MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

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

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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit the Suffolk University website. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be available via livestream and video will be available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing page on the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Boston Children's Hospital
Until every child is well™

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

September 20, 2019

David Seltz
Executive Director
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Dear Mr. Seltz,

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

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

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

Sincerely,

Sandra L. Fenwick
Chief Executive Officer
Boston Children's Hospital

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:
   Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

   a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

Boston Children's Hospital is the Commonwealth's only acute freestanding children's hospital. We provide care to some of the most complex pediatric patients from across the state, the country, and the world. Most children are not medically complex and are generally well; as such, pediatric primary care well child visits are highly standardized and benchmarked, presenting limited opportunities for finding cost savings in this segment of our population. The majority of pediatric health care expenditures are concentrated in a small group of children with medical complexity (CMC) who frequently have lifelong, complex care needs. With those considerations in mind, Boston Children's presents the following three examples of our priorities to reduce health care expenditures.

Serving as the State's Only Pediatric Focused Accountable Care Organization
In its first year, Boston Children's Accountable Care Organization (BCH ACO), now serving over 96,000 pediatric and young adult patients in Massachusetts, is demonstrating improved quality while managing cost. As the only ACO in Massachusetts that exclusively serves children and young adults, the BCH ACO includes nearly 20% of the pediatric and young adult population covered by MassHealth. As such, throughout the launch and implementation of MassHealth ACOs, the BCH ACO has served as a key voice for pediatric and young adult issues.

Furthermore, as a national leader in pediatric care, Boston Children's began implementing programs in anticipation of value-based care models prior to the BCH ACO going live. Our top priorities include:

- coordination of care for children with medical complexity;
- behavioral health integration in the primary care setting;
- addressing social determinants in a more rigorous fashion.

These efforts are more fully described in answer 2.a. below.

The BCH ACO works with Tufts Health Public Plans (THPP) as its Managed Care Organization (MCO) collaboration partner. Through this partnership, the BCH ACO hopes to learn more about insurance functions to better identify opportunities to improve quality and reduce costs through initiatives such as improving patient and family experience and decreasing low-value administrative burdens on providers and staff.

Developing a Community of Care to Keep Care Local

Since the inception of the HPC, Boston Children's has reported on our development of a pediatric network that enables the delivery of care in lower cost settings including community hospitals, ambulatory satellite facilities and a well-deployed primary care network.

Boston Children's has a long history of working closely with community hospitals in Massachusetts. Through these relationships, Boston Children's is able to support the delivery of and access to pediatric care for patients in the local communities in which they live and to facilitate patient access to higher level care when care cannot be provided locally. Today the Community of Care (CoC) network includes formal relationships with seven community hospitals in eastern Massachusetts where Boston Children's physicians provide clinical oversight and on-site physician coverage of emergency department, pediatric inpatient and/or neonatal services ranging from Level I – Level III nurseries. We now serve more patients in community hospital emergency departments each year than in our own. We have enhanced this work through ongoing capacity building including community hospital based quality improvement initiatives, simulation training, and tele-consultative supports. Some of Boston Children's community hospital relationships also include service arrangements for ambulatory surgical and/or specialty consultations/visits as well as remote services for interpretations (e.g. electrocardiogram and electroencephalogram). Additionally, Boston Children's maintains transfer agreements with 54 hospitals and other organizations within Massachusetts and the other New England states to support their neonatal, pediatric and adolescent medicine services.

As the largest pediatric referral center in the region, Boston Children's CoC network also includes four satellite and three physician office locations. Satellite locations include Lexington, North Dartmouth, Peabody, and Waltham. Physician office locations include Milford, Norwood, and Weymouth. These sites enable the provision of ambulatory surgical and medical care in lower costs settings, as well as the development of a range of intensive, multi-disciplinary programs serving medically complex children and children with chronic conditions. Beyond its satellites, Boston Children's and its physician foundations maintain a mix of formal and informal relationships and service arrangements with other pediatric specialists in the region who are generally based at the other smaller pediatric programs in Boston and surrounding areas (e.g. Boston Medical Center, Hasbro Children's in Providence, Rhode Island, UMass Medical Center in Worcester). These arrangements include management and provision of a specific service, recruitment of shared faculty, on-site sub-specialty care and consultative services, temporary support, education and training and referrals for care that is not otherwise available locally.

Finally, Boston Children's has a sophisticated primary care network that is increasingly focused on providing advanced primary care to complex patients. This is accomplished through both on-campus pediatric practices and 80 Pediatric Physicians Organization at Children's (PPOC)

practices serving 98 locations. See below for more detail on targeted investments in primary care. We have similarly served as the preferred pediatric provider for Atrius, where we have demonstrated improvements in quality, reduction in cost, better care coordination and the ability to "keep care local" in the Atrius system through our shared care collaborative efforts together.

Creation of the Boston Children's Hospital Operational Effectiveness Executive Committee
Boston Children's is celebrating our 150th year in 2019, but we remain focused on our future, expanding our ability to achieve our mission with a mindset toward continuous improvement. To this end, an Operational Effectiveness (OE) Executive Committee was formed three and a half years ago under the leadership of the Chief Operating Officer/President, Chief Nursing Officer, Chief Administrative Officer, Chief Financial Officer, Senior Vice President of Finance, Chief Human Resources Officer, and Chief Medical Officer. The challenges faced by this committee include evaluating and improving systems and processes to enhance quality, reduce excess costs, wasted time and extraneous efforts, while developing innovative new approaches and solutions that are smarter, more streamlined and more effective. The goal of this work is to help Boston Children's meet established financial goals in the most cost-effective way possible, so we can do more of what matters most—applying resources toward better care, expanded research and staffing needs, while positively impacting our value, outcomes, and employee, patient, and family experience. Three examples of thoughtful resource management launched by the OE Executive Committee include:

- Space: evaluating cost-effective use of space, bringing best practices to new buildings
- Systems, Processes and Automation: Creating well-designed and efficient systems, automated where appropriate, making work easier and less complicated
- Inventory: Ensuring the right inventory is available to provide safe, quality care to patients and support our staff.

To learn more about the work of the Boston Children's Hospital Operational Effectiveness Executive Committee, click here for a short video.

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

Develop a more comprehensive vision for child health in the Commonwealth within the Medicaid Program and expressly evaluate the approach taken in New York
In Massachusetts, MassHealth, the state Medicaid program, also includes the Children's Health Insurance Program (CHIP) and serves approximately two-fifths of the Commonwealth's children at any given point in time and one-half of all children in any given year. Boston Children's is deeply committed to partnering with MassHealth and providing care to pediatric MassHealth members. Currently, Medicaid and CHIP account for over 33% of the Boston Children's payor mix (and over 37% of our Massachusetts payor mix), one of the highest percentages in the state. MassHealth, the default health care program for children in the state, plays a critical role in eliminating intergenerational health disparities, and has a fundamental responsibility to assure we are envisioning and creating the right health care delivery system for children.

In the ongoing search for ways to improve the care provided and services available to MassHealth patients, we have spent time studying the New York State model and considering ways in which Massachusetts could potentially implement some of the successful programs that they have rolled out. Below, we offer you a summary of New York State's recent work for context.

New York State has made significant efforts through an extensive planning process in developing a more comprehensive vision for child health as they transition to a more value-based payment (VBP) approach. Their key takeaways include:

- The goals and design of VBP should reflect unique child health needs.

- The value proposition for children's health services stems from promoting optimal child health across the life course, which will lead to lower long-term health care costs and utilization (principally by preventing chronic conditions in adulthood), and producing savings and better outcomes for non-health sectors by improving child development. This stands in contrast to adult health care, where the value proposition typically comes from reducing costs over a one-to-two-year timeframe while maintaining or improving quality through more efficient care and better disease management.

- To generate that value, payment models must support high-quality pediatric primary care by incentivizing improvements in quality, encouraging less fragmentation in service delivery, and fostering the adoption of relatively low-cost health and development promotion services that improve outcomes over the life of a child.

- Because the development of VBP models for children's health services is still in a relatively early stage, payment model design should include input from children's health stakeholders. New payment models should also be tested in combination with innovative primary care models to ensure the incentive structures are appropriate.

Suzanne Brundage and Chad Shearer from The United Hospital Fund (UHF) in New York have written extensively about VBP models for children - more information can be found here. In 2017, UHF, along with the Schuyler Center and the New York Medicaid office, assembled a cross-section of over 200 stakeholders from education, child development, child welfare, pediatrics, and mental health to develop recommendations for how Medicaid could improve outcomes for the youngest New Yorkers, aged zero to three years, nearly sixty percent of whom are covered by Medicaid. The initiative, known as the First 1,000 Days, recognized that the first thousand days of life present a crucial period of opportunity to support optimal development, as a child's brain develops most rapidly during the first three years of life. Interventions that help ensure healthy development and reduce childhood adversity in these early years have been shown to contribute to lifelong improvements in physical and mental health. By taking an intentional focus on the early days, weeks, and years of a child's life, New York has the opportunity to make a real difference in the lives of our children, with benefits that continue into youth and adulthood. For more on the First 1,000 days from the Schuler Center click here.

Additional resources can be found at the New York State Department of Health website here or at the Center for Health Strategies here.

A program such as New York State's First 1,000 Days would be challenged by MassHealth's traditional financing approach if it were attempted in Massachusetts. The Medicaid program accounts for a significant portion of the state budget, but it is also one of the main revenue sources for the state thanks to federal contributions to the program via the Federal Medical Assistance Percentage (FMAP). We appreciate that as a public payor MassHealth faces unique challenges, especially during economic downturns. Historically, MassHealth's preferred budget management tool has been to cut provider rates.

As a result, MassHealth's widely recognized provider underpayment for care creates substantial distortions in the health care delivery system, requiring increasing levels of cross-subsidization by providers, a cost largely borne by employers and the public at large. The cross-subsidization occurs within providers (higher margin services supporting lower margin services), between providers (high Medicaid payor mix providers have disproportionate need to cost shift relative to low burden providers), and among payors (commercial plans relying on Medicaid to "wrap around" coverage, especially for residents with complex needs).

In addition to these historical challenges, the advent of ACOs in March 2018 has magnified some of these issues. As previously mentioned, Boston Children's oversees the only fully pediatric ACO in the Commonwealth. A lack of consideration for pediatrics in the creation of this program has resulted in the initial underfunding of the capitation rate for children for care coordination, care management, and member-facing services, as well as unpredictable budget setting, creating further instability in a program that covers a large number of children. We continue to work with the state to find solutions that will adequately and sustainably cover the health of children and young adults both in the BCH ACO and for all pediatric patients enrolled in these plans.

Boston Children's would like to see policy makers spend more time addressing how we might create a sustainable, reasonably financed, and predictable child health system in Massachusetts with a strong focus on the MassHealth program.

Children with Medical Complexity

The realities of Medicaid underpayment may prove especially challenging in providing care to children with medical complexity (CMC), some of the Commonwealth's most vulnerable children. While children are generally healthy, and the population of CMC is small, CMC are often covered by MassHealth either as their primary insurance or as secondary insurance. CMC have extensive, interdependent needs, and rely upon extensive networks of hospital, specialist, and community-based providers for care. They account for a disproportionate share of medical spending in the pediatric population and are at substantial risk for poor outcomes if timely access to care is unavailable or impeded. That is why we strongly support the HPC conducting an analysis of the CMC population in Massachusetts, in an effort to move the state towards a more sustainable, reasonably financed, and predictable child health system.

Address Rising Prescription Drug Costs and the Financial Impact of Drug Shortages

The August 2018 Center for Health Information and Analysis (CHIA) study on prescription drug use and spending identifies pharmacy spending as a major component of total health expenditures in Massachusetts, representing over 18% of commercial spending in 2015 and 2016. The increasing role that pharmacy costs are playing in the state budget as well as family budgets represents a call to action for both the HPC and the state legislature. While we appreciate the HPC's thoughtful approach to evaluating the pharmaceutical practices of "white and brown bagging," more can and should be done by the HPC in the future to conduct reports and provide policy recommendations that examine prescription drug pricing in a transparent manner. Specific areas of concern that Boston Children's is monitoring relative to prescription drugs are the financial and operational impacts of prescription drug shortages. In addition, drug prices continue to rise for medications used to manage chronic conditions often seen in pediatrics; examples of these medications include Epi-Pens and insulin. Finally, we are increasingly concerned about inconsistent authorization and payment policies for emerging high cost therapies such as Zolgensma and Spinraza, which are used to treat spinal muscular atrophy (SMA), Kymriah, which is used to treat pediatric leukemia, and Luxturna, which is a treatment for children and adults with inherited vision loss that can result in blindness.

In addition to rising prescription drug costs, drug shortages have become a major financial, operational, and patient safety concern. For example, there has been an ongoing shortage of Intravenous Immune Globulin (IVIG), which is an essential drug that millions of children and adults nationwide rely upon to treat debilitating and life threatening immunodeficiency and immune dysregulatory conditions. For many patients, IVIG treatment is necessary to prevent infection, serious illness, and other complications that arise among immune-compromised patients. Due to the critical nature of IVIG treatment for many of our pediatric patients, Boston Children's has had to take significant action to ensure that our patients receive optimal care despite a severely restricted supply of the drug. We understand that the causes of any drug shortage are often varied and complex, but we urge the HPC to partner with the Department of Public Health (DPH) and other state agencies to take action to better understand the underlying causes of these shortages, prevent them in the future and determine collective actions to provide short term relief to patients impacted by such shortages and bolster the ability of providers and the state government to respond to these crises in the future.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care; even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

As the Commonwealth's only acute freestanding children's hospital, we provide care to some of the most complex pediatric patients from around the state, the country, and the world at our Longwood Avenue location (404 beds). As mentioned above, we strive to keep low acuity care local when possible by operating satellite locations in places like Weymouth, Waltham, and Lexington while also partnering with local community hospitals in such locations as South Shore and Beverly to provide pediatric expertise and staffing.

Relative to primary care, Boston Children's has a long-standing commitment to support local primary care through its own primary care provider (PCP) practices at Primary Care at Longwood, Primary Care at Martha Eliot (PCM), and Adolescent and Young Adult Medicine, as well its affiliation with community pediatric PCPs of the PPOC. Combined, the PPOC locations span the Commonwealth from north to south and east to west and employs over 400 PCPs.

Boston Children's Primary Care at Longwood (PCL), located in the Longwood Medical Area on our main campus, serves more children than any other primary care practice in Boston. Our pediatric population is significantly sicker than average (more high complexity patients) and experience significant socio-economic burdens (approximately 80% are covered through MassHealth.) In addition to the basic wellness checkups and preventive care, we provide same-day visits (including weekends) for illnesses and other concerns and integrated behavioral health services.

Specialized team services that we offer our patients include:

- Advocating Success for Kids (ASK) assists families in meeting their child's educational needs
- One Step Ahead (OSA) helps children get to, and stay at, a healthy weight
- Young Parents Program (YPP) allows young parents and their children to get primary care together
- The Rainbow Program, for children with special health care needs and their families
- The Asthma Action Team, to help children with asthma lead healthy, normal lives

Similarly, our PPOC has made investments in the child focused medical home by developing quality and outcomes standards on a per practice basis. Each practice is expected to maintain care coordination access and many of the practices have integrated behavioral health capabilities (approximately 70% of the PPOC patients are served in practices with integrated behavioral health services). As a network, we have also invested substantially in implementing a common electronic health records (EHR) platform across the independent practice sites to enhance our ability to drive quality improvement initiatives. Finally, a range of efforts are underway in partnership with Boston Children's specialists to improve care management, hand offs and transitions between primary care and subspecialty care. These are diagnosis and/or condition specific efforts.

In line with our mission to support primary care, we launched the BCH ACO on March 1, 2018 (please see previous section for more detail on the BCH ACO). The BCH ACO has three strategic priorities for the Delivery System Reform Incentive Payment (DSRIP) opportunity to improve the outcomes and population health of our nearly 100,000 pediatric covered lives in our MassHealth ACO while reducing the total cost of care. Those three strategic priorities are centered on improving pediatric complex care management, investments in expansion of access to behavioral health services, and the assessment and development of targeted interventions related to social determinants of health.

In addition to our DSRIP investments, much work is being done in primary care as a result of our Medicaid ACO. The BCH ACO plans to continue and significantly expand the support for the development of high-performing medical homes, including the analytics and information technology (IT) programming support necessary to do this work. Similar planning and development work is being undertaken to implement care coordination and quality measure improvement for the BCH ACO. This work will include screening and analytics for understanding gaps in care, implementing new processes for outreaching to patients via electronic and/or telephone communications, utilization of population management processes and tools, and targeted efforts by community health workers and medical home care coordinators. This effort also includes data analysis and risk stratification of the population.

We anticipate that this work will continue to demonstrate opportunities to improve quality and reduce variability of performance across our network and improve our understanding of total medical expenditures (TME) for our population of children and those that are amenable to our interventions.

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

Boston Children's has a longstanding commitment to integrating behavioral health (BH) supports for our patients and their families into primary, specialty, and sub-specialty pediatric care as well as providing specialty behavioral health care through the Departments of Psychiatry and Developmental Medicine. In 2015, in recognition of the prevalence of BH needs across the enterprise, Boston Children's leadership engaged in business planning aimed at increasing access and expanding the continuum of behavioral health services available to our patients. Our 14 bed Community-Based Acute Treatment (CBAT) center and expanded community-based specialty care both resulted from these efforts. Since July 2019, Boston Children's leadership has re-engaged the business planning process in order to assess and respond to current needs.

Enterprise-wide initiatives

Boston Children's has a strong commitment to increasing access to BH care for patients across the enterprise, with the goal of providing patients with the right care at the right time and in the right place, and a commitment to making that happen in the least restrictive and costly setting possible. The activities below enumerate several new or expanded initiatives since 2018.

- **Behavioral Health Consultation in Primary Care:** Boston Children's is part of the Massachusetts Child Psychiatry Access Program (MCPAP) and the PPOC has a robust behavioral health integration program (BHIP) whose goal is to use a stepped approach to BH care to increase pediatric primary care capacity to treat patients with BH conditions. This program provides education and consultation to primary care pediatricians and integrated BH clinicians in order to decrease the use of specialty care. A Pediatrics (2019) study[1] by Walters, et al. reports on the successes of the first 5 years of BHIP, which include improved access to care, pediatric provider adherence to BH prescribing guidelines, and a 19% decrease in the cost of emergency department BH care.

- **Telemedicine:** With the benefit of lessons learned from a 2017-2018 HPC telemedicine pilot grant, over the past year, the Department of Psychiatry has increased its capacity for telemedicine in order to improve access to specialty outpatient behavioral health care. Since October 2018, Boston Children's clinicians have provided over 1500 specialty tele-BH appointments in Outpatient Psychiatry and an additional 250+ specialty visits provided at PPOC practices.

- **Substance use Consultation in Primary Care:** Over the past year, the PPOC piloted a program to provide specialty substance use treatment consultation to pediatricians in the PPOC, including for medication assisted treatment induction, and recently received a SAMHSA grant to expand this program. The success of this program also resulted in a recent contract with the state for Boston Children's Adolescent Substance Use and Addictions Program (ASAP) to provide consultation to pediatricians statewide.

- **Expansion of Outpatient Specialty Care**: In October of 2018, the Department of Psychiatry expanded services to our Waltham location, and since that time has provided over 2,100 psychopharmacology and therapy outpatient visits in this community-based setting.

- **Urgent Behavioral Health Care:** As part of its effort to increase access and to help alleviate ED boarding, the Department of Psychiatry created urgent care capacity within Outpatient Psychiatry.

[1] Walter, H.J., Vernacchio, L., Trudell, E.K., Bromberg, J., Goodman, E., Barton, J., Young, G.J., DeMaso, D.R. and Focht, G., 2019. Five-year outcomes of behavioral health integration in pediatric primary care. *Pediatrics*, p.e20183243.

Within BCH ACO

Embedded BH clinicians in the BCH ACO pediatric practices have demonstrated that their services are financially sustainable. These staff members incur minimal addition to indirect overhead and their billing covers their professional compensation, therefore overall they apply minimal burden to the practices while providing substantial benefit. The BCH ACO anticipates utilizing funds for start-up costs for practices hiring new embedded BH providers, including salary support for the provider until they are able to sustain their salary through billing. The BCH ACO will also test the use of NP prescribers to improve timeliness and cost of medication management for this population. Investments will also support central management for this BH integration program, expansion of an existing tele-psychiatry program, and educational initiatives for primary care and other providers regarding BH conditions. Additionally, the BCH ACO will utilize social workers and community health workers to provide follow-up and care coordination for patients with BH-related admissions, emergency department (ED) visits and other signs of high risk BH needs. The BCH ACO will also employ staff to build partnerships with high quality CBHI agencies to enhance community-based care for BH.

Innovation

Boston Children's has also made significant investments in innovative programs and technologies over many years. Our Children's Hospital Neighborhood Partnerships program is deeply involved in the Boston Public Schools, and provides significant capacity building for teachers, guidance counsellors, and associated personnel. We help schools identify service delivery gaps and support the development of school-based infrastructure at the local level to fill those gaps. We have assisted with training curricula that have been widely deployed. We are also piloting the use of technologies like depression screening tools, to support earlier identification and treatment of school age children.

Statewide Advocacy

Boston Children's supports a full-time position as one of the founding members and lead organizations of the Children's Mental Health Campaign (CMHC), a statewide network that advocates for policy, systems, and practice solutions and shared responsibility among government and institutions to ensure that all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. As part of CMHC leadership, Boston Children's is committed to engaging with policy-makers to ensure system-wide improvements for children and their families.

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

Our most in-depth work developing payment streams outside fee-for service billable services has been through the MassHealth ACO. A good example is the Primary Care Provider Value-Based Payment (VBP) program, a required component of the MassHealth Medicaid ACO that we have programmed to support a range of care coordination efforts. The goal of this program is to improve the quality and efficiency of medical care as a supplement to direct patient care.

Our VBP strategy requires multiple years of development and action; the first year focused on development and initial implementation of screening and identifying the social determinants of health that affect patients, coordinating post-acute behavioral health care in the PPOC practices and coordinating care for children with complex medical needs at the hospital-based practices. This strategy supports monitoring and improvement of the ACO quality measures for depression screening and follow-up, follow up after emergency department (ED) visits for mental illness, screening for health-related social needs, and treatment for alcohol and other drug misuse or dependence. In year two, the strategy will continue to focus on the work of screening and identifying the social determinants of health that affect MassHealth ACO patients. The other focus areas will address increasing BH screening (PPOC practices), implementing care plans for patients in the PPOC practices, and reducing unnecessary ED visits among BCH ACO patients in PPOC practices with the highest practice-level ED rates.

Relative to payer strategies that would be most beneficial to or most effective for Boston Children's to strengthen and support primary and behavioral health care, one our primary goals is to see the Commonwealth realize coverage parity for telemedicine services on the same basis as in person visits. In the absences of coverage parity for synchronous and asynchronous telemedicine services, we have not been able to put these services in many of our contracts. We discuss this further below.

> d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

Boston Children's has a strong commitment to supporting pediatric primary care with an integrated model designed to effectively treat children in cost-efficient community settings.

Passage of Comprehensive Telemedicine Legislation

Boston Children's is a proud founding member of the Massachusetts Telemedicine Coalition (tMED). tMED and its membership of over 30 statewide consumer advocacy groups, providers, and digital health companies continues to advocate for the successful passage of comprehensive telemedicine policy that would codify a definition of telemedicine, address the issue of coverage parity and solve for administrative burdens of adoption via proxy credentialing. House Bill 991/Senate Bill 612 collectively would achieve these goals and have over half of the state legislature signed on in support. Passage of this bill would eliminate antiquated barriers to the adoption of telemedicine and allow Massachusetts to assume leadership in the digital healthcare sector, unleashing our emerging digital healthcare cluster

that works in partnership with our world-class healthcare providers. This legislation will advance patient-centered care that will allow providers to deliver high-quality services as they control healthcare costs while improving the patient experience. In the absence of the adoption of comprehensive telemedicine policy, our efforts to expand access to telemedicine services at Boston Children's have been significantly limited. Boston Children's is currently offering, or hopes to offer soon, the services below through digital models that allow timely and appropriate access to care and can help reduce unnecessary hospital utilization. These services would also reduce the administrative, financial, and operational burden on the MassHealth non-emergency transportation (NEMT/PT-1) system while decreasing no-show rates to time-critical appointments and reduce unnecessary emergency room visits and hospital utilization. An example of the telemedicine services that Boston Children's currently offers (or hopes to begin offering upon the successful passage of comprehensive telemedicine legislation) include:

- Live (synchronous) video visits between a Boston Children's specialist or primary care physician and their patient allows for both scheduled and on-demand appointments (e.g. scheduled surgical follow-up, evaluation of urgent flu-like symptoms). This will have the impact of 1) reducing length of stay and allowing for earlier discharges, 2) improving adherence to treatment plans, 3) enhancing access to sub-specialty care, 4) increasing provider effectiveness, and 5) improving provider-patient experience ratings.
- Live video and "store and forward" (asynchronous) consults between a Boston Children's specialist and a community-based provider (e.g. Boston Children's pediatric Intensivist connecting directly to a community hospital Intensivist to provide treatment recommendations, preventing unnecessary patient transport and keeping care in local hospitals; a community-based pediatrician sending an asynchronous dermatology consult to a Boston Children's dermatologist to reduce duplication of visits and extend clinical expertise to distant communities). The goal of these efforts is to reduce unnecessary transfers and admissions, decrease length of stay, and increasing patient satisfaction by enabling them to remain in the local community setting.
- eVisits (asynchronous, protocolized questionnaire visits) to help triage acute or routine visits and decrease the number and frequency of higher cost visits that can be safely managed remotely.
- Automated care management (proactive, automated care for chronic patients) to proactively manage higher risk patients by having pre-identified check points during a patient's care journey.
- Hospital-at-home services to facilitate early discharge for complex care patients and equip these patients with medical devices in their home which interact directly with their care team (e.g. continuous sending of vitals, connecting to physician via video in emergent situations).

It is time for Massachusetts to join 38 other states, including the rest of New England, in passing telemedicine coverage parity laws in order to improve access to primary care and behavioral health services across the Commonwealth.

Investments in School Behavioral Health Services

It is critical for the health care system to be able to effectively partner with schools to maintain children's health. The successful implementation of the MassHealth school-based Medicaid policy that began July 1, 2019 is an essential aspect of partnering with schools, but it is not sufficient. In the move towards value-based payments, health systems must be allowed the flexibility to direct funding to schools in order to maintain children's health. State investment in school infrastructure, parental support mechanisms, as well as opportunities to reintegrate children who have had acute medical or behavioral episodes would advance this goal. This investment would also promote the three clinical priority areas of our Medicaid ACO: behavioral health, complex care, and social determinants of health. There is evidence that these interventions reduce system cost through decreased unnecessary ED utilization, reduced inpatient recidivism, fewer missed school days, fewer out of district placements, and higher graduation rates.

Investment in a continuum of care for youth with Autism Spectrum Disorder

Since 2011, ARICA (An Act Relative to Insurance Coverage for Autism) requires private health insurers in Massachusetts to provide coverage for the diagnosis and treatment of Autism Spectrum Disorder (ASD). However, insurance coverage alone is not sufficient for pediatric patients managing an ASD diagnosis, as families and pediatricians report a lack of access evidenced by consistently long wait lists, few culturally and/or linguistically competent providers, and few providers who can manage youth with co-occurring mental health and ASD. Families of youth with ASD and co-occurring mental health disorders cannot find timely treatment, and eventually are told to take their children to EDs, which are unsuitable at best and often make symptoms worse. The state must make investments to support workforce and capacity development for urgent home and community-based BH crisis intervention for youth with ASD. Additionally, as the prevalence of autism rises, a consultative model for pediatricians is essential to enable more pediatricians to maintain patients with autism in their practices. Developing best practices and continuing education support for pediatric practices as well as a telemedicine-supported network of consulting Developmental Pediatricians is a cost-effective means to improving care to children and adolescents with autism across the Commonwealth.

Pediatric Workforce development

Maintaining and growing the current pediatric workforce broadly is a challenge both locally and nationally. Locally, pediatric behavioral health workforce development was identified as a priority for the Boston Children's Determination of Need (DON) funded Collaboration for Community Health investments, with three funded projects in this area. It is widely understood that workforce shortages across the Commonwealth contribute to lack of timely access to behavioral health care. The Commonwealth would be well served to support the development of a career pipeline through partnerships with educational institutions.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Increasing regionalization of complex care for children at Boston Children's Hospital.	Major Contributing Factor

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	High
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium

Area of Administrative Complexity	Priority Level
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Medium
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Medium
Other, please describe: Out of State Provider Credentialing (especially Medicaid)	High

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☐ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume

Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)

Aligning payment models across payers and products

Enhancing provider technological infrastructure

☒ Other, please describe: Payors are generally not interested in APM's for pediatric populations. The state could seek to facilitate a child health focused conversation about the relevance and effectiveness of these models for children. Many of the longstanding APM's models have been predicated on the Medicare system, which does not serve children. If the utilization of these models is designed to result in cost savings there may not be appropriate opportunities for the inclusion of pediatric populations who are relatively low cost to begin with.

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any 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.

   See attached.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a. Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	292	45
	Q2	285	44
	Q3	227	44
	Q4	261	30
CY2018	**Q1**	289	10
	Q2	282	32
	Q3	316	16
	Q4	321	14
CY2019	**Q1**	349	28
	Q2	432	0
	TOTAL:	3054	263

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

Boston Children's records the creation of the estimate using functionality within our registration and billing system, Epic, via a program called Smart Texts. The Smart Texts are generated with date and time stamps, which enables Boston Children's to monitor time between request and response; 98% of our requests are responded to within 24 hours.

Of note, an April 2017 publication "Massachusetts Hospitals Score Poorly on Price Transparency…Again," by Pioneer Health, surveyed Massachusetts hospitals and found Boston Children's was able to generate estimates for an MRI within 35 minutes, the second fastest time found in the survey. In addition, the estimates provided by Boston Children's were found to be accurate and estimates were available via both phone and an online portal accessible on our website.

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

Creating an estimate based on patient reported needs is challenging. To generate an estimate, we require the procedure codes to build up the total charge. However, procedure codes may vary based on actual services rendered, and become more complex with complex procedures. Obtaining appropriate codes may be difficult, but working with internal coders and physician offices can help reduce these barriers. Helping patients understand how the macro-health care payment environment works is very important as price transparency continues to challenge us to be as consumer-centric as possible.

3. For hospitals and provider organizations corporately affiliated with hospitals:

   a. For each year **2016 to present**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

See below.

Boston Children's Hospital				
AGO Questions for Written Testimony				
FY16-FY18 (based on Strata)				
	FY2016	**FY2017**	**FY2018**	
(A) Commercial Business:				
Operating Margin - Financials	26.5%	24.7%	25.6%	
% Total Expenses	37.2%	38.2%	37.3%	
(B) Government Business:				
Operating Margin - Financials	-50.9%	-51.6%	-52.0%	
% Total Expenses	23.6%	23.2%	25.3%	
(C) International:				
Operating Margin - Financials	9.1%	9.3%	9.4%	
% Total Expenses	6.7%	5.0%	5.2%	
(D) All Other Business:				
Operating Margin - Financials	-11.9%	-9.8%	-5.2%	
% Total Expenses	32.6%	33.6%	32.3%	
Total Business:				
Operating Margin - Financials	2.6%	2.1%	3.1%	
% Total Expenses	100.0%	100.0%	100.0%	
NOTE: Expenses includes both clinical and non clinical expenses				
(A) Commercial includes all other payers not listed in (B), (C), and (D) below.				
(B) Government includes BMC, HSN, MA Medicaid, Medicaid Out of State, Medicare, MBHP, Network Health, and NHP.				
(C) International includes all International payers.				
(D) All other includes Self Pay, research, and other operating.				
Includes one time expenses.				

b. For **2018 only**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

AGO Provider Exhibit 1
Boston Children's Hospital
2015 Massachusetts & Out of State

2015	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based		Claims-Based Revenue		Budget		Quality Incentive						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$0	$0	$0	$0	$104,695,069	$211,512,823	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tufts Health Plan	$26,520,206	$44,669,383	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Harvard Pilgrim Health Care	$63,621,427	$47,679,793	$511,711	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Community Health Plan	$9,830,142	$36,105	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,041,571	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$47,422,593	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$43,098,711	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$9,881,514	$152,136,608	$0	$0	$0
Total Commercial	**$99,971,774**	**$92,385,281**	**$511,711**	**$0**	**$104,695,069**	**$211,512,823**	**$0**	**$0**	**$0**	**$0**	**$9,881,514**	**$273,699,483**	**$0**	**$0**	**$0**
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,478,279	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$51,854,248	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,908,436	$0	$0	$0
Health New England	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$253,551	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$47,107,406	$0	$0	$0
Total Managed Medicaid	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$121,601,921**	**$0**	**$0**	**$0**
MassHealth	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$82,093,351**	**$0**	**$0**	**$0**
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Commercial Medicare Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medicare	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$11,232,643**	**$0**	**$0**	**$0**
Other	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$14,608,128**	**$0**	**$0**	**$0**
GRAND TOTAL	**$99,971,774**	**$92,385,281**	**$511,711**	**$0**	**$104,695,069**	**$211,512,823**	**$0**	**$0**	**$0**	**$0**	**$9,881,514**	**$503,235,526**	**$0**	**$0**	**$0**

AGO Provider Exhibit 1
Boston Children's Hospital
2016 Massachusetts & Out of State

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based		Claims-Based Revenue		Budget Surplus/(Deficit)		Quality Incentive						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$0	$0	$0	$0	$109,267,265	$254,229,587	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tufts Health Plan	$25,354,440	$40,337,981	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Harvard Pilgrim Health Care	$79,372,361	$44,073,677	$617,890	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Community Health Plan	$9,479,710	$16,835	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,246,598	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$52,821,075	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$45,900,204	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,499,040	$178,896,029	$0	$0	$0
Total Commercial	**$114,206,510**	**$84,428,493**	**$617,890**	**$0**	**$109,267,265**	**$254,229,587**	**$0**	**$0**	**$0**	**$0**	**$10,499,040**	**$326,863,905**	**$0**	**$0**	**$0**
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,795,843	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	($2,819,983)	$0	$309,993	$0	$0	$41,704,246	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,287,946	$0	$0	$0
Health New England	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$442,562	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$56,712,301	$0	$0	$0
Total Managed Medicaid	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**($2,819,983)**	**$0**	**$309,993**	**$0**	**$0**	**$119,942,898**	**$0**	**$0**	**$0**
MassHealth	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$92,714,093**	**$0**	**$0**	**$0**
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Commercial Medicare Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medicare	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$10,114,190**	**$0**	**$0**	**$0**
Other	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$17,008,106**	**$0**	**$0**	**$0**
GRAND TOTAL	**$114,206,510**	**$84,428,493**	**$617,890**	**$0**	**$109,267,265**	**$254,229,587**	**($2,819,983)**	**$0**	**$309,993**	**$0**	**$10,499,040**	**$566,643,192**	**$0**	**$0**	**$0**

AGO Provider Exhibit 1
Boston Children's Hospital
2017 Massachusetts & Out of State

2017	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based		Claims-Based Revenue		Budget		Quality Incentive						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$0	$0	$0	$0	$119,547,795	$256,200,038	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tufts Health Plan	$26,451,366	$52,132,502	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Harvard Pilgrim Health Care	$75,108,817	$49,229,428	$610,575	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Community Health Plan	$13,200,912	$336	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$48,137,526	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$56,332,464	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$50,817,251	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,705,539	$177,000,184	$0	$0	$0
Total Commercial	**$114,761,096**	**$101,362,266**	**$610,575**	**$0**	**$119,547,795**	**$256,200,038**	**$0**	**$0**	**$0**	**$0**	**$16,705,539**	**$332,287,426**	**$0**	**$0**	**$0**
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,903,953	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$220,047	$0	$0	$33,250,180	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,560,003	$0	$0	$0
Health New England	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,233,979	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$50,552,669	$0	$0	$0
Total Managed Medicaid	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$220,047**	**$0**	**$0**	**$118,500,784**	**$0**	**$0**	**$0**
MassHealth	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$111,028,472**	**$0**	**$0**	**$0**
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Commercial Medicare Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medicare	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$9,173,170**	**$0**	**$0**	**$0**
Other	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$16,087,637**	**$0**	**$0**	**$0**
GRAND TOTAL	**$114,761,096**	**$101,362,266**	**$610,575**	**$0**	**$119,547,795**	**$256,200,038**	**$0**	**$0**	**$220,047**	**$0**	**$16,705,539**	**$587,077,489**	**$0**	**$0**	**$0**

AGO Provider Exhibit 1
Boston Children's Hospital
2018 Massachusetts & Out of State

2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based		Claims-Based Revenue		Budget		Quality Incentive						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$0	$0	$0	$0	$130,954,741	$287,037,358	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tufts Health Plan	$26,868,806	$58,529,348	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Harvard Pilgrim Health Care	$74,396,715	$47,885,826	$583,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Fallon Community Health Plan	$9,377,802	$54,692	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$53,751,919	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,764,816	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$53,259,854	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,247,052	$175,942,494	$0	$0	$0
Total Commercial	**$110,643,323**	**$106,469,865**	**$583,161**	**$0**	**$130,954,741**	**$287,037,358**	**$0**	**$0**	**$0**	**$0**	**$16,247,052**	**$344,719,084**	**$0**	**$0**	**$0**
Network Health <3/1/2018	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,490,134	$0	$0	$0
Network Health ≥ 3/1/2018	$0	$0	$0	$0	$0	$43,671,091	$0	$0	$0	$0	$0	$16,132,773	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,855,632	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,498,131	$0	$0	$0
Health New England	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,829,175	$0	$0	$0
Fallon Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,960,978	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$58,777,289	$0	$0	$0
Total Managed Medicaid	**$0**	**$0**	**$0**	**$0**	**$0**	**$43,671,091**	**$0**	**$0**	**$0**	**$0**	**$0**	**$113,544,112**	**$0**	**$0**	**$0**
MassHealth	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$96,330,258**	**$0**	**$0**	**$0**
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Commercial Medicare Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medicare	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$12,296,664**	**$0**	**$0**	**$0**
Other	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$15,522,510**	**$0**	**$0**	**$0**
GRAND TOTAL	**$110,643,323**	**$106,469,865**	**$583,161**	**$0**	**$130,954,741**	**$330,708,449**	**$0**	**$0**	**$0**	**$0**	**$16,247,052**	**$582,412,627**	**$0**	**$0**	**$0**