HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

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April 11, 2016

BY ELECTRONIC MAIL AND HAND DELIVERY

Darrell Villaruz
Manager of Health Policy, Bureau of Health Care Safety and Quality
Interim Manager, Determination of Need Program
Massachusetts Department of Public Health
99 Chauncy Street, 11th Floor
Boston, MA 02111

Lynn Conover, MBA
Determination of Need Analyst
Bureau of Health Care Safety and Quality
Department of Public Health
99 Chauncy St, 2nd Floor
Boston, MA 02111

Re: The Children's Hospital Corporation (Determination of Need Project 4-3C47)

Dear Mr. Villaruz and Ms. Conover:

This letter responds to the Department of Public Health's ("the Department") March 4, 2016 request for additional information pertaining to the application filed by The Children's Hospital Corporation ("the Applicant") for its Determination of Need ("DON") Project 4-3C47 (the "Project").[1] The Department has requested that the Applicant "describe the impact of this project on your Medicaid patient population." Specifically, Factor 2.1 of the DON application requires the applicant to address "[h]ow will this project affect accessibility of services for the prospective patients who are poor, medically indigent and/or Medicaid recipients?" The Applicant is pleased to provide supplemental information regarding our Medicaid (MassHealth) payor mix, and the impact of the Project as proposed on access to care for low income children given the erroneous assertions made by the "Friends of Prouty Garden" ten taxpayer group at public hearing and subsequently.

[1] The Applicant has separately responded to the Department's additional question regarding alternative sites considered under separate cover.

As background, Massachusetts is fortunate to have the lowest rate of uninsured children in the country as a result of the significant work of child health advocates over many years. (See, for example, Annie E. Casey Foundation, 2015 Kids Count Data Book 2015, available at http://www.aecf.org/2015db summarizing data from the Census Bureau's American Community Survey). The Applicant has been at the forefront of these efforts both locally and nationally, providing advocacy and support for efforts to expand coverage, assure eligible children are enrolled, and preserve access to comprehensive benefits. We were an early and consistent supporter of the *Children's Health Access Coalition* based at *Health Care For All* and one of the only hospitals in the Commonwealth to formally join the *ACT! Coalition* that led the 2006 health expansion. The Applicant also helped found and continues to support the *New England Alliance for Children's Health* based at *Community Catalyst*. Each of these initiatives has focused on reducing the number of uninsured children through expanded Medicaid/Children's Health Insurance Program (CHIP) coverage.

The Applicant has been consistently recognized for its advocacy efforts. We take care to assist families with enrolling children in coverage when uninsured patients present at our facility. As a result of the tremendous work in Massachusetts reducing the number of uninsured children, and our own emphasis on facilitating enrollment in public programs, we must treat very few uninsured or self-pay patients from Massachusetts and take great pride in this fact.

At the same time, as outlined in our DON Application, we are the Commonwealth's biggest provider of care to children enrolled in the Medicaid and/or CHIP (known as "MassHealth" in Massachusetts.) This commitment can be measured in terms of volume, and also in terms of payor mix. We discharge nearly as many children enrolled in MassHealth as the all of the other pediatric academic medical centers combined as shown in the chart of Massachusetts pediatric Medicaid discharges attached as **Attachment A**. We are particularly essential to those children requiring complex care due to either their underlying physiology and/or the acuity of their care needs as indicated in the chart of pediatric inpatient cases with case mix index (CMI) greater than or equal to 5 discharged from Massachusetts hospitals, attached as **Attachment B**. As a percentage of payor mix, we are second to only Boston Medical Center among Massachusetts hospitals in the percentage of care devoted to MassHealth members as indicated in the chart of percentage of gross patient service revenue from Medicaid attached as **Attachment C**

Boston Children's hospital does not anticipate any decline in its MassHealth or out-of-state Medicaid payor volume as a result of this project. Our experience over the past several years is that our Medicaid payor mix has actually trended up slightly, despite the relative growth of regional, national and international patient volume.[2] We remain committed to our values that all Massachusetts children should have access to our care regardless of whether they have commercial or public coverage.

In their comments and public testimony, the Friends incorrectly assert that Medicare and Medicaid are equivalent programs for the purposes of DON review, pointing to the hospital's relatively low "public payor" volume/payor mix. This is not the case, and is moreover inapplicable to a freestanding children's hospital such

[2] Our Medicaid payor mix trend (consistent with Attachment C): 30.1% (FY11), 30.4% (FY12), 32.9%(FY13), 33.2% (FY14).

as the Applicant's. First, DON review is explicitly focused on "poor, medically indigent and/or Medicaid" patients. While Medicare is a "public payor," it is not a means tested program and serves many middle class and wealthy individuals. It is administered by the federal government, has uniform rules across all jurisdictions, and reimburses providers substantially better than Medicaid.[3] Eligibility is predicated not on income, but rather on whether a beneficiary has contributed sufficiently through employment taxes for a sufficient period of time. Eligibility is almost exclusively limited to elderly (age 65 or greater) or disabled adults.[4] Because most hospitals serve a disproportionate share of elderly and disabled patients (who tend to utilize health care resources more frequently and more intensively), they have quite substantial Medicare payor mixes. For example, in Massachusetts, Medicare provides coverage for 59% of all medical discharges and 44% of all surgical discharges.[5]

Second, as a freestanding children's hospital, the Applicant does not and cannot serve a significant number of Medicare patients other than those with end stage renal disease and a small number of disabled adults that we have treated since childhood (e.g. those with complex congenital heart conditions). This is because adult and elderly patients do not generally use the services of a children's hospital. This is not a "lack of commitment" to these patients; it is the reality of how the programs are structured and who they serve. The relevant factor for DON consideration is our Medicaid payor mix, which has consistently been one of the highest in the state.

As an additional matter, some of the testimony opposing the Project has erroneously focused on the fact that the "undoubling" of patient rooms will result in Boston Children's inability to care for Medicaid patients. It is unclear whether this allegation is that this is our intent or a bi-product of creating a single-bed environment. In any event, this position is unfounded and reliant on an outdated provision in state regulations (130 CMR 415.408(G)). This provision was included not to restrict care, but rather to limit state costs by disallowing additional payments for private rooms in an era in which hospitals might charge more for them.

However, the Commonwealth has for many years paid the same amount per discharge regardless of room type. For example, this year's Medicaid contract provides that "in-state acute hospitals will be paid an adjudicated payment amount per discharge ("APAD"), which is an all-inclusive facility payment that will cover the MassHealth member's entire acute inpatient stay from admission through discharge..." Many, many MassHealth patients across the Commonwealth receive inpatient care in single-bedded rooms with no impact on access, including many patients at the hospital today. Indeed, the Department as a matter of facility review requires single-bedded room design due to concerns about patient safety, privacy and infection control. As a

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[3] Indeed, while the Internal Revenue Service recognizes Medicaid losses as a community benefit provided by non-profit hospitals, it does not allow hospitals to categorize alleged Medicare losses as such. For a good overview, see Sara Rosenbaum, Amber Rieke, and Maureen Byrnes, "Hospital Community Benefit Expenditures: Looking Behind The Numbers," Health Affairs: June 11, 2013 ("Medicaid participation is a community benefit; Medicare participation – a core business activity for virtually all U.S. hospitals – is not.")

[4] There is a very small category of pediatric end stage renal patients covered by the Medicare program as the result of Congressional action in 1972.

[5] (See Health Policy Commission, 2013 Cost trends Report: July 2014 Supplement, page 24, available at http://www.mass.gov/anf/docs/hpc/07012014-cost-trends-report.pdf).

children's hospital, we also have very specific concerns about mixing ages and genders (e.g. teens with young children), and also have heightened concerns about privacy issues given the developmental ages of our patients (e.g. exposure to "roommate" information that a young child may not understand).

With respect to the Applicant's intent in creating a single-bedded environment, we look forward to a time when all our patients, including our MassHealth patients, are able to experience a facility that truly meets both their medical and family-centered care needs.

Finally, one or two comments were made about our recently signed contract with Neighborhood Health Plan (NHP), a Medicaid Managed Care Organization (MCO) owned and operated by Partners Health Care. Under the terms of this contract, we will continue to treat any child authorized for care by NHP. This is the same standard we utilize for those commercial payors that have prior authorization requirements. We have also agreed to take financial risk for those patients that receive primary care from a BCH-affiliated primary care physician, and in this context are allowed to waive NHP's authorization requirements for them. We are choosing to do so because we believe that we are a high-quality, cost-effective option for children with medical and surgical needs.

Thank you for your consideration.

Sincerely,

Joshua Greenberg
Vice President of Government Relations

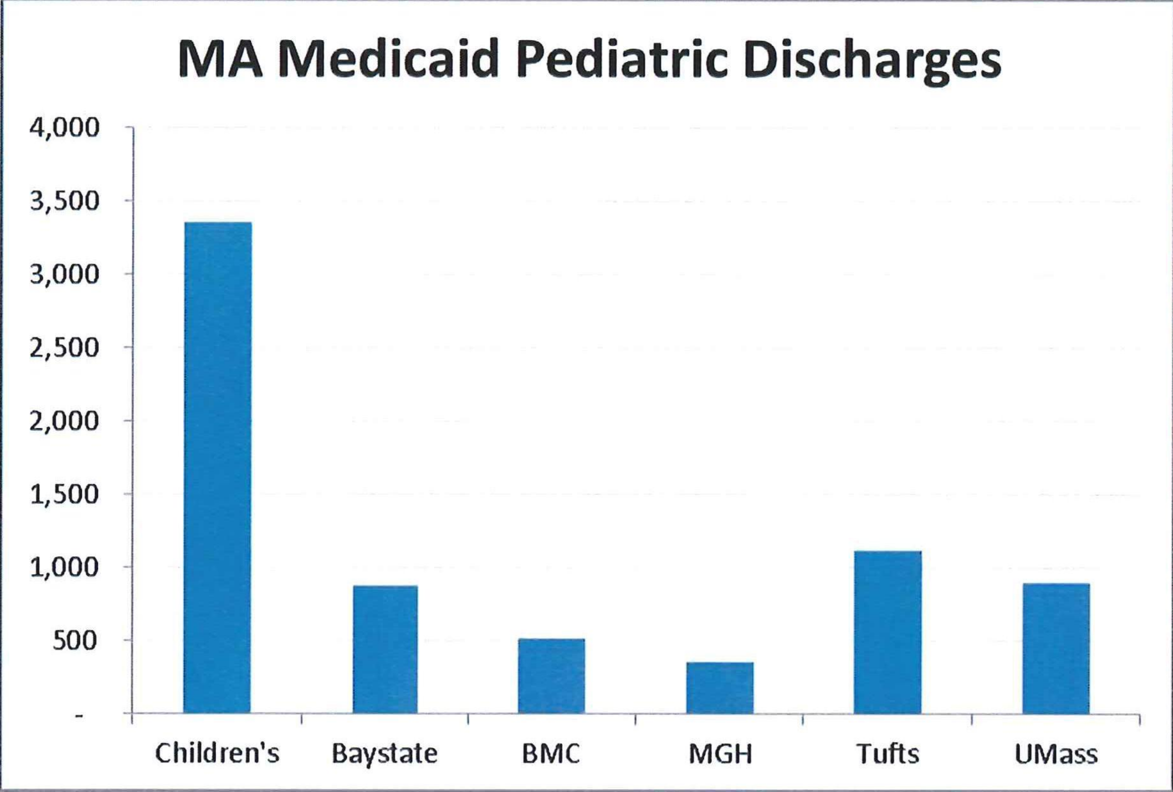
Melissa Aureli
Manager Facilities Planning & Design

cc: Michele Garvin, Senior Vice President and General Counsel

Enclosures

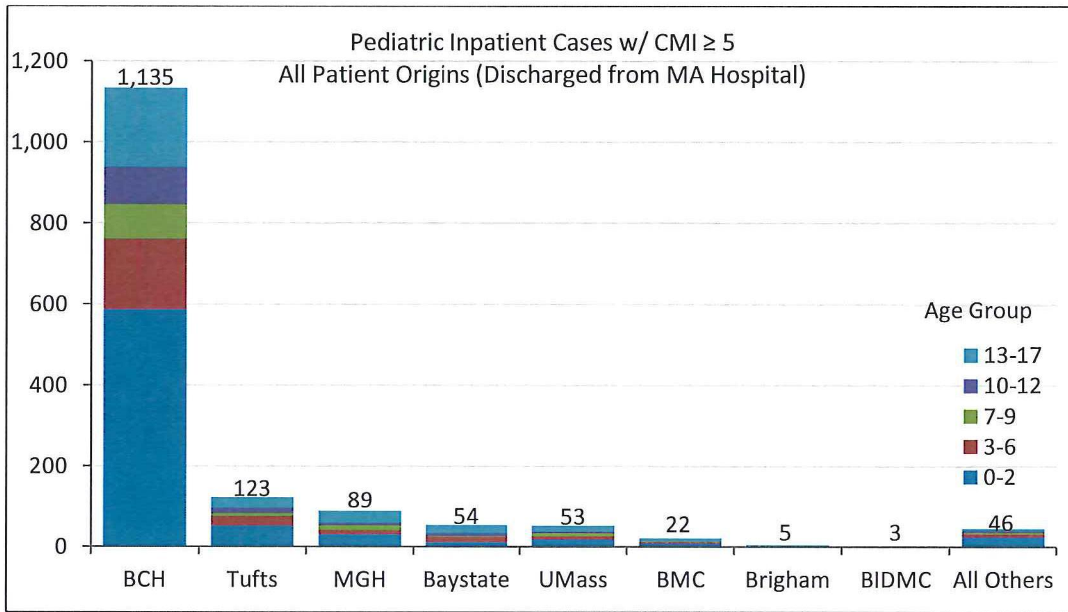
- Attachment A – Massachusetts pediatric Medicaid discharges
- Attachment B – Pediatric inpatient cases with case mix index greater than or equal to 5
- Attachment C – Percentage gross patient revenue from Medicaid

ATTACHMENT A



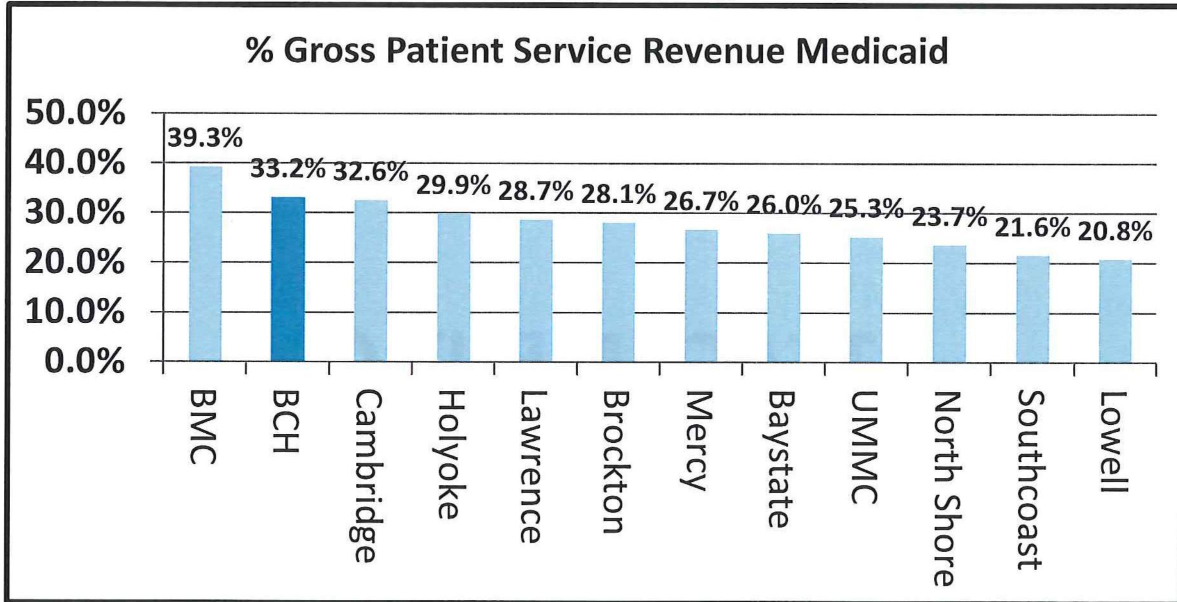
Source: Truven. "Medicaid" may include MCOs and other government payers (TRICARE, DMH, DPH, DSS, Other Massachusetts state and local agencies, out-of-state government agencies, and out-of-state Medicaid); data not detailed enough to distinguish. Graph reflects most recent data available (FY 2012).

ATTACHMENT B



Source: Truven. Graph reflects most recent data available (FY 2012).

ATTACHMENT C



Source: 2014 403 data. Includes FFS, MCO and Other Government (TRICARE, DMH, DPH, DSS, Other Massachusetts state and local agencies, out-of-state government agencies, and out-of-state Medicaid). Total Medicaid GPSR>$200m and Utilization>20%.