4, 2013

Richard C. Antonelli, MD, MS, Boston Children's Hospital*, Achieving Accountability for Optimal Outcomes: Care Coordination as a Driver to Integration of Behavioral and Medical Care Delivery*, February 4, 2013

Glenn Focht, MD and Marilyn Manion, MD, Pediatric Primary Care Organization at Children's (PPOC), *Challenges of Behavioral Healthcare Delivery in a Pediatric Primary Care Network and Discussion of a New Integrated Model*, March 4, 2013

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NIMH, Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005

NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011

Care Coordination and Integration

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Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251.

Integrated Primary Care: Organizing the Evidence. A. Blount. *Families, Systems & Health*, Vol. 21, No. 2, 2003.

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Patient and Family Engagement: A Framework For Understanding The Elements and Developing Interventions and Policies, K. L. Carman, P. Dardess, M. Maurer, S. Sofaer, K. Adams, C. Bechtel, and J. Sweeney. *Health Affairs* 32. No. 2 (2013): 223-23.

Integrating Evidence-Based Engagement Interventions Into Real World Mental Health Settings. McKay, M. et al. Brief Treatment and Crisis Intervention, Oxford University, 4, 2, 177-186, 2004.

Chapter 224

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Behavioral Health Screening

Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

CMCS informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions. Department of Health and Human Services, Centers for Medicare & Medicaid Services. March 27, 2013.

Massachusetts Child Psychiatry Access Program (MCPAP)

The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care. Wendy Holt. Commonwealth Fund pub. 1378, Vol. 41. March 2010.

Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatry Access Project. Barry Sarvet, Joseph Gold, Jeff Q. Bostic, Bruce J. Masek, Jefferson B. Prince, Mary Jeffers-Terry, Charles F. Moore, Benjamin Molbert and John H. Straus. *Pediatrics* published online Nov 8, 2010; DOI: 10.1542/peds.2009-1340.

Workforce Development

American Academy of Child & Adolescent Psychiatry
http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

National Federation of Families for Children's Mental Health http://certification.ffcmh.org/resources

Innovative and Evidence-Based Programs

Children's Behavioral Health Initiative: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/

Patient Centered Medical Home Initiative: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/

Child Health Quality Coalition: http://www.mhqp.org/collaboration/chqc.asp?nav=063700

Family Talk: http://fampod.org

Positive Parenting Program (Triple P): http://www.triplep-america.com/index.html

Prevention

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The System of Care Handbook: Transforming Mental Health Services for Children, Youth and Families. Stroul BA and Blau GM. Paul H. Brookes Publishing Co., Baltimore, 2008.

Attachment 5: Financial Performance by Payor/Revenue Category (Response to Exhibit C Question 1).

BOSTON CHILDREN'S HOSPITAL

Payor Analysis Breakdown by Commercial, Other Government, Medicaid, and Other

FY2009 to FY2012

Percent of GPSR				
Payor Type	**2009**	**2010**	**2011**	**2012**
Commercial	**64.8%**	**64.6%**	**63.1%**	**63.0%**
MA	47.0%	52.7%	43.1%	42.2%
Non-MA	17.8%	11.9%	20.0%	20.8%
Medicaid	**28.9%**	**28.1%**	**28.5%**	**29.4%**
MA	23.3%	24.6%	22.6%	22.8%
Non-MA	5.6%	3.5%	5.9%	6.6%
Other Government	**3.7%**	**3.6%**	**3.9%**	**3.5%**
MA	2.7%	3.0%	2.9%	2.6%
Non-MA	1.0%	0.6%	1.0%	0.9%
All Other	**2.6%**	**3.7%**	**4.5%**	**4.2%**
MA	0.6%	1.3%	0.5%	0.6%
Non-MA	2.0%	2.3%	4.0%	3.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Percent of NPSR				
Payor Type	**2009**	**2010**	**2011**	**2012**
Commercial	**71.6%**	**72.8%**	**72.6%**	**73.3%**
MA	50.7%	58.4%	48.3%	48.8%
Non-MA	20.9%	14.3%	24.4%	24.5%
Medicaid	**23.8%**	**21.6%**	**21.3%**	**20.5%**
MA	20.3%	19.3%	17.7%	16.5%
Non-MA	3.5%	2.3%	3.7%	4.0%
Other Government	**2.2%**	**2.1%**	**2.4%**	**2.2%**
MA	1.5%	1.6%	1.7%	1.5%
Non-MA	0.6%	0.5%	0.7%	0.6%
All Other	**2.4%**	**3.5%**	**3.8%**	**4.0%**
MA	0.3%	1.1%	0.2%	0.3%
Non-MA	2.1%	2.5%	3.6%	3.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Operating Margin ($) - Total				
Payor Type	**2009**	**2010**	**2011**	**2012**
Commercial	**$148,491,659**	**$160,937,933**	**$184,969,944**	**$156,214,824**
MA	$93,010,005	$126,525,148	$110,489,810	$97,421,229
Non-MA	$55,481,654	$34,412,785	$74,480,134	$58,793,594
Medicaid	**($15,981,353)**	**($33,271,173)**	**($31,848,629)**	**($59,065,372)**
MA	($1,903,154)	($25,267,492)	($20,593,949)	($41,949,958)
Non-MA	($14,078,199)	($8,003,682)	($11,254,680)	($17,115,414)
Other Government	**($10,889,224)**	**($10,252,878)**	**($9,923,676)**	**($9,414,048)**
MA	($8,514,832)	($9,191,908)	($8,193,670)	($7,992,527)
Non-MA	($2,374,392)	($1,060,971)	($1,730,006)	($1,421,522)
All Other	**($41,121,082)**	**($54,393,881)**	**($76,774,640)**	**($44,356,404)**
Overall	**$80,500,000**	**$63,020,000**	**$66,422,999**	**$43,379,000**

Net Revenue ($) - Total				
Payor Type	**2009**	**2010**	**2011**	**2012**
Commercial	**$684,652,804**	**$693,606,986**	**$680,901,001**	**$655,844,605**
MA	$484,474,045	$557,083,043	$452,542,153	$436,580,329
Non-MA	$200,178,759	$136,523,943	$228,358,848	$219,264,277
Medicaid	**$227,376,821**	**$205,909,268**	**$199,787,450**	**$183,381,536**
MA	$194,255,058	$183,708,306	$165,497,370	$147,171,582
Non-MA	$33,121,762	$22,200,961	$34,290,079	$36,209,954
Other Government	**$20,646,273**	**$19,977,416**	**$21,999,887**	**$19,504,487**
MA	$14,558,579	$15,526,205	$15,596,906	$13,788,521
Non-MA	$6,087,694	$4,451,211	$6,402,981	$5,715,967
All Other	**$363,619,103**	**$391,229,330**	**$406,281,663**	**$423,076,371**
Overall	**$1,296,295,000**	**$1,310,723,000**	**$1,308,970,000**	**$1,281,807,000**

Operating Margin (%) - Total				
Payor Type	**2009**	**2010**	**2011**	**2012**
Commercial	**21.7%**	**23.2%**	**27.2%**	**23.8%**
MA	19.2%	22.7%	24.4%	22.3%
Non-MA	27.7%	25.2%	32.6%	26.8%
Medicaid	**-7.0%**	**-16.2%**	**-15.9%**	**-32.2%**
MA	-1.0%	-13.8%	-12.4%	-28.5%
Non-MA	-42.5%	-36.1%	-32.8%	-47.3%
Other Government	**-52.7%**	**-51.3%**	**-45.1%**	**-48.3%**
MA	-58.5%	-59.2%	-52.5%	-58.0%
Non-MA	-39.0%	-23.8%	-27.0%	-24.9%
All Other	**-11.3%**	**-13.9%**	**-18.9%**	**-10.5%**
Overall	**6.2%**	**4.8%**	**5.1%**	**3.4%**