NORTHERN BERKSHIRE HEALTHCARE

September 27, 2013

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Re: North Adams Regional Hospital – Health Care Cost Trends Written Testimony

Dear Mr. Seltz:

In response to your letter dated August 26, 2013, Northern Berkshire Healthcare, Inc., d/b/a North Adams Regional Hospital, submits the enclosed written testimony and attestation of its President and CEO, Timothy Jones, in connection with the Health Policy Commission's health care cost trends hearing scheduled for October 1 and 2, 2013. Exhibit B includes the answers to the HPC's questions, and Exhibit C includes the answers to the OAG's questions.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Paul Hopkins
Director of Public Relations

Enclosure

Cc: Timothy Jones, President
James B. Art, Esq.

I, Timothy Jones, President and CEO of North Adams Regional Hospital, am legally authorized and empowered to represent North Adams Regional Hospital for the purposes of this testimony, which is signed under the pains and penalties of perjury.

Timothy Jones, President
North Adams Regional Hospital

Health Policy Commission Written Testimony
Exhibit B – Northern Berkshire Healthcare

Question 1 Summary: Northern Berkshire Healthcare serves a population that is rapidly aging, and is among the poorest in the Commonwealth. Our primary market area comprises approximately 38,000 residents. Approximately 60% of patient revenue is from Medicare and Medicaid sources. NBH entered Chapter 11 reorganization in June of 2011, emerging successfully one year later. We remain focused on offering efficient, low-cost care for our patients.

1.a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?
Northern Berkshire Healthcare and North Adams Regional Hospital are engaged in creating a new system of inpatient care that is designed to increase safety and quality, while reducing cost. Specifically the strategic plan calls for NBH to create a single 16-bed inpatient unit, with all rooms outfitted for telemetry, which will admit all patients requiring inpatient care at NARH. The plan expands the hospital's ability to provide telemetry care; revised staffing patterns will reduce the cost of care.

NBH regularly examines costs across the institution. In FY2013 NBH reviewed expenses and eliminated $906,000 within the last four months of the fiscal year.

1.b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?
Through our current strategic plan we intend to improve quality and efficiency of care (see answer to 1.a., above). Factors limiting our ability include current union contract language governing overtime and flexibility of staffing.

1.c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?
Regulatory easing, changes in union contract language, ability to be flexible in staffing, no mandatory staffing legislation, and simplifying billing and coding systems.

1.d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?
NBH's current financial situation dictates that cost savings are first used to stabilize the organization's financial position and ensure its viability in the community. However, we are committed to working with insurers and others to control costs in the future.

2. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?
The single largest element in our budget is salaries and wages. We have attempted to control the growth in personnel expenses by carefully examining vacant positions before filling them; working to reduce the cost of overtime; and reducing management expenses. In other areas we have carefully controlled overhead expenses, supply expenses, energy expenses, and capital expenditures.

Question 3 Summary: NBH and North Adams Regional Hospital have provided inpatient psychiatric services since 1988 through Greylock Pavilion, a locked 20-bed inpatient unit. NBH plans to close this unit by early 2014 as we transition to an outpatient service model, due to steadily declining volumes.

3.a. What potential opportunities have you identified for the integration of behavioral and physical health?
Our current strategic plan calls for shifting to an outpatient model for most psychiatric care. To that end we plan to provide outpatient clinic services as well as integrate psychiatric clinicians in our Emergency Department, Visiting Nurse Association, and local primary care offices. We expect to increase the number of patients we serve in this new model while reducing overhead costs and the cost of care.

3.b. What challenges have you identified in implementing such integration?
Besides the regulatory process involved in closing our inpatient psychiatric unit, we anticipate cooperation from local primary care offices (who have already expressed interest), our Visiting Nurse Association, and our Emergency Department.

3.c. What systematic or policy changes would further promote such integration?
Easing regulatory requirements; and altering the payment system to support an outpatient model for psychiatric care in non-traditional settings such as primary care and pediatric practices.

Question 4 Summary: NBH is beginning to employ LEAN management strategies to eliminate waste and improve efficiency in operations, while improving the value of our services to our customers. Our current strategic plan, approved by the NBH Board of Trustees this summer, calls on NBH to structure North Adams Regional Hospital to meet the future healthcare needs of our residents while achieving high levels of quality, safety, and efficiency.

4.a. Describe your organization's efforts to promote the goals of more efficient and accountable care through innovative care delivery model s or alternate payment methods.

Our strategic goals call for the creation of a new inpatient unit that provides safe, quality care in the most efficient setting possible, and for providing comprehensive outpatient psychiatric care in community settings.

Through Lean process improvement strategy, we are focusing on making patient flow more efficient and cost effective. Example: a recent process improvement exercise has reduced the average wait times in our Emergency Department by 60%, improving both efficiency and patient safety.

Additionally, our strategic plan calls on NBH to develop partnerships with other care providers, and to participate in the future as a partner in an accountable care organization.

4.b. What current factors limit your ability to promote these goals?
North Adams Regional Hospital employs a primarily full-time work force; combined with some limiting language in employee contracts, it is difficult to readjust staffing to patient volumes, resulting in inefficiencies and low productivity.

4.c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

Since our organization has very limited resources, any opportunity to reduce support services would allow for lower cost and more resources available for patient care. NBH serves a population that is older, on average, and poorer on average with a high reliance on public payer sources. A suggested policy change would be administrative simplification.

5.a. What units of analysis do you use to track cost structure?
Labor costs are tracked through productivity reports. Managers are accountable for productivity levels and are expected to develop action plans to improve productivity.

5.b. How does your organization benchmark its performance on operational cost structure against peer organizations?
The hospital has established productivity unit of service targets for each department. These targets were developed in collaboration with a national consulting firm and are based on national productivity ranges.

5.c. How does your organization manage performance on these metrics?
We require weekly reviews of productivity reports, and comparisons of budget-to-actual expenses. Each department submits responsibility reports that track any significant changes in cost vs. plan.

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.
At this date we do not have a cost accounting system that would be the mechanism to provide cost information by procedure. We do provide charge and payment data to patients upon request.

7. After reviewing the reports issued by the Attorney General and the Center for Health Information and Analysis, please provide any commentary on the findings presented in light of your organization's experiences.

NBH offers no further commentary at this time.

Health Policy Commission Written Testimony
Exhibit C – Northern Berkshire Healthcare

Question 1, concerning operating margins: Northern Berkshire Healthcare does not currently have a cost accounting system in place, and therefore is unable to submit this information.

Question 2, concerning contracts incorporating per member per month budgets: Northern Berkshire Healthcare has not entered into any such payment (per member per month) contracts.

Question 3, concerning risk contracts: Northern Berkshire Healthcare has not entered into any such risk contracts.

Question 4: NBH uses publicly available information to track the health status of our population, and does not conduct independent tracking.

Question 5: See attached tables.

Question 6: Provision for bad debt grew 71% from 2010 to 2012, as we adjusted reserves for bad debt collection.

Question 7: Northern Berkshire Healthcare does not offer specific wellness programs for patients of our primary care practice (Northern Berkshire Family Medicine), but does offer programs for the public at large. NBH does not have data regarding the cost benefit. The programs include:

Breast Health Program: promotes preventive screening and offers care navigation, education, and support services for women diagnosed with breast cancer and other cancers.

Tobacco Treatment Program: includes a community program for tobacco cessation.

Worksite and Community Wellness Health Screenings: provides glucose and cholesterol testing, blood pressure checks, and body mass index calculation, as well as general health counseling for workplace and community groups.

CPR, First Aid, and Basic Life Support Training: provides individualized certification for healthcare providers (BLS), and introductory and renewal certification for community members.

Health Screenings: Visiting Nurse Association provides a comprehensive schedule of free public health screenings at various locations in the region including senior centers, Wal-Mart, and food pantries.

NBH offers a wellness coaching program specifically for our employees through our Employee Assistance Program (EAP), which includes tobacco cessation, fitness, nutrition, and stress counseling, in addition to traditional EAP programs.

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA											8,854,953	4,498,372			
Tufts											2,438,116				
HPHC															
Fallon											-	598,002			
CIGNA												692,273			
United												770,032			
Aetna												323,677			
Other Commercial											3,713,679	2,665,710			
Total Commercial											15,006,748	9,548,066			
Network Health											-				
NHP											15,343				
BMC Healthnet											5,962,678				
Fallon											455,961				
Total Managed Medicaid											6,433,982				
Mass Health											-	4,431,612			
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare												16,980,229			
Misc Other												3,199,493			
GRAND TOTAL											21,440,730	34,159,400			

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA											8,231,941	5,086,887			
Tufts											2,028,475				
HPHC															
Fallon												-			
CIGNA												859,772			
United												656,469			
Aetna												589,936			
Other Commercial											4,459,181	2,763,423			
Total Commercial											14,719,597	9,956,487			
Network Health											-				
NHP											32,294				
BMC Healthnet											5,266,248				
Fallon											700,869				
Total Managed Medicaid											5,999,411				
Mass Health												4,008,803			
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal												-			
Medicare												17,514,968			
Misc Other												3,069,686			
GRAND TOTAL											20,719,008	34,549,944			

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA											7,751,938	4,199,016			
Tufts											1,967,169				
HPHC															
Fallon												-			
CIGNA												707,710			
United												778,284			
Aetna												600,606			
Other Commercial											4,793,150	2,677,368			
Total Commercial											14,512,257	8,962,984			
Network Health											379,454				
NHP											30,889				
BMC Healthnet											4,774,242				
Fallon											444,918				
Total Managed Medicaid											5,629,503				
Mass Health												3,768,263			
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare												19,886,263			
Misc Other												3,452,815			
GRAND TOTAL											20,141,760	36,070,325			