Boston Children's Hospital
Until every child is well

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

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November 5, 2025

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

Dear Mr. Seltz,

Attached, 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.

Warmest Regards,

Kevin B. Churchwell, M.D.
Chief Executive Officer

MASSACHUSETTS
HEALTH POLICY COMMISSION

2025 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 2025 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document 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 2024, 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. All submissions are public record and will be posted to the HPC's website.

You may receive questions from both the HPC and the Office of the Attorney General (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 relevant 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.

THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging the stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from $849 in 2019 to $1,049 in 2023 (a 29% increase), and residents paying $5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the Health Care Cost Growth Benchmark and the status of public and industry-led health care policy reform efforts.

1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on health care workers, patients, and patient care? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

Boston Children's Hospital will be impacted by many of the policy actions taken by the federal administration through regulatory actions and executive orders and by the current Congress through the recent reconciliation package. Many of these changes are occurring now, while others will be phased in over time. Boston Children's is particularly vulnerable to changes in the Medicaid program due to our very high Medicaid payor mix (46% for our Massachusetts patients) and our role as a regional and national safety net for other Medicaid-covered children. There are many analyses of the potential system-level financing implications of the cuts by the Blue Cross Blue Shield Foundation, the Massachusetts Taxpayers Foundation, and others. We note that these children are also dependent on a range of other community resources like SNAP and WIC benefits, special education services, and early education programs that are threatened with funding cuts or disruptions. These cuts are likely to pressurize our system in the near term if it becomes more difficult for families to meet their children's basic needs.

Boston Children's also serves a significant number of children who are either legal residents for immigration purposes or are citizen children of legally resident immigrant parents. We are deeply concerned about the potential that policy changes will have a chilling effect on children accessing benefits to which they are entitled. We also depend upon a workforce that includes many immigrant clinicians, researchers, and caregivers. As a general statement, Massachusetts' biomedical leadership success has depended upon talented individuals coming here for clinical and research training and staying to provide excellent care. At the entry level, all of our hospitals have been well served by frontline staff that are representative of our diverse community.

Boston Children's is also the leading pediatric research institution in the United States, and significantly dependent on federal research funding. We have experienced funding delays and disruptions, shifts in research focal areas, and staffing challenges at some of the federal agencies that make our basic day-to-day operations more challenging.

Lastly, we note the significant public health implications of the current anti-vaccine rhetoric perpetuated by some federal policy makers. Childhood vaccination is one of the most important and successful public health success stories in human history. We are very concerned that misinformation will lead to declining vaccination rates, the reemergence of preventable disease outbreaks, and associated stress on the clinical delivery system. The long-term implications for childhood mortality and morbidity are worrying.

From a policy perspective, we ask that health care market participants, policymakers, and the public consider the following actions to protect the Massachusetts health care system:

- We should maintain the Medicaid ACO delivery system structure, assure we are maximizing federal financing under the new financing ruleset, and make adjustments to provider tax and directed payment structures, as necessary.
- We should seek to preserve coverage for legally present immigrants to the extent possible and fund community-based education and outreach initiatives to reach eligible but not enrolled community members. (The redetermination work led by MassHealth following the end of the COVID-19 Public Health Emergency is a good model).
- We should invest in a collective vaccine education initiative to address vaccine misinformation and hesitancy, relieve some of the educational burden on individual providers, and maintain our nationally leading performance on childhood vaccination rates.
- We should avoid major disruptive changes to the delivery system or its financing unless we are certain they will maximize operational efficiency, will reduce cost burdens, and will not lead to unintended consequences.
- As always, if we are contemplating systemic reforms, we should ensure that the particular needs of children and the pediatric delivery system are considered and protected.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What strategies has your organization successfully implemented to improve recruitment and retention of clinical and/or non-clinical workers? What policy, payment, or health care system reforms does your organization recommend

to better sustain, strengthen, and diversify the health care workforce more broadly in Massachusetts?

The delivery of pediatric care frequently involves additional or specialized training that is often tied to the educational missions at teaching hospitals and can be challenging for smaller programs based at community hospitals to develop on their own. We also note that staffing involves a mix of education/training initiatives and recruitment and retention strategies which may differ by professional role (e.g., nursing, physician, associated clinical workforce).

Nursing

Issues

- Limited didactic preparation in pediatrics as a nursing specialty at the undergraduate levels adds time and cost to support transitions to clinical practice by new graduate nurses.
- Competitive wages and salaries for RNs and APRNs are essential given the complexity and demands of nursing roles, including STEM foundational stills, complex human caring and communication competencies, together with shift rotation, weekend and unpredictable work demand.

Boston Children's-Specific Strategies

- Professional governance participation in retention efforts for nursing and patient care operations.
- Professional development training cohorts for new nursing and patient care operations leaders.
- Annual nursing and patient care operations salary market reviews implemented by Boston Children's Human Resources to ensure competitive salary rates.
- Implementation of the American Association of Critical Care Nursing Healthy Work Environment survey for all clinical teams across the enterprise in addition to our annual Press Ganey survey.

Associated Clinical Workforce Strategies

Issues

- The clinical workforce is increasingly dependent on a range of professional roles that are hard to fill. Examples include pharmacy technicians, central sterile processing staff, and patient access representatives.

Boston Children's -Specific Strategies

- Student loan repayment: Incremental student loan repayment benefits with retention commitment to organization.
- Training-to-career pathways: Structured pathways for hard-to-fill roles that are aligned with local associate degree programs and community training programs to recruit students and non-traditional candidates.
- Expanded early talent programs to build awareness and interest in pediatric healthcare careers among underrepresented youth.
- Concerted recruitment efforts for hard to fill clinical positions.

Physicians and Advanced Practice Providers (APPs)

Issues

- Medical school and residency training takes a long time and results in substantial educational debt at the outset of one's career. This can be especially true for pediatric subspecialties that require additional fellowship training.
- Changes to ACGME training mandates requiring increased trainee time in ambulatory settings has resulted in inpatient workforce shortages.
- In general, pediatrics is under-reimbursed relative to adult specialties due to the heavy Medicaid payor mix. In recent residency match cycles nationally, both pediatric primary care and select subspecialties have not filled their allocated slots.
- There are shortages across a range of pediatric subspecialties including psychiatry, developmental medicine, neurology and endocrine as reported by National Academies of Sciences, Engineering, and Medicine.[1] These trends are leading to consolidation in regional centers, and a strong need for staffing models that can better support community hospital providers.
- At the primary care level, a great deal of care delivery still occurs in private practices that are essential to the delivery system but cannot always access state and federal support for workforce initiatives.

Boston Children's -Specific Strategies

- We train our own workforce through medical school, residency, and fellowship training. We have also created APP nursing educational opportunities with local schools of nursing.
- We enable APPs to work at the top of their license to address the shortage of pediatricians through a comprehensive program while allowing MD/DOs to focus on more complex cases. Our goal has been to enhance access to care and optimize healthcare resources while maintaining quality. Key outcomes of this work include:

[1] https://nap.nationalacademies.org/catalog/27207/the-future-pediatric-subspecialty-physician-workforce-meeting-the-needs-of

        - Improving coordination and continuity of care, enhancing patient outcomes and satisfaction.
        - Using APPs to extend service hours, reduce wait times, and increase the availability of outpatient and preventive care services.
        - Hiring over 30 APP FTEs to backfill inpatient service needs created by evolving ACGME requirements.
        - Maintaining legal and professional standards to provide a safe and compliant care environment.
        - Maximizing efficient use of healthcare providers' skills to increase provider satisfaction.
    - As reported in previous years' responses, we have devoted extensive resources to making clinicians available to community hospital programs through staffing arrangements in emergency departments, pediatric inpatient services and NICUs. This enables the preservation of important local capacity in community hospital settings.

Policy Recommendations

We propose the following educational approaches to specifically address pediatric shortages:

- Pediatric primary care curriculum requirements should be strengthened, supported, and standardized in MD/DO, nurse practitioner and PA programs, with more structured criteria for competencies and more equitable access to opportunities.
- Exposure to pediatric experiences should occur early and frequently in the medical school and nursing school curriculum.
- We should enhance the ability of medical students to rotate through community/private office pediatric primary care settings, for example by making transportation available.

Additional funding support for training tied to workforce commitments should be made available:

- Restoration of GME payments in Medicaid for training programs that do not receive sufficient Medicare GME funding or where there are significant shortages (primary care and behavioral health).
- Sustainable and predictable funding for earn-and-learn models.
- Expanded tuition support and loan forgiveness across professional areas including for APRNs and PAs.

We should maximize the use of foreign trained clinicians, where appropriate:

- Advance licensure and credentialling reforms that enhance our ability to employ and retain foreign trained physicians, nurses, and clinical personnel.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs of providing care?

Administrative complexity burdens clinicians, patients, and health systems alike—driving burnout, delaying and fragmenting care, and adding unnecessary costs across the system. Boston Children's Hospital applauds the Health Policy Commission's leadership in examining these impacts and advancing solutions that improve access, equity, and efficiency in health care delivery.

Most notably, Boston Children's strongly supports comprehensive statutory reforms to prior authorization (PA) processes, transparency, and patient protections—with the goals of reducing administrative burden and improving care.

Beginning in the summer of 2025, Boston Children's conducted a detailed community survey of more than 150 physicians, clinical staff, and administrative care team members to quantify the impact of prior authorization on pediatric care.

- 100% of pediatric physician respondents—including primary care providers, specialists, and hospitalists—reported that prior authorization both (i) contributes to workforce burnout and (ii) negatively impacts patient care.
- Among clinical staff, approximately 15% reported spending more than 7 hours per week on processing prior authorizations.
- 44% said the most common denials are overturned more than half the time.
- 90% reported encountering third-party appeal reviewers who lack the necessary pediatric expertise.

These findings underscore what pediatric care teams experience daily: prior authorization complexity and burden delay care, worsen patient outcomes, and consume valuable

time—without necessarily lowering costs or utilization. Boston Children's strongly supports comprehensive prior authorization reforms, including those contained in **S.1403, An Act relative to reducing administrative burden**, and **H.4616, An Act improving the health insurance prior authorization process**, to advance greater transparency, accountability, patient protections, timeliness, continuity of care, and electronic efficiency across the prior authorization system.

As the HPC has noted, administrative complexity does not begin or end with prior authorization—it cascades across the health system. For example, pediatric primary care providers and the families they serve face significant administrative burdens associated with annual school documentation requirements, including:

- **Redundant school and sports physical forms** that must be completed every year even when a child has had a recent comprehensive exam.
- **Return-to-school notes** after minor illnesses such as colds or fevers, requiring provider signatures even when there is no clinical need. Many providers will not write these notes without an office visit, resulting in families seeking care solely to receive a signed note.
- **Medication authorization renewals** for routine over-the-counter medicines (e.g., acetaminophen, ibuprofen) that could reasonably be approved by parents.
- **District-, daycare-, or preschool-specific asthma and allergy action plans** that duplicate existing care plans in the child's medical record.
- **Epinephrine auto-injectors prescribed and dispensed for every affected child**, frequently unused, which create additional family expense and waste resources.
- **Duplicate forms for extracurricular and club sports**, often requiring the same information already provided on school forms.

These processes add little to no clinical or safety value but consume significant clinician time, delay access to care, and contribute to missed school and workdays for families. Boston Children's Hospital supports efforts to consider streamlining and standardizing school health documentation to reduce administrative burden while maintaining safety and public health protections. Specifically, the Commonwealth should consider:

- **Standardizing forms statewide** for daycare, school health, medication administration, asthma/allergy action plans, and sports participation in collaboration with the AAP and that can be incorporated into electronic health record systems.
- **Continuing to require comprehensive school health forms only at key intervals**—such as Kindergarten, 4th, 7th, and 9th grade—or when a child enters a new school system.

- **Allowing parental attestations** in place of provider signatures for return-to-school clearance for minor illnesses of less than 48 hours' duration.
- **Permitting parental authorization** for common over-the-counter medications like acetaminophen and ibuprofen.
- **Requiring schools to maintain stock emergency medications** (e.g., epinephrine auto-injectors) rather than requiring each child to supply their own.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. If your organization includes primary care providers, what activities or investments are you pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your patients? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

The concept of the medical home originated in pediatrics several decades ago.[2] Since that time, work has evolved to further improve care coordination (with an especial emphasis on children with medical complexity), integrated behavioral health initiatives, and to expand the capabilities of clinicians to address conditions previously referred to subspecialists (advanced primary care). These efforts have required quality improvement, technical assistance, and ongoing systemic infrastructure investments to expand and sustain them.

In particular, we have invested heavily in integrated behavioral health care through our Pediatric Physician's Organization at Children's (PPOC):

- A critical focus of the PPOC Medical Home model is Behavioral Health integration. More than 70 of 81 independent pediatric practices in the PPOC have integrated one or more behavioral health clinicians into their practice. A subset also employ or contract with psychiatric prescribers.
- The PPOC has prioritized developmental and behavioral health screening, leading to early identification of symptoms that may need to be addressed by the PCP or by the internal behavioral health team. This model enhances equitable access to behavioral health services as the embedded providers are enrolled across payers, often a barrier to families seeking mental health care for their child in the

[2] Sia C, Tonniges TF, Osterhus E, Taba S. History of the medical home concept. Pediatrics. 2004 May;113(5 Suppl):1473-8. PMID: 15121914.

community. Practice-level care coordinators provide support for families who need to seek services beyond the medical home.

- The PPOC has a team that supports BH integration through the education of multi-disciplinary providers and practitioners across the network.
- Boston Children's is a Massachusetts Child Psychiatry Access Program (MCPAP) hub, supporting PCPs to manage the BH needs of their patients within the primary care medical home. The addition of access to autism, substance use disorder, and early childhood specialists through the MCPAP network enhances the capacity of PCPs to maintain the management of their patients.

Massachusetts has been a policy leader through its Medicaid ACO work, the Roadmap for Behavioral Health, and the Blue Cross Blue Shield AQC contracts and Boston Children's has been an active participant in many of these conversations that have focused on initiatives to enhance access to primary care. We are generally supportive of primary care spending targets as a way to incentivize increased spending on primary care. However, such spending targets should also explicitly address investment in pediatric primary care to ensure that the persistent underfunding in pediatrics is addressed.

5. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out of pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

In the preceding sections, we have noted a number of items designed to reduce costs over time, including the use of APRNs and APPs, the enhancement of primary care capabilities to reduce reliance on subspecialists, our staffing arrangements to maintain community hospital capacity for less complex patients, and our efforts to enhance behavioral health services for children (a long term population health cost saving). We have provided additional details on these and many other items in prior year's filings.

We have also invested heavily in technology designed to make our operations more efficient in order to better utilize available capacity and deliver better care. Two examples:

1. The post-pandemic closure of pediatric hospital beds across the New England region, including at local Boston hospitals, without expanded bed capacity at Boston Children's, has contributed to our need to adopt predictive data analytics for capacity management. This work aims to improve patient experience by reducing wait times and optimizing scheduling. Proactive demand management enables Boston Children's to maintain a high standard of care, even during peak times. Using predictive data analytics, Boston Children's has developed a robust system for managing hospital capacity and patient flow, ensuring that critical resources are available when and where they are most needed.

   For example, our scheduling calendar for elective procedures allows us to adjust elective cases based on the real-time demand from the ED and transfers from other hospitals, helping to prioritize urgent cases efficiently. Similarly, our Patient Flow and Capacity Center ensures constant monitoring and coordination across different units and departments, optimizing throughput and minimizing bottlenecks. Having a 24/7 operational center means that Boston Children's is well-prepared to handle unexpected surges in patient volume, providing flexibility and resilience in operations. Overall, these strategies demonstrate a commitment to maintaining high-quality patient care while effectively managing resources.

2. We established a formal relationship with Franciscan Children's Hospital which has increased access to beds and accelerated placement out of the Emergency Department, including a daily bed huddle in the morning with all parties including the Boston Children's ED. Longer term we are investing in Franciscan Children's to expand access to all levels of care, helping to move patients out of the ED and the Boston Children's inpatient setting. Furthermore, investment in workflows, process change, and equipment has resulted in accelerated access to appropriate levels of care for Behavioral Health patients who would otherwise be boarding on medical units, or longer in the ED. Over the last two years, Boston Children's has implemented process changes for pediatric patients' presenting with mental health concerns, enabling us to reduce the average time spent in the Emergency Room from 60 hours to 22 hours, while continuing to treat the same number of children. We have also recently invested in a patient transport van, which allows providers to accelerate patient transportation from the ED to a behavioral health treatment facility. In addition, it will reduce the reliance on our state's constrained ambulance system, which would otherwise be called to transport the patient.

Finally, we note that from a population health perspective, investment in child health is a relatively low cost, effective, and long-term approach to addressing both cost and quality of life/health outcomes. We spend less as a society on children than most other developed nations. Some proportion of our cost challenge is related to this approach.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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) 2023-2025			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2023	**Q1**	498	106
	Q2	404	103
	Q3	363	70
	Q4	404	53
CY2024	**Q1**	490	40
	Q2	225*	11
	Q3	458	22
	Q4	474	47
CY2025	**Q1**	503	46
	Q2	347	36
	TOTAL:	4166	534

*Please note that we underwent a major EMR transition in Q2 of CY2024 that may have resulted in an undercount for this quarter. Information reported for quarters thereafter are reported from our new EMR utilizing consistent methodologies as in previous reports.