

STAFF REPORT TO THE PUBLIC HEALTH COUNCIL FOR A DETERMINATION OF NEED	
Applicant Name	Berkshire Health Systems, Inc.
Applicant Address	725 North Street Pittsfield, MA 01201
Filing Date	September 1, 2023
Type of DoN Application	Original License
Total Value	\$2,850,000.00
Project Number	BHS-23072710-OL
Ten Taxpayer Group (TTG)	Yes
Community Health Initiative (CHI)	\$142,500.00
Staff Recommendation	Approval with Conditions
Public Health Council Meeting	December 13, 2023
<p style="text-align: center;"><u>Project Summary and Regulatory Review</u></p> <p>Berkshire Health Systems, Inc. (BHS or Applicant) submitted an application for an original hospital license to operate an acute care, Medicare-certified Critical Access Hospital (CAH) to be located at 71 Hospital Ave, North Adams, MA 01247 (North Adams Regional Hospital or NARH). The proposed site will include the following: 18 medical/surgical (M/S) beds, which will also be certified for use as 18 swing beds for skilled nursing facility (SNF) level care; a four-room mixed inpatient/outpatient surgical space; and imaging, emergency services and other outpatient services. The North Adams site encompasses 163,756 gross square feet. The capital expenditure for the Proposed Project is \$2,850,000.00; the Community Health Initiatives (CHI) contribution is \$142,500.00.</p> <p>Two Ten Taxpayer Groups (TTGs) formed in connection with this application. The Department received written comments and held a virtual public hearing on October 25, 2023. A list of commenters and summaries of the comments received can be found in Appendices V through VII.</p> <p>This DoN application falls within the definition of Original License, which are reviewed under the DoN regulation 105 CMR 100.000. The Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need Factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.</p> <p style="text-align: center;"><b>This Amended Staff Report Replaces the Original Staff Report in its Entirety. Changes appear in red on pages 33, 34, 41, 42, and 55 of this version of the Staff Report. Final Amended-12/8/23</b></p>	

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## Application Overview

### **Berkshire Health Systems, Inc.**

Berkshire Health Systems, Inc. (BHS or Applicant), is a private, non-profit healthcare network that consists of two hospitals; Berkshire Medical Center (BMC), a 298-bed community-High Public Payer Hospital<sup>1</sup> located in Pittsfield, MA; and Fairview Hospital (FVH), a 25-bed critical access hospital (CAH)<sup>2</sup> located in Great Barrington, MA. The BHS system also includes BMC Cancer Center; BHS medical group, a network of primary and specialty care providers; and a network of outpatient ancillary services. BHS provides emergency medical care at its two inpatient facilities, BMC and FVH, and at a Satellite Emergency Facility (SEF) on the BMC campus in North Adams.<sup>a</sup> The Applicant states that its services are integrated to allow for more streamlined and coordinated access across various health system locations. With over 4,000 employees, BHS is the largest employer in the region and serves as both the healthcare and the economic anchor of the Berkshires.<sup>b</sup> The Applicant states that it serves all residents and visitors to Berkshire County, which covers 946 square miles, and the surrounding areas. The region has been identified as mostly rural by the federal Health Resources and Services Administration (HRSA).<sup>c</sup> Berkshire County is the second most rural county in Massachusetts<sup>d</sup>. The County, which is made up of 32 communities, is commonly divided into three regions: north, central, and south.<sup>e</sup>

### **Berkshire Medical Center**

BMC, is a 298-bed, community-High Public Payer hospital located in Pittsfield, MA in the center of Berkshire County. BMC is a Level III Adult Trauma Center.<sup>f</sup> BMC provides a full continuum of medical specialties, state-of-the-art imaging and surgical technologies, and advanced imaging and laboratory technology.<sup>3,g</sup> BMC is designated by the Department of Public Health (the Department) as a Primary Stroke Service Hospital.<sup>4</sup>

### **Fairview Hospital**

FVH, is a 25-bed community-High Public Payer Hospital located in Great Barrington, MA in the southern part of Berkshire County. FVH is federally designated as a CAH and is designated by the Department as a Primary Stroke Service Hospital.<sup>h,5</sup> FVH provides inpatient medical services, general surgery, orthopedics, and maternity services with 24-hour emergency and hospitalist coverage, and a full range of ambulatory surgical services which include general

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<sup>1</sup> High Public Payer Hospitals (HPP) reported a minimum of 63% of gross patient service revenue from public payers.

<sup>2</sup> CHIA classified Fairview as a Community-High Public Payer Hospital.

<https://www.chiamass.gov/assets/docs/r/hospital-profiles/2021/fairview.pdf>

<sup>3</sup> Services include Orthopedic surgery/total joint replacement, Cancer care, Behavioral health/substance use disorder treatment, Substance use disorder treatment, General surgery, Urology, Obstetrics and gynecology, Neurosurgery, Cardiology, Gastroenterology, and Retail pharmacy.

<sup>4</sup> Designated Primary Stroke Services Hospitals: <https://www.mass.gov/info-details/designated-primary-stroke-services-hospitals>

<sup>5</sup> Designated Primary Stroke Services Hospitals: <https://www.mass.gov/info-details/designated-primary-stroke-services-hospitals>

surgery, gynecology, orthopedics, urology, plastic surgery, ophthalmology and gastroenterology.<sup>i</sup>

### **North Adams Regional Hospital**

North Adams Regional Hospital (NARH), formally located in Northern Berkshire County (North County), closed abruptly in March 2014. The Center for Health Information and Analysis (CHIA) reported that in FY12, NARH had 117 staffed beds representing 34% of all acute hospital staffed beds in the region. NARH accounted for 16% of all inpatient discharges from acute hospitals within the Berkshires region.<sup>j</sup> In addition, half of all inpatient cases treated at NARH in FY12 were from North Adams.<sup>k</sup>

The closure of NARH resulted in the loss of inpatient and outpatient services for Northern Berkshire County (North County). An emergency workgroup was convened to expedite the restoration of health care services to the region. It was determined that inpatient care could not be saved, and BHS reopened emergency and outpatient services in North Adams. In April 2014, BHS restored an emergency department (ED) (including imaging and laboratory services) by converting the existing hospital facility to an SEF. In addition, BHS recommenced the provision of ambulatory surgery and other outpatient services under BMC's hospital license. The NARH site now operates as a BMC SEF, providing emergency and outpatient services to residents of North Adams, Massachusetts, and the surrounding communities. Because inpatient services were not restored at the North Adams site, patients requiring inpatient and observation services are transferred to BMC's main hospital campus located in Pittsfield, or in some cases to Southwestern Vermont.

### **Proposed Project**

After the closure of NARH, the Department's Office of Rural Health engaged Stroudwater Associates (Stroudwater) to "provide an independent and objective third-party assessment of the healthcare market in the North Adams region" the purpose of which was "to evaluate the viability of healthcare services in existing and future healthcare market conditions."<sup>l</sup> Stroudwater issued a report recommending the development of "a clinically integrated delivery system for inpatient service with BMC, to include limited inpatient services provided in North County *only* if the BMC North site is designated as a Critical Access Hospital."<sup>m</sup> Due to recent Centers for Medicare and Medicaid (CMS) changes to the CAH Conditions of Participation (CoPs) for location and distance requirements, the Applicant is now able to pursue a CAH designation from CMS, an option that was not possible prior to the rule change.<sup>n,6</sup> Additionally, since the Balanced Budget Refinement Act of 1999, CMS recognizes the re-opening of closed and downsized facilities as CAHs.<sup>7,o</sup>

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<sup>6</sup> The Applicant states that CMS promulgated new regulations defining a "primary road" in terms of the CAH distance requirement to include numbered Federal Highways with two or more lanes. U.S. Route 7 is now considered a secondary road and the North Adams Campus now meets the requirement.

<sup>7</sup> Under section 1820(c)(2) of the Act, CAH designation was available only to facilities currently operating as hospitals. Section 403(c) of Public Law 106-113 amended the statute to permit a State to designate as a CAH a

BHS is proposing to obtain an Original License to operate an acute care, Medicare-certified CAH to be located at 71 Hospital Ave, North Adams (NARH). The Applicant intends to move BMC Satellite Services from BMC's license to the NARH license. This would entail a closure of the BMC satellite (North Adams campus of Berkshire Medical Center and Satellite Emergency Facility) and reopening of the services under the new original NARH license. NARH would then be licensed as an acute care hospital.

The Applicant has submitted an application for a Proposed Project that includes the following:

- 18 licensed M/S beds, which will also be certified for use as 18 swing beds for SNF level care;
- Four-room mixed inpatient/outpatient operating rooms (ORs) that will meet surgical and endoscopy needs; and
- Imaging, emergency services and other outpatient services.

The applicant states that the closure of NARH resulted in a lack of access to inpatient and observation services for residents of North County. Through the Proposed Project, the Applicant intends to seek a hospital license to open a CAH in order to restore inpatient and observation services and establish certain Outpatient Services to the NARH license to offer local, community-based integrated health care to the Patient Panel, which includes the residents of North County.

## Patient Panel<sup>8</sup>

The BHS Patient Panel consisted of 132,669 unique patients, in fiscal year 2022 (FY22). This represents all unique patients who have visited any BHS location. As shown in Table 1, the number of patients utilizing BHS's services decreased by 9% between FY20 and FY22.

**Table 1: BHS Patient Panel**

	FY20	FY21	FY22	% Change Rate
<b>Unique Patients</b>	146,286	134,592	132,669	-9%

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facility that previously was a hospital but ceased operations on or after November 29, 1989 (10 years prior to the enactment of Public Law 106-113), if that facility fulfills the criteria under section 1820(c)(2)(B) of the Act for CAH designation as of the effective date of its designation. The amendment also allows State CAH designation for facilities that previously had been hospitals, but are currently State-licensed health clinics or health centers if they meet the revised criteria for CAH designation under section 1820(c)(2)(B) of the Act as of the effective date of designation.

<sup>8</sup> As defined in 105 CMR 100.100, Patient Panel is the total of the individual patients regardless of payer, including those patients seen within an emergency department(s) if applicable, seen over the course of the most recent complete 36-month period by the Applicant or Holder.

The BMC Acute Care Patients North County Patient Population (BMC Acute Care) are BMC discharges from M/S units that represent the level of care that will be available at the new hospital. The BMC Acute Care patient population represents the patient population that will utilize inpatient and observation services in North Adams. The Applicant states that this patient population represents only those patients from the primary and secondary service areas of the new hospital. The Primary and Secondary Service Areas of north, central, and southern Berkshire are listed in Appendix II. The Applicant relied on patient visits because they were unable to determine number of unique patients from the electronic health record (EHR). There were 3,890 BMC acute care visits in FY22. As shown in Table 2, the number of acute care visits increased by 71% between FY20 and FY22.

**Table 2: BMC Acute Care Visits<sup>9</sup>**

	FY20	FY21	FY22	% Change Rate
Number of Acute Care Visits	2,279	3,827	3,890	71%

Table 3 shows the BMC Acute Care patient population by zip code.

**Table 3: BMC Acute Care Visits by Zip Code (FY22)**

Zip Code	City/Town	BMC Acute Care Patients with a North County Zip Code	Share of BMC Acute Care Patients with a North County Zip Code
01220	Adams	867	22.3%
01225	Cheshire	321	8.3%
01247	North Adams	1,883	48.4%
01256	Savoy	42	1.1%
01267	Williamstown	558	14.3%
01270	Windsor	42	1.1%
01343	Drury	*	N/A
01350	Monroe Bridge	*	N/A
01367	Rowe	12	0.3%
05261	Pownal, VT	21	0.5%
05350	Readsboro, VT	15	0.4%
05352	Stamford, VT	33	0.8%
12022	Berlin, NY	*	N/A
12138	Petersburg, NY	*	N/A
12168	Stephentown, NY	74	1.9%

<sup>9</sup> Patients were included regardless of their entry source (main BMC Emergency Department, Satellite Emergency Facility, Same Day Surgery). The Applicant states that the tables will differ from the Stroudwater feasibility study data, as that data only included patients who entered BMC through the Satellite Emergency Facility.

Zip Code	City/Town	BMC Acute Care Patients with a North County Zip Code	Share of BMC Acute Care Patients with a North County Zip Code
Other		21* <sup>10</sup>	0.5%
Total		3,889	100%

The North County Outpatients Patient Population (North County Outpatients) represents two patient populations:

- 1) Any patient who had an outpatient service at any BHS location and had a home zip code in the North Berkshire Service Area as identified in Appendix II, or
- 2) Any patient who had an outpatient service in a North Adams campus location regardless of home zip code.

There were 35,246 patients served in FY22. As shown in Table 4, the number of unique patients served decreased by 4% between FY20 and FY22.

**Table 4: North County Outpatients**

	FY20	FY21	FY22	% Change Rate
Unique Patients	36,806	35,182	35,246	-4%

Table 5 shows the North County Outpatients patient population by zip code.

**Table 5: North County Outpatients by Zip Code, FY22**

Zip Code	City/Town	North County Outpatients Unique Patients	Share of Patients	North County Outpatients Number of Visits	Share of North County Outpatients Visits
01220	Adams	7,163	20.3%	97,188	23.8%
01225	Cheshire	2,809	8.0%	35,709	8.7%
01247	North Adams	12,227	34.7%	167,921	41.1%
01256	Savoy	547	1.6%	5,902	1.4%
01267	Williamstown	5,699	16.2%	63,264	15.5%
01270	Windsor	586	1.7%	6,630	1.6%
01343	Drury	90	0.3%	805	0.2%
01350	Monroe Bridge	27	0.1%	265	0.1%
01367	Rowe	81	0.2%	997	0.2%
05261	Pownal, VT	419	1.2%	4,200	1.0%

<sup>10</sup> \*Other Zip Codes for Acute = 01343, 01350, 12022, 12138. Counts of less than 11 were combined for confidentiality.

Zip Code	City/Town	North County Outpatients Unique Patients	Share of Patients	North County Outpatients Number of Visits	Share of North County Outpatients Visits
05350	Readsboro, VT	230	0.7%	2,172	0.5%
05352	Stamford, VT	553	1.6%	5,190	1.3%
12022	Berlin, NY	63	0.2%	631	0.2%
12138	Petersburg, NY	95	0.3%	905	0.2%
12168	Stephentown, NY	590	1.7%	5,249	1.3%
Use of NC Location Services for patients who live Outside NC Service Areas		4,067	11.5%	11,776	2.9%
Total		35,246	100%	408,804	100%

Staff inquired about the changes in the size of the Patient Panel and patient populations between FY20 and FY22 that are noted above (9% decrease in BHS Patient Panel, 4% decrease in North County Outpatients, and 71% increase in BMC Acute Care Visits). The Applicant asserts that the fluctuations in the Patient Panel is not reflective of demand for services. The Applicant further explained the reason for the changes seen in the Patient Panel and patient populations.

- The 9% decrease in the Patient Panel is a result of several factors, including state-imposed limitations on non “COVID-19 Essential Services”, and a slow ramp up of utilization of services once the state limitations were removed.
- While the North County Outpatient population decreased by 4%, the number of visits increased by 48%, and this reflects increasing acute needs of the patient population. The 4% decrease is attributable to state-imposed limitations on services during this period and a challenging environment for physician recruitment and retention that the Applicant believes will be addressed through the more comprehensive healthcare delivery system that the Proposed Project will bring.
- The increase in BMC Acute Care visits reflects North County acute needs that required services beyond those offered at the BMC Outpatient Satellite. Utilization also increased as the COVID-19 pandemic subsided and North County patients were more willing to travel to BMC for inpatient and observation level care, and other outpatient services that were only offered at BMC due to provider availability.
- Table 6 shows surgical visits for North County patients increased 120% during this period, which was greater than the increase in surgical visits for Non-North County patients.

**Table 6: Population of Acute Care Surgical Visits**

	FY20	FY22	Change
	Number	Number	Percent



	FY20	FY22	Change
North County	635	1,395	120%
Non-North County	2,112	3,777	79%
Total	2,747	5,172	88%

The Applicant provided three years of demographic information for the Patient Panel and patient populations. For comparison purposes, demographic information for FY22 is shown in Table 7.

**Table 7: Overview of BHS, BMC Acute Care, and North County Outpatients Patient Populations**

	BHS patients	BMC Acute Care <sup>11</sup>	North County Outpatients
<b>FY22</b>	132,669 patients	3,890	35,246 patients
<b>Gender<sup>12</sup></b>			
Male	46.30%	47.10%	46.10%
Female	53.55%	52.90%	53.90% <sup>13</sup>
Other/Unspecified	0.14%	0.00%	
Total	100.00%	100.00%	100.00%
<b>Age</b>			
0-18	15.73%	1.88%	14.26%
19-49	33.53%	30.72%	36.24%
50-64	22.25%	21.13%	22.95%
65+	28.49%	46.27%	26.55%
Total	100.00%	100.00%	100.00%
<b>Race/Ethnicity</b>			
American Indian/Alaska Native	0.14%		0.14%
Asian	1.07%		1.10%
Black/African American	3.94%	3.14%	2.63%
Native Hawaiian/Pacific Islander	0.02%		
White/Caucasian	84.51%	94.70%	89.06%
Other	3.03% <sup>14</sup>	2.16% <sup>15</sup>	1.63% <sup>16</sup>
Refused/Unknown	7.30%		5.45%
Total	100.00%	100.00	100%

<sup>11</sup> Based on visits. The electronic health record (EHR) is unable to determine number of unique patients.

<sup>12</sup> The Applicant states that the capture of other/unspecified gender is done consistently, and that education is being provided to make sure the collection of this information is more accurate in the future.

<sup>13</sup> Includes Female and Other. For confidentiality, "Other" includes patient counts less than 11.

<sup>14</sup> Other is used by patients to represent multiracial or when they do not wish to choose one of the listed options.

<sup>15</sup> For confidentiality, "Other" includes all races not separately listed which all had patient counts less than 11, patients who use "Other" to represent multiracial, patients who do not wish to choose one of the listed options, or patients who selected refused/unknown.

<sup>16</sup> For confidentiality, "Other" includes all races not separately listed which all had patient counts less than 11, patients who use "Other" to represent multiracial, or patients who do not wish to choose one of the listed options.

	BHS patients	BMC Acute Care <sup>11</sup>	North County Outpatients
Hispanic Ethnicity <sup>17</sup>	3.78% <sup>18</sup>	1.95% <sup>19</sup>	2.10% <sup>20</sup>
<b>Service Area</b>			
Northern Berkshire PSA	22.08%	96.56%	
North County SSA		3.44%	
Central Berkshire PSA	51.16%		
Southern Berkshire PSA	11.68%		
PSA Sub-total	84.93%		
All Other <sup>21</sup>	15.07%		
Total	100% <sup>22</sup>	100.00%	
<b>Payer Mix<sup>23</sup></b>			
Public/Medicaid/Medicaid MC	19.84%	17.15%	20.48%
Medicare/Medicare MC/Advantage	28.49%	50.41%	28.02%
Private/Commercial/HMO	47.90%	29.41%	48.68%
Health Safety Net (HSN)	0.29%		0.31%
Other (self-pay/workers' comp/VA)	3.48%		2.50%
Other (self-pay/workers' comp/VA, HSN)		3.03%	
Total	100.00%	100.00%	100.00%

BHS Patient Panel Risk Contract participation for FY20 to FY22 is shown in Table 8.

**Table 8: BHS Risk Contract**

Contract Type	FY20		FY21		FY22	
	Number	Percent	Number	Percent	Number	Percent
Medicare	14,246	9.74%	18,605	13.82%	19,260	14.52%
Medicaid	14,756	10.09%	15,914	11.82%	17,248	13.00%
Commercial	938	0.64%	1,139	.85%	1,420	1.07%

<sup>17</sup> Hispanic Ethnicity is captured separately from the races listed and would be combined with any of the races listed above.

<sup>18</sup> The Hispanic Ethnicity of the population of Berkshire County is 5.5% based on data from 7/1/2022.

<sup>19</sup> The Hispanic Ethnicity of the population of the towns in Northern Berkshire County range from 0% to 6% based on data from US Census, ACS, 2017-2021, Table S0601.

<sup>20</sup> The Hispanic Ethnicity of the population of the towns in Northern Berkshire County range from 0% to 6% based on data from US Census, ACS, 2017-2021, Table S0601.

<sup>21</sup> All Other includes: 1) patients who live in towns in one of the three states or other Massachusetts counties that border Berkshire County, 2) patients who are part-time residents/second homeowners who use a home address as their out of state address, and 3) patients who come to Berkshire County as a visitor.

<sup>22</sup> Total comprises PSA Sub-total and All Other.

<sup>23</sup> The Applicant states that this is based on the primary payer for the most recent service, as patients may have multiple payers for a single visit or multiple visits in a year with different payer sources. In addition, Medicaid enrollment has continued to increase due to the Public Health Emergency that suspended the disenrollment process throughout this time period (FY20-FY22). The Applicant states that in FY21/FY22, there was an increase in Private/Commercial/HMO payers in response to the number of private businesses that contracted with the health system to perform COVID surveillance testing for their staff, and the DPH funded Stop the Spread testing and monoclonal antibodies is also included in this category.

The Applicant notes the following observations about the data:

- **Age:** The age 65 and older population comprises almost 30% of the BHS and North County Outpatients patient populations, and almost 50% of the BMC Acute Care patient population.
- **Race/Ethnicity:** Greater than 80% of patients in all three patient populations identified as White/Caucasian. Almost 4% of BHS patients, and 2% of BMC Acute Care patients and North County Outpatients identified as Hispanic.
- **Patient Origin:** Over 50% of BHS patients reside in the Central Berkshire primary service area (PSA), which includes 19 zip codes. Over 95% of BMC Acute Care patients reside in the Northern Berkshire PSA, which includes 9 zip codes.
- **Payer Mix:** Private/Commercial/HMO is the major payer for BHS patients (48%) and North County Outpatients (49%) followed by Medicare/Medicare MC/Advantage. Medicare/Medicare MC/Advantage is the major payer for BMC Acute Care patients (50%) followed by Private/Commercial/HMO. The Applicant notes that a significant portion of the Patient Panel is insured by a government public payer. The same is true of the BMC Acute Care and North County Outpatients patient populations.
- **Risk Contract:** The Applicant states that in FY21, a new partner was added to the Medicare risk contract that increased patient attribution to what is seen, and that the Medicaid risk contract has continued to increase due to the suspension of disenrollment during the Public Health Emergency.

## Factor 1: a) Patient Panel Need

In this section, staff assesses if the Applicant has sufficiently addressed Patient Panel need for the Proposed Project. The Applicant attributes Patient Panel need for an Original License to establish a CAH to the following:

### 1. Health Status and Disease Burden

It is estimated that more than 60 million Americans live in rural areas.<sup>p</sup> Residents living in rural areas tend to be older and have more serious health conditions than urban residents.<sup>q</sup> Studies have shown that rural residents are more likely to die prematurely from the leading causes of death in the U.S. which include heart disease, cancer, lung disease, and stroke.<sup>r,s</sup> Residents in rural areas may require more medical care but may encounter more limited access to healthcare.<sup>t</sup> In addition, they experience unique challenges accessing certain healthcare services, including limited availability of healthcare providers, traveling farther distances to access healthcare services and more limited transportation options for accessing care.<sup>u</sup>

The Applicant states that BHS has observed that patients in North County tend to defer or avoid care due to lack of transportation<sup>24</sup>, financial resources, and/or available social supports. BHS has also found that the number of diagnostic and therapeutic procedures performed on patients from North County are lower than would be expected based on patient numbers. The

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<sup>24</sup> The Applicant states that North County is served by a single bus line on U.S. Routes 7 and 8, and there is almost no access to services like Uber.

Applicant received comments from the North Adams community stating that they are experiencing delays in accessing care due to the challenges of getting to BMC. The Applicant affirms that utilization data and an increasing case mix index (CMI) for North County residents indicates that North County patients are more ill than previously. The Applicant points to the 120% increase in surgical visits for North County residents as compared to 79% for the rest of the Patient Panel as a possible indication of delays in accessing care. The Applicant cites Determination of Need (DoN) staff reports which have stated that deferring healthcare has negative health and financial implications. Delaying care can worsen health conditions leading to more intensive treatment, and higher healthcare costs.

To demonstrate need for the Proposed Project, the Applicant provided data on the health status and disease burden of the Patient Panel and patient populations. The Applicant's stated need for the Proposed Project is established through examining demographic information and health status of three populations. This is shown in Table 9.

**Table 9: Patient Panel and Patient Population Descriptions**

BHS Patient Panel	Represents all <b>unique patients</b> who have visited any BHS location
Berkshire Medical Center (BMC) Acute Care Patients North County Patient Population	Represent <b>BMC discharges</b> from medical/surgical units that represent the level of care that will be available at the new hospital and represents only those patients from the primary and secondary service areas of the new hospital as identified in Appendix II. Represents the patient population that will use inpatient and observation services in North Adams.
North County Outpatients Patient Population	Represents <b>two patient populations</b> : 1) Any patient who had an outpatient service at any BHS location and had a home zip code in the North Berkshire Service Area as identified in Appendix II or 2) Any patient who had an outpatient service in a North Adams campus location regardless of home zip code.

Together, BMC Acute Care patients and North County Outpatients represent need for the types of inpatient and outpatient care that will be provided at the proposed site, and further demonstrate need to restore inpatient and observation services at the proposed site to support coordinated and integrated inpatient and outpatient care in the same location.

The Applicant asserts that the North County patient population is an aging population with increasing chronic diseases and conditions. The Applicant states that this is reflected in the age 65 and older population of the Patient Panel and patient populations, and in the CMI of BMC patients and BMC Acute Care patients from North County. Table 10 shows that the age 65 and older population for the Patient Panel, and each of the patient populations, is greater than the age 65 and older population of Berkshire County (25.5% July 1, 2022) and of Massachusetts (18.1% July 1, 2022).<sup>v,w</sup>

**Table 10: Age 65 and older population for BHS, BMC Acute Care and North County Outpatients**

	FY20		FY21		FY22	
	Number	Percent	Number	Percent	Number	Percent
BHS patients	45,686	31.23%	36,819	27.36%	37,794	28.49%
BMC Acute Care (Visits)	1,270	55.73%	1,767	46.17%	1,800	46.27%
North County Outpatients	10,493	28.51%	9,061	25.75%	9,358	26.55%

Staff note that the age 65 and older population for BHS, BMC Acute Care and North County Outpatients has been decreasing since FY20. The Applicant explained that while the number of unique patients has been decreasing, overall visits for this age group have increased for the BHS Patient Panel and North County outpatients. The increase in visits described by the Applicant is shown in Table 11.

**Table 11: Age 65 and older Patients and Visits, FY20-FY22**

Fiscal Year	Population	BHS Patient Panel	BMC Acute-North County Patients	North County Outpatients
<b>FY20</b>	Unique Patients	146,286	NA	36,806
	Unique Patients age 65+	45,686 (31.23%)	NA	10,493 (28.51%)
	Patient Visits	950,065	2,279	276,494
	Patient Visits age 65+	409,492 (43.10%)	1,270 (55.73%)	114,844 (41.54%)
<b>FY22</b>	Unique Patients	132,669	NA	35,246
	Unique Patients age 65+	37,794 (28.49%)	NA	9,358 (26.55%)
	Patient Visits	1,493,971	3,890	408,804
	Patient Visits age 65+	658,242 (44.06%)	1,800 (46.27%)	173,935 (42.55%)

The Applicant explained further that the decline in this age groups reflects the impact of the COVID-19 pandemic on older adults and their greater vulnerability. The number of patients accessing care decreased as a result of public health restrictions and patient apprehension. The Applicant points to the last weekly DPH COVID-19 Public Health Report showing that Berkshire County had 99 confirmed deaths in long-term care facilities noting that older adults who died of other causes that may have been related to COVID-19 are not included in this number.<sup>x</sup> Patients in this age group that are presenting for care have more acute needs that require more services.

The Applicant states that the Medicare CMI demonstrates increasing severity of illness for Berkshire County patients. Table 12 shows the CMI for BMC and for the BMC CMI for the

Northern Berkshire Service Area (BMC Acute Care Patient Population). Tables 12 shows increasing CMI from FY20 to FY22, and a higher CMI for patients insured by Medicare.

**Table 12: BMC CMI and BMC Acute Care CMI**

	FY20		FY21		FY22	
	BMC CMI	BMC Acute Care CMI	BMC CMI	BMC Acute Care CMI	BMC CMI	BMC Acute Care CMI
All Payer	1.47	1.46	1.51	1.51	1.58	1.58
Medicare	1.61	1.57	1.65	1.61	1.73	1.68

The Applicant points to disease prevalence to demonstrate further need for inpatient and outpatient services. Table 13 shows disease prevalence for BHS patients, which includes the North County patient population. The Applicant notes that risk contracts and a clinical documentation program, with a focus on accuracy and completeness of coding, have improved coding of disease prevalence.

**Table 13: BHS Disease Prevalence**

Disease Prevalence	FY20		FY21		FY22	
	Number	Percent	Number	Percent	Number	Percent
Hypertension	31,205	21.33%	30,746	22.84%	31,273	23.57%
Mental Health	19,550	13.36%	19,523	14.51%	23,459	17.68%
Diabetes	13,124	8.97%	12,611	9.37%	12,662	9.54%
Cancer	10,585	7.24%	10,386	7.72%	10,755	8.11%
Respiratory Disease	9,763	6.67%	9,031	6.71%	10,059	7.58%
Substance Use	7,997	5.47%	7,356	5.47%	8,172	6.16%
Coronary Artery Disease	7,951	5.44%	7,813	5.80%	8,321	6.27%
Kidney Disease/Failure	5,312	3.63%	5,272	3.92%	5,427	4.09%
Chronic Obstructive Pulmonary Disease	4,853	3.32%	4,538	3.37%	4,496	3.39%
Heart Failure	3,989	2.73%	3,978	2.96%	3,975	3.00%

An examination of hospital utilization by the BMC Acute Care patient population provides an indication of the type of care and level of care that will be needed at NARH. Table 14 shows Reasons for Hospitalization for FY20 through FY22.

**Table 14: BMC Acute Care Patient Population Reasons for Hospitalization**

Diagnosis	FY20		FY21		FY22	
	Number	Percent	Number	Percent	Number	Percent
Sepsis	209	9.17%	216	5.64%	256	6.58%
Heart Failure	130	5.70%	187	4.89%	144	3.70%

Diagnosis	FY20		FY21		FY22	
	Number	Percent	Number	Percent	Number	Percent
Pneumonia	89	3.91%	52	1.36%	93	2.39%
Alcohol Related	80	3.51%	140	3.66%	140	3.60%
Total Joint (Knee or Hip)	63	2.76%	56	1.46%	38	0.98%
Kidney Failure	57	2.50%	67	1.75%	52	1.34%
Chest Pain	32	1.40%	49	1.28%	38	0.98%
Syncope and Collapse	31	1.36%	30	0.78%	33	0.85%
Transient cerebral ischemic attack	31	1.36%	30	0.78%	25	0.64%
COPD	24	1.05%	31	0.81%	36	0.93%
COVID-19	13	0.57%	82	2.14%	126	3.24%
Urinary Tract Infection	14	0.61%	24	0.63%	42	1.08%

Table 15 shows average length of stay (ALOS) for the BMC Acute Care patient population.<sup>25</sup> This represents the patient population that will utilize inpatient and observation services in North Adams and does not include North County patients who received services in BMC's ICU Progressive Care Unit or behavioral health patients. Therefore, most of this patient population should be eligible for hospitalization at the proposed facility. The Applicant states that this represents the actual LOS for patients selected based on discharge location and home zip code. Medicare rules for CAHs require that the annual average patient length of stay over the course of a federal fiscal year is 96 hours or less.<sup>y</sup> The rule does not preclude patients who have shorter or longer stays, as long as the annual average stay for the CAH is 96 hours. In Table 15, the ALOS is over four days in some instances. The Applicant maintains that there are patients in the group that would not have been eligible for hospitalization at North Adams due to the severity of their illness, and the expectation of an ALOS greater than four days. Additionally, some patients may have had an unnecessary stay longer than 96 hours due to barriers to discharge to a post-acute facility.

**Table 15: BMC Acute Care Patient Population ALOS**

Average Length of Stay (days)	FY20	FY21	FY22
Observation	1.57	1.55	2.01
Inpatient	4.70	4.96	5.07
Total	3.85	3.92	4.13

Of the Acute Care provided to BMC patients originating from North Berkshire Service Area, 75% is inpatient care, and 25% is observation care.

<sup>25</sup> Length of Stay (LOS) is calculated by adding up all patient days then dividing by total discharges. The total length of stay includes patient days and discharges for inpatients and observation patients.

Table 16 shows the number of Satellite Emergency Facility (SEF) transfers to BMC. The Applicant states that this includes patients who presented to the SEF and transferred to either the main BMC ED or to BMC inpatient services for hospitalization. The Applicant notes that lack of inpatient and observation services, and the resulting transfers to BMC result in longer transports by Berkshire County Emergency Medical Services (EMS), whose capacity is already strained. This was supported by oral and written comments provided by the Chief and General Manager of the Northern Berkshire EMS, the sole provider of emergency medical services to ten municipalities in Northern Berkshire and southern Vermont region. The comments explained that having a CAH in North Adams would reduce the need for trips to bring patients to BMC for inpatient care, which can take an hour to two hours round trip. Fewer trips to BMC, frees up EMS' capacity to respond to calls sooner and allows for better management of EMS' resources. A summary of public hearing comments and written comments can be found in Appendix VII.

**Table 16: SEF Transfers to BMC**

	FY20	FY21	FY22	% Change Rate FY20-FY22
Number of SEF Transfer – BMC	1,196	1,192	1,285	7%

The Applicant states that in FY22, there were 11 patients who requested transfer from the North Adams SEF to Vermont.<sup>26</sup> Transferring patients out of state for care leads to fragmented care, and reduces patient access to social supports.

According to the 2021 BHS Community Health Needs Assessment (CHNA), “Berkshire County’s rate of premature death is more than 30% higher than both the state and national rates and more residents report that they are in poor physical shape or have poor mental health than are reported at the state and national level.”<sup>z,27</sup> The leading causes of death identified in the CHNA for Berkshire County residents were: Circulatory Diseases (All Cardiovascular), Cancer (All types), Respiratory Diseases (Diseases of the lung other than lung cancer), Nervous System Diseases, and Mental Disorders (All).<sup>aa</sup> The CHNA states that Heart Disease Age-Adjusted Death Rate per 100,000 in Berkshire County (291.1) is above the state (254.4) in 2017-2019.<sup>bb,cc</sup> The CHNA noted disparities across heart disease and stroke among Black and Hispanic populations in the County.<sup>dd</sup> Leading causes of cancer deaths in Berkshire County are Lung, Breast, Prostate, Colorectal, and Pancreatic. The CHNA states that the total cancer Age-Adjusted Death Rate in Berkshire County is higher (152.9) than the state average (146.9) in 2015- 2019.<sup>ee,ff</sup>

In their report, Stroudwater examined the overall health status of the North County community and reported that North County was higher than the state and the U.S. for certain conditions including asthma, most cancers, and heart disease.<sup>28</sup> The Stroudwater report also stated that

<sup>26</sup> The Applicant states that this is based on available data.

<sup>27</sup> According to the Robert Wood Johnson Foundation’s Community Health Rankings (2021).

<sup>28</sup> Data from 2010-2012 comparing key health indicators in the region, the state, and the U.S.



“higher percentages of residents are overweight, report poor general health, and have a disability, creating a vulnerable population for healthcare services.”<sup>gg</sup>

The Applicant asserts that restoring timely access to inpatient and observation services will reduce the reliance on hospital transports to BMC for inpatient and observation level care, and address the health concerns of North County residents, locally, in the community, where patients and their support systems reside.

## 2. Critical Access Hospital (CAH) Designation

A Critical Access Hospital (CAH) is a federal designation under the Medicare Rural Hospital Flexibility Program (FLEX) that provides cost-based reimbursement for eligible Medicare services, and in some states Medicaid services. The Applicant notes that the CAH cost-based reimbursement is prescribed by both CMS and MassHealth. MassHealth uses the Medicare cost-based reimbursement methodology for both inpatient and outpatient services provided at CAHs.<sup>hh</sup> CAHs are reimbursed an amount equal to 101% of the Hospital’s allowable costs, for both inpatient and outpatient services.

The purpose of the CAH designation is to ensure that rural communities can maintain essential medical services. Each CAH must comply with Medicare’s Conditions of Participation (CoPs). Appendix III provides a list of some CoPs and a description of how the Applicant believes it meets the requirements.

As noted above, after the closure of NARH Stroudwater issued a report in 2014 with recommendations for restoring inpatient services to North Adams. In their report, Stroudwater defined demand for inpatient services, as a function of population, utilization rate, market share, and ALOS. To estimate inpatient bed demand that might be accommodated locally, Stroudwater evaluated Medical/Surgical bed need. North County market demand showed an existing need for 18 to 21 beds for acute inpatient medical services. An overview of the analysis and findings from the Stroudwater Report, which served as the basis for the proposed CAH designation to re-establish NARH, is shown in Table 17.

**Table 17: Findings from Stroudwater Report**

Service Area
<ul style="list-style-type: none"><li>North County Service Area is comprised of 37,000 people and includes the towns of North Adams, Adams, Williamstown, Cheshire, Savoy, Drury, Rowe, and Monroe Bridge.<sup>29</sup> The PSA for North Berkshire includes the same cities and towns as those the report, as well as the town of Windsor.</li><li>Most heavily populated areas of the service area are located within a 30-minute drive of the BMC North site. The report states that 82% of people living within the North County area are within a 30-minute drive from the BMC North site.</li></ul>
Analysis

<sup>29</sup> The analysis considered use of the local delivery system by areas outside of Massachusetts including patients who travel from Vermont and New York, and students and visitors.

<ul style="list-style-type: none"> <li>• Service Area Population Estimates by Age</li> <li>• Inpatient Utilization Rates</li> <li>• North County Discharges by Acuity and Service Line</li> <li>• Average Length of Stay Trends North County</li> <li>• Market Share Trends North County</li> <li>• Other data</li> </ul>
<b>Findings/Recommendations</b>
<ul style="list-style-type: none"> <li>• Market demand showed an existing need for 18-21 beds for acute inpatient medical services.</li> <li>• The higher costs of operating the medical-surgical services are not sustainable without the subsidies provided through the CAH Program. Designation as a CAH is the only option to cover the additional costs required for providing inpatient services at BMC North.</li> <li>• Recommendation is to develop a clinically integrated delivery system for inpatient service with BMC, to include limited inpatient services provided in North County <i>only</i> if the BMC North site is designated as a Critical Access Hospital. The report notes that without the CAH designation, the community need for inpatient services would need to be met at BMC.</li> </ul>

The Applicant notes that the feasibility analysis (Financial Impact Analysis) provided in the DoN Application materials did not include an updated inpatient bed assessment, but the Applicant believes there is still significant need for inpatient care in the service area based on additional information that was collected in the CAH evaluation process. In 2023, the Department's Office of Rural Health re-engaged Stroudwater to update the 2014 report, and with data from the Office of Rural Health, Stroudwater examined health outcomes, socio-economic status, age of population, level of chronic diseases, substance use, and smoking, and their analysis further confirmed the need for 18 to 21 beds.

The proposed CAH will have 18 inpatient beds that will be certified for use as 18 swing beds to provide post-hospital skilled nursing facility (SNF) level care which can support a continuum of care for patients.<sup>30</sup> The hospital will be able to use the swing beds interchangeably for inpatient acute care or SNF level care. The Applicant states that while all 18 beds can be used as swing beds the Applicant will first use the hospital licensed beds to meet the inpatient and observation needs of the community. Based upon historical experience at FVH, only a few beds would be used at a time as swing beds. However, there could be circumstances requiring the use of more swing beds to meet future patient needs.

Patients no longer in need of acute care but who continue to need care at the sub-acute level, will be able to receive sub-acute care in the same bed, as a result of the flexibility that swing beds provide. The Applicant points to Appendix W in the CMS State Operations Manual, Section §485.645, stating that a swing bed is a change in reimbursement status from acute care services to swing bed services, and not a change in certification.<sup>ii</sup> CMS approves a CAH's request to furnish swing beds. SNF certification is not required. Eligibility for approval depends on substantial compliance with SNF requirements under §485.645(d)(1-8) and CAH specific swing bed requirements under SNF regulations at §483. According to Appendix W, the use of swing

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<sup>30</sup> To be eligible for coverage of post-hospital swing-bed care, a beneficiary must have a qualifying 3-day inpatient stay in a participating or qualified hospital or participating CAH prior to admission to a swing-bed.

beds is intended for a transitional time period to allow a patient to recover before returning home or while awaiting placement in a nursing facility. Appendix W also states that the CAH is reimbursed for providing a SNF level of care, but that swing-bed patients are not SNF patients but are considered patients of the CAH. The reference to the swing bed is a patient care and reimbursement status – the CAH receives reimbursement for post-acute CAH extended care (skilled nursing services), as opposed to acute-care reimbursement.

The Applicant states that having the option to use the hospital beds as swing beds will reduce the potential for errors that can occur in care transitions, and delays in care when moving to post-acute settings. The Applicant states that the median occupancy rate of 92%<sup>31</sup> for Berkshire County skilled nursing facilities is one of the barriers to discharging patients to post-acute care facilities. The Applicant's biggest barrier to discharging patients to post-acute facilities, is patients requiring IV antibiotics. These patients remain in the hospital for 30+ days, and do not have a SNF able to meet their care needs. Other barriers cited by the Applicant include wound care, substance use disorder (SUD) services, and bariatric beds. The Applicant states that with its behavioral health resources, there is an opportunity to add hospital-based outpatient treatment in coordination with a swing bed stay.

In FY22, of the 3,890 discharges of North County patients at BMC, 562 discharges or 14.4% were from BMC to another facility for post-acute care. In FY22, 187 or 4.8% of visits were from patients who came to BMC from a SNF or LTC facility at the start of their encounter. Table 18 provides a summary of where patients went for post-acute care in FY22. The Applicant notes that Williamstown Commons and North Adams Commons receive the majority of discharges. However, 20% of patients did not receive their nursing care close to home. And there are limited post-acute options in North Adams.

**Table 18: North County Patients Discharged from BMC to another facility for post-acute care**

Post-Acute Location	City/Town	Number	Distance from BMC in miles	Distance from NARH in miles
<b>SNF</b>		<b>527</b>		
Williamstown Commons	Williamstown	201	21.2	5
North Adams Commons	North Adams	187	21.7	0.8
Hillcrest Commons	Pittsfield	29	3	22.1
Mt. Greylock	Pittsfield	32	0.6	20.3
Kimball Farms	Lenox	6	8	28.5
Fairview Commons	Great Barrington	10	20.5	48.4

<sup>31</sup> CMS HHSN Weekly Data that was cited by the Massachusetts Senior Care Association in their written comments.

Post-Acute Location	City/Town	Number	Distance from BMC in miles	Distance from NARH in miles
Springside	Pittsfield	18	4	25
Craneville Place	Dalton	21	4	20
Mount Carmel	Lenox	5	5	26
Lee Healthcare	Lee	4	10	31
Berkshire Place	Pittsfield	2	1	23
Out of County/State SNF		12	Ranges from 31.3 to 106 with an average of 43.9	Ranges from 17.8 to 117 with an average of 48.2
<b>Rehab</b>		<b>35</b>		
BMC Acute Rehab	Pittsfield	33	0	22
FVH SWING	Great Barrington	2	22	43

The Applicant states further that BMC case management tracks barrier days, which it defines as days when a patient is ready for discharge but has no appropriate discharge location. In FY22, there were 583 barrier days related to SNF bed availability that was unrelated to patient preference. The delays related to the lack of available beds impacted 307 of the 527 patients (58%) discharged to another facility for post-acute care. The average wait for these patients was three days. In FY22, there were 107 barrier days because of a transportation delay, 89% of which were related to either the lack of transportation or the inability to schedule transportation within the narrow admissions window made available by the SNFs.

Common uses for swing beds reported by CAH administrators and staff in a policy brief cited by the Applicant include physical and occupational therapy for orthopedic patients or for patients who need strengthening following their hospital stay, wound care and/or intravenous antibiotics, and hospice or end-of-life care.<sup>jj</sup> The Applicant also states that CAH beds can be used for short-stay, observation services. Medicare defines observation services as “hospital outpatient services you get while your doctor decides whether to admit you as an inpatient or discharge you.”<sup>kk</sup> Observation level care provides a temporary transition period prior to patient admission or discharge.<sup>ll</sup> In written comments provided to the Department, the Applicant stated that in the future it will examine ways in which the swing beds could be used to meet the needs of patients with substance use or dual diagnosis substance use disorder (SUD)/behavioral health conditions, many of whom are covered by Medicaid and who are often declined admission at a traditional SNF.

The Applicant further explained how the proposed 18 swing beds will be used. Hospitals can use swing beds, as needed, to provide either acute or SNF level care. Staff will provide services to both the M/S and swing beds, and staffing will be based on acuity. The Applicant anticipates that the most common diagnoses or health conditions of patients admitted to a swing bed include patients who no longer need an acute level of care but require intravenous antibiotics. The Applicant notes that these patients often have a dual diagnosis of Substance Use Disorder (SUD). In addition, BMC consistently has a unit of patients who no longer need acute care but who cannot be discharged to a SNF or home for a variety of reasons including but not limited to availability of services (a SNF bed or home care) and lack of resources to care for the patient at a SNF. The Applicant states that these patients have longer lengths of stay than other patients. Anticipated ALOS for swing beds is seven to 10 days for a medical admission and four to six weeks for IV antibiotics. In accordance with hospital discharge regulations, patients will be provided with a list of post-acute providers that serve the geographic area and the hospital will disclose any providers on the list that are owned or operated by the Applicant. To assess impact of the proposed 18 swing beds the Applicant states that it will look at discharges to home, 30-day follow-up status and functional status improvement. FVH currently participates in a study conducted by Stroudwater that collects swing bed data. The Applicant plans to enroll NARH in the study, if possible, to assess impact of the swing beds.

The Massachusetts Senior Care TTG Representative, Integritus Healthcare a provider of senior living, nursing home and hospice services in Massachusetts, and Administrators from several Integritus affiliated facilities, were some of those who provided oral and written comments expressing concern about the negative impact of allowing the hospital to certify all of the licensed M/S beds for use as swing beds. They expressed support for the CAH but argued that the swing beds would have unintended negative consequences that will threaten both choice and access to long term health services in Berkshire County. They state there is sufficient nursing home bed capacity in Northern Berkshire County, and that the swing beds, funded by Medicare, will shift Medicare revenue that existing nursing facilities rely on to offset severely low Medicaid underfunding, to the proposed facility. Nursing facilities with less Medicare revenue are more likely to close, experience lower staffing levels and poorer outcomes. Requests were made for a Condition to the approval of the DoN to limit the number of swing beds to two. Commenters raised a second issue that already scarce and invaluable clinical and ancillary staff will be recruited away from Berkshire County long term care facilities to work at the proposed facility. This will destabilize services at existing facilities and further exacerbate existing recruitment and retention challenges. Requests were made to impose a two-year moratorium on recruiting staff from existing facilities, instead requiring NARH to staff the proposed facility with travel nursing and agency personnel that are not already assigned to existing facilities. A summary of public hearing comments and written comments can be found in Appendix VII.

The Applicant responded to the TTGs statements explaining that BHS's goal in opening the new NARH is to run an acute care facility. BHS's planning and financial projections have been based on the assumption that the CAH will have anywhere from six to 15 patients on average who need acute-care support, a figure derived from BHS's real experience running a CAH at FVH in

Great Barrington. BHS is also pursuing CMS swing bed designation for the flexibility, value, and choice that swing beds can offer the community. The Applicant goes on to state that the CAH cost-based reimbursement model is not as lucrative as suggested, because CAHs are reimbursed on a cost basis for certain “allowable costs”, and CAH reimbursement is subject to a 2% reduction due to federal sequestration. The Applicant states that the proposed CAH would not have a competitive hiring advantage, pointing to its existing CAH, FVH. The FVH CAH coexists with SNFs without the problems that the TTG raised. In addition, the Applicant plans to staff the proposed facility from its own workforce within its community and through the investments that it has made in the workforce in the region. BHS’ recruiting approach seeks to align candidates with their preferred healthcare focus noting that the care at the proposed facility will primarily be an acute style of medicine that is different from the opportunities offered by the longer-term, more relationship-based nature of skilled nursing care.

The Applicant plans to return outpatient services, which currently are provided at the SEF, to the NARH license, including surgical services. Currently, the Applicant has two ORs and two endoscopy procedure rooms. The ORs and procedures rooms are located in separate suites requiring the Applicant to staff each one separately with a pre-operative and post-operative nurse and a minimum of two anesthesiologists. The Applicant will maintain a total of four rooms. Repurposing the space to have four ORs will allow for a more efficient staffing model, requiring only one pre-operative and one post-operative nurse, and one anesthesiologist. No additional staff are required. The Proposed Project includes decreasing the number of endoscopy procedure rooms by two and increasing the number of ORs by two. The Applicant will have four mixed inpatient/outpatient ORs to provide integrated surgical and endoscopy procedures. The ORs from the prior hospital and current SEF will be able to be used for all types of procedures, which the Applicant states will increase efficiency and reduce wait times. This will also allow for the rooms to be staffed and support any type of procedure/surgery in a given room, and this the Applicant states, will maximize the anesthesia providers’ time because they are involved in all types of procedures.

Annual operating room volume is 322 and annual procedure room volume is 1,300. The Applicant states that utilization of the existing ORs is a function of the availability of staff in North County. North County patients receive endoscopies in both North Adams and Pittsfield, so for the purposes of understanding procedure wait times, the Applicant provided a blended wait time for endoscopies of approximately 7 weeks, based on the third next available appointment. The Applicant states that wait times, and the need to perform procedures in Pittsfield are impacted by the recent retirement of a physician in North Adams. Outpatient surgical wait times in North Adams is approximately one to two months.

Project implementation is expected to occur in January 2024. Table 19 shows the planned service changes that will result.

**Table 19: Planned Service Changes**

	Current	Projected
Discharges	0	1,141
Patient Days	0	3,428

	Current	Projected
Occupancy	0	52%
ALOS	0	3 days
Operating Room Volume (inclusive of Endoscopy)	OR=322 Endoscopy=1,300	1,248

To project discharges at NARH after project implementation, the Applicant considered two distinct methodologies:

- 1) Medically appropriate patients historically admitted to BMC from North County, and
- 2) Fairview Hospital's unique patients and its catchment area population relative to the North County population.

Based on this methodology, the Applicant is projecting 1,141 discharges, 741 of which are acute discharges and 400 of which are observation discharges. This, the Applicant states, results in an average daily census (ADC) of 9.39, 8.39 patients represent existing volume from BMC and one patient that is expected to transition from Southwestern Vermont Medical Center and remain in North Adams when the Proposed Project is implemented.

Projected OR volume, shown in Table 19, is based on two assumptions: new inpatient volume is consistent with the Applicant's other CAH, FVH; and a slight uptick in surgical procedures for outpatient volume, given staffing. The Applicant anticipates a decline in endoscopy procedures due to the winding down and retirement of a provider. However, the Applicant asserts that it is recruiting for a replacement. The Applicant anticipates volume will increase as soon as it recruits a replacement physician, and that over time it will be prepared to address the natural growth in volume with the four ORs.

The Applicant states that projected occupancy rate was developed using daily census data from Fairview Hospital, the population of the Fairview service area, and the consideration of a competitive provider in Southwestern Vermont where North County patients could elect to obtain services. The Applicant also looked at the number of North County patients that came to BMC that would be appropriate for inpatient/observation care at NARH. The Applicant states further that it may experience increased inpatient volume as a result of two factors: inpatient and outpatient surgeries that are currently being done at BMC and that require observation stays, and the utilization of swing beds. These were not factored into the projected occupancy rate.

The Applicant asserts that there is continued need for inpatient and observation services in North County and that restoring these services at NARH will, together with existing outpatient services, address Patient Panel need for local, community-based, integrated care.

### ***Analysis***

Based on a review of the application materials and additional analysis, staff finds that the Applicant demonstrated sufficient need to obtain an Original License to operate a CAH at the North Adams site. The Proposed CAH will have 18 licensed inpatient beds, with the option to add seven additional beds, under the CAH designation. The 18 licensed beds will be certified for use as swing beds. Because the proposed CAH can use inpatient beds for either inpatient or SNF level services, patients will be able to receive nursing level services in the same place as inpatient care, which reduces patient transfers, and wait times for accessing post-acute care.

Oral and written comments provided by the Applicant, employees of BHS, and community members, affirmed need for the Proposed Project. Commenters noted that residents in Northern Berkshire face challenges accessing timely medical care due to distance and transportation leading some to forgo care resulting in patients arriving sicker after postponing care. The Proposed Project would expand access to healthcare to the underserved region of Northern Berkshire and offers an opportunity to address barriers to patient care, promote social and economic improvement, and advance the health and wellness of the Northern Berkshire community and the entire region. In addition, the proposed swing beds would provide a convenient transitional care option close to home and reduce reliance on EMS transport for inpatient care. A summary of public hearing comments and written comments can be found in Appendix VII.

Staff points to the existing challenges that residents of North County experience in accessing inpatient and observation services, including traveling long distances to access care and transfers to BMC and Southwestern Vermont for care. The BHS 2021 CHNA notes that Berkshire County includes a limited-schedule bus system, and that most residents rely on private automobile for transportation in the county, which poses barriers for those without a car.<sup>mm</sup> In addition, transportation to and from healthcare locations was identified as a challenge to accessing quality healthcare. The Massachusetts Health Policy Commission, in their report titled, *“Community Hospitals at a Crossroads,”* states that patient drive times for inpatient care increase when a community hospital closes, and this is particularly so in more rural areas.<sup>nn</sup> Because inpatient services were not restored after the closure of NARH, patients are transferred from the SEF in North Adams to Pittsfield. With limited transportation options, the Applicant states that it will offer taxi vouchers to those who do not have transportation to the proposed facility.

The literature examining the closure of rural hospitals shows several challenges specific to rural hospital closures that further demonstrate need to restore local access to inpatient and observation services for North County residents. Closure of rural hospitals is associated with a reduction in local residents’ access to healthcare resulting in treatment delays and adverse health outcomes, an exacerbation of health disparities, longer travel distance and times for patients, outmigration of healthcare professionals or fewer healthcare professionals than areas without hospital closures, and worsens pre-existing challenges in accessing specialty care.

<sup>oo,pp,qq,rr</sup> Rural older adults, racial and ethnic minority groups, and those with low income experience a higher travel burden to access care.<sup>ss</sup> One study stated that rural hospital closures



increase mortality more than urban hospital closures.<sup>tt,32</sup> The adverse impact of such closures was noted to be larger for Medicaid populations and racial minorities.<sup>uu</sup>

The BHS 2021 and 2022 CHNAs further demonstrate need for healthcare services. For 2021: Berkshire County ranked 13th of 14 counties for health outcomes and 11th of 14 counties for health factors, Berkshire County's rate of premature death is more than 30% higher than both the state and national rates, and more residents reported that they are in poor physical shape or have poor mental health than are reported at the state and national level.<sup>vv</sup> The COVID-19 pandemic affected the health status of Berkshire County residents, deepened existing inequities in health, and strained the capacity of local health systems.<sup>ww</sup> Emergency department (ED) visits indicate a growing need for ED and inpatient services in rural areas and as the population ages. Between 2014–2017, 20% of all ED visits in the United States were made by patients aged 60 and over, and nearly 25% of ED visits among patients age 60 and older resulted in hospital admission, and this percentage increased with increasing age.<sup>xx</sup> In terms of ED use, patient visits to rural EDs have increased by more than 50% from 2005 to 2016.<sup>yy</sup> The Center for Health Information and Analysis (CHIA) report on ED utilization at acute care hospitals in Massachusetts from FFY 2016 to FFY 2019 stated that in FFY 2019, there were over 3.1 million ED visits in the Commonwealth, a decline from 3.2 million in 2016. In 2019, per capita ED visit rates were highest in Western and Southeastern MA and lowest in Metro Boston. ED visits for patients aged 65 and over increased over the four-year period that was examined (FFY 2016–2019), whereas visits declined for all other age groups.<sup>zz</sup>

To ensure the Proposed Project addresses Patient Panel need for inpatient and observation services as the Project is implemented, staff recommends a Condition of reporting on the metrics as described in Condition 2 in the Conditions section of the report.

As a result of information provided by the Applicant and with additional analysis, Staff finds that with the Condition, the Applicant has met the requirements of Factor 1(a).

## **Factor 1: b) Public Health Value, Improved Health Outcomes and Quality Of Life; Assurances Of Health Equity**

In this section staff will assess if the Proposed Project adds measurable public health value in terms of improved health outcomes and quality of life for the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

### **Public Health Value- Evidence-Based-Improved Health Outcomes**

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<sup>32</sup> An examination of hospital closures in California from 1995 to 2011 to assess the effects of rural and urban hospital closures on inpatient mortality.

## Rural Health Care and Access

In the 1993 book titled, *Access to Health Care in America*, the Institute of Medicine, now known as the National Academies of Sciences, Engineering, and Medicine, defines access to health care as “the timely use of personal health services to achieve the best possible health outcomes.”<sup>aaa,bbb</sup> Rural residents face specific challenges accessing health care, which can lead to health disparities.<sup>ccc</sup> These include: long travel distance to access care, which can be costly and require time away from work; lack of reliable transportation; a shortage of healthcare professionals, due to limited supply of healthcare services; and social stigma and privacy concerns due to less anonymity. In 2021, children and adults under 65 living in rural areas were more likely to be uninsured than their urban peers.<sup>ddd</sup> Lack of health insurance is a barrier to accessing care and may lead some to defer accessing care.

Citing an article from the U.S. Government Accountability Office (GAO), the Applicant states that residents living in rural areas face certain challenges concerning access to healthcare. As noted above, residents in rural areas are older and have worse health outcomes than urban residents, in general; hospital closures in rural areas lead residents to travel longer distances to receive care; and rural areas without hospitals have fewer healthcare providers overall.<sup>eee</sup> In its report, GAO examined the effects of rural hospital closures on residents living in the areas of the hospitals that closed.<sup>fff</sup> The GAO analysis estimated that residents travel a median distance of 20 miles for common health care services like inpatient care after a rural hospital closure compared to 3.4 miles before closure.<sup>33,ggg</sup> In addition to increasing distance to access care, the Applicant cited another article stating that rural hospital closures have been shown to increase inpatient mortality.<sup>hhh,iii</sup>

The Applicant maintains that the Proposed Project will accomplish the following:

- Reduce transportation needs including long ambulance rides.
- Increase access to care locally which will allow patients to remain in their community closer to family, friends and social supports.
- Add a second community hospital in the BHS system that will support community appropriate discharges and the delivery of care in the most appropriate setting.
- Add single-bedded rooms which have been shown to have a number of benefits. Single-bedded rooms have been shown to enhance recovery for patients, promote infection control, reduce ambient noise to promote better sleep and rest, improve patient safety and recovery, improve communication between patients and providers, and family members by increasing patient privacy, and increase patient satisfaction.<sup>jjj</sup>
- Allow the hospital to develop programs over time that further serve the North County community.

## CAH Designation

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<sup>33</sup> GAO Analysis of data from the Department of Health and Human Services and North Carolina Rural Health Research Program. Distance in miles between patient and hospital before closure (2012) and Distance in miles between patient and hospital after closure (2018).

The United States Federal Government created the CAH Program through the Balanced Budget Act (BBA) of 1997 due to a record number (~400) of rural hospital closures in the 1980s and 1990s.<sup>kkk</sup> The designation is given to eligible rural hospitals by CMS.<sup>lll</sup> The CAH designation is designed to reduce financial vulnerability of rural hospitals, and improve access to healthcare by keeping essential services in rural communities.<sup>mmm</sup> The cost-based reimbursement contributes to ensuring that healthcare services can be supported in rural communities. Medicare pays for the same services from CAHs as for other acute care, including inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days.<sup>nnn,ooo</sup> CAHs are paid based on the cost of providing services, receiving 101% of their costs.<sup>ppp,qqq</sup> Not all services are eligible for cost reimbursement and CAHs may not receive 101% of their costs under current law due to payment reductions imposed by a budget sequester on Medicare payments and limits on the share of hospital bad debt payments reimbursable by Medicare.<sup>rrr,sss,34</sup> Medicare beneficiaries cost-sharing generally includes a standard hospital deductible for inpatient services and 20 percent of charges for outpatient services.<sup>ttt</sup>

The Applicant cited the following benefits of CAH Designation<sup>uuu,vvv</sup>:

- Cost-based reimbursement from Medicare at 101% of their reasonable costs and other cost-based reimbursement for swing beds, ambulance transports, outpatient services and telehealth;
- Flexible staffing and services, to the extent permitted under state licensure laws;
- Capital improvement costs included in allowable costs for determining Medicare reimbursement; and
- Access to Flex Program educational resources, technical assistance, and/or grants.

The Applicant notes that North County is located in a health professional shortage area (HPSA)<sup>35</sup>. Rural hospital closures are connected with the local physician supply.<sup>www,36</sup> Lack of inpatient services makes it difficult to recruit physicians to the area, and the Applicant notes that it is challenging to recruit and retain physicians to replace what it describes as an aging physician workforce. The Applicant states that 43% of North County physicians are over age 63, as compared to 16% in the central Berkshires. The average physician tenure in North County is generally 1.7 years shorter than in central Berkshire County and approximately 5.8 years shorter than in southern Berkshire County. CMS provides incentives for CAHs to bring health care professionals to rural areas. This includes a health professional area physician bonus

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<sup>34</sup> The Budget Control Act's provision implementing Medicare sequestration, CAHs receive just 99 percent of allowable costs. Sequestration policies are currently in effect through 2031.

<sup>35</sup> A Health Professional Shortage Area (HPSA) is designated as having a critical shortage of either primary care, dental or mental health providers. Each type of HPSA is further classified as being a specific geographic area, a specific population group, or in some cases, a specific facility.  
[https://www.mass.gov/info-details/shortage-designation-management-system-sdms?\\_gl=1\\*lc279o\\*\\_ga\\*OTQyMjQzOTY2LjE2NDY5MzQwOTc.\\*\\_ga\\_MCLPEGW7WM\\*MTY5Mjg4NDMxMC4xNi4xLjE2OTI4ODQ5ODguMC4wLjA](https://www.mass.gov/info-details/shortage-designation-management-system-sdms?_gl=1*lc279o*_ga*OTQyMjQzOTY2LjE2NDY5MzQwOTc.*_ga_MCLPEGW7WM*MTY5Mjg4NDMxMC4xNi4xLjE2OTI4ODQ5ODguMC4wLjA).

<sup>36</sup> Using data from the Area Health Resources Files for the period 1997–2016, examined the relationship between rural hospital closures and the supply of physicians across different specialties in the years leading up to and after a closure.

program, and graduate medical education and certified registered nurse anesthetists programs to aid in hiring healthcare providers.<sup>37,38</sup>

### ***Analysis: Public Health Value- Evidence-Based- Improved Health Outcomes***

Staff find that the Applicant has demonstrated the Proposed Project may improve health outcomes and quality of life for the Patient Panel, through addressing the existing challenges and barriers to accessing care experienced by the Patient Panel, which includes residents of North County. The Applicant has provided several measures to assess the impact of the Proposed Project, and the increase in access to inpatient healthcare services. Staff has reviewed the measures and suggested additional reporting measures. The revised measures appear in Appendix I.

### **Health Equity**

The Applicant asserted its commitment to advancing health and wellness for all residents of Berkshire County, to provide a welcoming, inclusive and personalized environment, and to strive to be the region's trusted health care partner and community advocate towards improving quality of life.

The Applicant outlined the steps it is taking to improve health equity for the Patient Panel.

Health Care Equity Certification. The Applicant is in the process of obtaining this certification from The Joint Commission. The Applicant states that the Certification will recognize BHS's past, ongoing, and future work with regards to health equity. BHS's system-wide strategy to improve health equity focuses on four key components:

- **Information.** Collecting and analyzing a representative sample of data.
- **Relationship.** Building new partnership and soliciting honest feedback.
- **Education.** Empowering individuals and populations to support generational change.
- **Action.** Engaging sensitively and thoughtfully with patients, people and the community.

BHS's processes to address health disparities are listed in Appendix IV.

### **Language Access**

Almost a quarter (24.5%) of Massachusetts residents and 7.1% of Berkshire County residents speak a language other than English in the home (2021).<sup>xxx</sup> With the understanding that communication is an important component of healthcare encounters, BHS maintained its

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<sup>37</sup> The Health Professional Shortage Area Physician Bonus Program pays physicians, including psychiatrists, a 10% outpatient professional services Health Professional Shortage Area (HPSA) bonus if they provide CAH care in a primary care or mental health HPSA, within a designated geographic area. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/critaccesshospfctshst.pdf>

<sup>38</sup> CAHs can get reasonable cost-based funding for certain certified registered nurse anesthetist (CRNA) services through Medicare Certified Registered Nurse Anesthetist Services Rural Pass-Through Funding. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/critaccesshospfctshst.pdf>

commitment to making sure providers are equipped with the resources to maintain strong clinical relationships with their non-English speaking and limited English proficiency (LEP) patients. Qualified interpreters are available to all BHS patients and their families, who speak languages other than English or who use American Sign Language (ASL). Interpreters are available at no charge 24 hours a day and seven days a week. BHS has full-time, in house, in-person interpreters available in Spanish and Russian. Access is provided to over 200 languages in a timely manner, via in-person, video, or telephonic interpreting. Interpreters can assist patients and families when discussing a number of issues including procedures and consents to treatment, medications, and social determinants of health (SDoH). In FY22, BHS provided 13,116 interpretation encounters (via all modalities). The majority of encounters were in Spanish (89%). The Applicant states that it coordinates with its vendors to fill requests for interpreter services for other languages.

To support equitable access to interpreter services, the Applicant's staff is trained on the use of interpreter services for both in-person and telemedicine visits. The Applicant outlined the processes for requesting interpreter services and filling requests for interpreter services. The Applicant states that BMC will provide the same interpreter services with the expansion of inpatient services at NARH and the potential increase in demand for interpreter services. The Applicant states that this will include interpreting over Zoom, which started since the COVID-19 pandemic, and in-person interpreters.

#### ***Analysis: Health Equity***

Staff finds that the Applicant's planned language access services are appropriate for patients receiving care at the proposed facility, NARH. The Applicant has appropriately outlined at a high level that it has provided reasonable assurances of health equity for the Patient Panel. The Applicant has included two measures related to health equity as part of its annual reporting requirement. These can be found in Appendix I.

As a result of information provided by the Applicant and with additional analysis, Staff finds the Applicant has met the requirements of Factor 1(b).

### **Factor 1: c) Efficiency, Continuity of Care, Coordination of Care**

Currently, North County patients requiring inpatient care may require long ambulance rides to BMC in Pittsfield or to Southwestern Vermont. Patients transported out of the community for care may not have access to social and emotional support of family and friends during their care and may encounter difficulty finding transportation home. The Applicant states that a lack of local access to inpatient and observation services means that more of the care provided to North County residents is unanticipated and unscheduled care due to delayed treatment rather than planned, coordinated, care, which is more efficient. This is especially true when patients have to be transported to Vermont for care. Comments from BHS staff further support the importance of having local access to inpatient services noting that the proposed facility will make it easier for patients to seek care when they need it, instead of when their symptoms worsen. It can assist BHS with deepening its relationship with patients and can help to reduce the likelihood that patients will defer or delay access to care.

The Applicant states that the Proposed Project will operate efficiently and effectively by increasing access to inpatient care and observation services locally which will reduce transportation barriers and allow for patients to remain in the community closer to social supports. BHS will provide local access to inpatient and outpatient surgical care services that can reduce wait times and ensure continuity of care, allowing for a better patient and provider experience.

To support continuity of care and care coordination, the Applicant states that it will have a dedicated case manager at NARH that will be supported by the case management team in Pittsfield. The case manager team in Pittsfield will be able to provide coverage when there is high volume, and on weekends or vacations. The case manager at NARH will follow the same discharge processes that are used at BMC. This includes working with each individual's care plan, and identifying patient needs and linking them to appropriate home or community-based services.

In terms of primary care physicians (PCPs), all but one are part of the Applicant's system or work for the local federally qualified community health center (FQHC). The Applicant states that these physicians will have access to the electronic medical record (EMR) that is used for BMC Satellite Services in North Adams, and that will be used at the proposed NARH. The PCPs are informed when their patient is admitted and discharged from the SEF and they receive a copy of the discharge summary. This process will be extended to admissions and discharges from the inpatient beds at NARH. The PCPs receive daily notifications showing all patients admitted and discharged from the SEF and this process will be extended to inpatients at the proposed Facility. The PCPs, including the one without access to the EMR, receive notification at their office of all patients admitted and discharged from the SEF. This process will also extend to inpatients at the proposed facility. These processes allow PCPs, and mid-level staff to have timely access to the information. The Applicant states that the one physician without access to the EMR is nearing retirement and has a small patient panel and receives a copy of their patients' discharge summaries.

The Applicant maintains that additional components of the project support continuity and coordination of care. The proposed 18 inpatient beds will be certified for use as 18 swing beds, allowing patients to remain in one place to receive inpatient care and short-term skilled nursing care.<sup>39</sup> The Applicant states that this will create continuity of care for patients, and will help to relieve pressure on the post-acute care system, which is experiencing long wait times for entry. Mixed inpatient/outpatient ORs will be able to be used for all types of procedures, which will increase efficiency and reduce wait times. In addition, surgical and endoscopy needs will be met without having to utilize two separate teams. The Applicant states that physician recruitment will improve because of an increase in healthcare services in the area and because of physician recruitment programs available to CAHs.

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<sup>39</sup> A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements.

<https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/SNFPPS/Swingbed>

## Analysis

The Applicant has demonstrated that the Proposed Project will operate efficiently and effectively through restoring access to inpatient and observation services and enhancing care coordination and integration by providing inpatient and observation services, and outpatient services in the same location. Given that outpatient services are currently delivered through a BMC satellite, services will continue to be integrated with the BMC system to allow for patients to receive care in the most appropriate setting. The Applicant has shown that the option to use inpatient beds as swing beds will reduce care transitions, which can improve health outcomes and reduce complications.<sup>yyy,zzz</sup> In addition, it will relieve pressure on the post-acute care system, which is experiencing long wait times for entry.<sup>aaaa</sup> Rural hospital closures result in loss of healthcare workforce, and make it difficult to attract physicians. Berkshire County is designated as a Medically Underserved Area/Population (MUA/P).<sup>bbbb,40</sup> The Applicant has shown that restoring a full complement of healthcare services at NARH will support its ability to attract and retain healthcare professionals and support continued access to inpatient and outpatient healthcare services for the Patient Panel.

As a result of information provided by the Applicant and with additional analysis, Staff finds the Applicant has met the requirements of Factor 1(c).

## Factor 1: d) Consultation

The Applicant has provided evidence of consultation, both prior to and after the Filing Date, with all government agencies that have licensure, certification, or other regulatory oversight, which has been done and will not be addressed further in this report.

## Factor 1: e) Evidence of Sound Community Engagement through the Patient Panel

The Department's Guideline<sup>41</sup> for community engagement defines "community" as the Patient Panel, and requires that at minimum, the Applicant must "consult" with groups representative of the Applicant's Patient Panel. Regulations state that efforts in such consultation should consist of engaging "community coalitions statistically representative of the Patient Panel."<sup>42</sup>

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<sup>40</sup> MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. These designations help establish health maintenance organizations or community health centers. Berkshire County's Index of Medical Underservice Score is 46.3. The lowest score (highest need) is 0; the highest score (lowest need) is 100. In order to qualify for designation, the IMU score must be less than or equal to 62.0, except for a Governor designation, which does not receive an IMU score.

[https://ippsr.msu.edu/sites/default/files/LLP/MUA%26P%20Fact%20Sheet\\_MIPCO\\_2019-03.pdf](https://ippsr.msu.edu/sites/default/files/LLP/MUA%26P%20Fact%20Sheet_MIPCO_2019-03.pdf)

<sup>41</sup> Community Engagement Standards for Community Health Planning Guideline

<sup>42</sup> DoN Regulation 100.210 (A)(1)(e). <https://www.mass.gov/files/documents/2018/12/31/jud-lib-105cmr100.pdf>



To ensure sound community engagement throughout the development of the Proposed Project, the Applicant took the following actions:

- **Press Release** issued on June 29, 2023 and carried on many major media outlets, including the Berkshire Eagle.
- **Notice** about the Proposed Project was published in the *Berkshire Eagle* and iBerkshires.com on August 1, 2023.
- **Community Meeting** held on August 3, 2023 at Massachusetts College of Liberal Arts in North Adams. The Applicant approximates that there were 100 people in attendance. The presentation reviewed the purpose of the Proposed Project, the impact of the Project for patients and the community and provided a general overview of the required regulatory processes. The Applicant states that the feedback received at the meeting was overwhelmingly positive and supportive of the Proposed Project. The Applicant notes that it received 52 letters of support for the Proposed Project at the community meeting. The Applicant provided the slides that were presented at the meetings.

### **Analysis**

Staff finds that the Applicant met the minimum required community engagement standard of Consult in the planning phase of the Proposed Project. As a result of information provided by the Applicant and with additional analysis, Staff finds the Applicant has met the requirements of Factor 1(e).

## **Factor 1: f) Competition on Price, Total Medical Expenses (TME), Costs and Other Measures of Health Care Spending**

The Applicant states that the Proposed Project will create permanent access to health care services, locally in the community. This will, the Applicant maintains, provide many benefits to the Patient Panel including, increased access to care which has the potential to decrease likelihood that care will be delayed or deferred, increased social support to encourage utilization of care, and improved health outcomes resulting from a reduction in delays in diagnosis and treatment.

The Applicant asserts that the Proposed Project will compete on the basis of price, total medical Expense (TME), provider costs and other recognized measures of health care spending based on the following:

- A substantial number of the North County patient population is already receiving health care from BHS either through the BMC satellite Services or observation and/or inpatient services at BMC, therefore, overall, the costs to the patient will remain the same. The Applicant estimates that 2% or less of a subset of BMC North County patients who will be impacted by the additional cost-sharing related to Medicare reimbursement for patients receiving observation services and then admitted to the hospital, do not carry secondary insurance that will cover the cost. The Applicant will provide support to these



patients to address the cost-sharing and any other eligible patients through its financial assistance policy, as it currently does at FVH.

- The Applicant proposes to close two endoscopy procedure rooms and re-open two ORs that were available prior to the NARH closure. These ORs will be mixed inpatient/outpatient ORs that will be used for all types of procedures, and that will continue to meet need for surgical and endoscopy procedures. The Applicant asserts that maintaining the same number of rooms that it currently operates will allow the Applicant to gain efficiencies that will minimize costs, and the efficient staffing model that will be used in the repurposed ORs will reduce the Applicant's TME.
- The Proposed Project will contribute to a long-term reduction in TME by increasing timely access to care in the appropriate setting, on an inpatient and outpatient basis.
- Patients who elected to seek care in Southwestern Vermont, and who choose to then seek care at the proposed facility, will receive care that is more coordinated and integrated in the BHS, and the return of these patients to North Adams for care can help lower MassHealth costs for their care, because out-of-state providers are reimbursed at a higher rate.
- The swing beds further contribute to a lower TME because **it leverages the "core staffing" model of the CAH to make hospital operations more efficient** ~~because the CAH will be reimbursed for providing a SNF level of care.~~
- The Stroudwater Financial Impact Analysis finds that projected revenues will offset projected costs which indicates that the Proposed Project will have a slight impact on the Commonwealth's TME, but this impact will be offset by the anticipated benefits to the Patient Panel, which were mentioned above.

The Proposed Project's ability to compete was further supported in written comments provided by the President and CEO of Berkshire Health Systems. It is noted above that CAHs receive cost based reimbursement from CMS. The comments explained how the CAH reimbursement model can impact the cost of care and reimbursement, noting that federal reimbursement rates are subject to certain terms and conditions that modify the final rate received. CAHs are not fully funded by CMS but are reimbursed on a cost basis for certain allowable costs. Further, reimbursement to CAHs is reduced by 2% due to federal sequestration. The comment goes on to state that the "core staffing" model, which is critical to the operation of a CAH and caring for patients in swing bed status, makes hospital operations more efficient and can lower the **per patient** costs of care. A summary of public hearing comments and written comments can be found in Appendix VII.

### ***Analysis***

Cost containment on a statewide level is impacted through pricing, which is a function of what providers charge payers, what payers agree to pay, and which services are rendered. While payment contracts between providers and Medicare and Medicaid are relatively transparent, those between individual providers and commercial payers are confidential.<sup>cccc</sup> As a result, staff cannot assess how BHS's contracts with payers, which may incentivize more or less utilization of services, are structured.

To assess potential commercial spending impacts of the Proposed Project, using publicly available data, staff examined two factors that influence healthcare spending: unit prices and utilization.

**Unit Prices:** The reimbursement rates providers receive from payers.

With the addition of a new hospital to the BHS system, new prices will need to be negotiated for NARH's services. The Applicant has not indicated how the Proposed Project might impact NARH's prices. To assess potential commercial spending impacts of the Proposed Project, staff examined relative price (RP) data developed by CHIA for Calendar Year 2021 of the two existing acute care hospitals in the BHS system for two of their largest commercial payers: Blue Cross Blue Shield (BCBS), and Health New England (HNE).<sup>43</sup> This is shown in Table 20. Staff focused on inpatient RP data since the project entails the expansion of new inpatient capacity. A relative price of 1.0 represents each payer network's average price across inpatient services. The information shows that the inpatient RP of BMC and FVH are slightly above the network average for BCBS, but slightly below the network average for HNE.

**Table 20: Inpatient Relative Prices (RP), BMC and FHV**

	BMC	FHV
Network Average=1.0	RP	RP
Blue Cross Blue Shield	1.04	1.18
Health New England	0.75	0.67

To further examine the potential impact of the Proposed Project on commercial spending, staff examined the payer mix of BHS' existing facilities. The proposed facility will be part of BHS, and many of its anticipated patients are already receiving care through BHS. BHS' existing facilities serve a high proportion of public payer patients. Both existing hospitals in the BHS are community-High Public Payer hospitals with public payers comprising more than 63% of gross patient revenue. In 2021, CHIA reported that 73.0% of BMC's and 64.7% of FVH's gross patient service revenue was from public payers.<sup>dddd,eeee</sup>

The Applicant provided payer mix data for Baystate BMC Acute Care patients, which represent BMC discharges that reside in the North Berkshire primary and secondary service areas. Almost 68% of this patient population is insured through Medicare and Medicaid and approximately 29% through commercial payers. Based on the 1,141 projected discharges at the proposed facility and the current BMC Acute Care patient population payer mix, roughly a third of potential inpatients could be insured by commercial payers, which would, equate to 376 patients. The Applicant also provided the payer mix for SEF transfers to BMC and this showed

<sup>43</sup> The data allow for comparison of hospital inpatient RP within a payer network. A RP of 1.0 represents each payer network's average price across inpatient services. Providers with a RP above 1.0 receive higher-than-average payments in a payer's network. A relative price of 1.2 means that the provider's price level is 20% above the average inpatient price in a payer's network.

that 74% were insured through Medicare or Medicaid in FY22, and approximately 14% through commercial payers.

Staff note that the proposed hospital is a small community hospital, with a likely high public payer mix. Given the small volume of commercial patients and the likelihood that any differences in inpatient prices between NARH and other BHS facilities serving those patients will be small, the Proposed Project is unlikely to have a significant impact on commercial spending.

**Utilization:** The frequency with which patients use health care services.

Staff does not expect that utilization will change significantly as a result of the Proposed Project, but that care will shift from BMC to the proposed NARH. The shift in volume from BMC to the proposed NARH is not likely to have significant impacts on spending as discussed previously above. The Applicant noted that increasing inpatient care at NARH will allow for more care to take place in the appropriate setting. As noted above, residents of North County are transferred to BMC for inpatient care, or in some cases to Southwestern VT. The Proposed Project will result in a decrease in out of state transfers for inpatient care. Shifting care from out of state to the proposed facility has the potential to decrease spending.

Any increase in total utilization that does result from the increased access that the Proposed Project provides may increase total spending, but with potential positive implications for the Patient Panel, in terms of improved health outcomes and quality of life. As mentioned above, lack of local access to inpatient and observation services contributes to North County residents delaying or deferring care and leads to fragmented care. Delaying care can worsen conditions that may then require more intensive, costly treatment. Based on the aforementioned, staff find that the Proposed Project is likely to have fairly small commercial spending impacts due to changes in utilization and that any such impacts may be balanced by improved access to care for the Patient Panel.

As a result of information provided by the Applicant and with additional analysis, Staff finds the Applicant has met the requirements of Factor 1(f).

## FACTOR 1 SUMMARY

As a result of information provided by the Applicant and additional analysis, staff finds that with the standard reporting requirements outlined below, and with the Conditions detailed in the Conditions section the Applicant has demonstrated that the Proposed Project has met Factor 1(a-f). The Applicant proposed specific outcome, and process measures to track the impact of the Proposed Project. Staff reviewed the suggested measures that will become part of the annual reporting to DPH. To ensure that the Proposed Project will add measurable public health value in terms of improved health outcomes and quality of life, staff has suggested additional reporting measures. The revised measures are described in Appendix I below.

## Factor 2: Cost containment, Improved Public Health Outcomes and Delivery System Transformation

### **Cost Containment**

The Applicant asserts that the Proposed Project aligns with the Commonwealth's cost containment goals because it will increase access to inpatient and observation care which will allow for continued access to healthcare in the community, thereby reducing delays in diagnosis and treatment. In addition, increasing local access to care will help to address barriers to care, such as transportation, that may cause residents to delay or avoid seeking care. The ability to use the proposed 18 inpatient beds as 18 swing beds, and the access to short-term and long-term hospital services that it provides in one location, will allow for an efficient use of beds, and prevent wait times for post-acute care after patient discharge. As noted in Factor 1f, the staffing model at the proposed facility, and flexibility of swing beds can support efficient operation of the hospital and help lower costs.

#### ***Analysis: Cost Containment***

Staff finds that the Applicant has adequately explained how the Proposed Project aligns with the Commonwealth's cost containment goals through increasing access to high-quality, coordinated care, and efficient health care services that will address Patient Panel need locally and conveniently without a significant capital expenditure.

### **Improved Public Health Outcomes**

The Applicant asserts that the addition of inpatient and observation services will meet the anticipated increasing demand from residents as the population ages and experiences increasing age-related diseases and conditions. The Applicant anticipates that increasing timely access to healthcare services will improve health outcomes and patient experience.

#### ***Analysis: Public Health Outcomes***

As described above in Factor 1, lack of access to inpatient and observation services adversely impact access to care, patient outcomes, and patient experience, resulting in more acute diagnoses and longer inpatient stays. Establishing a CAH at the North Adams site will allow BHS to provide a continuum of integrated care locally for the Patient Panel which can improve health outcomes and quality of life.

### **Delivery System Transformation**

The Applicant asserts that it is in the process of implementing SDoH screening across the system, and that by the end of August 2023, the SDoH screening will be conducted at all of its primary care practices, which are a major touchpoint for its Patient Panel. Community health workers (CHWs) are available to assist patients with a positive SDoH screen through offering referrals to appropriate community-based organizations and resources.

The Applicant states that all patients seen at BMC's SEF in North Adams can be assessed based on their social history for SDoH, including insecurities related to housing, food, transportation, and utilities (phone and heat), and for issues concerning education, employment, domestic issues. These assessments are documented as part of the patient's social history assessment. The Applicant is working to put in place a formal SDoH screening process that will be completed for each patient at NARH. Patients will be screened for the domains mentioned above, when admitted or when a patient arriving to the ED has not had screening completed within the previous 90 days. Screening compliance will be monitored through NARH's Quality Assurance and Performance Improvement (QAPI) Program and will be reported as part of the CAH indicators.

The Applicant has also noted that SDoH impact access to care for rural residents, and that the proposed CAH can serve to address the SDoH through screening and referral. This was further supported in oral and written comments from BHS' Diversity, Equity, and Inclusion Officer, and the Executive Director of Northern Berkshire Community Coalition. The comments described existing healthcare gaps in Northern Berkshire and how the proposed hospital will serve as a touchpoint for SDoH screening. In addition, the Applicant will collect and analyze patient data at the hospital to better understand the health challenges of the community, and forge partnerships to address pressing health challenges. The Applicant has included a reporting measure regarding SDoH to ensure SDoH screening is occurring at the Proposed Project. This measure can be found in Appendix I.

### ***Analysis: Delivery System Transformation***

Central to the goal of Delivery System Transformation is the integration of social services and community-based expertise. The 2021 BHS CHNA identified economic and social factors that can impact the health of Berkshire County residents including food insecurity, a median household income that is lower than the state average, and almost 14% of children under age 18 living below the poverty level.<sup>ffff</sup> The Applicant has described how patients are screened for SDoH and the process by which positive screens are referred to community-based organizations and resources.

As a result of information provided by the Applicant and with additional analysis, Staff finds the Applicant has met the requirements of Factor 2.

## **FACTOR 2 SUMMARY**

As a result of information provided by the Applicant and additional analysis, staff finds that with the standard reporting conditions, the Applicant has demonstrated that the Proposed Project has met Factor 2.

### Factor 3: Relevant Licensure/Oversight Compliance

The Applicant has provided evidence of compliance and good standing with federal, state, and local laws and regulations and will not be addressed further in this report.

### Factor 4: Demonstration of Sufficient Funds as Supported by an Independent CPA Analysis

Under Factor 4, the Applicant must demonstrate that it has sufficient funds available for capital and operating costs necessary to support the Proposed Project without negative impacts or consequences to the existing Patient Panel. The Applicant has provided DoN Staff with a report titled, *Critical Access Hospital Financial Impact Analysis: North Adams Regional Hospital* prepared by Stroudwater Associates (dated August 8, 2023), for submission to CMS for North Adams Regional Hospital's CAH designation. The Applicant states that the Department's Office of Rural Health engaged Stroudwater to conduct a financial impact analysis for the Proposed Project pursuant to the CAH application process for the Office of Rural Health and CMS. Stroudwater performed a financial impact assessment of converting the North Adams (NA) campus from a department of BMC to a CAH. The financial impact analysis is used in order to form an opinion as to the reasonableness and feasibility of the Proposed Project.<sup>44</sup>

Stroudwater used the following information as the basis for performing a financial impact assessment:

- Revenues and expenses for the departments currently operating at the NA campus
- Additional expense and revenue assumptions provided by BHS
- Most recently filed Medicare hospital cost report, and PS&R for NARH prior to closure
- Inpatient volume assumptions based on the proposed hospital bed count
- Current outpatient utilization data
- Staffing assumptions based on the proposed hospital structure
- Detailed square footage for departments located on the NA campus
- Payer mix and payer rate information
- Applicable state laws and Centers for Medicare and Medicaid Services (CMS) regulations

Table 21 shows a summary of the financial impact of the CAH based on the assumptions and analysis.

#### **Table 21: Summary of Financial Impact (based on the assumptions and analysis)**

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<sup>44</sup> Reasonableness is defined within the context of this report as supportable and proper, given the underlying information. Feasibility is defined as based on Management achieving the hypothetical assumptions used, the plan is expected to result in "sufficient funds available for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel" (per Determination of Need, Factor 4(a)).

	Estimated NARH
Gross Patient Service Revenue	97,343,451
Less: Contractual Allowances	(46,067,811)
Less: Provision for Bad Debt	(910,902)
Net Patient Service Revenue	47,364,738
Other Revenue	392,000
Total Revenues	47,756,738
Operating Expenses	41,150,178
Operating Income	6,606,560
OOI/NOI	-
Total Margin	6,606,560
Estimated BHS Cumulative Impact	1,040,000
Operating Gain / (Loss)	13.9%
Total Margin / (Loss)	13.9%
NPSR %	48.7%
Contractual %	-50.4%
Bad Debt %	-0.9%

Based on their analysis, Stroudwater estimates the following:

- Conversion to CAH status would result in an overall operating income of approximately \$6.6M and a potential operating margin of 13.9% for NARH, which the report states indicates financial viability.
- The estimated total net benefit to BHS is \$1M and the anticipated benefit is primarily impacted by the shift of inpatient volumes from BMC to NARH once NARH is open, and increased outpatient rates from cost-based payers for NARH as a CAH compared to current operations as an outpatient department of BMC.
- The results of this financial feasibility study indicate financial viability given the initial bed count of 18.

### **Analysis**

Staff is satisfied with the analysis of Applicants decision to proceed with the Proposed Project. As a result, Staff finds the Stroudwater Financial Impact Analysis to be acceptable and that the Applicant has met the requirements of Factor 4.

## **Factor 5: Assessment of the Proposed Project's Relative Merit**

The Applicant has provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs identified by the Applicant pursuant to 105 CMR 100.210(A)(1). Evaluation of 105 CMR 100.210(A)(5) shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.



The Applicant considered and rejected one alternative to the Proposed Project.

- **Maintain status quo.** The Applicant states that continuing to provide healthcare services to North County residents through the BMC SEF is not an optimal alternative.
  - Quality: Patients requiring inpatient or observation level care would still be required to travel to BMC in Pittsfield (25 miles distance) or to Southwestern Vermont (18 miles distance) to receive care. The Applicant states that a lack of local inpatient and outpatient services contributes to lower utilization for the population. In addition, it poses socioeconomic and transportation barriers to access for patients and makes it difficult for patients to involve their support systems in their care. This alternative does not address the challenge of providing access to convenient and reliable transportation for patients between North County and Pittsfield.
  - Efficiency: Continuing to transfer patients from the SEF puts a strain on BMC's inpatient capacity.
  - Capital Expense: None
  - Operating Costs: No new operating costs.

In response to staff inquiry about other alternatives pursued, the Applicant explained that it has been continuously exploring alternatives from a quality, efficiency, capital expense and/or operating cost perspective. In doing so, the Applicant has implemented numerous initiatives that resulted in bringing back outpatient services to the former hospital and expanding services to include dialysis and cardiac rehabilitation. The Applicant notes that in 2014, the Stroudwater Report confirmed that it would not be possible to reopen hospital inpatient beds without the CAH designation, and that it was only the recent changes in federal regulation that allowed the Applicant to act on the findings from the Stroudwater Report and pursue the CAH designation to reopen hospital inpatient services.

### ***Analysis***

Staff finds that the Applicant has appropriately considered the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternative. As a result of information provided by the Applicant and with additional analysis, staff finds the Applicant has met the requirements of Factor 5.

## **Factor 6: Fulfillment of DPH Community-based Health Initiatives Guideline**

*Summary and relevant background and context for this application:* This is a DoN Proposed Project for an original license for NARH of BHS that will result in a Tier 1 Community-based Health Initiative (CHI). Recognizing that NARH is applying to be a new hospital entity of BHS, the CHI team and the Applicant worked together to identify appropriate Factor 6 requirements to give the Applicant time to stand up a reasonable CHI



infrastructure, including the creation of a community advisory body (CAB) that would have responsibilities for the implementation of the CHI for this project only. To fulfill Factor 6 requirements, BHS submitted its 2022 Community Health Needs Assessment (CHNA) and a CHI Narrative. BHS will provide the remaining Factor 6 materials—Self-Assessment and Stakeholder Assessments—when its ~~new Community Advisory Board (CAB) is established (tentatively Fall 2023)~~ project-specific CAB begins meeting.

**The Applicant’s Community Health Needs Assessment (CHNA)** was conducted in 2021 and commissioned by BHS in 2022 to collaborate with the Coalition of Western Massachusetts Hospitals/Insurers (“the Coalition”) around shared health priorities going forward. BHS joined the Coalition in 2022, which formed in 2012 to coordinate resources and activities, including their CHNA, and consists of 10 nonprofit hospitals, clinics and insurers in the region. The CHNA assessed Massachusetts’ Berkshire County using a literature review, secondary data sources and primary data gathered from community conversations and key informant interviews. Guided and informed by the Coalition’s 2022 CHNA structure and process, the Applicant’s CHNA prioritized community health needs as they related to social influencers of health, barriers to healthcare access, and health behaviors and outcomes. The prioritized health needs of the Applicant’s service area include: (1) youth mental health, (2) social and economic determinants of health (e.g., social environment, housing needs, access to health food, transportation, places to be active, employment and educational needs), (3) barriers to accessing quality healthcare (e.g., insurance challenges, limited availability of providers, need for increased culturally sensitive care, etc.), (4) health conditions and behaviors (e.g., mental health and substance use, chronic health conditions).

Using the 2022 CHNA, the Applicant will need to engage its newly established CAB to select key health priorities and identify strategies for implementation with the funds associated with this proposed project.

**The Self-Assessment** will be submitted to DPH within 3 months of the CAB ~~being established and seated~~ holding its first meeting in relation to this project. After establishing their ~~new~~ project-specific CAB, the Applicant will complete the form to provide a summary of community engagement processes and socio-demographic information, data and highlights related to topics and themes of community needs related to the 2022 CHNA.

**Stakeholder Assessments** will be submitted to DPH within 3 months of the project-specific CAB ~~being established and seated~~ holding its first meeting in relation to this project. Individuals who make up the Applicant’s CAB will provide information on their individual engagement levels (e.g., their personal participation and role) and their analysis of how the Applicant engaged the community in community health improvement planning processes.

**The CHI Narrative** provides background and overview information for the CHI processes. The narrative also outlines efforts to establish a decision-making body for the advisory and allocation committees. Additionally, the narrative outlines the CHI funds breakdown and the anticipated timeline for CHI activities. The Applicant proposed that CHI monies will primarily

serve Northern Berkshire County, where the proposed project will primarily operate. This is typically understood to include the following municipalities: Adams, Cheshire, Clarksburg, North Adams, Florida, Savoy and Williamstown. The Applicant also highlighted the significant community needs related to substance use and behavioral health disorders exacerbated by the opioid crisis.

To establish a CAB, the Applicant plans to ~~engage with~~ **deploy** Berkshire Medical Center's Office of Community Health **to engage** with the North Adams HEALing Communities Coalition (NAHCC). Working to address SUD challenges of the Northern Berkshire community for over 10 years, ~~the NAHCC~~ **this group** is a pre-existing, local advisory committee, **currently operating under a HEALing Communities Grant**, that **the Applicant proposes** will act as the decision-making body for the proposed CHI project.

Moving forward, the Applicant must conduct activities to ensure ongoing work with the ~~newly established~~ **project-specific** CAB will align with the CHI Health Priorities and Planning Guidelines. The **Applicant expects that the** NAHCC will be recruiting for any missing constituencies on the **project-specific** CAB, and DPH will work with the Applicant and the CAB to ensure the group's make up is sufficient to help them make decisions in line with CHI principles. The Applicant may also need additional touchpoints with DPH staff to establish a process for planning and implementation work. Regarding the implementation of specific CHI strategies, DPH will work with the Applicant in moving upstream, and identifying needs at the root cause level to support sustainable systems level solutions.

The proposed timeline and use of evaluation and administrative funds are all appropriate and in line with CHI planning guidelines. ~~The anticipated timeline for CHI activities includes the establishment and first meeting of the Advisory Committee six weeks post approval, identifying the Health Priorities Strategies 3 months post approval, and releasing an RFP six months post approval, with funding awarded to successful RFP applicants 3-4 months thereafter. The Applicant will decide the full breakdown of evaluation and administrative funds after conferring with their advisory body.~~

*Summary Analysis:* As a result of the information provided by the Applicant and additional analysis, staff finds that with the conditions outlined below, and the ongoing communication on items outlined above, the Applicant will have demonstrated that the Proposed Project has met Factor 6.

## Public Comments on the Application

Any person, and any Ten Taxpayer group, may provide written or oral comment at any time during the first 30 days following the Filing Date of an Application, or during the first ten days after a public hearing.

### **Public Hearing**

The Department held a virtual public hearing in connection with the Proposed Project on October 25, 2023. A total of 24 people provided oral comments at the public hearing. Pursuant to the DoN regulation, the Department determines whether need exists for a Proposed Project, based upon whether the Applicant meets each of the relevant factors set out in those regulations. Oral comments provided at the public hearing for consideration in DoN's review and analysis would be ones that address the Applicant's ability to meet the requirements of each of the relevant factors. The transcript of the public hearing is available online on the DoN website. The names of those testifying at the hearing are listed in Appendix V, and a summary of comments is in Appendix VII.

### **Written Comment**

The Department received written comments on the Proposed Project from 50 people. Pursuant to the DoN regulation, the Department determines whether need exists for a Proposed Project, based upon whether the Applicant meets each of the relevant factors set out in those regulations. Comments for consideration in our review and analysis would be ones that address the Applicant's ability to meet the requirements of each of the relevant factors. The names of those submitting written comments are listed below in Appendix VI and a summary of the written comments is provided below in Appendix VII. The full text of written comments is available online on the DoN website.

### **Ten Taxpayer Groups (TTGs)**

Per the DoN Regulation, any ten taxpayers, organized as a group, may participate in the review of an Application for Determination of Need or request to amend a previously issued Notice of Determination of Need. Said group must register with the Department at any time during the first 30 days following the Filing Date of an Application, or during the first ten days after a public hearing held pursuant to 105 CMR 100.445.

Two Ten Taxpayer Groups (TTGs) registered in connection with the Proposed Project. Registration information for the TTGs is available on the DoN website. Table 22 below provides a brief overview of each registered TTG and their participation in the application review process.

**Table 22: TTGs Overview**

TTG Name	Date Formed	Representative	Requested Public Hearing	Requested Independent Cost Analysis (ICA)	Oral Comments Provided at Public Hearing	Written Comments Provided
1199SEIU	October 2, 2023	Elisabeth Daley			✓	✓

Massachusetts Senior Care Association	October 2, 2023	Tara Gregorio	✓		✓	✓
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## Findings and Recommendations

Based upon a review of the materials submitted, Staff finds that, with the addition of the recommended conditions detailed below, the Applicant has met each DoN Factor for the Proposed Project, and recommends that the Department approve this Determination of Need, subject to all applicable standard and Other Conditions.

## Other Conditions

1. Of the total required CHI contribution of \$142,500.
  - a. \$14,250 will be directed to the CHI Statewide Initiative.
  - b. \$128,250 will be dedicated to local approaches to the DoN Health Priorities.
2. The holder shall, on an every 6 month basis, commencing with the approval of this DoN and continuing for a period of 5 years after the opening of the NARH Critical Access Hospital provide the following information to the Department:
  - a. Number of acute medical/surgical admissions refused due to lack of bed capacity
  - b. Percent of patients in swing beds admitted directly after a discharge from an NARH M/S bed
  - c. Average daily census (ADC) for med/surg beds and for swing beds
3. To comply with the Holder's obligation to contribute to the Statewide CHI Initiative, the Holder must submit a check for \$14,250 to Health Resources in Action (the fiscal agent for the CHI Statewide Initiative).
  - a. The Holder must submit the funds to HRiA within 30 days from the date of the Notice of Approval.
  - b. The Holder must promptly notify DPH (CHI contact staff) when the payment has been made.

Payment should be sent to:  
 Health Resources in Action, Inc., (HRiA)  
 2 Boylston Street, 4th Floor  
 Boston, MA 02116  
 Attn: Ms. Bora Toro

## APPENDIX I: Required Measures for Annual Reporting

The Holder shall, on an annual basis, commencing with approval of this DoN, and continuing annually for a period of five years after the Project is complete, report on the following data elements, pursuant to 105 CMR 100.310(A)(12). Reporting will include a description of numerators and denominators.

- 1. Health Outcomes – Transfers from the NARH Emergency Department (“ED”) to Other Health Care Facilities.** It is important that patients transferred from the emergency department to another health care facility have all necessary communications made available to the receiving facility in a timely manner to avoid medical errors and redundant testing. To have complete Emergency Department Transfer Communication (EDTC) all eight categories need to be met: home medications, allergies/reactions, medications administered in the ED, ED provider note, mental status/orientation assessment, reason or transfer/plan of care, tests/procedures performed, and tests/procedures results.

- a. *Measure:* The number of completed Emergency Department Transfer Communication (EDTC) annually.

*Projections:* The Applicant will provide baseline measures and three years of projections one year following implementation of the Proposed Project.

- 2. Health Equity – Social Determinants of Health (SDoH) Screening.** SDOH screening will assist the Applicant in connecting NARH patients with appropriate referrals and/or resources they need outside of the health system to support their well-being and meet their social needs.

- a. *Measure:* The number of completed Health Related Social Needs (HRSN) Screenings annually.

*Projections:* The Applicant will provide baseline measures and three years of projections one year following implementation of the Proposed Project.

- b. The number of positive screens annually, and the number of referrals made for positive screens annually.

- 3. Health Equity – Data Collection.** To ensure the Applicant is best positioned to meet the needs of the NARH patients, it is necessary for NARH to have a complete and accurate medical record. One focus will be the accurate capture of patient race, ethnicity, and language (REL) to allow NARH and/or the Applicant to address any specific needs the patients might have.

- a. *Measure:* Rate of Patients with a documented REL information in the medical record, completed monthly.

*Projections:* The Applicant will provide baseline measures and three years of projections one year following implementation of the Proposed Project.

The Holder shall, on an annual basis, commencing with the approval of this DoN, and continuing for a period of five years after the Proposed Project is complete, provide the following information as part of the annual report required by 105 CMR 100.310(A)(12):

**4. Discharges**

- a. Number of M/S discharges, and number of unique patients
- b. Number of M/S discharges to a swing bed by
  - age cohort,
  - race/ethnicity,
  - payer and
  - city/town
- c. Number of swing bed discharges to a SNF, to home, to another hospital, or Other location.

**5. Discharge Diagnoses**

- a. Five most common discharge diagnoses for swing bed patients.

**6. Readmission**

- a. Number of swing bed discharges readmitted to the hospital for acute care within 30 days

**7. Average Daily Census (ADC)**

- a. M/S ADC
- b. Swing Bed ADC

**8. Acuity Level by Case Mix Index (CMI) for M/S patients**

**9. Average Length of Stay (ALOS)**







- a. M/S bed ALOS
- b. Swing Bed ALOS

## APPENDIX II: Primary and Secondary Service Areas for North Berkshire (North Adams Regional Hospital), Central Berkshire (Berkshire Medical Center), and Southern Berkshire (Fairview Hospital)

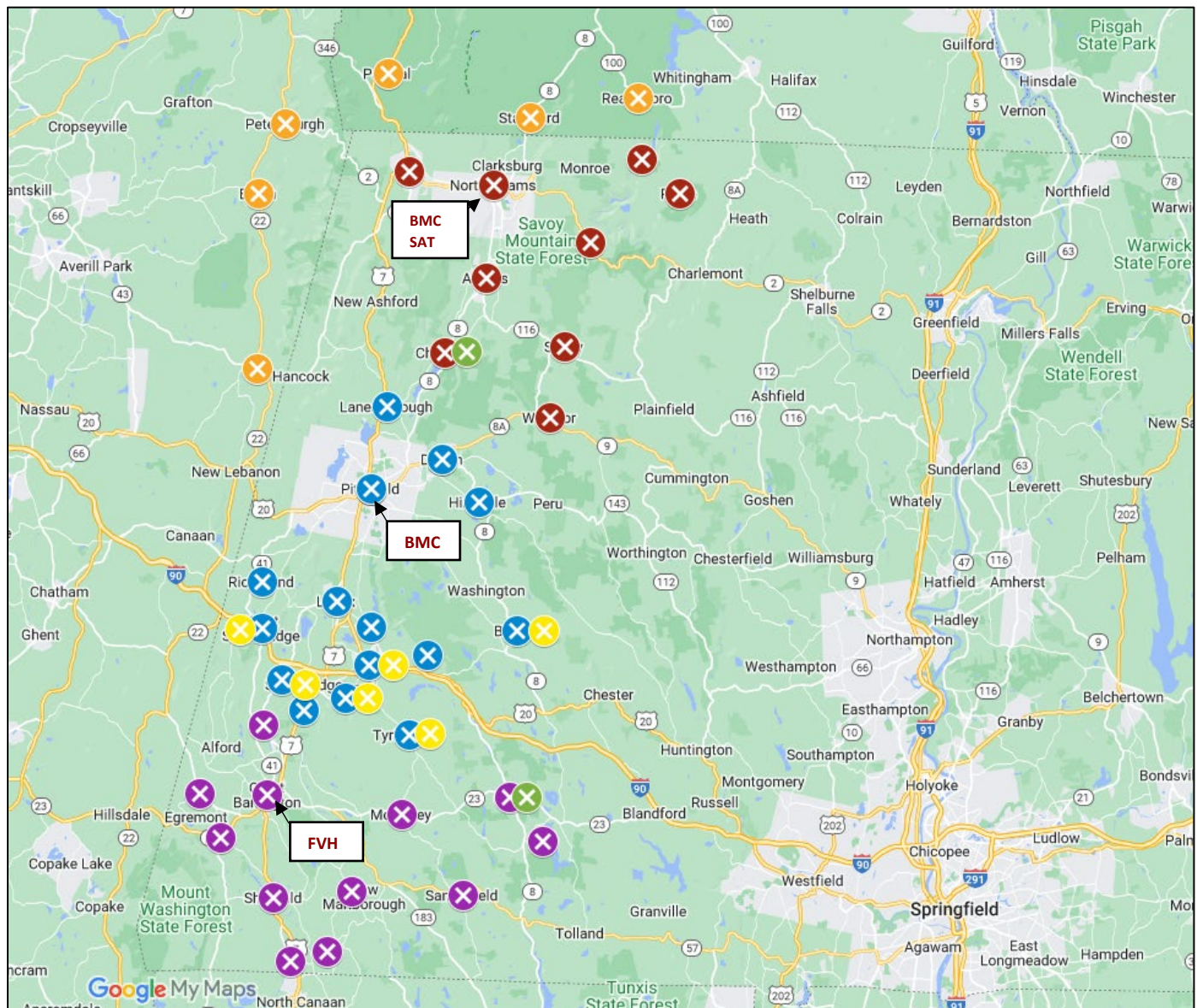
North Berkshire (NARH) Service Area		
Zip Code	Service Area	City/Town
01220	PSA	Adams
01247	PSA	North Adams
01256	PSA	Savoy
01267	PSA	Williamstown
01270	PSA	Windsor
01343	PSA	Drury
01350	PSA	Monroe Bridge
01367	PSA	Rowe
01225	PSA	Cheshire
05352	SSA	Stamford VT
05350	SSA	Readsboro VT
05261	SSA	Pownal VT
12022	SSA	Berlin NY
12168	SSA	Stephentown NY
12138	SSA	Petersburg NY

Central Berkshire (BMC) Service Area		
Zip Code	Service Area	City/Town
01201	PSA	Pittsfield
01202	PSA	Pittsfield
01203	PSA	Pittsfield
01223	PSA	Becket
01224	PSA	Berkshire
01226	PSA	Dalton
01227	PSA	Dalton
01229	PSA	Glendale
01235	PSA	Hinsdale
01237	PSA	Lanesborough
01238	PSA	Lee
01240	PSA	Lenox
01242	PSA	Lenox Dale
01254	PSA	Richmond
01260	PSA	South Lee
01262	PSA	Stockbridge
01263	PSA	Stockbridge
01264	PSA	Tyringham
01266	PSA	West Stockbridge
01225	SSA	Cheshire
01253	SSA	Otis

Southern Berkshire (FVH) Service Area		
Zip Code	Service Area	City/Town
01029	PSA	East Otis
01222	PSA	Ashley Falls
01230	PSA	Great Barrington
01236	PSA	Housatonic
01244	PSA	Mill River
01245	PSA	Monterey
01252	PSA	North Egremont
01253	PSA	Otis
01255	PSA	Sandisfield
01257	PSA	Sheffield
01258	PSA	South Egremont
01259	PSA	Southfield
01264	SSA	Tyringham
01266	SSA	West Stockbridge
01263	SSA	Stockbridge
01262	SSA	Stockbridge
01260	SSA	South Lee
01238	SSA	Lee
01223	SSA	Becket

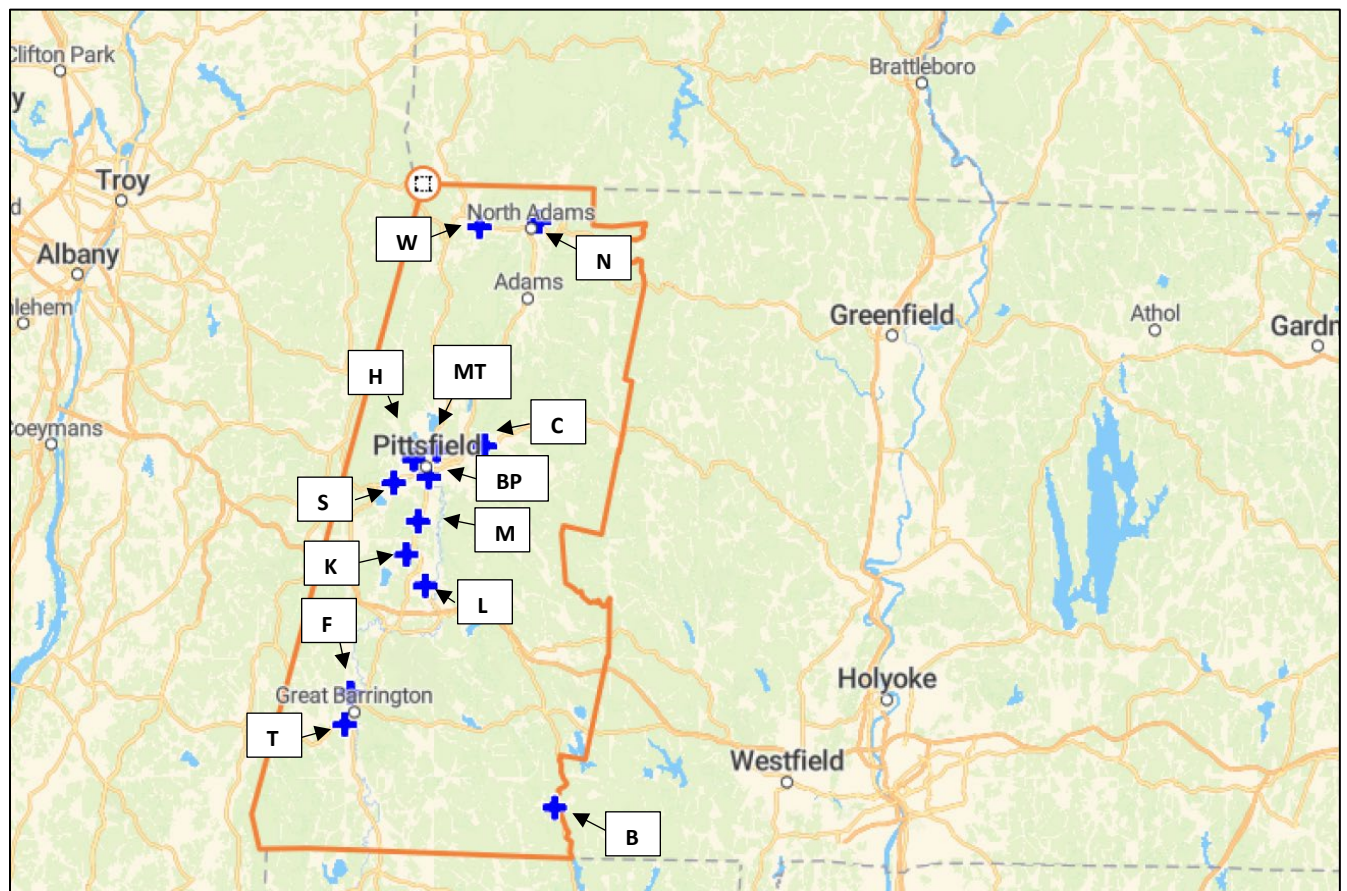
	North Berkshire (North Adams Regional Hospital) Primary Service Area
	North Berkshire (North Adams Regional Hospital) Secondary Service Area
	Central Berkshire (Berkshire Medical Center) Primary Service Area
	Central Berkshire (Berkshire Medical Center) Secondary Service Area
	Southern Berkshire (Fairview Hospital) Primary Service Area
	Southern Berkshire (Fairview Hospital) Secondary Service Area





+	Nursing Facilities (2030) Source: HRSA Policy Map	Location
W	Williamstown Commons Nursing & Rehab	Williamstown, MA
N	North Adams Commons Nursing & Rehab Center	North Adams, MA
H	Hillcrest Commons Nursing & Rehabilitation Center	Pittsfield, MA
MT	MT Greylock Extended Care Facility	Pittsfield, MA
C	Craneville Place Rehabilitation & Skilled Care CT	Dalton, MA
BP	Berkshire Place	Pittsfield, MA
M	Mount Carmel Care Center	Lenox, MA
S	Springside Rehabilitation & Skilled Care Center	Pittsfield, MA
K	Kimball Farms Nursing Care Center	Lenox, MA
L	Lee Healthcare	Lee, MA
F	Fairview Commons Nursing & Rehabilitation Center	Great Barrington, MA
T	Timberlyn Heights Nursing & Rehabilitation	Great Barrington, MA

+	Nursing Facilities (2030) Source: HRSA Policy Map	Location
B	Berkshire Rehabilitation & Skilled Care Center	Sandisfield, MA



## APPENDIX III: Conditions of Participation for CAH Designation<sup>45</sup>

Condition	Summary	Applicant Appears to Meet Requirement
Location	<p>Must be located in a rural area. Pursuant to 42 CFR 485.610(b), the CAH must be in one of the following to be eligible for CAH designation and certification:</p> <ul style="list-style-type: none"> <li>• Located in a rural area; or</li> <li>• Treated as rural in accordance with 42 CFR 412.103, which states the hospital is located in a rural census tract or designated as rural by any State law</li> </ul>	<p>NARH is located in an area defined as rural by the Health Resources &amp; Services Administration (HRSA)</p> <ul style="list-style-type: none"> <li>• NARH would be considered rural based on the definitions as outlined in state law and regulations.</li> <li>• The CMS Regional Office will make the final determination as to whether a CAH applicant meets the rural location requirement</li> </ul>
Distance Criteria <sup>46</sup>	<ul style="list-style-type: none"> <li>• Meet the federal distance requirement that a CAH must be at least a 35-mile drive on primary roads or in areas with only secondary roads available, 15 miles to the nearest hospital or CAH</li> </ul>	<p>The closest hospitals to NARH are BMC (25.5 mi) and Southwestern Vermont Medical Center (18.0 mi) Both hospitals are greater than 15 miles from NARH on secondary roads</p>

<sup>45</sup> Table adapted from PowerPoint Presentation titled, "Critical Access Hospital Financial Impact Analysis."

<sup>46</sup> The definition of a primary road was recently refined and included in Federal regulations (see §485.610(c)(2)) effective January 1, 2023; this change excluded US Highways with single lanes in each direction from the definition of a primary road; a primary road is now defined as one of the following: A numbered Federal highway, including interstates, intrastates, expressways, or any other numbered Federal highway with 2 or more lanes each way; or A numbered State highway with 2 or more lanes each way. Given this definition of a primary road, a secondary road would be considered any road with less than 2 lanes each way, regardless of designation as a Federal or State highway



Condition	Summary	Applicant Appears to Meet Requirement
Emergency Services	<p>Offer 24-hour emergency department 7 days a week, laboratory, and diagnostic X-ray services.</p> <ul style="list-style-type: none"> <li>All emergency services must be provided as a direct service in the CAH and the ED cannot be a provider-based off-site location</li> <li>The hospital must ensure that a Doctor of Medicine or osteopathy, a PA, a NP, or a clinical nurse specialist with training and experience in emergency care is on call and immediately available by telephone or radio, and available on-site within 30 minutes, 24 hours a day</li> </ul>	The North Adams (NA) campus currently operates an ED which would become part of NARH; therefore, NARH should meet this CAH Condition of Participation
Inpatient Bed Limit	Operate with 25 or fewer inpatient beds (which may be used for either inpatient, ICU, Labor and Delivery (LDRP) and or swing-bed services); does not include distinct part units (DPUs)	NARH is anticipated to operate 18-beds, which is below the maximum 25-bed requirement.
Average Length of Stay (ALOS)	Maintain an average length of stay of 96 hours (4 days) or less per patient for inpatient acute-care services. ALOS calculation excludes Swing Bed, Observation and Nursery days.	NARH is anticipated to maintain an ALOS below 96 hours per regulation. Change in Service form projects an ALOS of 3 days.
Psychiatric and Rehabilitation Distinct Part Units	To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit of which the distinct part beds are excluded from the 25 inpatient-bed count limit specified in §485.620(a)	NARH would not operate a distinct inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF)
Comply with all federal, state, and local laws, including Commonwealth of Massachusetts hospital licensure regulations		The Applicant will Comply with all federal, state, and local laws, including Commonwealth of Massachusetts hospital licensure regulations

## Appendix IV: BHS Health Equity Work<sup>47</sup>

Initiative	Overview
Language Services	Provide Foreign Language and American Sign Language (ASL)
Age-Friendly Care	BMC Emergency Department has a Geriatric Emergency Department Accreditation from the American College of Emergency Physicians BMC has a Geriatric Fracture Program Participant in Institute for Healthcare Improvement (IHI) Age-Friendly Care Collaborative
SDoH Screening	Expanding to all BMC Primary Care Practice for all payers by end of August Comprehensive community resources list created by category of need
Flexible Services Program	Use funding through the Flexible Services Program Grant from the Medicaid ACO to support additional resources for Housing, Food Insecurity, and Transportation, three areas of need identified in the CHNA and through analysis of the Medicaid population. Services provide in collaboration with community partners
Phelps Cancer Center Care Navigation	Collaborative Member with Dana Farber Distress screen for all new patients Integrated Health Services provided free of charge Nurse Navigation to assist with accessing care Social Worker to perform SDoH screening and referral Nutritionist
Substance Use Support Programs	Substance use is a top 10 issue in Berkshire County Services in place in the BHS system across multiple levels of care Hillcrest Family Health Treatment Clinic Provide referrals and partner with community programs Harm Reduction Perinatal Support
Behavioral Health Programs	Behavioral Health Integration Adolescent Intensive Outpatient Program
Prevention Programming	Community Pharmacy, Community Events, Talent Pipeline Program, and Initiatives Program, a collaborative program to support formerly incarcerated individuals

<sup>47</sup> Based on Joint Commission Health Equity Review. August 2023. See DoN Application Materials for Full Presentation.

## APPENDIX V: Speakers at the Public Hearing

First Name	Last Name	Middle Initial	Title and Organization
Darlene	Rodowicz		President and CEO of Berkshire Health Systems
Jennifer	Macksey		Mayor, North Adams
Paul	Mark	W	MA Senator, Berkshire, Hampden, Franklin and Hampshire District
John	Barrett III		MA Representative 1st District Berkshire
Alec	Belman, MD		Chief of Staff at Fairview Hospital
Tara	Gregorio		President of Massachusetts Senior Care Association, Massachusetts Senior Care Association TTG Representative
James	Birge Ph.D.	F	President of Massachusetts College of Liberal Arts
John	Lipa		Born and raised, North Adams, MA
Richard	Alcombright		Community Member, BHS Board of Trustees, Former Mayor of North Adams
Lou Ann	Quinn, RN		Former Site Director of the North Campus/Clinical Manager of the Satellite Emergency Facility. Nursing Director for NARH from 1976 to 2014.
Jackie	Felix		Resident of North Adams
Patrick	Borek		Vice President for Human Resources for BHS
Jason	Ogiste, MD,	S	Urologic Surgeon, BHS
Charles	Redd		Diversity, Equity, and Inclusion Officer at BHS
Amber	Besaw		Executive Director of the Northern Berkshire Community Coalition
Scott	St. George		Chief Financial Officer at BHS
Diane	Spina		Union Delegate of the former NARH, and Phlebotomist
Marie	Harpin		North Adams City Councilor, Community Member
William (Bill)	Jones		President and CEO, Integritus Healthcare
Ryan	Cuthbertson		Massachusetts Senior Care Association; Hooper, Lundy, and Bookman
John	Meaney		Chief and General Manager of Northern Berkshire EMS
Elisabeth	Daley		1199SEIU Member, 1199SEIU TTG Representative
Jodi	Ouimette		Administrator, Mount Carmel Care Center
Michele	Biron		Resident of Adams, MA; Community Member

## APPENDIX VI: Names of People Who Submitted Written Comments

First Name	Last Name	Middle Initial	Title and Organization
Richard	Neal	E	Congressman, 1st District of Massachusetts
Paul	Mark	W	MA Senator, Berkshire, Hampden, Franklin and Hampshire District
John	Lipa		Born and raised, North Adams, MA
Debbie	Richardson		Vice President of Talent Management at Integritus Healthcare
John	Meaney, Jr., NRP, I/C	P	Chief and General Manager of Northern Berkshire EMS
James	Birge, Ph.D.	F	President of Massachusetts College of Liberal Arts
Darlene	Rodowicz		President and CEO of Berkshire Health Systems
Richard	Alcombright		Community Member, BHS Board of Trustees, Former Mayor of North Adams
Alec	Belman, MD		Chief of Staff at Fairview Hospital
Amber	Besaw		Executive Director of the Northern Berkshire Community Coalition
Michele	Biron		Community Member
Patrick	Borek		Vice President of Human Resources, BHS
Marie	Harpin		North Adams City Councilor, Community Member
Jennifer	Macksey		Mayor of North Adams
Jason	Ogiste, MD		Surgeon, BHS
Lou Ann	Quinn, RN		Former Site Director of the North Campus/Clinical Manager of the Satellite Emergency Facility
Charles	Redd		Diversity, Equity, and Inclusion Officer at BHS
Scott	St. George		Chief Financial Officer, BHS
Jill	Landis, RN		VP of Quality Management for Integritus Healthcare
Christina	Hall		Nurse, Resident of Northern Berkshire County
Dane	Rank		Administrator of Charlene Manor, Integritus Healthcare
Jackie	Felix		Resident of Northern Berkshire County
William (Bill)	Jones	C	President & CEO of Integritus Healthcare
Smitty	Pignatelli		State Representative, 3 <sup>rd</sup> Berkshire District
William	Kittler		Administrator of Kimball Farms Nursing Care Center
Tricia	Bragdon, LICSW	L	VP-Operations, Integritus Healthcare
Richard	Herrick	J	Vice Chair of Integritus Healthcare Board of Trustees
Lisa	Gaudet	A	Vice President Business Development, Integritus Healthcare
Tara	Coughlin, MBA, LNHA		Regional Director of Operations, Integritus Healthcare

First Name	Last Name	Middle Initial	Title and Organization
Robert	Post		Administrator of North Adams Commons Nursing & Rehabilitation Center
Andrew	Kowal, RPh	H	Director of Pharmacy, Pharmacist Manager of Record, IntegriScript Inc. Integritus Healthcare
Doris	Meier		VP Information Technology, Integritus Healthcare, Inc.
Monique	Tanguay, RN		Director of Clinical Network for Integritus Healthcare
Ryan	Cuthbertson	J	Hooper, Lundy & Bookman, P.C, Massachusetts Senior Care Association
Sherry	Roberts		Resident of Richmond, MA
Michael	Smith		Resident of Great Barrington, MA
Tara	Gregorio		Massachusetts Senior Care Association Ten Taxpayer Group (MSCATTG)
Kathleen	Coburn		Administrator of Williamstown Commons Nursing & Rehabilitation Center
Michael	Marcus		Regional Director of Operations, Integritus Healthcare
Jeffrey	Heinze	N	Administrator of Linda Manor Extended Care
Ellen	Beckwith, RN		Registered Nurse at Fairview Hospital
Nicholas	Lausier, LNHA	F	Regional Director of Operations, Integritus Healthcare
Gary	Sacon		Chief Financial Officer for Integritus Healthcare
Elisabeth	Daley		1199SEIU Member, 1199SEIU TTG Representative
Maria	Craft, BSRT, LNHA	T	Administrator of Mt. Greylock Extended Care Facility
Marsha	Moquin, MSW		Director of Case Management and Social Services at Fairview Hospital
Brenda	Cadorete, MSN, RN, NEA-BC		Chief Nursing Officer, BMC.
Stanley	Monsky		Resident of Hillsdale, New York
John	Caron		Resident of Monroe, MA
Gaurav	Chawla, MD, MBA, CPE		Chief Medical Officer, Integritus Healthcare



## APPENDIX VII: Summary of Public Hearing Comments and Written Comments Submitted on the Proposed Project

Commenters include: the President and CEO of Berkshire Health Systems, a number of elected officials, and both TTG representatives. None of the commenters expressed opposition to the Proposed Project in its entirety. The 1199 SEIU TTG Representative expressed full support for the Proposed Project. The Massachusetts Senior Care Association TTG Representative; President and CEO of Integritus Healthcare, the largest nonprofit provider of senior living, nursing home and hospice services in the Commonwealth; various nursing home Administrators affiliated with Integritus; and additional commenters spoke in support of the Proposed Project to increase the availability of acute care services for residents of Northern Berkshire County, but expressed concern about the negative impacts of the proposed 18 swing beds.

### Comments in Support of the Proposed Project

#### **Factor 1a: Patient Panel Need**

Rural communities face distinct challenges in accessing convenient, timely healthcare. North Adams remains a community with significant healthcare needs. The community is faced with socioeconomic and health challenges and limited opportunities for economic advancement. The closure of North Adams Regional Hospital disrupted access to fundamental healthcare and the community's well-being and economic stability. The need for the proposed hospital was made clear in the Stroudwater report that was commissioned ten years ago and that need remains true today.

Aging residents in Northern Berkshire face challenges accessing timely medical care due to distance and transportation. Traveling to Pittsfield to receive care is prohibitive for some due to transportation challenges and weather challenges. Northern Berkshire residents facing barriers to accessing care, such as lack of financial resources and social supports, forgo care resulting in patients arriving sicker after postponing care.

The Proposed Project would expand access to healthcare to the underserved region of North Berkshire and will address health disparities in more rural areas of western Massachusetts. The CAH designation, with its cost-based reimbursement, helps to ensure the continuation of health services in rural and underserved areas. The project offers an opportunity to address barriers to patient care, promote social and economic improvement, and advance the health and wellness of the Northern Berkshire community and the entire region. The Proposed Project ensures that healthcare provided is accessible, sustainable, and of high-value to the public. In addition, having a CAH will assure access to care for those looking to relocate to the area, and for students attending college in the area.

Swing beds are a necessary flexibility that is an essential feature of a CAH. Swing beds offer flexibility, value and choice. They provide a convenient transitional care option close to home,

especially for those with a high level of health and social need, reduce reliance on EMS transport to Pittsfield, and preserve availability of acute patient resources for those with higher acuity needs.

The Proposed Project will improve the community's health and economic landscape and will create new healthcare jobs. The project has the potential to recruit and retain healthcare providers to the area, including surgeons. BHS partnerships with local educational institutions, such as the Massachusetts College of Liberal Arts, Berkshire Community College, and McCann Technical School, provide a learning ground for local students and create pathways for clinical training and employment for future healthcare professionals.

The Proposed Project will create 60 to 70 positions on the North Adams campus, and potential staff include former and current BMC staff. BHS expressed full agreement with both SEIU and MNA that existing bargaining units and labor agreements will remain in place. BHS has been meeting with both unions to discuss changes, and gain input and suggestions on the transition. In response to the concerns expressed over the staffing of the proposed facility, a BMC employee involved in developing the nursing role at the new facility stated that acute care and skilled nursing care are complementary with acute care requiring a higher level of expertise. And for this reason, an acute care nurse can easily provide post-acute care to patients in swing beds status, but it is less likely that a staff member of an independent SNF would have the necessary training needed to transition to the level of care experience that will be required for all staff at NARH.

#### **Factor 1b: Public Health Value**

Returning inpatient beds to the community will increase timely access to care which can improve health outcomes, reduce transport to Pittsfield and Vermont for care, and create an integrated hospital system. It will create access to essential healthcare closer to home where family, friends, and community resources are located, and which have been shown to improve outcomes. It would mean fewer hour and a half to two hour round trips by Emergency Medical Services (EMS) to connect patients to inpatient care in Pittsfield which will free up EMS resources and improve their ability to serve the community. Ensuring faster and more efficient access to care will make it easier for patients to obtain care when they need it in a local, and familiar environment. BHS expects that a significant portion of patients they serve at the proposed facility will be beneficiaries of Medicare and Medicaid, and that the proposed facility improve access to care and health outcomes for vulnerable populations covered by Medicare and Medicaid.

BHS has cared for patients in swing beds status at Fairview Hospital (FVH) since 2004, and the experience has provided insight to the value of swing beds for patients, family, and community. At FVH, swing bed patient length of stay is usually between six and 12 days. The care provided helps patients transition home safely. The decision to transition a patients from an acute care bed to a swing bed is made jointly by the care team, but the final decision is made by the patient themselves, and patients have the choice to select their preferred facility. The team

provides physician management, physical, occupational and speech therapy, respiratory therapy, skilled nursing care, IV infusion, wound care, case management and nutritional and disease management education. The nursing and multidisciplinary team develop a care plan that is individualized and reassessed based on patient progress. Family and interdisciplinary meetings occur weekly. One of the key requirements of patients admitted to a swing bed is learning about taking care of themselves and/or making progress towards recovering strength and mobility to be able to return home or transfer to a SNF for further recovery. Swing beds are an important option for older people who live alone and who do not have a partner or someone to provide assistance. And it eases the burden on families that are there to care for them. The swing bed program at Fairview Hospital has been a benefit to the community, as evinced through several testimonials from former patients. BHS noted no prior complaint or notable impact of recruitment of Integritus' two skilled nursing facilities that operate in close proximity to FVH.

### **Factor 1c: Efficiency, Continuity of Care, Coordination of Care**

Without the BHS swing bed option, there are only two facilities in the Northern Berkshire region offering SNF-level care. Massachusetts hospitals are experiencing increased patient wait-times due to the inability to discharge patients from hospital beds to post-acute facilities. This is reported on in the Massachusetts Health and Hospital Association Throughput Survey Report issued in June 2023.<sup>gggg</sup> In Western MA, an average of 131 patients were waiting to be discharged to post-acute settings between March 2022 and February 2023, and at Berkshire Medical Center (BMC), 15-18 patients at any given time are waiting to be discharged to post-acute care. The proposed swing beds could help address this throughput issue. Caring for patients in swing beds increases the efficiency of hospital operations and lowers the cost of care.

### **Factor 1f: Competition on price, total medical expenses (TME), costs and other measures of health care spending**

In response to TTGs concerns over the CAH reimbursement model, BHS President and CEO stated the CAH reimbursement model can impact the cost of care and reimbursement. Federal reimbursement rates are subject to certain terms and conditions that modify the final rate received. CAHs are not fully funded by CMS but are reimbursed on a cost basis for certain allowable costs. Further, reimbursement to CAHs is reduced by 2% due to federal sequestration. The "core staffing" model, which is critical to the operation of a CAH, and caring for patients in swing bed status makes hospital operations more efficient and can lowers the costs of care.

**Factor 2: Health Priorities – Delivery System Transformation:**

The proposed facility will be a touchpoint for screening and addressing the SDoH and connecting patients with resources. The hospital will analyze data to understand patient needs and extend partnerships in the community to address them.

Comments expressing concern about the proposed 18 swing beds.

**Factor 1a: Patient Panel Need/ Factor 1f: Competition on price, total medical expenses (TME), costs and other measures of health care spending**

The proposed 18 swing beds would have unintended negative consequences that will threaten both choice and access to long term health services in Berkshire County. Currently, there is sufficient nursing home bed capacity in Northern Berkshire County to serve the population there. The two nursing homes are North Adams Commons Nursing & Rehabilitation Center and Williamstown Commons Nursing & Rehabilitation Center. Each has excess capacity. The existing facilities provide high-quality care that is accessible near where residents live, and where their social supports and connections reside. Family members are critical to social engagement and emotional health. Families that live near their loved ones who live in a nursing home are able to visit them more easily and more often and can be involved in their care.

The Medicaid program pays for the care of 70% of nursing facility residents in Massachusetts. The second primary source of funding is Medicare, which covers 15% of nursing facility residents' care. Short-term post-acute patients tend to be younger and healthier, and generally pay with Medicare or commercial insurance. North Adams and Williamstown average 30 Medicare residents. Medicaid underfunds costs for long term care and nursing homes. MassHealth underfunds nursing facility care by \$47 per patient per day. Medicare revenues from short-stay patients fund that shortfall. Medicare reimbursement allows nursing centers to cover loss created through MassHealth and to reinvest in wages, buildings, and services.

Swing bed services are funded by Medicare which is the revenue that nursing facilities rely on to offset severely low Medicaid underfunding. Other nursing homes are not entitled to the same reimbursement as swing bed services (cost plus profit) and are reimbursed less than their costs, this also makes the existing facilities a lower-cost option for post-acute care. For the six Integritus nursing homes throughout Berkshire County, their combined costs were underfunded by \$13.3M. In the year ended December 31, 2022, for the two Integritus nursing homes in Northern Berkshire County, their combined costs were underfunded by \$4.7M.

There is a strong relationship between the financial viability of a nursing facility and its payor mix. Nursing facilities with less Medicare revenue are more likely to close, experience lower staffing levels and poorer outcomes. In Berkshire County, currently 17% of the total residents in community nursing facilities are covered by Medicare. However, the Centers for Health Information and Analysis (CHIA) cost reports for calendar year 2022 show that Berkshire County

nursing facilities are under extreme financial pressure with the median (midpoint) showing the typical facility operating at almost a \$100,000 annual loss with a negative 1% margin.

The need for nursing facility care is expected to grow over the next decade, and the Commonwealth cannot withstand voluntary nursing closures. Median occupancy for the existing 13 Berkshire County skilled nursing facilities is 92%.<sup>48</sup> Within a 25-mile radius of the proposed hospital, there are eight nursing facilities totaling 911 beds that are most vulnerable to the potential negative impact of the proposed 18 swing beds. The proposed 18 swing beds will destabilize nursing homes in the area and create an access issue requiring residents to travel longer distances to receive long term care and short-term rehab skilled nursing care and requiring family members to travel to see loved ones. Nursing Homes in the same areas as FVH have experienced a decrease in Medicare admissions and a reduction in reimbursement due to the Hospital's swing bed program.

There is an existing shortage of certified nursing assistants and licensed nurses in Massachusetts. The COVID-19 pandemic further strained the operations of healthcare providers, especially in the skilled nursing sector. Quality of care and quality of life for individuals living in nursing facilities is directly dependent upon an adequate number of caregivers. Current vacancy rates in Northern Berkshire County for certified nursing aids (CNAs) and licensed nurses are 64% and 28%, respectively, and 52% and 42%, respectively in all of Berkshire County. North Adams Commons and Williamstown Commons have only 50% of Certified Nursing Home positions filled. Vacancies are filled by more expensive temporary nurses, which is not a sustainable model for staffing existing facilities. Integrity employs several traveling nurses from other states that charge a premium of 70% more, with a cost of \$3.7M for the two Northern Berkshire skilled nursing facilities. Already scarce and invaluable clinical and ancillary staff will be recruited away from Berkshire County long term care facilities to work at the proposed facility, which will have government funding to offer competitive wages above the pay rates at the existing facilities. This will destabilize services at existing facilities and further exacerbate existing recruitment and retention challenges. It will also undermine investment in existing efforts to recruit and train new staff, and investments in the pipeline for CNAs and licensed staff.

Suggested Other Conditions to the approval of the DoN that seek to preserve vital long term care services in Berkshire County while also supporting this new project include:

- Capping the number of beds authorized for swing bed designation at two to mitigate harm to the local post-acute and long term care infrastructure, while still providing the ability to provide adequate post-acute care at the hospital location.
- Requiring BHS commit to not actively solicit clinical and ancillary staff within skilled nursing facilities located within a 25 mile radius of the CAH effective from date of DoN approval and for two years after project approval to allow for a transition period. During the restricted period, the hospital would have access to existing Berkshire Health System staff and staff the proposed facility with travel nursing and agency personnel that are not already assigned to existing facilities. This restriction would provide a

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<sup>48</sup> CMS NHSN Weekly Data

reasonable transition period for affected skilled nursing facilities to plan and prepare for potential staffing impacts.

- Requesting the HPC conduct a Cost and Market impact review on the proposed project. Other requests were made for a community health needs assessment to be completed.

#### **Factor 1e: Community Engagement**

BHS' community engagement efforts did not include other key stakeholders, such as long term care providers, who could have provided insight into the role of long term care providers in the community, and who will be impacted by the re-opening of NARH.

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