MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 Pre-Filed Testimony
PROVIDERS

As part of the
Annual Health Care Cost Trends Hearing

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

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 2022**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2021, if applicable. If a question is not applicable to your organization, please indicate that in your response.

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

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

HPC CONTACT INFORMATION

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

AGO CONTACT INFORMATION

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

INTRODUCTION

This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

Introduction – As a framing matter, Boston Children's Hospital (BCH), like many others, is enduring a very challenging cost environment, resulting from a range of external factors over which we have limited control. These include labor related dynamics, increased patient demand from patients experiencing behavioral health or social related needs issues (further explained below) resulting in bed utilization exceeding our existing capacity, and supply chain inflationary pressures in the areas of technology, supplies, etc. There are also a range of important societal demands that impact our long-term financial picture, such as environmental sustainability, that are both expensive to address and not easily financed through existing health care payment mechanisms. As a result, inflation trends and increasing external costs at BCH exceed the HPC's cost trend targets in the current environment and potentially for the foreseeable future. Our understanding is this is consistent with the experience of all other providers in Massachusetts.

Workforce shortages and labor costs – Our dedicated and talented workforce is our greatest asset here at Boston Children's Hospital; however, growing costs of recruiting and retaining talent creating operating cost inflation well in excess of health care costs growth targets and driving significant operating deficits. The stresses of enduring a pandemic in a hospital setting over the past two years have led to retirements or job changes in a competitive market, resulting in a reliance on high-cost travelling clinical support staff, nurses, and other professionals, or offering increasingly competitive salaries for workers. Additionally, our workforce frequently requires specialized pediatric training or experience especially for our more complicated patients. As mentioned in the testimony last year, the behavioral health workforce is especially prone to these market forces as there is a small pool of talented pediatric behavioral health care professionals which all hospitals and community providers are competing for to attract for employment. BCH is committed to offering training and retraining opportunities to workers seeking to fill job openings but this consumes time and resources as well.

Behavioral health capacity and costs – As part of our mission, one of the most important things we do at BCH is care for children and adolescents with behavioral health needs, issues that are often exacerbated by underlying issues of poverty, racism, and other external factors outside our hospital walls. However, unrecognized costs in the larger health care delivery system continue to stress hospital finances and hospital staff. Each day, children come to the emergency department often in acute crisis by the time they reach our doors, resulting in costly 1-1 observation for the patients. Children board on inpatient units while waiting for placements for which the hospital does not receive adequate reimbursement.

Our busy emergency department is confronting this overwhelming need while simultaneously trying to provide care to the many other medically emergent and trauma cases that depend upon us as a safety net pediatric provider. Staff shortages, specifically for child psychiatry, continue to exacerbate waitlists and limit access to upstream preventative services. Parents and staff are experiencing burn out caring for children in psychiatric crisis leading to clinical turnover and it takes a long time to train or recruit staff with pediatric behavioral health experience. Since our very first response to the HPC's pre-filed testimony and every year thereafter, BCH has drawn attention to the critical need to better design and finance the pediatric behavioral health system in order to improve lifetime health outcomes and avoid the long-term costs associated with untreated behavioral concerns.

Health equity – Investing in children is an investment in future health and a long-term solution to promoting health equity. Research shows that addressing the social determinants of health is a critical component to long-term health equity and the Health Policy Commission has recognized their importance in several policy recommendation reports. BCH is committed to doing our part to make community investments and advocate for increased access to affordable housing, healthy foods, sustainable transit, and other measures. But many of the costs that fall outside of the traditional health care system end up right at our door; for example, homeless families come to the emergency department without a safe place to spend the night or to prove residency for access to emergency shelter, with no real health emergency but utilizing staff time and resources. Increasing costs of medicine, food, and housing are all things that are making what should be a human right increasingly out of reach to the patients we serve.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

Medicaid ACO – Our commitment to participating in the MassHealth ACO program is part of our long-term efforts to provide coordinated, high-quality health care for 125,000 of the most vulnerable children in the Commonwealth. As you know, about 40% of all children in Massachusetts receive coverage through MassHealth. The ACO program has enabled us to identify and begin to address key social determinants in the community informed by our community health needs assessment and to integrate behavioral health supports throughout (see below). The ACO has also established better care coordination and access for children with complex medical needs to create an integrated, multidisciplinary care plan for each patient. We have performed well on both quality and financial measures, and built a strong infrastructure for the next five year performance period. For the ACO, telehealth modalities such as virtual visits (live video and audio-only), eConsults, and remote patient monitoring (RPM), have become critical digital tools used to care for the pediatric and adolescent patient populations. In comments recently provided to MassHealth and our previous testimony to the HPC, we have noted that telehealth has become essential for clinicians engaging with patients and families to make care more accessible and equitable for patients, with visits occurring for more than 38,000 unique patients at BCH with MassHealth across 46 specialties and tens of thousands more visits, especially in

behavioral health, in our affiliated pediatric practices. Telehealth provides patients with timely access to care and audio-only options promote equitable access for patients who do not have access to internet or video availability.

Behavioral health – Upstream behavioral health prevention is a key component of keeping children safe and in lower-cost settings of care. We have integrated behavioral health into our primary care office settings, where roughly 2/3 of the BCH affiliated primary care practices have access to integrated behavioral health, addressing immediate needs and streamlining referrals to specialty evaluations and more intensive/longer-term interventions. For pediatric patients needing inpatient care, we have been working diligently to expand capacity and services, including the addition of 12-pediatric psychiatric beds at the Waltham satellite facility. Under an affiliation agreement with long-time collaborator Franciscan Children's Hospital, we will further increase access to behavioral health services across the two hospitals and expand access to care.

Social determinants of health – Boston Children's Hospital has a long history of advancing community health, knowledge, and practice, and is committed to addressing health inequities in collaboration with our community-based funded partners, investments through the Determination of Need process, and through our ACO efforts. These range from investments in behavioral health, early education, and youth development, to food access, housing stability, and asthma treatment and prevention. Examples of community-based partners include community health centers, the Boston Public Schools, the Community Asthma Initiative, and the Collaboration for Community Health among many others. Since testifying last year, we have opened a community food program within the Boston Housing Authority next to Boston Children's at Martha Eliot distributing 18,500 pounds of food, almost half of which is fresh produce, to patients and neighborhood residents each week. For patient families who may be experiencing poor health outcomes caused by legal needs in the areas of housing, education, and benefits, the Medical Legal Partnership (MLP) program supports clinical work by eliminating the legal barriers that act as obstacles to better health. Connecting patients with these services starts with screening patients to determine their needs and coordinating with a wide range of community partners in the clinical setting.

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

Boston Children's Hospital attempts to collect patient/parent-reported race, ethnicity and language on all patients at the time of scheduling, registration, check in and through the MyChildren's portal. REaL data are collected via several electronic, confidential, selfservice options in English and Spanish: 1. Pre check-in via MyChildren's Portal before coming to visit, 2. Self check-in via Kiosk upon arriving to hospital, and 3. Self check-in option via iPad upon arriving to clinic (lunched in all BCH outpatient clinics in 2022). If unable to collect

electronically or if patient prefers, front desk staff collect REaL data during in-person check-in using scripting and support materials. In addition, REaL data can be added or changed at any time through the MyChildren's Portal.

Over the past year, we increased our rate of REaL data collection in the ambulatory setting from 80% in FY21 to 90% in FY22. Among inpatients, our rate of REaL data collection is ~85%; however, the rate is lower among patients who are transferred into our institution, typically patients admitted to an ICU. We have implemented a QI project to improve the data collection process for these patients.

As we reported last year, we do not regularly collect disability status or sexual orientation/gender identity in our registration process. With respect to disability status, we do collect extensive information on chronic and congenital medical conditions experienced by our patients, analyze that information in multiple ways, and plan for care delivery and access requirements accordingly because children need different support for activities of daily life at different ages the definition of disability needs to be adjusted by age groups based on developmental stage. With respect to gender identity issues, our medical records capture this information in certain care settings. We would note that there are some very complicated practical and ethical issues involved in collecting this information from children and adolescents when parents or other caregivers may have access to information that the child may therefore not wish to disclose.

Boston Children's Hospital has numerous efforts to measure and advance health equity. The Health Equity Quality Report is an annual, board-level report comprised of enterprise-wide quality measures as well as high priority local clinical quality measures stratified by race and ethnicity, language, and payer. Additionally, we report our rate of REaL data collection on our monthly Enterprise QAPI Dashboard to provide visibility to this important process. Additionally, clinical departments monitor the equity of care for high priority and process measures. Performance is reported to leadership through their Safety and Quality Improvement Dashboards.

We have a number of QI projects to improve equity of care in all care settings. Examples include: reducing readmission rates in our patients/families with limited English proficiency through structured communication and discharge teaching, reducing disparities in the use of ionizing radiation during the evaluation of children with suspected appendicitis, reducing disparities in patient experience in the Adolescent/Young Adult Clinic.

At the national level, BCH participates in health equity initiatives focused on best practices for collecting and improving the collection of REaL data. Since 2017, BCH has been a member of the Pediatric Health Collaborative that shares best practices across its member hospitals on collecting REaL data and also provides benchmarking opportunities for innovative health equity initiatives., BCH has been a long-standing member of the Solutions for Patient Safety (SPS) and well-represented on several of its workgroups. More recently, in 2019, BCH became a member of the SPS Health Equity Leadership Workgroup that piloted

the national Patient Harm Associated with Race and Ethnicity (PHARE) study in 2021. BCH was a part of this pilot and submitted performance on central line-associated bloodstream infections (CLABSI) and unplanned extubation (UE) stratified by race and ethnicity. Pooled analyses across the >30 hospitals, identified disparities in both measures. Work is ongoing to understand the drivers of these disparities and identify potential targets for improvement. BCH's participation in this pilot helped to identify other opportunities to understand and improve race and ethnicity data collection particularly in our ICUs. In collaboration with our ICU leadership, Office of Health Equity and Inclusion, and Program for Patient Safety and Quality, we are reviewing and analyzing the processes that are specific to the ICU that may present barriers to collection of race and ethnicity data, and we are working to identify the necessary process improvements.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

Workforce – BCH as an enterprise is attempting to address the workforce concerns articulated in section (a) above in the short term. We are doing so by recruiting and orienting new clinical staff on an accelerated hiring schedule, while filling in gaps with high-cost contract labor and finding non-clinical cost savings where possible across the enterprise. However, we, like others, need help to solve the long-term labor market challenges.

The state should continue making available job training and retraining initiatives for health care settings. Encouraging young, diverse individuals to consider the many opportunities available to them in the health care occupation will produce a thriving health care system. The state should also consider how workplace safety impacts the availability of the workforce, workforce burnout, and the competition for skilled employees. Another area of assistance to employees would be loan forgiveness for eligible health care jobs, especially where there are high needs. Entering into the interstate compacts for health care professionals would also alleviate some of the immediate workforce needs, but the state needs to establish a cohesive long-term plan for the future of the health care workforce.

Health Equity – Health equity needs a comprehensive plan and approach if the state is going to move the needle on our equity goals. There are issues that transcend the health care system and will need all industries to come to the table to create an equitable system for patients and their families. Issues such as affordable housing, access to early education and quality elementary education, and healthy food for example go well beyond the efforts of our hospital systems. Going above and beyond the health system to bring stakeholders to the table to address the external factors that cause the health issues we see is going to take collaboration and partnership with many voices at the table, especially the voices of those experiencing historical inequities in our state.

Payment parity – As noted elsewhere in this testimony, health systems are grappling with both the immediate-term acute needs of a population-level behavioral health crisis and the need to dedicate resources to building a continuum of services to support wellbeing and address behavioral health challenges in community settings before they escalate. This work

is happening in the shadow of historic underpayment for behavioral health care, which has contributed to the lack of providers and program space we currently confront. We appreciate and support the work Governor Baker and this administration have put into the behavioral health roadmap and other proposals to begin remedying the structural and system-level behavioral health parity issues that have made it difficult for providers to offer needed services. We also acknowledge the work of the Blue Cross Blue Shield Foundation and others that have called attention to this issue. Further action to enhance payment rates for behavioral health care to achieve true parity, as well as support for the administrative steps needed to improve behavioral health access, are necessary.

Lower-cost settings – The state should adopt and promote policies that encourage providers to offer care in lower-cost settings, including outpatient offices or in the home. Many procedures that previously required an inpatient stay are now able to be managed at home. Telehealth, which has continued to greatly benefit pediatric patients, should be paid at in-person parity rates and the state should do more to better understand the technologies being used to complement care at home. Laws and regulations should be updated to promote advances in virtual care, including remote patient monitoring, and should especially be viewed from a kid-focused angle. Moving kids from inpatient to outpatient settings, including for behavioral health should be closely looked at as an alternative to inpatient care when appropriate and advisable.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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

Health Care Service Price Inquiries Calendar Years (CY) 2020-2022			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1	409	52
	Q2	231	43
	Q3	385	102
	Q4	387	56
CY2021	Q1	323	68
	Q2	398	98
	Q3	364	107
	Q4	422	87
CY2022	Q1	379	79
	Q2	360	77
	TOTAL:	3658	769