2011 HOUSE HUMAN SERVICES

HB 1152

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1152
January 19, 2011
Job #13102

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

To provide a grant that will help sustain critical access hospitals.

Minutes: *See attached Testimonies #1 - #7*

Chairman Weisz: Called the meeting to order on HB 1152.

Rep. Bill Devlin: From District 23 introduced and sponsored the bill. (See Testimony #1.)

Rep. Bellew: The $18,000,000 is that going to be a continuing appropriation or is it a one time funding thing? How did you come up with the $18,000,000?

Rep. Devlin: This is a onetime grant. I think the case can be made for a lot more than $36,000,000. When we started out with this bill and started out with the funding, we were looking at $1,000,000 average per critical access hospitals. That $36,000,000 was cut to $18,000,000. I thought I'd do the work for appropriations because whenever you have a bill before you, you cut the funding in half. I've done that for you and think you should be able to pass it out the way it is now and everything is fine.

Rep. Vigesaa: From District 23 a co-sponsor of the bill testified in support. A couple of statistics I want to share with you. Not only do the critical access hospitals provide essential medical care for the citizens of rural North Dakota, but also have a tremendous economic impact in our communities. The Cooperstown Medical Center in my home community, they employ 165 people at which 100 are full time. Their monthly payroll is $400,000. That is $4.8 million into our community and surrounding areas on an annual basis. Just want to share that not only do they provide the very essential medical care, they also are a very important part of our economy in rural ND. I would ask for a Do Pass on HB 1152.

Sen. Randel Christmann: From District 33 a co-sponsor of bill testified in support. I didn't do written testimony as I figured most of it would be the same as Rep. Devlin's just not as well written: A lot of the discussion had to do with the need for healthcare for rural people and aging people in rural areas. These hospital people can explain it to you better. From a little bit different perspective is the energy industry whether it is coal with a little bit of oil in my area and as you go west it becomes predominantly oil and natural gas production. If

we are going to keep the energy patch going, jobs going and keep that kind of tax revenue flowing, we need healthcare out there. These are the only hospitals that are out there. Frankly, companies aren't going to be inclined to do business in an area where they have to go extreme long distances for healthcare. Worst of all, they aren't going to get the good employees that they need if there is no healthcare around. In my area where I'm most knowledgeable, the gasification plant and the state's largest coal mine are just north of Beulah and without our critical access hospital in Hazen, it's about 80 to the nearest hospital. That is too far for those kinds of high risk jobs to go for healthcare.

Rep. Lee Kaldor: From District 20, a co-sponsor of the bill testified in support. I served for several years on a hospital board in the Mayville community and have seen the struggles the critical access hospitals or small hospitals in our states have to endure. Rep. Devlin has pointed out the need and justification. One thing that has been beneficial is the basis of designation. Critical access designation has been a real help to rural hospitals in ND. We continue to be frustrated with new costs, reimbursements that are not adequate to cover the costs of operations. Most of these hospitals operate at a loss. Those losses are made up in the community generally by foundations and donations and efforts to make sure they can retain these much needed facilities. These are the core employers in many of the communities they serve and represent a real economic impact. They are more than that in terms of quality of life. People who retire and want to live in their hometowns and small communities, often times their first criteria is healthcare availability and where will they go if they need the help. I'm here today to sign on in support. Rep. Nelson and I will have to convince the Appropriations Committee, but we hope we convince the Human Services today that this is a worthy effort. Thank you. (Handed out some information. See attachment #2.)

Rep. Jon Nelson: From District 7, co-sponsor of the bill testified in support. I served on the hospital board in Rugby. The state legislature has increased Medicaid reimbursement for hospitals dramatically the last two sessions. Unfortunately for many hospitals Medicaid isn't a big part of the payer mix for those facilities. Critical access reimbursement is based on allowable cost. The costs are above the reimbursement and that causes the shortfalls. Our facility for example is approaching $20,000,000 a year revenue generated. We just integrated the clinic into our facility. We have a long term facility. Sometimes the long term facility has brought in revenue profitability, but the hospital part of it has been a drain on the system for a number of years. It is all based on recruitment efforts. Everybody in rural ND is short of family care physicians. That is what generates the business. This is not going to go away very soon. We employ over 350 in Rugby that work at the hospital and clinic combined. Two reasons why people would come into town for retirement is medical care and a good school. It is important these critical access areas have a high quality medical care to recruit people into their communities. We've all heard about the health bill that was passed in Congress last year, the frontier amendment and how much money that brought into the state. Very little if any of those dollars went to critical access hospitals. They went to the PPS hospitals in the state of which are located in the bigger cities. It is up to us to step forward if we don't there is nobody left to do it. I've heard the threat that in two years there is going to be one to three less hospitals in the state. I think we are approaching that and will see the realization of that if we don't do something real soon. Thank you.

Marlene Miller: Program director at the UND Center for Rural Health. (See Testimony #3.)

Rep. Schmidt: You indicate the economic impacts; those I assume would be benefits to the community.

Marlene: Correct.

Rep. Schmidt: Elgin is in my district. Would you be able to compare the costs to the benefits? I see the benefits, but I don't see the costs and I do not know what those are.

Marlene: Not off hand I don't, but we certainly do have that information and can get it to you.

Rep. Schmidt: I would appreciate it as I think it would help justify our position.

Rep. Nelson: You point out in your testimony that 100% of the critical access hospitals are experiencing shortage in staffing. In ND we are potentially blessed by having a medical school. When family practice graduates come out, very few stay in the state. What kind of suggestions do you have from a policy standpoint to improve that situation?

Marlene: In the last legislative session this was heavily weighed. We are number one in the nation for retaining graduates practicing rural primary care, but that number is so small and barely makes a dent to your point. Last session appropriations were set aside to help the school of medicine address some of those issues. A piece of that came to the center of rural health where we hired workforce specialists who filled a gap in terms of working with alumni that leave the state and how to get them back. Haven't had anybody in ND that has been tapped to build those relationships to bring those people back. That is a role that is now being filled however; it could take years to see the impact of that. The School of Medicine had some bills in terms of looking at options and terms of increasing the size of the medical school and how many we can pull throw there. As we look at the delivery of healthcare and the use of technology, such as telemedicine, I think that opportunities are there and patients seem to be receptive to having with a nurse practitioner or physician's assistant and if a physician is available tele whatever. There are creative solutions we are already trying to implement.

Rep. Nelson: We need to get a chance for those new positions and nurse practitioners, nurse's assistants and nurses to place them in ND first. If some of the studies I've seen are still true, if we can place them in a community for three years, the odds they will stay in that community increase greatly. That's where I think the emphasis has to be put on. When we recruit outside the state, there are 49 other states recruiting with us and some advantages socially, financially and climate wise at times that we are in a deficit with. I think it is important to start placing our UND of Medicine graduate in ND first and then they would have that flexibility. Important that the message be sent back to the UND Medical School because that will come to a head at some point and time. We need to change this soon.

Marlene: Can I react to that, even though I don't think you are asking me a question?

Chairman Weisz: You may respond.

Marlene: I should have mentioned that the med school received funding to entice medical students to stay. There are funds available for eight students I think. If they sign a commitment to practice in rural ND then their tuition is waived after a five year period which is longer than many programs have requested. That should make a significant difference. With state appropriations we have started scrubs camps which is exposing children from kindergarten through 12th grade in health careers. We require the school, hospital, EMS, public health and whoever to collaborate to create these camps locally. Over 25 camps have been held since last session.

Rep. Wieland: When it gets past policy down to our committee, there is a lot of information that I would like to see and not sure it can be provided to me. I would like to see a PML on each one of these, not the whole PML just the final number whether they made a profit or not in the last two years. $18,000,000 is still a lot of money. Also, what the use of money would be if they would get it. Assuming these grants would not exclude brick and mortar. I'd also like to know the age of that particular facility. If it is a problem to identify, I don't need to have the identification or the name of the facility if they don't want that disclosed. They could be numbered. It that information could be made available, I would like to see that.

Marlene: I'm not the person with that information, but Darrold Bertsch is speaking and he has a fair amount of that information. We could pull that together for you.

Darrold Bertsch: CEO of Sakakawea Medical Center in Hazen, ND testified in support. (See Testimony #4.)

Chairman Weisz: In your Appendix C, South Dakota has somewhat similar patient mix as ND, why is their net margin 3.32% is it because they are getting substantially higher Medicaid reimbursement rates?

Darrold: I can't speak to what SD gets in reimbursement for Medicaid. There has been a variety of studies to see what the difference is with ND? One thing we discovered and we have been advocating for the four years, is increased reimbursement from BC/BS of ND. As a provider we get paid a lot less than the other states would for BC/BS subscribers. The biggest thing that was found when this analysis was done from independent financial experts, we need to advocate with BC/BS for higher reimbursements and that will help the critical access hospitals.

Rep. Porter: Is there a differentiation in the reimbursement from BC/BS that follows the Medicare and Medicaid model that gives enhanced payment to a rural facility? Or, is it one size fits all, no matter where you would be a patient.

Darrold: BC/BS has two fee structures for facilities in ND. One is for the acute care hospitals and other for the rural facilities. Separate tiers of reimbursement there where they pay. They do pay rural facilities more.

Rep. Porter: As the percentage of reimbursement, with Medicare be at your cost plus 1%, where does the BC reimbursement fit into that ratio in comparison to your costs?

Darrold: It depends upon the size of the facility. A larger facility has more units of service and thusly have a lower cost per unit of service that they provide. Where the most struggle in ND is, is the smaller facilities located in the rural areas. We have less volume, so we have a higher cost per unit. BC doesn't cover our cost because it is higher per unit than it is for the larger facilities that have higher volume.

Rep. Porter: Looking at that fee schedule that lumps all of the rurals into one category even though their size is varied; is there a need to have three or four rural fee schedules that would more appropriately represent those different sized facilities across the state?

Darrold: That might be beneficial and has been part of our advocacy with BC. Blue Cross was paying what they define as those tweener facilities. Those that weren't real rural and those that weren't the urban acute facilities, they would have included Dickinson, Jamestown, etc. They were reimbursed in a tier in-between those two. I can't say this is the way it has been this year, but it has in the past.

Rep. Porter: Following ND Medicaid and I know they are a smaller percentage of reimbursement back to a critical access hospital, are they on a one set fee schedule or do they have the multiple fee schedule for the urban, Dickinson, Jamestown, tweener and critical access hospitals?

Darrold: Not sure about that, but someone else testifying may be able to answer that. Medicaid does pay us cost now accept for lab and clinic services.

Rep. Porter: So Medicaid would be higher than what BC would be because they are at full cost of services provided, just like Medicare is?

Darrold: They could be. It depends on the size of the facility.

Rep. Porter: I agree with you overall. CAHs are having trouble, but I look at HB 1152 and talk about reimbursements all we want, but this bill isn't even dealing with that. It is dealing with grants with equipment or infrastructure. If is is only onetime funding we can't put it into patient care unless there is going to be an untweaking of the bill. I sympathize with you, but I question whether 1152 is going to help and what you are going to buy is infrastructure or improvements or equipment. I don't see 1152 helping. You can't get a federal match with these general dollars so you are just getting a grant for four or five hundred thousand dollars. Am I looking at this bill wrong?

Darrold: It will not specifically or directly help with the financial statement of operations, but what we think it can do to help us is, it will free up the money we can use for operations and invest in staff and education and those kinds of expenses that we have. If we have the support through these grant dollars to purchase equipment and to make facility improvements that are needed, we'll have resources available then to expend and to hopefully make our bottom line better.

Rep. Pollert: I understand that, so this can't be onetime funding then.

Darrold: If we all had our way as critical access hospitals, we'd like it to be more, but it is my understanding that this is a onetime request for funding that would significantly help. In my case for example, it would help us replace the windows that desperately need to be replaced. We could purchase key equipment that we need and payoff our boiler and we need to replace our generator. It would help solidify our infrastructure so it will still help us significantly.

Rep. Paur: In my district 19 the Northwood hospital needs to redo their heating system and the cost to that would be a million dollars. The energy savings would over time pay for that system, but they cannot get the million to replace the system. In that instance it would be a double benefit. It would get the system and free up working capital because of the reduced costs.

Rep. Nelson: What is your Medicaid mix in your facility?

Darrold: We have a small Medicaid mix, maybe 10%.

Rep. Nelson: This bill is definitely an attention grabber. It certainly has gotten everybody looking at critical access hospitals from a needs based situation. For your facility, would we be better off, giving you a onetime shot in the arm so you can replace your windows or whatever else you are looking at? Or, would you rather that we work with reimbursement issues? That would be an ongoing revenue source for you if we went there. On the choice of one of the two, which would you prefer?

Darrold: Today, I would rather have the grant funding so we make some of the enhancements and improvements that we need to make. Three years from now, I'd probably have a different opinion, but I will still have the need to replace the facility enhancements that I need to do three years from now. Either we don't have the cash or the ability to borrow money to replace some of these things.

Rep. Nelson: If you had increased and improved reimbursements, wouldn't that allow that margin to exist for you? Would you have more access to funding sources, whether it be loans, profitability of the plant and as a critical access to the hospital?

Darrold: I think in a facility such as ours, the enhanced Medicaid reimbursement will help to the tune of maybe 10 to 20 thousand dollars a year. It pales in comparison to grant money we could get to do some of these major things. Some facilities in the state may have 5% Medicaid.

Rep. Nelson: Is there another area of improved reimbursement that you could look at other than that particular area that would be a source of ongoing revenue that would be helpful to your situation in Hazen?

Darrold: I can assure you that not only to benefit Hazen, but across the state, we will continue to advocate with BC/BS and we do that quarterly every year. We have met with the Insurance Commissioner and the Governor in the past and will continue that advocacy

to get enhanced reimbursement from BC/BS and raise awareness of the concerns. The other thing we are going to do is take this message to the Association of Counties and the cities so they understand the need for financial support in the rural communities. All the communities are going to have to step to the table and help out their local hospital if they want to sustain them.

Rep. Louser: What does the exemption from the perspective payment system mean?

Darrold: I'll use an example. If I'm a Medicare beneficiary and have pneumonia and I go into St. A's or Med Center, that facility is going to get paid a perspective payment rate. It is determined based on labor costs, etc. That facility might get paid $2,000 for that pneumonia stay that I had. Whether I'm in the hospital 2 days or 7 days that facility will get paid $2,000. If you go to a critical access hospital, we are exempt from that type of reimbursement. They reimburse us based on cost. If I go into the hospital in Hazen and am on Medicare, if I'm there 3 days the hospital is going to get paid 3 days times $11,000 that is the ND rate. It is based on the number of days I am there and that comes from the cost that it took to provide care to me.

Rep. Porter: On your appendix E as it flows through time, it appears that the operating margins have substantially increased over time up to the 2009 number of the $100,000 loss. Then you go down to the $174,000 loss. How are those revenues shortfalls made up so that facility keeps their door open? Are you having funded depreciation funds and then not doing any projects so that you are falling behind? At the end of the day you have to come out zero because you can't be -$1.00 and still operate.

Darrold: Most facilities are minimizing some of the losses by not doing some of the needed improvements that they need. From a cash flow perspective, if you look at cash flow, which is different than the bottom line of the financial statement; as long as you have less of a loss than our depreciation expense, we can still cash flow. It limits our ability to invest in our facilities again.

Rep. Porter: Last legislative session we had a transfer of funds from the bank of ND to the health information technology group to cover or start the IT process. I think it was around $5,000,000. How did that play into your facility as far as building out that infrastructure in healthcare technology?

Darrold: Our facility specifically did not access those loan funds. We had loans in place from before I got there for the basic infrastructure that we had for IT. I know a lot of facilities did access it and found it helpful as well, but again it was loan funds.

Rep. Porter: Look at the programs already available in the state of ND from the personnel standpoint of loan repayment programs for dentists, doctors and nurses and the IT projects. A couple of sessions ago I had introduced a bill on the medical pace program to use dollars through the formation of a program with the Bank of ND. It was to provide low interest loans to cover some of the infrastructure expenses so that the facilities were still responsible for making sure they had good management and good business skills, but had the ability to access a lower interest loan. Now we were told during those hearings, even though this kind of expanded because it did talk about some of the IT project. Then we gave

$5,000,000 for those last session. The medical pace program, inside of the existing flex pace program and regular pace program because of the jobs created inside of those communities; some of those dollars are available to the healthcare community to do some of what is being explained in this bill. As we look at this model of a straight grant type program or the enhancements that are already out there, we need to see what is all available today in programs between the IT, loan repayment programs and the enhanced Medicaid reimbursements we did last session for just rural facilities. At any enhancements that could be made to allow access to those interest buy downs for the facilities. I personally think that would be money better spent to enhance our existing programs than to go with a one-time grant and then take it away. The long term survivability also comes with something that is sustainable in those programs so the facilities can access them as they need them.

Chairman Weisz: We will get that information. We will recess until 2:00 p.m.

Chairman Weisz: Called the hearing back to order.

Pete Antonson: CEO, Northwood Deaconess Health Center testified in support. (See Testimony #5.)

Rep. Devlin: It was mentioned this morning that the frontier amendment I think it was called. Can you tell me what benefits that brought to your facility?

Pete: The health reform bill did nothing for the critical access hospitals of ND. There was significant funding for the urban hospitals in the bigger communities like Minot, Fargo, Bismarck and Grand Forks. There is nothing in there for the rurals to identify. There is no increased reimbursement. We are really just dealing with the side effects of it which are a whole lot of paper work and increased potential costs to our health insurance and whole lot of other things. In my opinion, we got nothing out of it.

Rep. Paur: I'd like to make the comment that both my father and my sister made use of the Northwood hospital and it was an exemplary experience. That is a fantastic place and I'd hate to see anything threaten that.

Rep. Schmidt: I sit on another 501C3 and we have a loan from USDA Rural Development and we must maintain a high level of reserves in which we can draw. And we use those funds to do some of our improvements on our water system. Do you not have the same opportunity?

Pete: We are required to have a reserve as part of our USDA loan. Right now they are not allowing us to access it for this project. And it really wouldn't take care of this project. We have about $300,000 in our reserve and the funding requirement as part of that loan is $600,000. We are deficient by $85,000 from what our schedule is. We are supposed to up to $385,000. Because of cash flow we have been unable to fund that. At this point they have not offered that as an option for us to have.

Rep. Kaldor: In your hospital, what are your uncollectible accounts as a percent of your services provided?

Pete: Uncollectible accounts, I think on average we are 3-5% per year for collection agency and charity care. It fluctuates from year to year.

Rep. Kaldor: How much in charity care are you providing in addition to that.

Pete: We budget for charity care and set a target of $30,000 a year. We don't turn anyone away because they can't pay.

Rep. Kaldor: What does the 3-5% come out to in dollars?

Pete: That would be between $75,000 - $120,000.

Rep. Porter: I'm confused on the frontier amendment provisions for Medicare. The critical care access hospitals were already getting a 100% of costs for Medicare? So the frontier amendment didn't do anything because you already had a 100% of your cost.

Pete: That is correct. Remember what was brought up earlier. It was our allowed cost and there are costs that are not allowed from Medicare physician recruitment cost, advertising, cable television, telephone costs in a room. Generally those costs run anywhere from 2-5%. That is a broad range.

Rep. Nelson: Is your clinic owned by the doctors in town and they operate the clinic?

Pete: It is owned by an independent clinic group that is a non-profit organization called Valley Community Health Center.

Rep. Nelson: Who runs the ER?

Pete: The hospital.

Rep. Nelson: You have a physician contracted and a physician's assistant?

Pete: Position from mid levels of the Valley Community Health group, they provide our coverage for our ER and hospital.

Rep. Nelson: Given your location and close proximity of church area center, I'm interested in your contract whether it is contract nursing and how much of a strain on your budget is that portion of your business?

Pete: Locums hasn't been our significant strain. Our local clinic does provide coverage for our emergency room on the weekends. However, we do pay for and contract for that separately. When I think of the term locum, I think it of it as our (inaudible) coming from 50 or a hundred miles away. They are all based out of Northwood, but we do pay for that weekend coverage. The cost to our budget is about $200,000 a year.

Rep. Nelson: The emergency room isn't a revenue producer necessarily. How about contract nursing, do you have to use some contract nursing in your nursing home and in on the floor?

Pete: Yes we do use contract nursing. We have done a number of things to try and minimize that and have seen a significant reduction in that. We have hosted an LPN training program right in Northwood and helped nurses to go back to school and become RNs. We have instituted signing and retention bonuses for nurses. We have cut our annual agency cost from $250,000 a year to $65,000 to $70,000 a year. We'd like to see it be zero, but it is a process.

Rep. Nelson: What are the averages of losses in your facility in the last 3 or 4 years?

Pete: Our approximate operating losses for the last 3-4 years has probably averaged about $100,000 per year.

Cathy Swenson: A nurse and CEO of Nelson County Health System in McVille, ND testified in support of the bill. (See Testimony #6.)

Rep. Nelson: Can you tell me in relation to your facility, do you have any life safety deficiencies that you need to address in your facility?

Cathy: We should actually move our oxygen tank outside. We can't afford to do lights downstairs (in audible). We separated our building during a life safety course and asked them to take this portion of our building with only 74 addition because in the 1957 modernization, it is only business office (inaudible). So right now we don't, but it depends on the surveyor who might come in. Do I have sprinklers? Yes I do.

Rep. Nelson: You have a nursing home as well, right?

Cathy: Yes. People ask if I can get a loan. I can get a loan and we have paid off all the loans on the hospital. Can I make a loan payment? No. I wouldn't have enough income to make the loan payments.

Rep. Nelson: Do you get any public support for your hospital through county mil levy support?

Cathy: No. My support comes from the foundation that raises money. We don't have a hospital district or any of that.

Rep. Nelson: Do you have any knowledge to how many critical access hospitals in the state do draw from (drops sentence).

Cathy: I think there are two health districts. One is Linton and one is Griggs County in Cooperstown.

Rep. Nelson: I think Towner County is another one.

Cathy: I don't think they are a health district though. They may have a special appropriations.

Tim Blasl: Vice-President of the North Dakota Hospital Association presented Testimony for Jerry Jurena the President of the NDHA. (See Testimony #7.)

No Opposition

Chairman Weisz: Closed the hearing on HB 1152.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1152
February 1, 2011
Job #13820

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Rep. Devlin do you have some information on 1152?

Rep. Devlin: What is coming in tomorrow and appropriations is aware of this, is a proposal that any critical access hospital that has lost money two out of the last three years in the Medicaid cost report would be eligible for a grant not to exceed $200,000. The critical access hospital that does not qualify in other words has made money two of those three years would qualify for a grant not to exceed $100,000. The two long term acute hospitals could also be eligible for the up to $100,000. We removed improvements, basic care needs and basic care equipment needs and went to extraordinary expenditures, deferred measures such as, major building repairs, onetime capital purchases in energy efficient upgrades. Essentially every hospital in the state other than the 6 in the large cities, who got money under the frontier amendment, would be eligible for grants up to $100,000 or $200,000. I think there were about 24 of them that lost money two of the last three years. The FN now is 6.2 and then we put $300,000 because we weren't sure exactly how it was going to break out on the people managing, the grant process. There will be a little left over. If nothing else, I've done the work of the Appropriations Committee by cutting the bill from $36,000,000 to $18,000,000 down to $6,000,000; one-sixth of where I started.

Chairman Weisz: Ok Committee, so that you are aware that is what is out there. We are adjourned.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1152
February 2, 2011
Job #13837

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Called the meeting to order on HB 1152. Are there any possible amendments? (See attachment #1.)

Rep. Devlin: The grants will go to all of the hospitals except the 4 large ones. They got the frontier amendment dollars, the Veteran's Home and the State Hospital. We did changes on quality of care issues. We were more interested in them being able to use the money for building repairs and capital purchases and energy efficient upgrades which is on page 1, line 16. We removed the $500,000 for recipient and went to two different levels of grants. (Read from amendment under a, b and c.) The fiscal note came to 6.2 million after we did that. I talked to Rep. Nelson from Appropriations and we put the six five into cover the cost of ND Hospital Association doing the work on it. That is the amendments to the bill and I move the amendments.

Rep. Kilichowski: Second.

Chairman Weisz: On subsection C, can you explain the difference on a long term care acute hospital?

Rep. Devlin: I can't, but Rep. Porter maybe can. There are two long term acute hospitals. One in Mandan and Fargo that don't fall under the critical access hospital and are kind of by themselves. We wanted to include all the hospitals except the ones that got money from the frontier amendment.

Rep. Porter: They are the patient that the Medicare payment system stops while the patient is still in the hospital. They still require an acute level of long term care that isn't available from a skilled nursing facility such as ventilator, wound care, IV antibiotics, and IV medications. They are outside of both systems and this is an in-between stomping grounds for that patient when they aren't sick enough to be in an acute care facility, but not well enough to be in a long term care.

Rep. Holman: Rep. Porter, does that differentiate from what we commonly call swing bed?

Rep. Porter: Yes it does. There is another level called a transitional care bed and they aren't at this level. This is a step up.

Chairman Weisz: Is this any different than the reimbursement? How does that work as far as third party?

Rep. Porter: That I am not totally sure on. The way the Medicare system is developed, the hospitals can't keep them because they would lose money so the patient is discharged to the long term acute facility. But, I'm not sure how the reimbursement changes back and forth between the two. I know there is a penalty for the acute care facilities for keeping that patient once they reached the end of their payment schedule, the DRG.

Rep. Conklin: What is DRG?

Rep. Porter: It is diagnostic related group. If they are cued into say pneumonia, then with that diagnostic related group pneumonia, then there are so many days available for simple complex pneumonia. Once they reach the end of that, if the diagnosis hasn't changed, a lot of times Medicare is done paying for it.

Voice Vote on amendment: Motion Carried.

Rep. Devlin: I'm not prepared with an amendment at this time, but I'd be the first to admit there is a lot more to this than just providing them with funds at this time. If we ever talk about doing a study that is more than a meaningless study that so many in the interim are, this would be an area we need to do that with. If this bill gets out of committee we will make the case for that at Appropriations along with possibly some other changes, but I'm not prepared to offer it on this bill at this time.

Rep. Devlin: Motion a Do Pass as Amended and rerefer to Appropriations.

Rep. Holman: Second.

Rep. Devlin: June Hermann handed you her packet today and one of them is the ND hospitals and referral centers, if you have that and want to pull it out. To me it speaks volumes to what we are trying to do here. If ND is going to be a viable state and have economic development in all areas of the state, not just the four larger cities, but the rural areas as well; have economic development that doesn't just relate to oil fields, we have to provide access to healthcare across our state and keep what is there. This may be just the nose under the tent, the way it was put four years ago. I know we need to do more than just give them this check at this time, but I also give us a two year window to address reimbursement and many other things that would help rural hospitals survive. To me it is just unfathomable that we would sit as a state and not do everything we could to make sure the people in small communities have the same access of quality healthcare facilities as we do in Grand Forks, Fargo, Minot and Bismarck. I believe this money is vital to their needs at this stage. Everyone of the twenty-four critical access hospitals lost money last year. Some was of that money was lost because they didn't have the energy efficiencies they should have had. Some of this money can be used to fix this. Some of the money would be used to improve their IT system which will save them personnel money. I would much rather be dealing with a $1,000,000 per hospital because I think I could justify that for everyone of you them. That is not the cards I am being dealt. I know that besides the

access to healthcare, to me this is a rural economic development issue. Everyone of these, this is their biggest employer, I would hazard to guess. If we were dealing with a loss of the biggest employer in a major city in this town, if we weren't in session, we would be in special session to see what we could do to help them. I think the time has come for us to step forward. This is not only a healthcare issue, it is an economic development issue. It's critical to the citizens of our state and we need to pass this bill out of here. Rep. Porter has some great ideas on some other things we could do to improve this bill, but I think it needs to be done in Appropriations. I would ask this committee to give this bill a do pass rereferred to Appropriations and let me take my chances there.

Chairman Weisz: I agree a 100% with Rep. Devlin that access is critical throughout the state. The issue I have when I look at this bill, I don't think it addresses the problem that we are seeing now in that access from the hospital end. It's obvious they could use that money, but does it address the problem. The issue I see is we give them a band-aid; then the easiest solution is to just increase to size of the band-aid instead of again the underlying issues that are there and will have to address if we want to keep those hospitals on the map viable.

Rep. Anderson: I know in Rugby's case I'm involved with a bunch of different businesses there. When we are within twenty minutes of a medical facility, the insurance rates for those companies doing business in Rugby, they lower them. It is hard to attract any industry to these small areas if you don't have a hospital. In Rugby's case, the hospital is starting to make money and I think we have turned the corner there. I know they need some money for IT. Our problem is a lack of physicians.

Rep. Porter: This is a difficult issue for the state. We have lost hospitals in the past. The reimbursement system from the government is not a very good picture of what the true cost of operating the facility represents. The biggest problem with federal government is they always take the approach one size fits all and never looked at regions or individual needs. I don't agree with the concept of this bill. I don't think our responsibility is a straight out grant program whether a facility is making it or not. If this bill went to the floor the way it looks, I would not support it. There's not involvement from the community or due diligence to make sure a facility is even sustainable to the point of taking the grant dollars available and then pushing them back out. I am willing to support Rep. Devlin's motion to take this to Appropriations for one reason; that it will give the concept of something that needs to be looked at to the Appropriations folks and will open up doors for low interest loan type programs from the Bank of ND. Also give the sponsor the time to draft the language to present to Appropriations with a funded study to look at the reimbursement system, the volumes out there and the things we haven't had a chance to look at to see if they can be plugged into the bill. I would offer that to Senate to Approps to allow that on-going discussion. If it came out of Approps in this form, I would be the first person to vote no on the floor and stand up and talk against it. I think some of those other concepts are viable and are needed and will give the sponsor the time to put those together and work with it. I give the full disclosure that I would never support this kind of band-aid approach. It needs to be a comprehensive plan that comes out of there that has community buy-in, viability attached to it and has a look at the reimbursement structures and the co-pays and the other complex situations that the Approps folks deal with. I think it deserves a chance to be

looked at in Approps before it would either be hog housed into something else or die on the floor.

Rep. Damschen: I'm torn on this one and I tend to agree with Rep. Porter and his feelings. Along those lines, can you give us the best and the worst we can expect if this went to Appropriations.

Chairman Weisz: They can send it out with a do not pass. They could take half of the money out and leave just as is. They could strip everything out and put a study in it.

Rep. Damschen: Let me rephrase the question and ask the bill sponsor what is his best hopes if it does go to Appropriation?

Rep. Devlin: I think if we can get it to Appropriations we can probably get more of a long term plan that would benefit the critical care access hospitals and the other hospitals in the state based on ideas Rep. Porter has.

Rep. Schmidt: I too am torn as having a critical care hospital in Elgin. They did make a profit last year so I forwarded the e-mail to some of you. I didn't understand how made this and being a neophyte in this, I apologize not having enough experience to make a sound decision. My thoughts are if this is a problem of volume, patient paying their fair share, hospital management, or mission creed, it doesn't help. I don't know what the problem is. Because I don't know what the problem is, I'm not willing to put this bill down at this time. I think it needs to carry so at least I myself can make a good sound decision for my constituents. Because right not I can't.

Rep. Louser: I took some notes early on in the testimony and I guess I'm going to piggyback on the neophyte, so that is where this question is coming from. I'm just wondering are there similar grants in the past that the Dept. of Health has administered where it was determined through the process that the recipient wasn't using the grant money appropriately or was inconsistent with the purpose? Was it ever refunded? Has that every happened where a grant has been given and then we followed up to say it was used inconsistent with the purpose?

Chairman Weisz: You would assume that has happened, but I'm not aware of any instances.

Vote: 9 y 4 n Do Pass As Amended and Rereferred to Appropriations Carried

Bill Carrier: Rep. Devlin

FISCAL NOTE

Requested by Legislative Council
02/15/2011

Amendment to: Engrossed HB 1152

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,926,259		
Expenditures			$1,527,802	$1,926,259		
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amended Bill provides for Medicaid supplemental payments to critical access hospitals.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The amended Bill provides for Medicaid supplemental payments to critical access hospitals for which the Department of Human Service will seek federal approval and medicaid funding to support the supplemental payments.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenue in the 11-13 biennium is the additional federal funding the State will receive due to the Medicaid supplemental payments being made to critical access hospitals.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

It is estimated the Medicaid supplemental grant payments to critical access hospitals will cost $3,429,061 of which $1,515,302 is general fund and $1,913,759 is federal funds for the 11-13 biennium.

It is also estimated that a vendor contract will be needed at a cost $25,000, with $12,500 being general fund, to calculate the supplemental payment amounts for each critical access hospital.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The amended Bill provides the Department of Human Services with a total appropriation of $3,454,061 of which

$1,527,802 is general fund and $1,926,259 is federal funds for the 11-13 biennium.

Name:	Debra A. McDermott	**Agency:**	Dept of Human Services
Phone Number:	701-328-3695	**Date Prepared:**	02/15/2011

FISCAL NOTE

Requested by Legislative Council
02/04/2011

Amendment to: HB 1152

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$112,529		$55,265	
Appropriations			$112,529		$55,265	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for grants to critical access hospitals through a contract with the ND hospital association to administer the grant under the oversight and review of the Department of Health.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill requires the department to contract with the hospital association, to monitor the grant program for 36 or more projects, review periodic reports for the 36 or more projects and post award reports for the 36 or more projects, distribute the funds, monitor the appropriate use of funds, and require the return of funds that were not used appropriately from grantees.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

FY 2011-2013
The department will require a .5 temporary employee for the biennium to provide the management and oversight to the ND hospital association as well as the oversight to the grant program applicants identified in section B of this fiscal note. Salary and benefits for the .5 temporary employee is $91,979 and associated operating costs of $20,550 for a total cost to the department of $112,529 during the FY 2011-2013 to implement and monitor this grant program.
FY 2013-2015
It is anticipated that many of the projects will include remodeling or new construction which will not be concluded by the end of the 2011-2013 biennium. To provide the follow-through by the department as required by this bill, the department will need the .5 temporary employee to continue to provide the oversight to the third party and the other oversight to the grant program applicants identified in section B of this fiscal note until such time as the projects are completed, including determination by the department that the funds were used appropriately or require return of the

funds by the grantees. Salary and benefits for the .5 temporary employee for the first year of the FY 2013-2015 biennium is $45,990 and associated operating costs of $9,275 for a total cost during the FY 2013-2015 biennium of $55,265 to complete this work.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Funds for this project are not included in the Department's appropriation bill (HB 1004). The Department will need an appropriaiton for these funds to carry out this project.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	02/07/2011

FISCAL NOTE

Requested by Legislative Council
01/22/2011

Bill/Resolution No.: HB 1152

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$112,529		$55,265	
Appropriations			$112,529		$55,265	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for grants to critical access hospitals through a contract with a third party to administer the grant under the oversight and review of the Department of Health.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill requires the department to contract with a third party, to monitor the grant program for up to 36 projects, review periodic reports for the 36 projects and post award reports for the 36 projects, distribute the funds, monitor the appropriate use of funds, and require the return of funds that were not used appropriately from grantees'.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

FY 2011-2013
The department will require a .5 temporary employee for the biennium to provide the management and oversight to the contract third party as well as the oversight to the grant program applicants identified in section B of this fiscal note. Salary and benefits for the .5 temporary employee is $91,979 and associated operating costs of $20,550 for a total cost to the department of $112,529 during the FY 2011-2013 to implement and monitor this grant program.
FY 2013-2015
It is anticipated that many of the projects will include remodeling or new construction which will not be concluded by the end of the 2011-2013 biennium. To provide the follow-through by the department as required by this bill, the department will need the .5 temporary employee to continue to provide the oversight to the third party and the other oversight to the grant program applicants identified in section B of this fiscal note until such time as the projects are completed, including determination by the department that the funds were used appropriately or require return of the

funds by the grantees. Salary and benefits for the .5 temporary employee for the first year of the FY 2013-2015 biennium is $45,990 and associated operating costs of $9,275 for a total cost during the FY 2013-2015 biennium of $55,265 to complete this work.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Funds for this project are not included in the Department's appropriation bill (HB 1004). The Department will need an appropriaiton for these funds to carry out this project.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	01/31/2011

11.0346.02001
Title.03000

Prepared by the Legislative Council staff for
Representative Devlin
January 31, 2011

VR
2/2/11

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1152

Page 1, line 1, remove "critical access"

Page 1, line 3, remove "**CRITICAL ACCESS**"

Page 1, line 4, remove "a third"

Page 1, line 5, remove "party, such as"

Page 1, line 5, remove the second comma

Page 1, line 6, remove "critical access"

Page 1, line 10, remove "must be a critical access"

Page 1, line 11, replace "hospital in the state which has" with "may"

Page 1, line 11, after "not" insert "have"

Page 1, line 15, remove "quality of care issues, which may include facility"

Page 1, line 16, replace "improvements, patient care needs, and patient care equipment needs" with "extraordinary expenditures and deferred maintenance, such as major building repairs, one-time capital purchases, and energy efficiency upgrades,"

Page 1, line 18, replace "A grant award may not exceed five hundred thousand dollars per recipient." with "In order to qualify for a grant under this section, an applicant:

a. Must be a critical access hospital that has experienced a loss based on at least two of the previous three years of medicare costs reports in order to qualify for a grant not to exceed two hundred thousand dollars;

b. Must be a critical access hospital that does not qualify under subdivision a in order to qualify for a grant not to exceed one hundred thousand dollars; or

c. Must be a long term care acute hospital in order to qualify for a grant not to exceed one hundred thousand dollars.

5."

Page 2, line 5, replace "5." with "6."

Page 2, line 10, replace "$18,000,000" with "$6,500,000"

Page 2, line 12, remove "critical access"

Renumber accordingly

Date: 2-2-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1152

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Kilichowski

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion Voice Voice Carried

Date: 2-2-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1152

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Holman

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ		✓	REP. CONKLIN	✓	
VICE-CHAIR PIETSCH		✓	REP. HOLMAN	✓	
REP. ANDERSON	✓		REP. KILICHOWSKI	✓	
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD		✓			
REP. LOUSER		✓			
REP. PAUR	✓				
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 9 No 4

Absent _____

Floor Assignment Rep. Devlin

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1152: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (9 YEAS, 4 NAYS, 0 ABSENT AND NOT VOTING). HB 1152 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "critical access"

Page 1, line 3, remove "**CRITICAL ACCESS**"

Page 1, line 4, remove "a third"

Page 1, line 5, remove "party, such as"

Page 1, line 5, remove the second comma

Page 1, line 6, remove "critical access"

Page 1, line 10, remove "must be a critical access"

Page 1, line 11, replace "hospital in the state which has" with "may"

Page 1, line 11, after "not" insert "have"

Page 1, line 15, remove "quality of care issues, which may include facility"

Page 1, line 16, replace "improvements, patient care needs, and patient care equipment needs" with "extraordinary expenditures and deferred maintenance, such as major building repairs, one-time capital purchases, and energy efficiency upgrades,"

Page 1, line 18, replace "A grant award may not exceed five hundred thousand dollars per recipient." with "In order to qualify for a grant under this section, an applicant:

a. Must be a critical access hospital that has experienced a loss based on at least two of the previous three years of medicare costs reports in order to qualify for a grant not to exceed two hundred thousand dollars;

b. Must be a critical access hospital that does not qualify under subdivision a in order to qualify for a grant not to exceed one hundred thousand dollars; or

c. Must be a long term care acute hospital in order to qualify for a grant not to exceed one hundred thousand dollars.

5."

Page 2, line 5, replace "5." with "6."

Page 2, line 10, replace "$18,000,000" with "$6,500,000"

Page 2, line 12, remove "critical access"

Renumber accordingly

2011 HOUSE APPROPRIATIONS

HB 1152

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Committee
Roughrider Room, State Capitol

HB 1152
2/10/11
14360

☐ Conference Committee

Committee Clerk Signature Meredith Traeholt

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide for a hospital grant; and to provide an appropriation.

Minutes: You may make reference to "attached testimony."

Chairman Delzer: Opened discussion on HB 1152. The title was read.

Representative Nelson: This originally provided for grant payments to critical access hospitals. The hearing on this bill was a joint meeting between House Human Services Committee as well as our Human Resource section. Of the 36 critical access hospitals in the state, 24 are losing money. A grant program to distribute, across the board, doesn't show the need that came out in the hearing. Another thing with a grant is that it doesn't correct the problem, it's a one-time infusion. The lab and CRNA coverage is limited by Medicare, and this amendment I'm proposing, .03001, provides critical access hospitals a supplemental payment for lab and CRNA coverage. This would be an across the board, ongoing payment, that would take hospitals up to the true cost in these two areas. This amendment will take that issue off the board and this will become part of the Medicaid state policy in subsequent bienniums. It's a $1.527 million appropriation that will be necessary for this, but it does meet the needs of the original intent, and the prime sponsor is aware of the amendment and supportive of it. This will help facilities, and it's a small step in the right direction to correct those inequities that occur when Medicaid utilization is greater in some rural facilities. See attachment 1. I move amendment .03001 be adopted.

Representative Pollert: Second.

Chairman Delzer: We have a motion and a second to amend HB 1152 with amendment .03001. If this passes, we'll have to make sure in the second half the funding for DHS is within the budget. Last session I think we had a supplemental payment just for the Rolla hospital, and that will not have to be made if this passes.

Representative Nelson: That is correct on both accounts, the situation in Rolla is covered by this amendment, and the appropriation would need to take place in the Human Service budget.

Chairman Delzer: Questions or discussion by the committee.

Representative Pollert: Last session's $400,000 for Rolla, that is not in the current DHS budget. I know there was going to be an amendment coming forward to provide some funding to them, so that wouldn't need to happen if we pass this bill. I support the amendment.

Vice Chairman Kempenich: Where is the $1.9 million on the federal side coming from?

Representative Nelson: It is from CMS, it is part of FMAP. That's the other aspect of this amendment, it leverages federal dollars. The numbers on attachment 1 are for one year.

Chairman Delzer: The total 11-13 cost is 1454. Further discussion on the motion to amend?

Representative Kaldor: Are those FMAP dollars, dollars that are not or will not be utilized in any other way?

Chairman Delzer: FMAP is whatever we spend, we get that percentage back, so it does not affect any current appropriation and won't take away from anyone else.

Representative Bellew: If we pass this, what effect will it have on the numbers on attachment 1? Will these critical access hospitals get the money we pass, plus this money?

Representative Nelson: As it stands today, there's only one hospital in the state that gets a supplemental payment. This would be inclusive to all critical access hospitals.

Chairman Delzer: The bill before us has a $6.5 million appropriation in it; the amendment would replace it with this.

Representative Bellew: What's the white sheet for then?

Chairman Delzer: It shows which hospitals the amendment goes to. Further discussion on motion to amend? Motion carries by voice vote. HB 1152 is before us, amended.

Representative Nelson: I move Do Pass as Amended on HB 1152.

Representative Pollert: Second.

Chairman Delzer: We have a motion and a second for Do Pass as Amended on HB 1152. Roll was called. Motion carries 21-0. Representative Nelson will be the carrier.

FISCAL NOTE

Requested by Legislative Council
02/04/2011

Amendment to: HB 1152

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$112,529		$55,265	
Appropriations			$112,529		$55,265	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for grants to critical access hospitals through a contract with the ND hospital association to administer the grant under the oversight and review of the Department of Health.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill requires the department to contract with the hospital association, to monitor the grant program for 36 or more projects, review periodic reports for the 36 or more projects and post award reports for the 36 or more projects, distribute the funds, monitor the appropriate use of funds, and require the return of funds that were not used appropriately from grantees.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

FY 2011-2013
The department will require a .5 temporary employee for the biennium to provide the management and oversight to the ND hospital association as well as the oversight to the grant program applicants identified in section B of this fiscal note. Salary and benefits for the .5 temporary employee is $91,979 and associated operating costs of $20,550 for a total cost to the department of $112,529 during the FY 2011-2013 to implement and monitor this grant program.
FY 2013-2015
It is anticipated that many of the projects will include remodeling or new construction which will not be concluded by the end of the 2011-2013 biennium. To provide the follow-through by the department as required by this bill, the department will need the .5 temporary employee to continue to provide the oversight to the third party and the other oversight to the grant program applicants identified in section B of this fiscal note until such time as the projects are completed, including determination by the department that the funds were used appropriately or require return of the funds by the grantees. Salary and benefits for the .5 temporary employee for the first year of the FY 2013-2015

biennium is $45,990 and associated operating costs of $9,275 for a total cost during the FY 2013-2015 biennium of $55,265 to complete this work.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Funds for this project are not included in the Department's appropriation bill (HB 1004). The Department will need an appropriaiton for these funds to carry out this project.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	02/07/2011

VK
2/11/11

11.0346.03001
Title.04000

Prepared by the Legislative Council staff for
Representative J. Nelson
February 4, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1152

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for medicaid supplemental payments to critical access hospitals; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAID SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The department of human services shall provide a medicaid supplemental payment to critical access hospitals. The department shall seek federal medicaid funding to support the supplemental payments.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,527,802, or so much of the sum as may be necessary, and from federal funds, the sum of $1,926,259, or so much of the sum as may be necessary, to the department of human services for the purpose of providing medicaid supplemental payments to critical access hospitals under section 1 of this Act, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

Date: 2/10
Roll Call Vote #: 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1152

House Appropriations Committee

Legislative Council Amendment Number 11.8146.03001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Nelson Seconded By Rep. Pollert

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer			Representative Nelson		
Vice Chairman Kempenich			Representative Wieland		
Representative Pollert					
Representative Skarphol					
Representative Thoreson			Representative Glassheim		
Representative Bellew			Representative Kaldor		
Representative Brandenburg			Representative Kroeber		
Representative Dahl			Representative Metcalf		
Representative Dosch			Representative Williams		
Representative Hawken					
Representative Klein					
Representative Kreidt					
Representative Martinson					
Representative Monson					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

.03001 to provide for medicaid supplemental payments to critical access hospitals

Voice vote carries

Date: 2/10
Roll Call Vote #: 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1152

House Appropriations Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Nelson Seconded By Rep. Pollert

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X		Representative Nelson	X	
Vice Chairman Kempenich	X		Representative Wieland	X	
Representative Pollert	X				
Representative Skarphol	X				
Representative Thoreson	X		Representative Glassheim	X	
Representative Bellew	X		Representative Kaldor	X	
Representative Brandenburg	X		Representative Kroeber	X	
Representative Dahl	X		Representative Metcalf	X	
Representative Dosch	X		Representative Williams	X	
Representative Hawken	X				
Representative Klein	X				
Representative Kreidt	X				
Representative Martinson	X				
Representative Monson	X				

Total (Yes) 21 No 0

Absent 0

Floor Assignment Rep. Nelson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1152, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (21 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1152 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for medicaid supplemental payments to critical access hospitals; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAID SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The department of human services shall provide a medicaid supplemental payment to critical access hospitals. The department shall seek federal medicaid funding to support the supplemental payments.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,527,802, or so much of the sum as may be necessary, and from federal funds, the sum of $1,926,259, or so much of the sum as may be necessary, to the department of human services for the purpose of providing medicaid supplemental payments to critical access hospitals under section 1 of this Act, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

2011 SENATE HUMAN SERVICES

HB 1152

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1152
3-2-2011
Job Number 14867

☐ Conference Committee

Committee Clerk Signature PAMorrison

Explanation or reason for introduction of bill/resolution:

To provide for Medicaid supplemental payments to critical access hospitals; and to provide an appropriation.

Minutes: Attached testimony.

Senator Judy Lee opened the hearing on HB 1152.

Representative Bill Devlin (District 23) introduced HB 1152. Attachment #1

Senator Judy Lee asked what the mileage needs to be between hospitals in order to be deemed critical access.

Rep. Devlin replied that it needs to be 35 miles.

Representative Jon Nelson (District 7) explained that HB 1152 started out as a grant to the 36 critical access hospitals in the state with a price tag of 18 million dollars. It's important to note that 24 of those 36 lose money. (Attachment #2) Appropriations looked at Medicaid utilization for some hospitals and the lack of cost payment for lab and CRNA coverage. The amendment in appropriations changed this bill to a supplemental for cost payment for all critical access hospitals. It had the full support of the sponsors and it met the approval of the Appropriations Committee in the House and on the floor.

Senator Judy Lee asked if there was a state match for the federal dollars for the supplemental payment.

Rep. Nelson replied that it is part of the FMAP.

Senator Tim Mathern asked if this match from the federal government was available at the time the Governor's budget was prepared. Was it not requested or just not available?

Rep. Nelson deferred to **Maggie Anderson**. He wasn't sure of the timeline.

Rep. Boe (District 9) testified in support of HB 1152. He spoke about how important it is to Rolette Co. The hospital at Rolla, Presentation Medical Center, has a larger than normal

Medicaid clientele. It is important to get the funding in order to keep the critical access hospitals in rural North Dakota.

Senator Judy Lee pointed out that Devils Lake also has a higher than average Medicaid population. Both places are involved with tribal members who are served M-F by Indian Health Services for some of their needs but end up having to make use of the services in Rolla and Devils Lake – evenings, weekends and for things HIS doesn't provide.

Senator Dick Dever wondered if the money appropriated last session for Rolla is included elsewhere in the budget or if this is it.

Rep. Boe replied that this is it.

Senator Dick Dever asked if this is one time funding.

This is just the biennium funding discussed here. It is a continuing appropriation.

Jerry Jurena (ND Hospital Association) testified in support of HB 1152. Attachment #3

Supporting testimony from **Daniel Kelly**, Chief Executive Officer of the McKenzie County Healthcare Systems in Watford city, was presented by **Mr. Jurena** in his absence. Attachment #4

Senator Judy Lee – Medicaid does pay for hospice services and is certainly involved with skilled nursing. They have never paid for assisted living.

Mr. Jurena said when they do the cost report those are carved out of the hospital costs.

Senator Dick Dever wondered what the impact is on the hospitals in the oil patch.

Mr. Jurena explained that a lot of people come into the state and profess to have insurance from a company out of state then leave and the bad debt has dramatically increased. The ER's are very busy. They don't have enough staff. They can't pay what the oilfields are paying. Housing costs are skyrocketing.

The high numbers of Williston were discussed. Part of Williston is the oil industry but also partly because of the close proximity to New Town.

Darrold Bertsch, CEO of Sacajawea Medical Center in Hazen, provided a financial analysis of ND critical access hospitals and asked for support of HB 1152. Attachment #5

Senator Tim Mathern asked if he had any indicators, variables, to differentiate a hospital that is losing money from one that is making money.

Mr. Bertsch said they planned on doing additional research and analysis on that specifically. By putting together the information for the four years that he presented there was only one facility that had consistently made money from operations over the four year period. Typically a larger facility which has a lower cost per unit of whatever it is selling has

a better likelihood of making a profit. The more rural facilities that don't perform as many of the services have a higher cost per unit of service they are providing. It varies but a lot has to do with the volume.

Senator Tim Mathern asked if there were any reasons why ND was losing and SD would be making money.

Mr. Bertsch couldn't say with 100% certainty but thought part of the reason was that there are a lot of facilities that are associated with Sanford Health or other tertiary providers where the critical access hospitals get more of that support from the larger facilities.
When ND had some financial analysis done by an independent firm from out of state they found that part of the challenge was that states such as MN and SD have higher reimbursement from third party insurance.

Bad debt & charity expense was discussed.
About 5 of the critical access hospitals deliver babies.

Maggie Anderson, Dept. of Human Services, provided some information to earlier questions.
There is a provision in the Social Security Act that says they must pay lab off the Medicare fee schedule.
There has been a long standing Medicaid policy on CRNA's that they are paid off the physician fee schedule rather than at cost.
She went on to explain the history of what happened with the current Rolla supplemental payment.

Senator Judy Lee asked, if the CRNA's are reimbursed at the physician fee schedule level, why are we supplementing that.

Ms. Anderson thought it was 75% of the physician fee schedule and even though they pay about 140% of Medicare now, the Medicaid physician fee schedule, it still does not equate to cost.

Senator Tim Mathern asked if this was part of the Governor's request. If not was the program available?

Ms. Anderson replied that this was not part of the Governor's budget. Even the $400,000 appropriated last time for Rolla was not. In terms of a program, supplemental payments have been available in the Medicaid program.

Senator Tim Mathern asked if there is any indication of continuance of these kinds of supplemental payments in future federal budgets.

Ms. Anderson said they have not received any indication that the ability for states to do supplemental payments would be going away. The affordable care act calls for reductions in an area called disproportionate share hospital payments. Over time the intention is that if more people have coverage and there is less uncompensated care then the need for disproportionate share hospital payments would be reduced.

Senator Tim Mathern asked if, in their contacts with CMS in terms of this provision, they are assured of its availability or does passage of this bill only direct them to ask for it.

Ms. Anderson said that their conversation with CMS was not financial in nature. Last session they were limited to Rolla because of the way the state plan was written.

With no further testimony the hearing on HB 1152 was closed.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1152
3-7-2011
Job Number 15056

☐ Conference Committee

Committee Clerk Signature MMonson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments.

Senator Judy Lee opened committee discussion on HB 1152.

Senator Tim Mathern presented amendment .04001 dated 3-3-2011 for discussion. Attachment #6 He also provided information from the Strategic Planning Session for Patient-Centered Medical Home (PCMH), a workshop he attended. Attachment #7
This amendment is the result of Senator Tim Mathern going to Legislative Council and asking for a study resolution which doesn't have any immediate financial implications but that gets them to look at what the consequences are to the hospitals. The goal is to get to another level of functioning that is more consequential.
He checked with the sponsors of the bill and heard back from Rep. Nelson who thought it made sense but suggested an alternative of putting it on 2012, the Dept. of Human Service bill. Sen. Mathern asked if they wanted to put the amendment on 1152 or if he should ask for it to be put on 2012. He felt the amendment was important.

Senator Judy Lee supported the idea of doing this as an amendment in 1152 rather than on 2012.

Senator Dick Dever asked if his intention is that the section 2 study replaced section 2 appropriations.

Senator Tim Mathern answered that was not his intention.

Senator Gerald Uglem asked what the difference was between the physician and the medical home. When he thinks of medical home he thinks of his gp physician.

Discussion indicated that it is for him but not for everyone. Some may be the Medicaid family. Institutions will need to be in the system. Chronic disease management is part of it, also. It is having the data base so the physicians can keep close track of patients.
The medical home is a provider but there is a data base that goes with it.
Discussion continued on challenges to rural hospitals.

Senator Dick Dever suggested that the bill as it is is just giving the hospital a band aid. There was some committee agreement to that.

Senator Tim Mathern spoke about the workshop he attended.

There was discussion that if the amendment is put on this bill and the bill fails they probably want to put it on 2012, the appropriations bill.

Senator Judy Lee had a concern with the supplemental payment – the general philosophy becoming more prevalent in Washington that the feds are overspending that ultimately the supplemental payments could go away, too. That's why she felt the study is important.

Senator Dick Dever asked whether the term "patient centered medical homes" is universally used across the state.

Senator Tim Mathern replied that he gave Legislative Council material on the different ways that phrase was used and they thought that would be the closest to describe what most people understood to be that concept.

Senator Gerald Uglem said he could see where the hospital was going to be hurt but the physician would become more involved by keeping up with the patient on a regular basis.

Senator Judy Lee recessed committee work.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1152
3-8-2011
Job Number 15134

☐ Conference Committee

Committee Clerk Signature AMorton

Explanation or reason for introduction of bill/resolution:

Minutes: Attachment

Senator Judy Lee reopened committee work on HB 1152.

Senator Tim Mathern gave a review of the amendment he had previously proposed. Attachment #6 He pointed out that he would also take the amendment to appropriations and try to put it on there in case this bill is defeated.

Senator Dick Dever moved to accept the amendment .04001.

Seconded by **Senator Tim Mathern**.

Discussion continued on the patient centered medical homes and if that can be a solution for the critical access hospitals by providing the services needed for that type of care.
There is a need for hospitals to change their business plan in order to provide some of those services.
This is an ongoing appropriation as it is set up. It would have to be rereferred to appropriations so they can decide if they want to do it for this biennium. The study amendment would be added on.

Roll call vote 5-0-0. **Amendment adopted**.

Senator Tim Mathern moved a **Do Pass as Amended and rerefer to appropriations**.

Senator Spencer Berry seconded the motion.

Senator Dick Dever said he wasn't sure he liked the bill.

Senator Judy Lee explained that it is a band aid but hopes the study will bring them something that might be better. She went on to talk about the history of the Long Term Care facilities not wanting to have anything to do with Basic Care or Assisted Living and how that has evolved into including those areas in their organization.

Discussion: The original appropriation of 18 million dollars was reduced down and is restricted to the actual dollars total for lab, which is only reimbursed at the Medicare level and CRNA's who are at 75% of the physician cost level. Neither of those reflects the actual cost to the critical access hospital.

There was agreement that this is a band aid but that there was a need for the study.

Roll call vote 4-1-0. **Motion passed**.

Carrier is **Senator Judy Lee**.

Attachment #8 – Additional information from Dan Kelly

11.0346.04001
Title.05000

Prepared by the Legislative Council staff for
Senator Mathern
March 3, 2011

3-8-11

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

Page 1, line 1, after the semicolon insert "to provide for a legislative management study;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakotans experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

Date: 3-8-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1152

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .04001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Dever Seconded By **Sen.** Mathern

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-8-2011

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1152

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0346.04001 Title 05000

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever		✓			
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1152, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1152 was placed on the Sixth order on the calendar.

Page 1, line 1, after the semicolon insert "to provide for a legislative management study;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakotans experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

2011 SENATE APPROPRIATIONS

HB 1152

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152
03-15-2011
Job # 15466

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A BILL for an ACT to provide for Medicaid supplemental payments to critical access hospitals; to provide for a legislative management study; and to provide an appropriation.

Minutes: See attached testimony.

V. Chair Grindberg called the committee to order on Tuesday, March 15, 2011 at 2:30 pm in reference to HB 1152. All committee members were present except Chairman Holmberg. Tammy R. Dolan, OMB and Sara Chamberlin, Legislative Council were also present.

Senator Christmann, District 23 and co-sponsor of the bill and Representative Devlin.

Representative Devlin, District 23, Finley, ND, testified in favor of HB 1152 and presented (Written Testimony attached # 1). He introduced HB 1152 which is critical bill for health care as we know it in our state. He provided a map showing the 36 critical access hospitals in our state. Also provided (Written Testimony attached # 2) ND Department of Human Services Medical Services Division named "Estimate of Critical Access Hospital Supplemental Payment dated January 2011".

John Nelson, District 7, Rugby. There was a general fund appropriation that was provided for Presentation Medical Center in Rolla that does exactly what this amended bill does. It pays that hospital the upper limit of Medicare payments for lab and CRNA coverage. In the interim, that was a general fund appropriation, last session. In the interim, the Medical Services, Dept. of Human Services, did apply for a waiver and were granted that waiver. We had every intention of bringing this issue forward in a vehicle this session and as this bill evolved in the House, it appeared this might be the best vehicle that we had to bring this issue before the legislature this session. With the waiver, we were able to leverage federal money, to be able to utilize this payment, to help the hospitals across the state. There are several hospitals where it is going to make a real difference. I did have a handout that shows the one year payment projections for 2010 and that in the next biennium can be doubled for the facilities that are in many of your communities. This bill is a systemic fix for this particular issue and is an ongoing expense but with passage of this, those facilities that are having undue pressure from Medicaid clientele and not getting paid for this, would have a real impact on those facilities. It is a good bill and it will make a difference across the state but some of those facilities such as Presentation Medical in Rolla, Mercy Hospital in Devils Lake, Valley City, Jamestown, Dickinson and Williston. The prime sponsor of the bill and all the co-sponsors

approved of this method and had a lot of help from the Hospital Association in developing the criteria and moving in this direction. Everyone was on board when we did this.

Senator Wardner asks what leverage is the federal Medicaid dollars, is it the state dollars we put into it, is that what leverage is? Why couldn't we get it before? What is it about this bill that allows us to get these federal dollars?

John Nelson states, my understanding is we went outside the CMS payment schedule two years ago, when we appropriated general fund money, for that one particular hospital. By applying for the CMS waiver, we were able to leverage the dollars that come through the Dept. of Human Services, Medical Services Dept., that do assist us with Medicare reimbursement in the state. So this in the category of medical services now and part of our state system.

Senator Wardner states so it's the waiver that kind of sets the stage for this thing.

John Nelson states, "Exactly, the waiver allows us to go statewide". Otherwise, we would again not have the $1.926 million and it would not be available. All we would do is appropriate to the general fund to assist a hospital or multiple hospitals. With this we double the effort of what we did last session and we do it for all hospitals in the state that are critical assess.

Senator Kilzer asks, what is the specific relationship between the Rolla story and this bill? As I recall, that was such a unique situation because they had a disproportionate percentage of Medicaid patients. That is not true of all these hospitals that you are talking about in this bill, as I see it?

John Nelson states, that this is the qualifier. This is all based on Medicaid utilization, just like it was two years ago. Every hospital that has Medicaid utilization approaches 40% in their case. That is why the numbers show what they do for those facilities today. This document, you are looking at, was put together by Maggie Anderson in DHS. That is the estimation that the Dept. made based on Medicaid utilization. That is still the qualifier.

Senator Kilzer asks is the code referred to, in section 3, is that what relates to nurse anesthetists and labs?

John Nelson states, I will defer to someone in the medical field.

Jerry Jerena President of ND Hospital Association testified in favor of HB 1152 and provided (Written Testimony attached # 3). And a list of NDHA Member Hospitals by Region. (WrittenTestimony attached # 4). He requested a Do Pass on HB 1152.

Senator Wardner asks, is this a 2 year bill?

Jerry Jerena states, this is ongoing, if this is passed.

Senator Kilzer states, I've had conversations with you previously, continuing on Senator Wardner's line, I don't think this is going to solve the problem, short term or long term. We know that Medicaid population is going to increase, in fact, nationally it is going to double and that is in the short term. We can anticipate a huge deficit in Medicaid reimbursement. Just last

session, we rebased to 100% for hospitals and some other nursing homes. We rebased at 75% for 4 other categories including ambulance drivers and physicians. This is a direct consequence of the health care reform act. They said $470 Billion to cuts in Medicare and that is what the rebasing is on, Medicare. We can anticipate this. As far as the future goes, I don't see any alternative, if this is past, to continue this, the cost shifting, we have been doing over to the commercial insurers and private payers, there isn't room any more. Every third party payer has a fee schedule and if they didn't, they would be out of business. There isn't wiggle room. I can see the predicament the hospitals are in. It is a direct consequence of supporting the health care reform act.

Jerry Jerena states, you are right. This has been building for some time. When you rebase the critical assess hospitals in 2007, to cost, it was rebased to Medicare allowable costs not their true costs. They were rebased, up to a point, where they were 7-8% behind their actual or true costs to provide services.

Jerry Jerena states he has 3 critical access CEO's with me, who would like to testify.

Darrold Bertsch, CEO of Sakakawea Medical Center, Hazen, ND. Testified in favor of HB 1152 and provided (Written Testimony attached # 5). ND Critical Access Hospital Financial Analysis. How we compare with the neighboring states, in regards to our financial position and how the critical access hospitals, themselves, compare with each other in ND. On page 2, top slide, CAH Financial Indicators 2008. This is done nationally, by a consortium of University of Minnesota, University of Southern Maine and University of North Carolina. It is called the FLEX Program. They take a look at the cost reports that are submitted, by critical assess hospitals, from across the country. They compare key financial indicators. The indicators, that I have chosen to share with you today, are critical to the financial operations of critical access hospitals. I compare ND, with the national averages, and then with the averages of our neighboring states. You can see the number of critical assess hospitals that were included in this study in 2008, the net margins for ND facilities, compared to the national average, and in comparison to states in our region. You can see ND shows negatively, in comparison to, hospitals in the region and hospitals in the national average. Looking at "Days of Cash on Hand" makes it very challenging for critical assess hospitals to pay their bills and sustain their operations, make needed facility improvements, purchase necessary equipment and to pay staff the wages they deserve. The category, "Medicare in-patient Cost/Day", shows that Medicare pays us, based on the cost of providing services to Medicare, in another state. The category "Average Age of Plant" is another illustration of the age of our facilities and the age of equipment, we are utilizing to provide patient care. The higher the number, the older the equipment and facilities are. This information is providing you, regionally, of how hospitals compare. On the bottom of Page 2, you see a graph of financial indicators, specific to net margins, over a five year period. You can see consistently, ND critical access hospitals have been challenged financially, to maintain a bottom line, in comparison to facilities in our region. On page 3, map of North Dakota and yellow highlighted are all critical assess hospitals that were included in a study that I will be referencing later. The FLEX monitoring.org information is great information about 2009 statement of operations for the 36 critical access hospitals in ND.

You will see that 23 of these hospitals had an operating loss for 2009. Subsequent pages shows information for 2008, 2007 and then page 7, 2006. Other information I would like to share with you include: many of the rural critical access hospitals in ND also provide primary

care in their communities. If it would not be for the critical access hospitals in many of the small communities, Hettinger or Bowman, there would not be any access to primary care services in those areas. These facilities don't provide primary care clinics because they are big money makers and they are not. The graph I have here, page 7, shows that for those critical assess hospitals that own the clinic, the clinic operating margin, was a negative, as well. In order for all of us to have access to critical care in our rural communities, the critical access hospitals need to be there to provide and support those primary care services in the area. On page 8, shows "ND Critical Assess Hospitals" and the various services that they provide to their communities. Page 9, is the "Statement of Operations".

Senator Robinson states, I am from Valley City and I served 9 years on the hospital board, which is a tremendous value to the committee, but we struggled.

Darrold Bertsch states, before healthcare reform, this isn't a total fix for all the hospitals. But every little bit we can secure from our different payers, will help us all be able to make ends meet. The most advocacy we have done is with BCBS of ND. One of the biggest financial challenges we have, is the reimbursement we receive, from BCBS of ND. With Medicare nationally, to try and get people to understand the challenges that the rural health care delivery program has. We think this bill will help those hospitals, especially those that have a higher Medicaid population.

Senator Robinson states it's ironic, if you live in rural ND, there is a real fear of the ability to sustain the quality of life and an economic development without health care. Valley City is pretty aggressive, trying to land jobs and grow our economic development base. The question comes up all the time about the stability of your health care facility in the community.

Darrold Bertsch states many communities are stepping up to help with these challenges. The city of Bowman adds a percentage on their sales tax that helped subsidize the availability of health care services in the area. The county commission in Bowman is very supportive of providing funding for the needed equipment for needed improvements. You see different foundations, cities and counties, that are stepping up to the table to help their local communities. That is why I have on my agenda this year, to talk to the Association of Counties, the Economic Development Association and League of Cities, to stress the importance and challenges of the critical access hospitals in the state and the importance of them to get behind and support that within their communities.

Daniel Kelly, Chief Executive Officer of the McKenzie County Healthcare Systems, Inc, in **Watford City, ND** testified in favor of HB 1152 and provided (Written Testimony attached # 6). This shares the 3 reasons he supports this bill. 1. 2/3 of ND Critical Access Hospitals Experience an Operating Loss. 2. Rural Hospitals are Safety Net Providers, 3. HB 1152 affords some relief for ND Critical Access Hospitals. I would strongly urge the passage of HB 1152.

Paula Wilke, CFO of Presentation Medical Center, Rolla, testified in favor of HB 1152 and provided (Written Testimony attached # 7). She is asking for continued financial help for her facility.

V. Chair Grindberg asks, if there is any further testimony in support of the HB 1152? Any opposition to HB 1152?

Senator Kilzer asks, are we going to hear from Maggie Anderson about the specific match and the details?

LeAnn Thiel, DHS, Medical Services Division and I can try to answer any questions.

Senator Kilzer states we have heard all this testimony and the great savior was going to be the Frontier amendment and I haven't heard that mentioned today. Will that bail us out in the coming biennia? We saw the statistics up through 2009 but I know the Frontier Amendment doesn't kick in right away.

LeAnn Thiel states the Frontier Amendment doesn't apply to critical care, only to acute care in the big cities.

Senator Kilzer states that it specifically was the Medicare reimbursement system; the resource based relative value system of 1983. That affected Medicare levels of reimbursement and was disproportionate in various states around the country. That is what all the complaining is about, rebasing, being based upon Medicare rates. So the Frontier amendment may not directly affect Medicaid but it certainly does affect the rebasing.

LeAnn Thiel states, Medicare pays critical access hospitals a per diem rate, a daily rate. That rate is 101% of cost. So what Medicaid does is we take that Medicare has established and we pay 100% of their rate.

Senator Kilzer states that was suppose to change with the Frontier amendment.

LeAnn Thiel states, only for the hospitals that are paid on a DRG. In ND, there are only six of them.

Senator Kilzer states that this will not be a viable alternative to think the Frontier amendment is going to solve our problems. Is this request going to be a biennial event then?

LeAnn Thiel states, "Yes". We have to do a state plan amendment which would be to amend the state plan; to do a supplemental payment for these and that would have no end date until it was revoked. It would be included in our request, every biennium.

Senator Kilzer states, with the Medicaid population increasing, it will be a pretty rapidly increasing request.

LeAnn Thiel states the amount that they would pay out is based upon the Medicaid utilization in each specific hospital and based upon what is called a cost to charge ratio. We are going to pay them up to their costs, based upon their Medicaid utilization for each year. So if their Medicaid utilization goes up, it could affect their payment.

V. Chair Grindberg asks if anyone in opposition of HB 1152.

V. Chair Grindberg closes the hearing on HB 1152.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152 Subcommittee
March 24, 2011
Job # 15990

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee on HB 1152 concerning the critical access hospitals.

Minutes: You may make reference to "attached testimony."

Chairman Kilzer called the subcommittee hearing to order on HB 1152.
Other subcommittee members are: **Senator Fischer** and **Senator Robinson.**

Becky J. Keller - Legislative Council; **Lori Laschkewitsch** – OMB.

Senator Kilzer said we all know what it does, but they are supposed to look at finances part of the bill. He turned it over to Maggie Anderson to tell them of the situation of critical access hospitals and what will happen in their financing and what their reimbursement will be if this bill fails totally and what it would bring them up to if it passes in the present level of reimbursement.

Maggie Anderson, Department of Human Services, Medical Services replied that HB 1152 as it currently stands would provide a supplemental Medicaid payment to critical access hospitals. The way that we currently pay critical access hospitals was set back in the 2007 legislative session. The legislature authorized the department to pay critical access hospitals at 100% of cost. That is Medicare allowed cost and that is for the services that were able to pay 100% of costs which is essentially most services, in and out patient, with the exception of lab which there is a federal statute that says we have to pay lab off of the Medicare fee schedule and CRNA services (nurse anesthetist). We had a ND payment policy that said we pay those services off of the fee schedule. Those services were concluded in the estimates provided during the 2007 session and the movement toward 100% of cost. Those were two areas that weren't "paid at cost". During the 2009 legislative session, the legislature provided to the department.....

Senator Kilzer: Let's stay with 2007 a little bit – when you say 100% of cost, is there a precise calculation for that? Is it the same for everybody? How is that determined?

Maggie Anderson: Each facility has their own (on the outpatient side) cost to charge ratio and that's set as a preliminary number by Medicare and then it's finalized. Then both Medicare and Medicaid cost settle with the facility. On the inpatient side its set as a per diem or per day amount. That is also cost preliminary and then its cost settled.

Senator Kilzer: When you say cost settled... It's a finalization of some kind.

Maggie Anderson: After the year is complete and they file all their Medicare cost reports and everything is finalized and then we go back and let's say, we were paying $127/day and it turned out that their true costs were $126, then for that period of time, we'll see how many days and then we reduce it. If it shows up as $130, then we actually have to pay out more money. Because it takes several years to finalize and get the year closed out, then file the Medicare cost report, have it audited and all of that, so we are just now auditing that first year which was July 1, 2007 through June 30, 2008. We are finalizing those cost settlements now. In the aggregate, some of them have to pay money back and some are paying money out. We're estimating to pay out about $668,000 more over what those interim rates were.

Senator Robinson: That's for these two services?

Maggie Anderson: No, that's just for the payment methodology of paying at cost.

Senator Robinson: This is for 100% back then? Answer – In 2007, yes. It's where we started from.

Maggie Anderson: Every biennium, as we go through this, the department will continue to cost settle with the facilities. If 1152 doesn't happen, we will still cost settle based on the '07 methodology that was put forward.

In 2009, the legislature provided money specifically for Rolla – only city to qualify. In the intent language that was provided with the money, the Legislature asked the department to try to maximize federal dollars if we were able to receive federal authority for those payments. We were able to secure federal approval to provide that supplemental payment and receive Medicaid match for it. The basis for the supplemental payment is this difference between cost for the CRNAs and lab and what we've been paying. It's not that we're just giving them a check for the difference between lab and CRNAs because we can't do that. We can't just pay cost for lab. We have to do a supplemental payment but CMS did approve that. We have made the first and shortly making the second payment to Rolla and it was $128,000. It's what they received last year and what they will receive this year.

HB 1152 was modified from its original introduced version to the way it sits before you today. It would be taking that supplemental payment – that CMS approved per Rolla, removing the population criteria, the Medicaid revenue criteria, and just saying for all critical access hospitals in North Dakota we want to provide a similar supplemental payment. When Rep. Nelson first approached me about doing something like this, we did contact CMS and said, 'what if we would remove that first qualifying part of our request to you where we laid out the size of the community and the Medicaid revenues and all that, would this state plan still be approvable'. They said 'yes, it would'. In fact, we took the state plan, removed the language and sent it in as draft to get their comments and they had no concerns about that. From the CMS side, they told us that it would be approvable.

What happened in order to get the dollars that are before you is we took the same methodology that we used for Rolla and we calculated what that impact would be for all of the critical access hospitals and then we broke that out by how much would cover some of the lab

shortage versus the CRNA shortage and then we have to still compare that to what we call the upper payment limit. In appropriations I talked about that a little bit but more specifically related to nursing homes, but we also have an upper payment limit for hospital services. So in the aggregate, we cannot pay more than what Medicare would pay and of course Medicare pays 100% of costs. We looked at what we pay and made sure we were still within the upper payment limit and the $3.454 M is the total by facility of how much they would receive under this amendment. The larger facilities, plus Rolla, because Rolla has a very high Medicaid revenue rate there, they're the one that would receive the most money. For example, Devils Lake is estimated to receive about $231,000/year; Jamestown about $152,000; Rolla about $167,000 so their rate would go up for the next time; Williston about $249,000.

Senator Kilzer: Is this matching?

Maggie Anderson: Yes, we do receive federal match. It would be what we use for FMAP so

Deb McDermott, Dept. of Human Services: 55.81 federal.

Senator Kilzer: Is that FMAP now or over a certain period of time? I thought the FMAP was lower than that.

Deb McDermott: For federal fiscal year 2012 its 55.4, but for basically the first 2 months of the biennium, its 60.35. If we didn't have the stimulus money, it would be that rate right now.

Senator Fischer: When we did that last session with Rolla, it had to do with the Medicaid population more than anything, that they were running in the red because of the overabundance of Medicaid cases.

Maggie Anderson: They have a higher Medicaid revenue than all other critical access hospitals and they also have a high Medicare revenue and uncompensated care. It's kind of the combination of those three.

Senator Kilzer: They were over 50% and I don't think any other hospital was.

Maggie Anderson: For the combination of Medicare and Medicaid.

Senator Fischer: Are all the critical access we're looking at meet that?

Maggie Anderson: No. I don't know what all their various Medicaid revenue streams are, but by far, Rolla would be the highest. I've heard of 10% or less for some of the other ones.

Senator Kilzer: This is practically all the small hospitals in the whole state that we're talking about.

Maggie Anderson: This is all of the hospitals with the exception of the 6 PPS.

Jerry Jurena, North Dakota Hospital Association (Lobbyist #028) - The two long-term care hospitals , state hospice, and psych.

Senator Robinson: You used Devils Lake at two hundred some thousand dollars – that's a biennium?

Maggie Anderson: That's a year.

Senator Robinson: So they're going to get about $560,000 for planning. That is in total funds or is the matching on top of that?

Maggie Anderson: That's total funds. When I talked about the $3.454 M, it's in the appropriations section of the bill. It's $1.5 general and $1.9 M of federal, so my numbers are the total dollars that the hospital receives.

Senator Kilzer : Was this in Department of Human Services request?

Maggie Anderson: No, it was a stand alone bill that started out as a grant and was modified for this. This was not in our budget request and it was not an optional adjustment request. There are some of the critical access hospitals who we are estimating no additional payments because right now, whatever their cost is for lab and CRNA, it's not exceeding what they're receiving from us.

Senator Robinson: We received a document or print out on the nursing home long term care and their financial status. Is that available for the critical access hospitals? Is there a document that could give us a snapshot of their financial condition?

Maggie Anderson: The department doesn't maintain anything like that, but in the policy hearing on that, the gentlemen from Hazen, they've been looking at a study so I would have to defer to the Hospital Association or members to see if they have that. Shelly Peterson may provide that for you.

Senator Kilzer: One of the reasons they are struggling, and this goes back 20-30 years ago, is because of the change over to the DRG (diagnostic related groups) system in the middle and late 80s. It used to be that the small hospitals, if you would do a drop in study, they might have 20 beds and they might have 8 or 10 patients, but you go there now, and in particularly with Medicare, they have definite prospective requirements for admissions to a hospital. I can remember going to a small hospital not too long after the DRGs really cut their admissions and in one hospital they only had two inpatients and 25 beds. Occupancy has really changed with the DRGs and all the medical reviews; ongoing and the retrospective. It wasn't unusual for some admissions to be outright denied.

Senator Fischer: We're looking at 36 hospitals and ¾ are in trouble. How are we going to deliver medical care in the future to rural ND? Do you have that answer? Does it involve airstrips in nursing homes or triage and moving them to the four big cities?

Senator Robinson: This is a complex issue in trying to bring professionals into smaller communities. Some want to come here, but our hospital is small and is often down to 3,4,5,or 6 patients. I was on the board for 9 years and you end up with weekend ER coverage. Our ability to grow in rural ND sustaining some kind of quality of life without medical care makes it much more difficult. I don't know. It's scary.

Discussion centered on rural health care; hospitals, medical centers, satellite clinics.

Senator Robinson (to Roxanne Woeste) Is there anything out there in a study resolution? We talk about the need for 30% more medical professionals in 15 years or whatever, not that a resolution would solve the issue, but keeps it on the radar screen. I'm not aware of anything this session.

Roxanne Woeste: I am not aware, but I haven't taken an extensive look through for a proposed study.

Senator Kilzer: We've had the Rural Health Center at UND and what have they been doing for 30 years? They've been there, studying it and getting a lot of money. I've often felt that if they'd use that same money to actually give some care, we'd probably be ahead.

Senator Robinson: I like the idea of a study, if it's more of an independent review to keep this issue at the forefront. Is that something that you think we should pursue? We still have the bill to deal with in terms of a fiscal note and those things.

Senator Kilzer: I would like to see a study whether it's done from a hospital or medical perspective. There should be some of those out there, especially with Healthcare Reform.

Senator Robinson: If Roxanne could see what's out there in terms of comprehensive study.

Roxanne Woeste: You would like me to find a study? I'm not sure I could find one in two days.

Senator Kilzer asked **Mr. Jurena** to search out possibilities and maybe not specifically hospitals or clinics, but the way the demographics are coming.

Jerry Jurena – Tim Blasl and I are going to a conference in Jamestown and will be hearing a presentation on "What a successful hospital looks like". So I can pass that on. There's information out there.

Senator Kilzer closed the hearing on HB 1152.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152
March 28, 2011
Job # 16089

☐ Conference Committee

Committee Clerk Signature Rae Lanning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee on HB 1152 concerning the critical access hospitals.

Minutes: You may make reference to "attached testimony."

Chairman Kilzer called the subcommittee hearing to order on HB 1152.
Other subcommittee members are: **Senator Fischer** and **Senator Robinson.**

Roxanne Woeste- Legislative Council; **Lori Laschkewitsch** – OMB.

Jerry Jurena, ND Hospitals Association (Lobbyist # 028): Went to the Jamestown Hospital board retreat on Friday and information was presented on what a successful critical access hospital looks like, but the study was based strictly on Jamestown. I gave Senator Kilzer a copy of what I got and it wasn't what I was looking for. I thought it would be more in-depth global picture, but it was strictly on the Jamestown Hospital.

Senator Kilzer: I spent some time over the weekend looking for the rebase procedures that you gave us two years ago. I wasn't able to find them, but they were pretty good documents. I remember there was some disparity among the groups. We had nursing homes and hospitals at 100% and we had physicians, chiropractors, ambulance people at 75% of the rebasing and we also had dentists at 75% of their charges.

Maggie Anderson, DHS Medical Services Division Director states, the only one I would change would be ambulances. We rebased them to Medicare rates not the 75% of the cost to Medicare.

Senator Kilzer states, when I hear what the House is doing on the physician's side, I had more of an incentive to find those things, which I didn't find. When are you willing to teach a class on rebasing?

Senator Robinson states, it is very confusing for those who don't have experience in the medical world.

Senator Kilzer states, I don't fully understand it all either. From Mr. Jurena's comments, you wonder if the system is flawed. Just on the surface, when you say 100%, you don't expect your clients to come in and say, we are this many million dollars short.

Senator Robinson asks, in reference to Jamestown hospital. We hadn't decided what to do with appropriation and we still have to deal with the fiscal note. We were hopeful to come up with a study paragraph that would capture the intent of the subcommittee hopefully to get a handle on this over the course of the next two years. Is it your feeling that information is still available or not? Are there other potential resources of capturing that language? Or is this a challenge that is too complicated to capture in a couple of paragraphs?

Jerry Jurena states, it is complicated. We have Medicare fee schedule and Blue Cross fee schedule and when we talk about cost, people relate to one of those two fee schedules. (Explained fee schedule). Neither come up to the cost of providing service. I attended a conference and heard speakers. They had a speaker brought in from California talking about successful clinic operations. We did not stay for that. We talked about bringing someone in during October meeting to discuss what critical access hospitals should look like, if the future could be self sufficient or viable operations. He suggested, Allen Larsen Company, out of Minneapolis. We are hoping to have Eric Schell come and talk with specific guidance, not to talk about a specific hospital, but a global prospective of ND. Also, Allen Larsen comes in and does the same thing, to see if we can come in with a proposed model or a pattern, that they could model after. All 36 of our critical access hospitals are very different. What is successful in one place, won't be in another. We need 36 models to be successful.

Senator Kilzer states, we are faced with a funding bill (1152). Before we had one camel's nose under the tent, now it's 36. We need to get the information on rebasing and a few more statistics on what the funding has been by Medicaid. Not so much for the total for each hospital but the total for all the hospitals over the several biennia because there is that 5% increase noted on one of the footnotes in here. I would like to get that information from Legislative Council or from Maggie, going back 2 or 3 biennia, as far as the Medicaid, to all the hospitals, PBS and the critical access.

Senator Fischer asks, how do you come by the numbers that we are seeing in HB 1152?

Maggie Anderson states, you use the same methodology that we were given the money from, last session to provide the supplemental income for Rolla. That same methodology that the federal government approved to make that payment to Rolla. We used that same methodology and we have the cost reporting information from critical access hospitals and we have our utilization information from our claims system. We bring those two pieces together, based on that same methodology; this is how much we would pay to each facility under this same methodology. We know that all, do not receive the same amount. The larger facilities have more Medicaid clients and in turn receive higher payments.

Senator Fischer asks, did you look into percentage of Medicaid patients that each hospital has and compare them to each other? The answer is no. Rolla received a large amount of funding due to the large amount of Medicaid patients they have, isn't that correct?

Maggie Anderson states, that is correct. It was tied to Medicaid population. They said it was onetime funding, critical access hospitals eligible, only if the percentage of medical payments exceeds 25% of its annual revenue etc.

Senator Kilzer asks, in these hospitals, you said some would not get payments? Is that because their percentage of Medicaid is so low or is it because their DRGs don't show loss? What would be the criteria?

Maggie Anderson states, possibly their Medicaid population is so low so they don't generate supplemental payment. When we looked at their cost reports (Crosby) and what they were already being paid above, what the cost was from us. Whatever they are being reimbursed for lab is covering their cost.

Senator Kilzer asks, you said in their case it would be because of their relatively lower percentage of Medicaid patients?

Maggie Anderson states, it could be that or it could be their cost. Their cost happened to be lower on average than someone else's. For example, Lab, we pay off the Medicare fee schedule for current access hospitals and we pay off the fee schedule for everybody. However, one criteria for supplemental payment, is to use what they are paid for lab off the fee schedule and the difference between what they are paid and cost to determine the amount of the supplemental.

Senator Kilzer asks, why allow costs to be variable and why not go by fee schedule?

Maggie Anderson states, we are paying off fee schedule.

Senator Kilzer asks, when the put together costs, I assume they have the salary of the lab tech and the other chemicals that they need for doing diagnostic tests. Why would there be very much difference to one hospital to the next?

Maggie Anderson states, I can't answer that. Mr. Jurena may have an answer to that.

Jerry Jurena states, no I do not have that. To answer your question about the lab, every time you run a lab test you have to run a standard and one or two controls with that. If I am in a large facility and I have 15 patients to run, I still run one standard and two controls with that so my cost of the test is going to be lower and if I am in a small hospital I am going to run one patient at a time. Each time I do that, I am running 4 tests, standard and 2 controls on a patient, so the cost is going to go up.

Senator Kilzer states, if we pass this and give money to hospitals that claim to have higher costs; this is a disincentive for the hospitals to hold their costs. This encourages them to increase their costs. It's a built in incentive. On the CRNA's, does every hospital have them?

Jerry Jurena states, no they don't but at certain times when they come in. Rugby paid for CRNA coverage up there. You may have one that works 8 hours a day and then on call.

Senator Kilzer asks, how many of 36 hospitals don't have CRNA's?

Jerry Jurena, states, Williston, Dickinson, Hettinger, Oakes, Jamestown, Rugby, Devils Lake – all have CRNA's (also Carrington) and the rest have marginal. He states that less than half have CRNA's.

Senator Robinson asks, how many other hospitals in the system would fall in that category, of the 36?

Maggie Anderson states, there are two that receive no payment, Kenmare and Crosby. They will receive no payment for lab or CRNA.

Senator Fischer states, by passing this bill, with the dollars that are in it, we are going to start a trend. The state will have to support all these hospitals in the future. What we need to do is get handle on how we are going to deliver health care to the rural part of the state. This is nothing but a stop gap. Things are not going to go away. Maybe in some areas they are going to get better and some worse. That is where I am at. What happened last time caught on in a hurry. If we pass this as is, we will have higher rate, costs will go up and then we will be sitting here again dealing with this bill again and we haven't addressed the problem.

Senator Kilzer states, that is why I would like to have Maggie Anderson's class. If there is a defect in the rebasing and they are being rebased on 100%, then we should make that correction. If not, then these hospitals need to live with the reimbursement and become more efficient or get their costs down etc. in order to live within their means.

Maggie Anderson states, in July of 07, since then, we rebase to cost every year. They are set each year. The PPS hospitals, 15+ years that they were rebased, was last year, July 2009. We talk about rebasing coming out of the 09 session, really didn't have any impact on the critical access hospitals. Until the legislature tells us to change our payment methodology for them, they will be rebased at cost each year.

Senator Kilzer states, that is the reason I asked for history of what the increases have been, so we could see if the amount they are short or claim to be short, is the same or is the lack of an increase. I need to get those from you or Legislative Council. We can't be taking on additional responsibilities without this information. Mr. Jurena, asks what are locals doing about each of these hospitals? Are any of them asking for local tax support?

Jerry Jurena states, Yes, some have subsidized sales tax or a community tax that is helping them with some of their losses.

Senator Kilzer asks, is there a list available? Mr. Jurena states he has it in this office. If we see local subdivisions are making an effort to keep their hospitals open, we are more in tune to be a part of it.

Jerry Jurena states, he will get the list to him tomorrow.

Jerry Jurena states, I would like to respond to statement by Senator Fischer about the stop gap measure. I think it is just a finger in the dike and I think if we move forward, the utilization of the rural areas is going to continue to decline. I also think that some of them are going to find less available staff to work in those areas. As we move forward, we are going to have to move forward to find a new model to deliver access to the rural areas. The current structure of bricks and mortar isn't healthcare, it's people and technology and we need to figure out how to get there. That is why I was interested in going to this presentation at Jamestown hospital to see if there was a model there. It was a good conference but did not answer my questions that I was looking for.

Senator Kilzer closed the hearing on HB 1152.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152 subcommittee
March 30, 2011
Job # 16190

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee on HB 1152 concerning the critical access hospitals.

Minutes: See attached testimony # A - B.

Chairman Kilzer called the subcommittee hearing to order on HB 1152.
Other subcommittee members are: **Senator Fischer** and **Senator Robinson.**
Sheila M. Sandness – Legislative Council; **Sheila Peterson** – OMB.

Senator Robinson explained amendment 11.0346.04003 (see attached # A) We had discussions regarding the future of rural healthcare delivery and particularly our critical access hospitals. The people representing those facilities referred to a need for those facilities to develop a model for their respective service area. That model would probably have much in common with the model for other service areas. It would also include a number of issues that are not common across the region. Our thought was it would be important given the challenges we have statewide that we have a study. In section 3 it underlines the intent of focus on delivery of healthcare in rural areas of the state. It would include input from the UND School of Medicine and Health Sciences Center for Rural Health. It would report its findings to the next session of the legislature. This is timely. We just came away from a time with our EMS providers from rural North Dakota. In a way it is all related. I like the language. It says "shall hear". They don't always like to see this language, but this is so important to the future of our state.

Senator Kilzer: The problem is caused by Medicaid. Is there any mention of Medicaid in here? Or is it just overall the health delivery system? Do you think that should be restricted or are you satisfied with the wording?

Senator Robinson: We can say it's implied, but maybe we should include language to provide insurance that we want special focus on, on the Medicaid system.

Senator Kilzer: Keeping that idea in the back of our head ----I had another thought of Senator Bowman's question– he asked what are local communities doing about this situation? Do they have some irons in the fire as far as putting this road to this very popular place? So I asked Mr. Jurena to list the 36 critical access hospitals that presently have city sales tax or other local money that they put into their fund. His response was read and there are 10 who are putting in

local money. Maybe that should be a requirement, that it's a matching unit or some threshold. It could start off getting back into the black. I don't think there is too much left to asking hospitals to lower costs. I've been working Saturday mornings. I know what it's like to have to call in a lab person for a single analysis.

Senator Robinson: In our community, they are getting local tax dollars through the city development corporation to fund a nurse training program. In a number of other ways they have provided support for various fundraising efforts. What you are talking about here might be part of the new model of critical access hospitals in terms of the various components that need to be on the table as we move into this new era of rural healthcare. I don't know what reception will be, but a matching requirement is getting skin in the game.

Senator Kilzer: I have concern that this will become a biennial event.

Senator Fischer: I think communities should have skin in the game. The language for one time is in here, and I think that is important. Until we come up with an updated model we need something. The model we have is ancient as far as delivery goes. We should have started 6 years ago when we talked about it.

Senator Kilzer: Shall we as part of an additional amendment include in these that there has to be a match or a certain threshold or a maximum? What are we going to say?

Senator Robinson: The discussion should involve dollar for dollar match. Are we looking at anything of "in kind"?

Senator Fischer: Addressing Senator Robinson's concern, why not use mill levies because you have all different kinds of participation in the amount of money they get. Also who is going to evaluate "in kind" for an equivalent?

Senator Kilzer: In this bill, there is $1.5 million general fund and $1.9 million federal funds. Is that the FMAP distribution formula?

Maggie Anderson: Yes.

Senator Kilzer: If we would require a local political subdivision to match, would they have to match the $1.4 million or would they have to match the whole thing, the $3.4 million? What would be the specifics of the match?

Maggie Anderson, Department of Human Services, handed out previously requested information: Estimate of Critical Access Hospital Supplemental Payment (Attachment #B). We had a similar issue come up where Richardton needed to give up the Critical Access hospital designation, so Dickinson could receive the designation. HB 1433 from last session provided a supplemental payment to Richardton and the city brought forward the match but it was city owned so the city brought the match to the table. We have to look at how the match could work. If that whole community comes forward with a non-federal share the non-federal share would be the 1.5 million that cumulatively the cities or communities would have to come up with. Then the department would be able to draw down the 1.9 million and then that would be received.

Senator Kilzer: If the community brought forth $1.5 million and state $1.5 million, how much would feds match?

Maggie: We could only match to the upper payment limit. With these calculations we would still be restricted in what we could pay for the Medicaid payment. If you wanted to do an additional general fund payment, that could happen but we would be restricted in what we could draw out from the federal and pay out because of the Medicare upper payment limits.

Senator Kilzer: So in that situation, even if the state put in general fund money, that probably wouldn't draw a match from the feds.

Maggie: No additional match. Certainly you could leave this scenario as it stands but ask for proof from various hospitals that the community has supported their local hospital separate from this. It's just like a certification and proof that they would have to provide for the department before we would provide this supplemental payment to them. If you want to prorate that based on how much they are estimated to receive, because you can see from this there are some facilities that would receive very little or none and some that would receive a considerable amount. These are annual estimates.

Senator Kilzer: What's your initial impression of this line of thinking?

Senator Robinson: What further information would we need here?

Maggie: What I'd want to do is to provide you with what we could do if you were to use the city money as the match. I'd like to confirm whether it has to be city-owned in order to do that. 2nd question – what would be that maximum that we go to before we hit that upper payment limit and then at that point any additional state funds are not going to draw federal dollars. But then there is that alternative of leaving this as it is and then just having the city certify it to us. I don't think I have to provide anything additional.

Senator Kilzer: I do like your first scenario, if the local would contribute to a certain threshold. Over that level the state would kick in the remaining part so it would match up to the feds maximum allowable. There is a threshold that the local political subdivision would have to come up with. And there is the maximum that the feds have and the state would work in between there. That would be the donor green of this situation, right?

Senator Robinson: How much time would you need to put that information back together?

Maggie: I will go back and review the regulations with our regional offices. I should be able to have it by this afternoon.

Senator Kilzer: It's hard for one size to fit all, but it will help quite a bit. I don't want a biennial event where they all turn up with hands out. I'm not sure we could do it quickly enough for this coming biennium but cities and subdivisions aren't able to come up with money that quickly. We're causing more work, but it's a long term problem. We would like to use Maggie's figures.

Sheila M. Sandness: You are looking at a local match as a prerequisite to the grant. Is that how it's working? Maybe just some language at the appropriations section to say the moneys appropriated to the department of Human Services for the purpose of providing Medicare supplemental payments to critical access hospitals for the biennium the department would provide the payments upon receipt of certification from the hospital that....

Senator Kilzer: The hospital would have to go through an application process. Correct?

Maggie: It would depend on how you want to handle that "city match". If you want to handle the city match with the city, the accumulation of all the cities would be responsible for the state match portion. Then that would need to be spelled out very similar to 2009 HB 1433 if you want to look at that for a reference. But if you just want to have the city certified to the department that as a city we have contributed $5000 to the hospital this year and any amount of contribution then kicks in them being able to receive the supplemental payment. That would be different language because then you are not dealing with the federal Medicaid bill. You are just saying we want them to have some dollars on the table before we allow the supplemental. That is really more philosophical how the committee would want to approach it.

Sheila M. Sandness: We would probably have to wait with this amendment until we get the additional information from you and exactly how they want that match to work.

Senator Kilzer: I think we are very open to what is the most convenient and has the biggest bang for the buck. We could use city or county mill levies...

Sheila M. Sandness: We will have to wait for determination.

Senator Kilzer: Some place in that amendment, we will want to restrict the study down to Medicaid. Are there any other items? When you put this together will it be .04003 or .04004?

Sheila M. Sandness: It will be .04004.

Senator Kilzer closed the hearing on HB 1152.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152 subcommittee
March 31, 2011
Job # 16264

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee hearing on payments to critical access hospitals.

Minutes: See attached testimony # C

Senator Kilzer called the subcommittee hearing to order on HB 1152.
Roxanne Woeste & **Sara Chamberlin** – Legislative Council; **Lori Laschkewitsch** - OMB.

Maggie Anderson, Dept. of Human Services handed out Information on Financing the Non-Federal Share of the Medicaid Supplemental Payment for CAHs (attachment #C). We did some checking on the federal financing piece. The way the bill is written, it would be state general funds matched with federal Medicaid dollars to make the payment. What was asked was what if a portion or all of that state portion could be made with city or county tax dollars. Just the fact that part of it is CNS is saying it is permissible. We could use what they call an intergovernmental transfer from either the city or the county to finance the non-federal share of the supplemental payment. Essentially the way that would work, the city or county whichever has the tax authority would collect those dollars. They would send them to the department. The department would then draw down the federal share from the Centers for Medicare and Medicaid Services and then we would make the entire supplemental payment to the particular critical access hospital. So it's not that the city would transfer money to the hospital; they would have to transfer the money to us and then we would get the federal dollars and make the payment to the hospital. The second paragraph in my document lays out the federal requirements. Paragraph three says it would be permissible for the city/county to pay a portion of the non-Federal share for the remainder to be paid with general funds.

"Considerations" on attachment #C: each of the hospitals that receive some funding from city/county vary. I have no idea if the amount of the tax for those 10 that currently receive something would be enough to fund their non-federal portion or whether it would be too much. We have no idea of those details. The piece that impacts the timing of being able to do this is the fact that that leaves 26 of the 36 with no mechanism in place today to have a city or county tax. They would need to implement such a tax. I spoke to Blaine Braunberger this morning and what we understand from visiting with him is most communities in order to do a tax would need actually two votes from the people. The first would be to establish the home rule charter and the second would be to implement the tax. In addition to that any city or county would have to

file a request for that tax with the tax commissioner's office 90 days prior to the implementation and then it would be effective the first day of the following quarter. So in terms of the July 1, 2011 implementation of what is being asked for in HB 1152 using any kind of city sales tax would likely delay that quite a bit. The other piece is if we do the financing mechanism while CNS has said it's approvable, we wouldn't have problems with it. What I said earlier is that they are going to make us jump through a few additional hoops than if it's a straight state/federal match. So the state plan piece could take longer to approve. I would not expect the state plan piece to take longer than what it would take for the cities and counties to come up with that approval. I would expect ours to be able to be done in 4 or 5 months where the city and counties sales tax would take much longer. The bottom part is an attempt at providing you with some options.

Senator Kilzer thanked Maggie.

Senator Kilzer asked committee members if they had any other questions. I am still thinking about a threshold or an incentive to make political subdivisions bite. I think we do want to use Senator Robinson's 2 study paragraphs in the bill.

Senator Robinson: In the first option, I don't know, there could be incentive language that underscores this being an ongoing... something about moving forward. Maybe it could be strengthened a bit.

Senator Kilzer: I would hope that tomorrow we can give Roxanne better direction. We will try to find time tomorrow to do some of these things. I would like to get it to them before the weekend.

Senator Kilzer closed the hearing on HB 1152.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152 subcommittee
April 4, 2011
Job # 16305

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee on the Critical Access Hospitals.

Minutes: You may make reference to "attached testimony."

Chairman Kilzer called the subcommittee hearing to order on HB 1152.
Other subcommittee members are: **Senator Fischer** and **Senator Robinson.**

Becky J. Keller - Legislative Council; **Sheila Peterson** – OMB.

Senator Kilzer handed out amendment 11.0346.04004.
Discussed section 3-4

Becky J. Keller said they let **Maggie Anderson** review the amendment and her only suggestion was to change the title where it says "Medical Supplement payment". Turn the word "Medical" to "Medicaid".

Senator Kilzer: Where it says Section 2 – Legislative Intent. It should all be Medicaid instead of "medical". So reading it, the language says, "It is the intent of the 62nd Legislative Assembly that any future requests for a Medicaid supplemental payment to critical access hospitals include a local funding commitment equal to 50% of the non-federal share of any payments."

And section 3 and section 4 are legislative management studies. Section 3 is patient centered medical homes and section 4 is the health care delivery.

Senator Fischer moved amendment # 11.0346.04004.
Senator Robinson seconded.

Senator Fischer –Yes
Senator Kilzer –Yes
Senator Robinson – Yes

A Roll Call vote was taken. Yea: 3 Nay: 0 Absent: 0
Amendment passed.

Senator Kilzer: The appropriation will stand of $1.4M general funds and $1.9M federal funds.

Senator Fischer moved that HB 1152 be forwarded to the full appropriations committee as amended.
Senator Robinson seconded.

Unanimous vote.

Senator Robinson will explain the bill to the Senate Appropriations Committee.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1152
04-04-2011
Job # 16327

☐ Conference Committee

Committee Clerk Signature Alice R Selzer

Explanation or reason for introduction of bill/resolution:

A ROLL CALL VOTE FOR A DO PASS AS AMENDED ON CRITICAL ACCESS HOSPITALS

Minutes: You may make reference to "attached testimony."

Chairman Holmberg called the committee to order in reference to HB 1152. Tammy R. Dolan, OMB and Becky J. Keller, Legislative Council were also present.

Senator Robinson explained amendment # .04005. We had extensive hearing on this bill a couple of weeks ago. The subcommittee met a number of times. Senator Kilzer was the chairman. Senator Fischer and myself were the other members. If you recall two years ago we provided special funding to the hospital in Rolla because of their high counts of Medicaid patients. They are a critical access hospital. We have 36 of them in ND Most of them are financially challenged for all of the above reasons, primarily reimbursement but the demographic changes we are experiencing in the state. We have a new hospital in Jamestown coming up right along the road, which is a critical access hospital and they too will have their fair share of challenges. The proposal came in to provide Medicaid supplemental coverage for 2 specific procedures not covered. One of them is the Certified Nurse Anesthetist, and the other one is the Lab Service. Those two procedures are not covered. The package before you in the amendments would provide $1.5M of general fund money, coupled with $1.9 from the federal side to reimburse the critical access hospitals in ND with those two services. And the payments would vary from one hospital to another. Your committee spent a lot of time deliberating what the answer was here. The answer we came up with and reached consensus on is embedded in the amendments you have before us that we would continue payments to the critical access hospitals, we had the one, now we have 36 that would qualify at different levels for the next 2 year time period only. We did find 10 that have a mill levy in place to supplement their operations. Those ten, some of them cities, some of them counties, some of them both, but based on that we thought all of them should have something to support their local hospital. Section 3, I think this is an important part, we as a committee thought it would be important because of what's happening out there. And we heard from the hospital spokesman that all of these hospitals are struggling trying to find the right model of care for their respective community. They won't all be alike, they will have to look at a new model of care that can cash flow, that continue to provide quality medical services to that community and continue to provide medical care to rural ND. There's a number of these in the northeast part of the state but the hospital in Dickinson, which is a nice large hospital is a critical access,

Hettinger is no stronger than it's weakest link and we never know when we are going to be hunting in southwest ND and need medical attention or in an accident in northwestern ND or falling at the International Peace Gardens as one of our colleagues did several years ago.

Senator Robinson moved the amendment # 11.0346.04005. seconded by Senator Kilzer.

Senator Kilzer: This started out last session, $400,000 to Rolla hospital. This initially came in at $18M which would give $500,000 to each one of the 36 critical access hospitals. It is an indirect result of the health care reform because these 36 critical access hospitals were not included in the rebasing, that was just the larger 6 PPS hospitals around the state. But in the Medicaid reimbursement, the cost, they do consider the maximum allowable cost by Medicare and of course, that is going down. As you recall, part of the health care reform was to paid for by $470 billion in Medicare savings, supposedly, and they are starting to feel it and that's what this is about really.

Senator Christmann: I think a mountain got shrunk to a molehill and now it's growing into a mountain again. The bill was pretty big at first. It got shrunk down a lot in the House. I have two big concerns here with these amendments. First of all doing all these studies, it's fine with us, someone will pay our salary and mileage, and we'll come into town and whoever is on that committee we'll get taken care of but we are asking 36 hospitals to all send someone to Bismarck, and then to Fargo and the next meeting is over there and for the next two years chasing around working on these studies, and I don't know if they are going to end up with enough left to justify what they had to go through in order to qualify for some help. Secondly, as far as the Section 2 amendment, I know the hospital in my area, looking at a property tax thing, and I really came down strongly against it. I said we're buying down the property tax as the legislature is trying to get property taxes reduced, hold your bake sales, hold your wine gala, and we'll have a little auction and raise money and that sort of thing but don't get on the property tax. Now we are asking them to do it. I don't think we need all these studies. I don't think we need all these requirements. We know whether we want them to survive, or whether we want them more regionalized. Certainly we don't need a hospital in every town in the state. We don't need 3 or 400 hospitals. How many do we need? At what distance are we satisfied with wanting our hospital care and I think it's generally pretty good right now and I just think we are getting carried away here.

Senator Robinson: I appreciate the concern Senator Christmann expressed. I will say in committee, often change is evolutionary not revolutionary and I think our hospitals are seeing more and more of that. Change needs to take place. We are seeing hospitals that have reached that financial tipping point where they can't go on. So the new model hopefully will evolve and I don't know how many are in that situation but I know there are several at that point, that are trying to look for a new model, partner with a community down the road. I know in northeastern ND there are several, Park River, Grafton, in that area, and change is in the air, in a big way, I don't see them continuing for a long time without a whole new model evolving.

Senator Kilzer: The demographics are changing quite rapidly. Within the last generation, it's not only the hospitals, it's the medical centers, it's largely all of the providers are changing what they do and don't do, and the referral patterns. We really are developing in to a 2 or 3 tiered system which is getting pretty tight. A generation ago, it was fee for service. That was

the reimbursement. In the 1980s we went to DRG's, which is a complete turnaround. It's like farming. You get reimbursed for a certain product and you have nothing to say about your reimbursement levels. We call it fee schedules. I am sure all of us can remember a big push, about 15 or 20 years ago, everybody had to publish what they charged for a procedure. If you did an appendix operation you had to post with your receptionist what your charge for that is and the receptionist or you had to reveal to the media or patient or anybody what your charge was. That was almost silly because by the time that even became law, it didn't matter what you charged. You were paid a fee that was preset by the 3rd party payer. If you ask BCBS what they pay for a certain procedure they will say it's none of your business, it's proprietary. Negotiations at the present time are on reimbursement fee schedules, or whatever you want to talk about are done between he 3rd party payers and the large clinics. These 36 critical access hospitals, they have little? (THE RECORDER STOPPED FOR A FEW SECONDS HERE) (Meter 13.09) The demographics are changing. That's why we want the studies to anticipate what might be happening in just the next few years because I'm sure it will change even more. This is kind of a blip in the road as far as the whole reimbursement picture is and that is why we chose in our subcommittee to come up with what we did here. Frankly, the hospitals were surprised. This health care reform and the maximum allowable charges by the Medicare formula that they have to abide by it through Medicaid has been a surprise to them. I wouldn't say they were totally caught off guard but they weren't anticipating the large Medicare cuts that are coming and will be coming more severe in the next few years. I am sure we want this to be a one-time thing, but they'll be here every session. I see nothing in the future that would change the pattern of them coming in for supplemental appropriation every coming session.

Senator Christmann: Just thought I would point out how quickly times do change. Before we took our last break, I didn't hear near as much concern about changing demographics and staying in touch with the changing times and that sort of thing when we were dulling out money to 15 institutions of Higher Education for less than 700,000 people. We just continue right on and they are all coming back for more too.

Chairman Holmberg: It was good discussion. Would you call the roll on the amendments.

A roll call vote was taken on amendment # .04005. Yea: 12; Nay: 1; Absent: 0.

Senator Robinson moved Do Pass as Amended. Seconded by Senator Kilzer.

A ROLL CALL VOTE WAS TAKEN ON A DO PASS AS AMENDED. YEA: 12; NAY: 1; ABSENT: 0. Senator Robinson will carry the bill.

The hearing was closed on HB 1152.

11.0346.04005
Title.

Prepared by the Legislative Council staff for
Senator Kilzer
April 4, 2011

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

In lieu of the amendments adopted by the Senate as printed on page 698 of the Senate Journal, Reengrossed House Bill No. 1152 is amended as follows:

Page 1, line 1, after the semicolon insert "to provide legislative intent; to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. LEGISLATIVE INTENT - MEDICAID SUPPLEMENT PAYMENT - CRITICAL ACCESS HOSPITALS.** It is the intent of the sixty-second legislative assembly that any future requests for a medicaid supplemental payment to critical access hospitals include a local funding commitment equal to fifty percent of the nonfederal share of any payments.

SECTION 3. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

Date: 4-4-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1152

Senate APPROPRIATIONS Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0346.04005

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Robinson Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Warner	✓	
Senator Bowman	✓		Senator O'Connell	✓	
Senator Grindberg	✓		Senator Robinson	✓	
Senator Christmann		✓			
Senator Wardner	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 12 No 0

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 4-4-11

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1152

Senate APPROPRIATIONS Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Robinson Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		**Senator Warner**	✓	
Senator Bowman	✓		**Senator O'Connell**	✓	
Senator Grindberg	✓		**Senator Robinson**	✓	
Senator Christmann		✓			
Senator Wardner	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Robinson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1152, as reengrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1152, as amended, was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the Senate as printed on page 698 of the Senate Journal, Reengrossed House Bill No. 1152 is amended as follows:

Page 1, line 1, after the semicolon insert "to provide legislative intent; to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. LEGISLATIVE INTENT - MEDICAID SUPPLEMENT PAYMENT - CRITICAL ACCESS HOSPITALS.** It is the intent of the sixty-second legislative assembly that any future requests for a medicaid supplemental payment to critical access hospitals include a local funding commitment equal to fifty percent of the nonfederal share of any payments.

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Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

2011 HOUSE APPROPRIATIONS

CONFERENCE COMMITTEE

HB 1152

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

HB 1152
April 13, 2011
16552

☒ Conference Committee

Committee Clerk Signature Julia Voigle

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide for Medicaid supplemental payments to critical access hospitals; and to provide an appropriation

Minutes:

Chairman Nelson called conference committee to order. Clerk took role and quorum declared. Chairman Nelson opened hearing on HB 1152. (recording inaudible until 1:50) Chairman Nelson went through the changes that the Senate made, both in the Senate Human Services committee and Senate appropriations, stating that most of the changes took place in the appropriations committee (see version .6000)

Senator Lee: When I spoke with Senate appropriations about having an appropriations member here, the chair thought that since most of the changes were policy so it would be appropriate to have policy members part of the conference committee. Senator Kilzer had a concern that there should be a local match because there are some communities that have a sales tax that is dedicated to healthcare facilities. There are some of us who recognize that, that is sometimes possible to do, but I know the community I grew up in didn't have a sales tax match, but had fundraisers and other types of things to support the hospital in the community to make sure it stayed open. Not every small town that holds a critical access hospital has the ability to do that. Senator Kilzer felt that if 10 of them could have sales taxes to support the projects that the rest should. I am not defending it, but providing information.

Chairman Nelson: Section 3 of the bill added a patient centered medical homes legislative management study and the House did include that very study in the Human Service budget.

Legislative Council: Yes, the same study is included in section 7 of the agency's appropriation bill.

Chairman Nelson: Section 4 was a healthcare study and we didn't address that issue in the Human Service budget. That is new language. The way it looks is that it is a permissive study that Legislative Management would have the ability to choose or not to choose to study in the interim. That is a new issue. I don't have a problem with that. In section 5, the money is the same, but I do believe the language, starting in line 9, is different. In the

House it was to run through this biennium. I don't know of a Medicaid payment that has to be renewed every biennium. It seems to me that once you are in the system, that those facilities, especially the high use Medicaid facilities, need this funding to operate. To me, it should be in the baseline budget. For those that aren't familiar with it, that was applied for by the dept and approved and seems to be an appropriate use of state and federal dollars for those facilities. In both bills, it looks to me that it runs out at the end of the biennium.

Legislative Council: the difference between the two is that the Senate version provides the onetime language that would not include it in the base budget. Then it would be backed up and it would be re-addressed at the next session.

Chairman Nelson: is it your understanding with the language in the House version (.04000) that, that would be included in the next budget (Human Service)?

Legislative Council: Office of Management and Budget sometimes looks at these individually and determines whether or not they need to back them out of the agency's base budget. When they come in separate bills, they tend to, but I think the Senate's language would make it clear to Office of Management and Budget that it's not part of their base budget and it would be backed out then when they calculate their base budget for the next biennium.

Senator Uglem: in the .4000, it's for the biennium, pending June 30th, 2013, so does it really make a difference that the additional lines are added?

Chairman Nelson: I think it does because the intention of the original bill was that this was not a onetime payment. It does specify that in the .06000 version. I think it's important that these facilities have the assurance that the state of ND and CMS is going to participate to cover the lab and the CRN A coverage for the facilities and that it was always our intention that this would be an ongoing funding source.

Representative Devlin: that was the intent from the final version of the bill in the House. When it started out, there was an $18M price tag, so it did change from there. When it came out of Senate appropriations, the policy people fully supported it on the floor because it was our thought that it would be a continuing appropriation and certainly one that can be justified across the state for the 36 critical access hospitals.

Senator Lee: that same thought was supported by the policy committee on the Senate side. We haven't tampered with the dollars. If we can figure out a way to satisfy the majority of the folks on both sides with other things then we'll be okay. We felt that the amendment about the medical homes that you moved into the Dept of Human Services (DHS) budget was important. We can't have them continuing to business the way they are. The circumstances are such, with a high volume of Medicare and Medicaid payments, that they are just strangling the way it is. If we look at how important they are to patient centered medical homes and access to healthcare and then what do we do as the reimbursement for lab and CRNAs is at a different level, so that's important. I'm willing to talk about how we can resolve the concerns that Senate Appropriations has. In other words, what can we do that will not be a threat to the hospitals that are in this situation and will satisfy the concerns

of the people who just have a hard time with additional states afford in this area. We are all in the same place with the bulk of it and it's a matter of tuning up some of the rest.

Chairman Nelson: It's my recollection that in that testimony, it did prove that of the 36 critical access hospitals in the state, 24 are losing money. Some have a public support mechanism. With local governance, there are some issues that are very important communitywide. First of all for a community support or a public support to take place, a vote of the people would be necessary and that's not always doable in every community. There is a governance issue as far as the board; how that would have to be set up in relationship to public funding. In my opinion, it's a local issue. All hospitals in the state are having a hard time showing a profit. I think that the work that was done in the House to change the bill to this fashion was well thought out and I don't know how long a window will be open to accept the supplemental payments given the federal situation either. We do know that it's available today and I am one to think that we should take advantage of it. As far as the two studies that are involved in this, is there a problem as far as having this study in 1152 and that exact language in 2012?

Legislative Council: I don't believe there would be an issue. Legislative management will consider it and then I can't imagine that they would approve two studies, so they'll just choose and it'll be in both. I can get back to you on that.

Chairman Nelson: I would suggest that we go back to the House version (.04000), add the two studies to it and run it up the ladder.

Senator Lee: Personally I would vote for that right this minute, but out of respect for the Senate appropriations, I would like to talk to them and see if there is a comfort level we can achieve with them so that we can make sure it goes through the Senate smoothly too.

Chairman Nelson: That is just fine. You can bring that information back and we'll reexamine things. Chairman Nelson adjourned the hearing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

HB 1152
April 14, 2011
16611

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide for Medicaid supplemental payments to critical access hospitals; and to provide an appropriation

Minutes:

Chairman Nelson called conference committee to order stating to let the record show all the conferees are here. He opened hearing on HB 1152.

Senator Lee provided proposed amendment .04006. The Chairman of Senate Appropriations thought it would be fine if we left out that local match, but he felt strongly about leaving in the part about the sunset which we would be addressing in another session anyway as well as the onetime funding. That is the area that we'll have to discuss. If I had to pick one, the one that this amendment got rid of was more painful.

Chairman Nelson: I would agree that, that is the most onerous section in the Senate version.

Representative Devlin: Could we end the pg 1, line 13, after than first sentence (.04006), so it would say "This funding is considering to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium" and not include the next sentence? I don't think the rest of it is needed if you are just doing the one-time funding.

Senator Lee: Yes, if that is something that would please the rest of the group.

Chairman Nelson: (read the next sentence that Representative Devlin proposed to remove) and stated that would mean they would come in next session and report on the use of that particular funding source. Maggie Anderson, when I talked with her, seemed fine about that.

Senator Lee: I move that the Senate recede from Senate amendments and re-amend HB 1152 with amendment .04006 with the removal that was suggested of the second sentence in 'the section of the amendment, pg 1, line 13, after period insert' (amendment .04007)

Senator Dever: Second

Roll call vote taken on motion to **recede from Senate amendments and re-amend HB 1152**, resulting in 6 yes, 0 no, 0 absent, thus **motion carries**.

Representative Nelson adjourned hearing.

VR
4/15/11

11.0346.04007
Title.07000

Prepared by the Legislative Council staff for
Conference Committee
April 14, 2011

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

That the Senate recede from its amendments as printed on pages 1424 and 1425 of the House Journal and page 1173 of the Senate Journal and that Reengrossed House Bill No. 1152 be amended as follows:

Page 1, line 1, after the semicolon insert "to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 3. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

2011 HOUSE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: House Appropriations Human Resources Division

Bill/Resolution No. 1152 as (re) engrossed

Date: 4/14/11

Roll Call Vote #: 1

Action Taken

- ☐ HOUSE accede to Senate amendments
- ☐ HOUSE accede to Senate amendments and further amend
- ☐ SENATE recede from Senate amendments
- ☒ SENATE recede from Senate amendments and amend as follows

House/Senate Amendments on HJ/SJ page(s) 1424 - 1425

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) 1152 was placed on the Seventh order of business on the calendar

Motion Made by: Senator J. Lee Seconded by: Senator Dever

Representatives	4/13	4/14		Yes	No		Senators	4/13	4/14		Yes	No
Chairman J. Nelson	✓	✓		✓			Chairman Uglem	✓	✓		✓	
Representative Devlin	✓	✓		✓			Senator J. Lee	✓	✓		✓	
Representative Holman	✓	✓		✓			Senator Dever	✓	✓		✓	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier — Senate Carrier —

LC Number 11.0346.04007 of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

adopt amendment

REPORT OF CONFERENCE COMMITTEE

HB 1152, as reengrossed: Your conference committee (Sens. Uglem, J. Lee, Dever and Reps. J. Nelson, Devlin, Holman) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1424-1425, adopt amendments as follows, and place HB 1152 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1424 and 1425 of the House Journal and page 1173 of the Senate Journal and that Reengrossed House Bill No. 1152 be amended as follows:

Page 1, line 1, after the semicolon insert "to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 3. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

Reengrossed HB 1152 was placed on the Seventh order of business on the calendar.

2011 TESTIMONY

HB 1152

11.0346.02001
Title.

Prepared by the Legislative Council staff for
Representative Devlin
January 31, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1152

Page 1, line 1, remove "critical access"

Page 1, line 3, remove "**CRITICAL ACCESS**"

Page 1, line 4, remove "a third"

Page 1, line 5, remove "party, such as"

Page 1, line 5, remove the second comma

Page 1, line 6, remove "critical access"

Page 1, line 10, remove "must be a critical access"

Page 1, line 11, replace "hospital in the state which has" with "may"

Page 1, line 11, after "not" insert "have"

Page 1, line 15, remove "quality of care issues, which may include facility"

Page 1, line 16, replace "improvements, patient care needs, and patient care equipment needs" with "extraordinary expenditures and deferred maintenance, such as major building repairs, one-time capital purchases, and energy efficiency upgrades,"

Page 1, line 18, replace "A grant award may not exceed five hundred thousand dollars per recipient." with "In order to qualify for a grant under this section, an applicant:

a. Must be a critical access hospital that has experienced a loss based on at least two of the previous three years of medicare costs reports in order to qualify for a grant not to exceed two hundred thousand dollars;

b. Must be a critical access hospital that does not qualify under subdivision a in order to qualify for a grant not to exceed one hundred thousand dollars; or

c. Must be a long term care acute hospital in order to qualify for a grant not to exceed one hundred thousand dollars.

5."

Page 2, line 5, replace "5." with "6."

Page 2, line 10, replace "$18,000,000" with "$6,500,000"

Page 2, line 12, remove "critical access"

Renumber accordingly

Chairman Weisz and members of the House Human Service Committee and Chairman Pollert, Chairman of the Human Services Human Service Sub-Section of appropriations and members of that committee I am very happy to appear before this esteemed group.

For the record I am Rep. Bill Devlin of Finley. I represent District 23 in the Legislature. District 23 is a rural District that encompasses all or part of five rural counties in eastern North Dakota. We have two Critical Access Hospitals in our District located in Cooperstown and McVille.

I am here to introduce HB 1152 which is a vital bill for the citizens of our state and for health care as we know it North Dakota. It provides funding to Critical Access Hospitals across our state. (The third sheet in your packet shows where they are located) There are substantial costs in dealing with this issue but I believe if this legislative body does nothing about the crisis facing most of the 36 Critical access hospitals in this state, there will be an even greater cost to our citizens.

The term Critical Access Hospitals speaks for itself. The Hospital in that area of the nation has been deemed critical to providing accessibility to health care to the residents of a state. It is critical to the citizens of our state that we make sure they have accessibility to primary health care to meet their needs for chronic care, preventive care and emergency care.

These hospitals are not getting anywhere close to the reimbursements needed to cover the true costs to operate their facilities. We hear the term Medicare allowable costs a lot when dealing with hospitals. What we don't hear are the actual costs. These hospitals have not received their actual cost reimbursement for years. Experts that follow me will explain that in more detail. However, I want

to make it clear that I believe the facts will show that the failure to provide hospitals with reimbursements that cover their true costs forces them not fund critically needed expenditures for capital improvements, repairs, IT needs and many other vital needs. That fact threatens their very existence and it, in my opinion, the state must step in with financial help to protect our citizens.

We talk a lot about infrastructure needs in this body. But, in my humble opinion, infrastructure means more than roads, bridges, water and sewer systems and other things normally associated with the term. To me infrastructure means the things people need to live and work in our state and that includes the access to health care. Accessibility to quality health care is as important to Economic Development and the growth of our state as any of the other factors we always use when we make the case for those needs.

There are 36 critical access hospitals in our state. The last report I saw was for 2009, the second sheet of your packet, it shows that 23 of them lost money, four of them were slightly in the black while nine of them made a profit from $1.1 million to $3.5 million. This bill allows each of them to access $500,000 in funding based on strict criteria that these two committees will further refine.

The top sheet in your packet shows not only the Critical Access Hospitals and the Referral Centers in the larger towns. I put that in there to show how inter-connected the health care system in your state is and note that many of the patients in the larger hospitals started in the smaller ones. One of the larger hospitals reported that over 50 percent of their patients were from outside their local service area. Another said in their situation it was nearly 50 percent. It is in

everyone's best interest to work together to insure the viability of all hospitals.

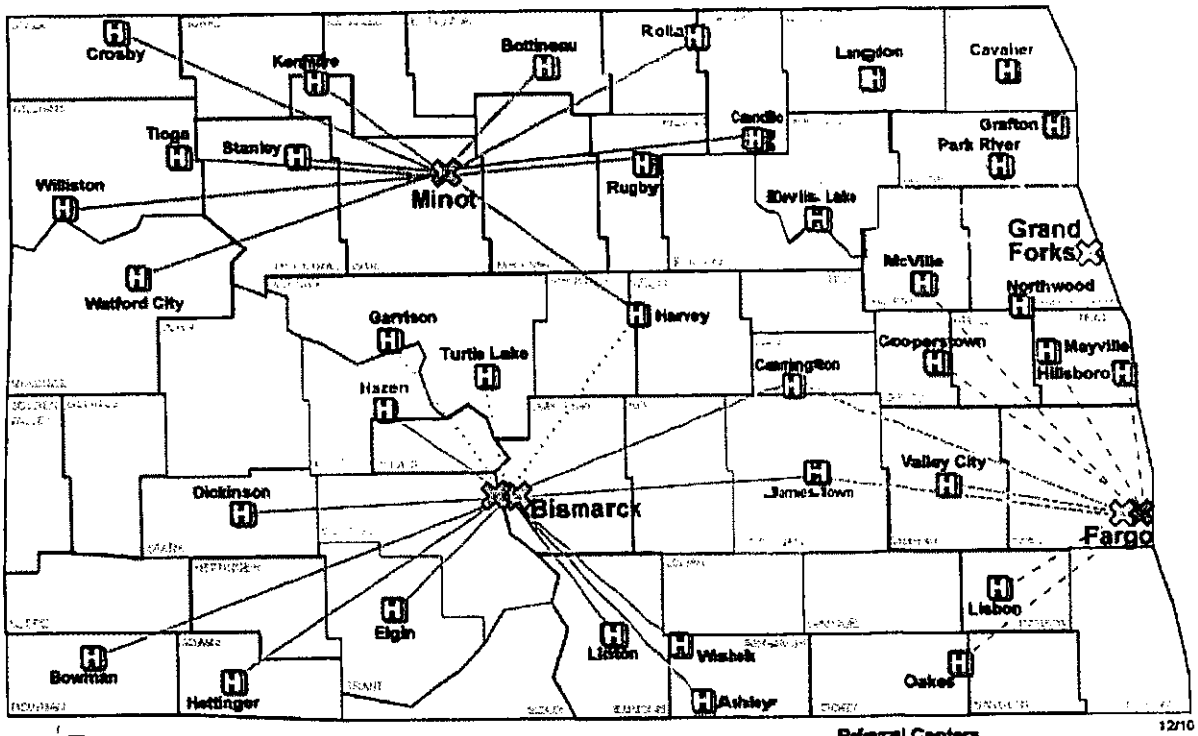
I expect the committee will refine the bill and tighten up the criteria for obtaining a grant. I have no problem with that. What I do have a problem with is if this legislative body, in a time of unprecedented prosperity, turns it back on the need for critical health care services in all areas of our state based on costs.

The map of Critical Access Hospitals shows a chain of life for our citizens. If the chain breaks, people in one or more areas do not have the accessibility they need to health care. We are all connected by this chain of life. I respectfully ask the committees to support the concept, work with the sponsors and hospitals to refine the bill but don't turn your back on these needs based on costs alone. Life is priceless and our citizens deserve nothing less than that full access to hospitals in every area of our great state.

.

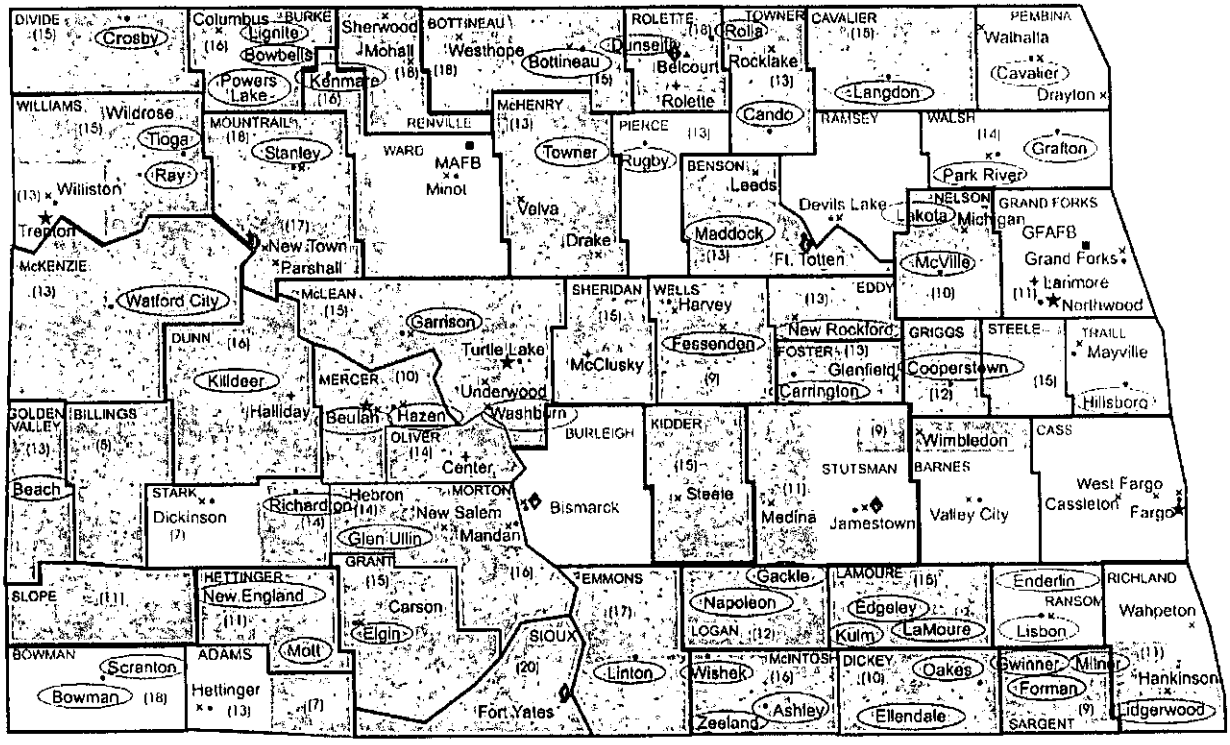
Chairman Weisz, Chairman Pollert and members of the committees, that concludes my testimony. I know you have a lot of questions but I think most if not all of them will be answered by the people that follow me here today. I hope you will wait until that time to ask them. As you are fully aware, as a member of the House Human Services Committee I will be here when we start our deliberations and can provide any additional information needed. Thank you!

North Dakota Critical Access Hospitals & Referral Centers

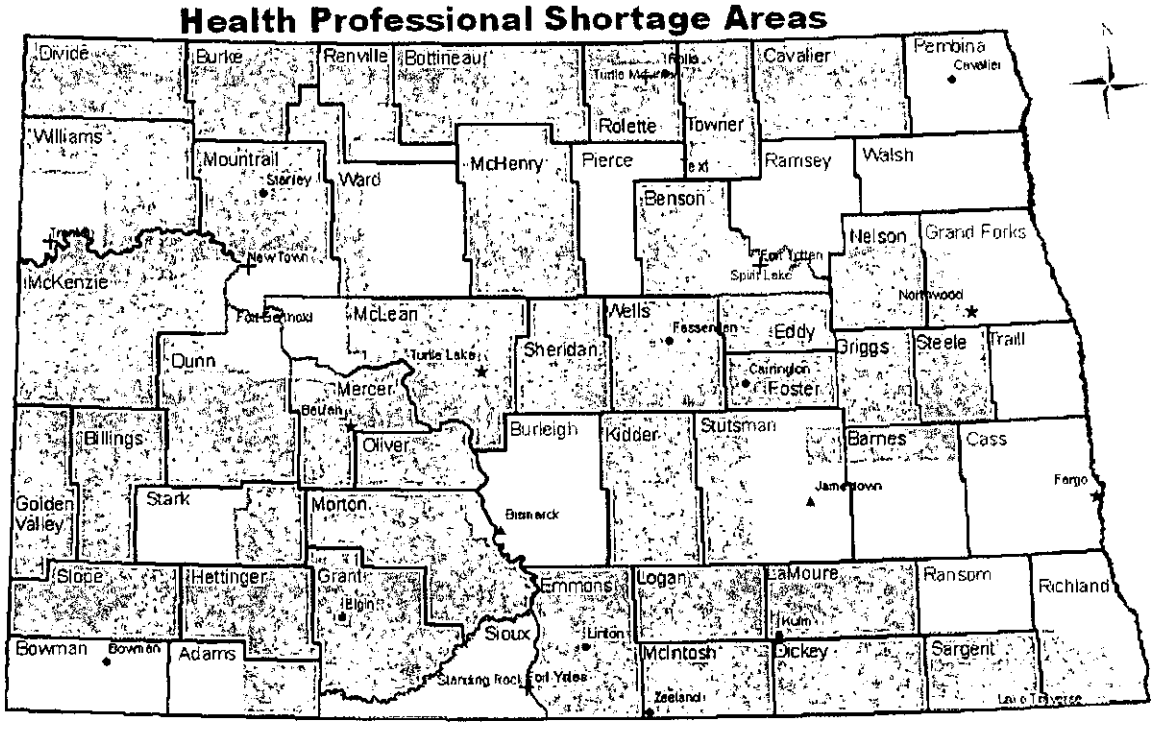


Center for Rural Health
The University of North Dakota
School of Medicine & Health Sciences

North Dakota Health Professional Shortage Areas
Rural Hospitals, Clinics, CHCs and RHCs



North Dakota Primary Care Health Professional Shortage Areas



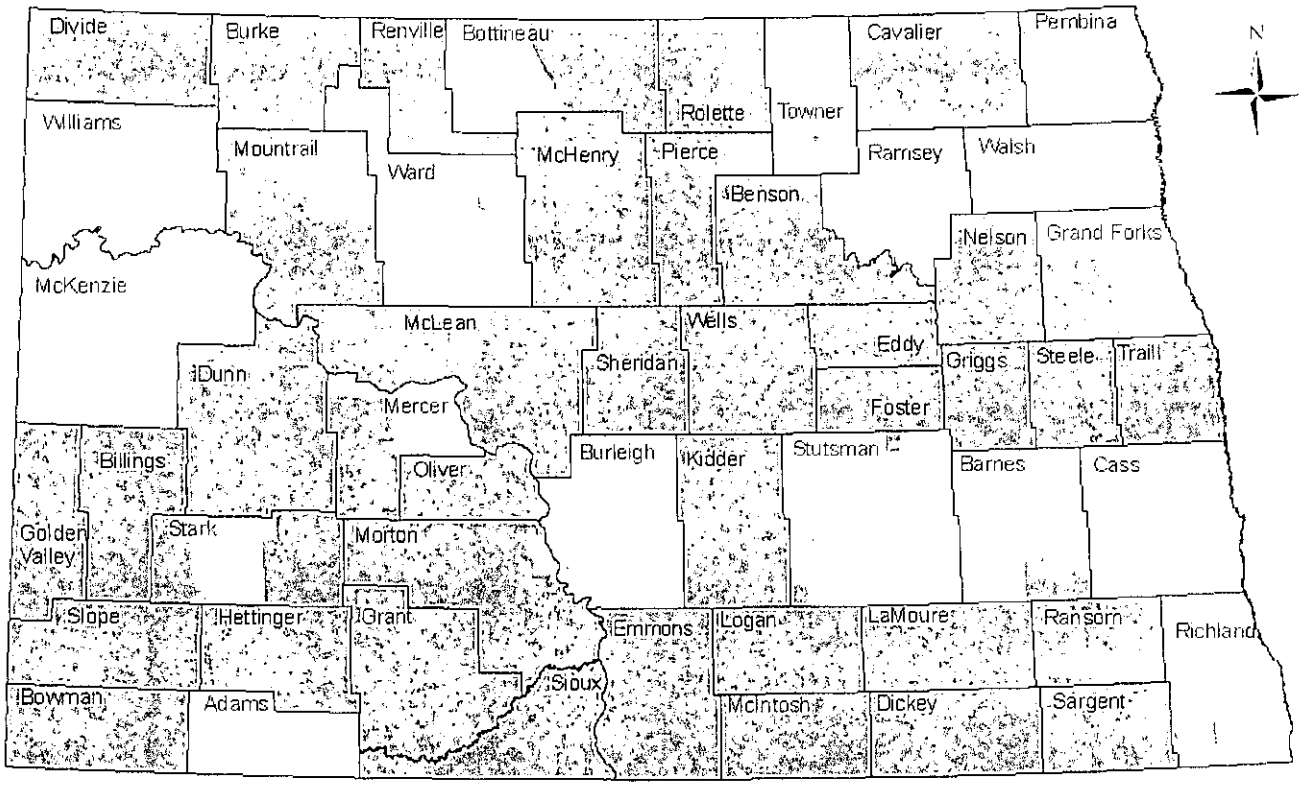
Primary Care Health Professional Shortage Areas

- Designated Geographic HPSAs
- Designated Population HPSAs
- Reservations
- \+ IHS_Facilities *Automatically Designated*
- • RHC - *Requested Automatic Designation*
- ★ CHC *Automatically Designated*
- ▲ Designated Facilities

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

2/10

North Dakota Medically Underserved Areas/Populations



Medically Underserved Areas/Populations

Medically Underserved Areas

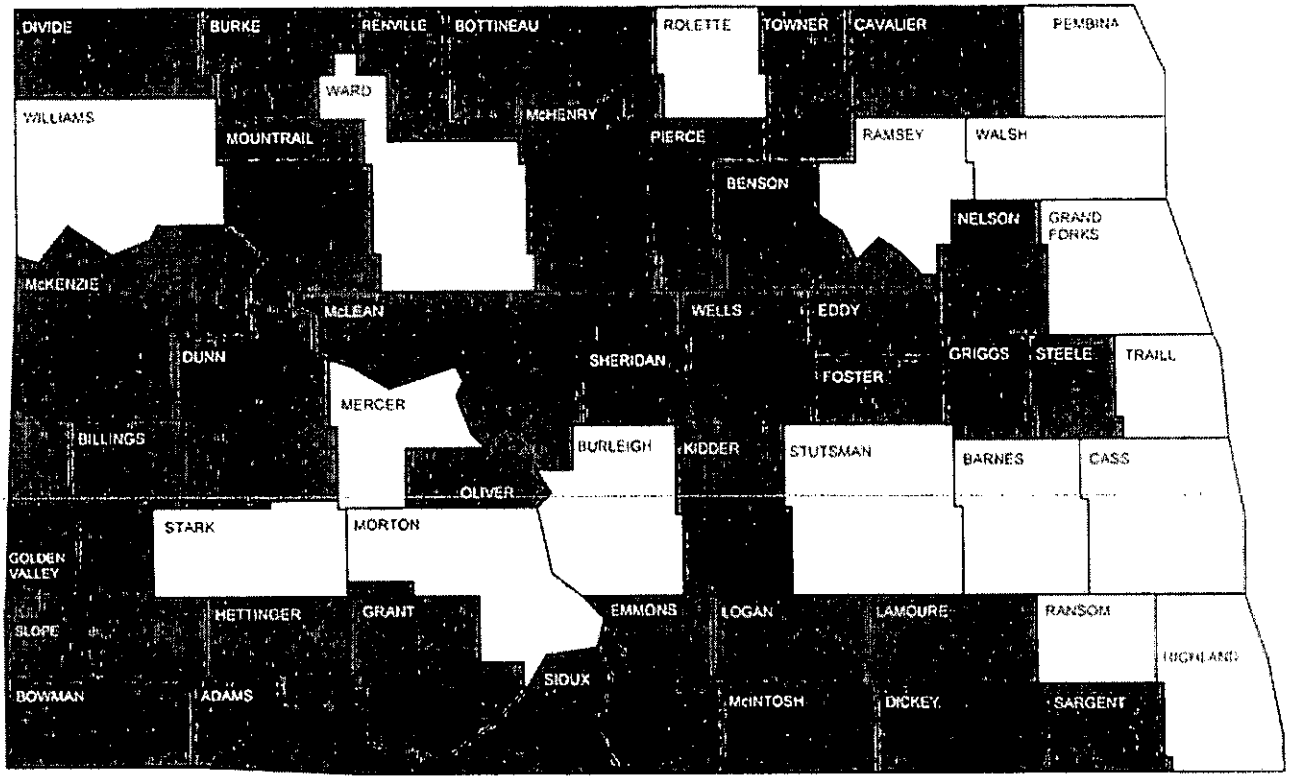
Medically Underserved Populations

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

0 15 30 60 Miles

1/08

North Dakota Frontier Counties



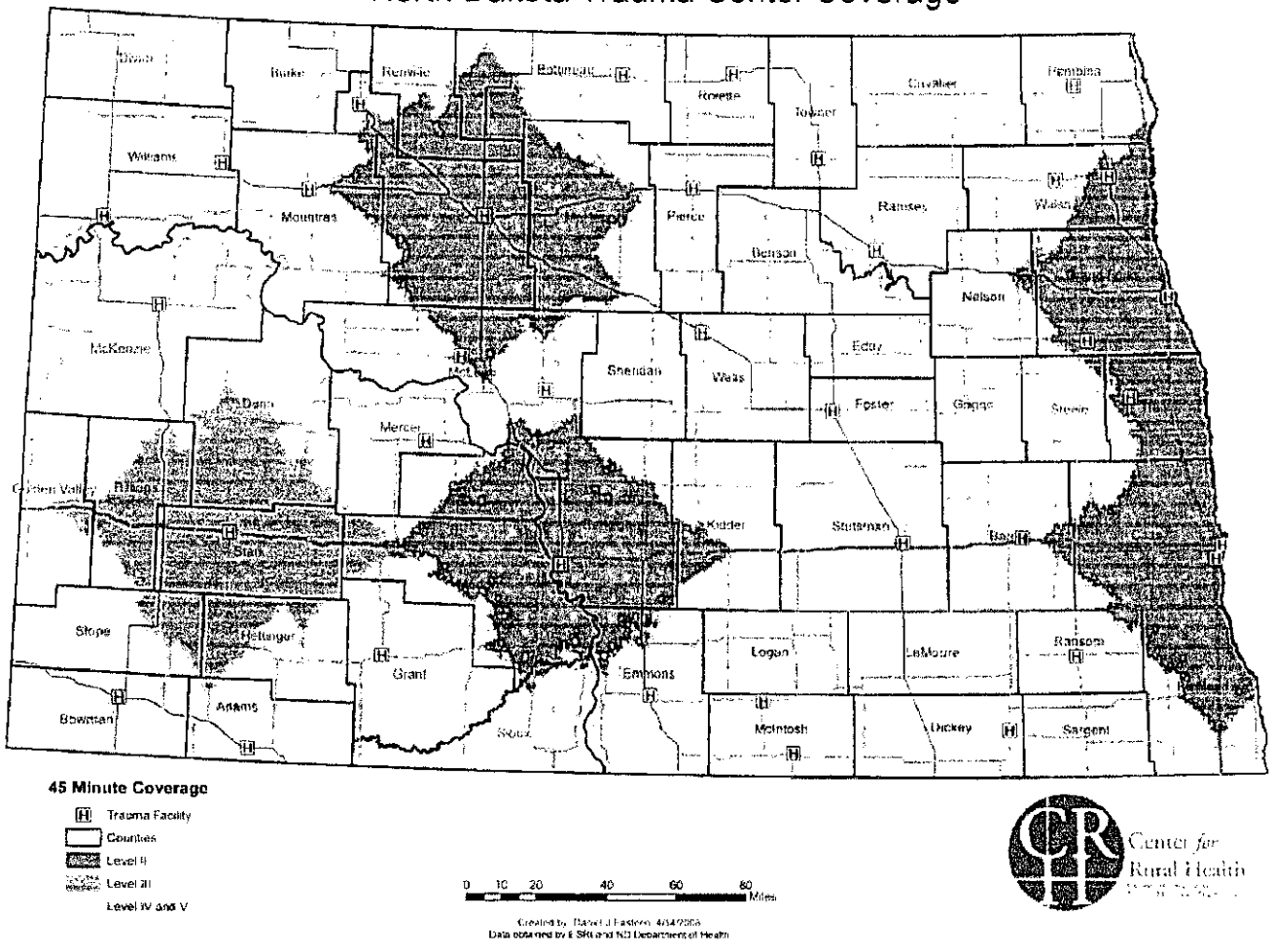
Center for Rural Health

University of North Dakota
School of Medicine & Health Sciences

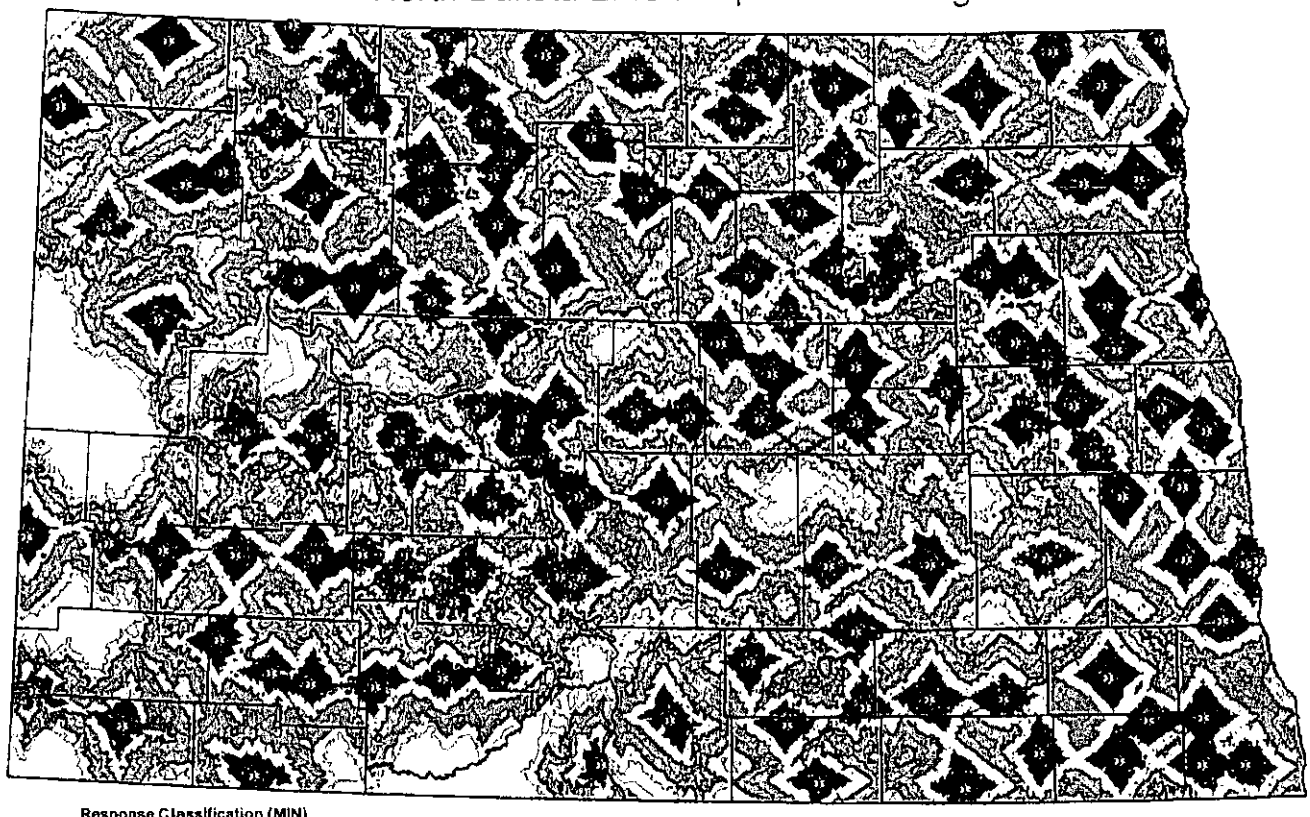
36 of 53 North Dakota Counties designated as Frontier
(less than 6 persons per square mile) Based on 2000 Census

1/03

North Dakota Trauma Center Coverage



North Dakota EMS Response Coverage



19269

Prepared by the North Dakota Legislative Council staff for the Public Safety and Transportation Committee

March 2010

EMERGENCY MEDICAL SERVICES FUNDING

This memorandum provides information regarding funding generated by property tax levies and provided by legislative appropriations for emergency medical services (EMS). Based on Tax Department information, EMS-related property taxes under North Dakota Century Code (NDCC) Chapter 57-15 generated $3.2 million of tax collections in 2009. The State Department of Health distributed $1.1 million of funding from the insurance tax distribution fund appropriated in 2009 Senate Bill No. 2004 to EMS providers in fiscal year 2010. Other sources of funding for EMS include funding from a county or city general fund, countywide sales tax collections, or third-party reimbursements for EMS.

State-administered EMS funding may cover licensed EMS operations--ambulance, air ambulance, or quick response unit services--that provide the transportation of an individual to a hospital emergency room as well as EMS personnel and licensed EMS professionals who provide the related services of prehospital medical stabilization for EMS operations. The State Department of Health is responsible for the issuance of EMS operations licensing. As of February 2010, there are 147 ambulance services and 69 quick response units licensed in the state.

The 2009 Legislative Assembly also appropriated $500,000 from the insurance tax distribution fund in Senate Bill No. 2004 to the State Department of Health for a training grant. The grant is to be used to contract with an organization to develop, implement, and provide an access critical ambulance service operations assessment process, leadership development training, and a biennial EMS recruitment drive. In addition, the organization would provide regional assistance to ambulance services to develop quality review processes for EMS personnel and develop a mechanism to report to medical directors. The State Department of Health issued its first request for proposal (RFP) in November 2009, resulting in one proposal that was not approved for failing to meet requirements. Subsequently, a second RFP was issued in February 2010.

PROPERTY TAX LEVIES FOR EMERGENCY MEDICAL SERVICES

North Dakota Century Code Section 23-27-04.7 requires the board of county commissioners of every county to conduct an annual review of the EMS coverage within that county and to submit an annual report to the State Health Officer addressing funding needs. A taxing district that levies a special EMS levy is required to ensure that every ambulance service that has portions of its service area in that taxing district receives a portion of the revenue from this tax. Taxing districts allocate special tax levy revenue to each ambulance service based upon the taxable value of the property within each township of the taxing district, allocating the taxable value of each township to the ambulance service that serves the largest area within that township.

North Dakota Century Code references relating to property tax rates for EMS operations include:

- County - Section 57-15-06.7(23) provides that a county may levy a tax of up to 10 mills for county EMS. If the county contains a rural ambulance service district or rural fire protection district that levies for and provides EMS, the property within that district is exempt from the county tax levy.
- Township - Section 57-15-20.2(7) provides that a township may levy a tax of up to 10 mills for EMS.
- City - Pursuant to Section 57-15-51, a city may impose a levy of up to 10 mills upon its taxable valuation for the purpose of subsidizing city EMS. Whenever a tax for county EMS is levied, any city levying a tax for EMS may be exempted from the county tax levy.
- Rural ambulance service districts - Pursuant to Section 57-15-26.5, a rural ambulance service district may levy a tax not exceeding 10 mills on the taxable value of property within the district.

A detailed report of each property tax levy collected per county and associated mill rates for EMS is attached as Appendix A. Attached as Appendix B is a summary report illustrating total amount of property tax collections for EMS per county.

EMERGENCY MEDICAL SERVICES GRANTS FROM INSURANCE TAX DISTRIBUTION FUND

The 2009 Legislative Assembly, in Senate Bill No. 2004, appropriated $2.25 million from the insurance tax distribution fund for grants to EMS operations. North Dakota Century Code Chapter 23-40 and the State Department of Health North Dakota Administrative Code (NDAC) Chapter 33-11-08 govern this funding disbursement.

Eligibility requirements for these grants under NDCC Chapter 23-40 include the following:

- Emergency medical services operations must be licensed with the State Department of Health for a period of at least 12 months before the filing of the application.
- Emergency medical services operations must bill for services at a level at least equivalent to Medicare billing levels.
- Applications must be filed before November 1 of each year with the State Department of Health. Applications must include affirmation of

the operations billing levels and document the availability of local matching funds.

- Emergency medical services operations must be in conformance with any additional requirements established by the Health Council.

The Health Council has established the following administrative rules regarding eligibility requirements for these grants under NDAC Chapter 33-11-08:

- Applications for the grant must be made in the manner and timeframe prescribed by the department.
- The ambulance service must be based in North Dakota.
- The ambulance service must be licensed as a basic life support ground ambulance as described in Chapter 33-11-02 or licensed as an advanced life support ground ambulance as described in Chapter 33-11-03 for at least 12 months prior to the filing of the application.
- Criteria for grant approval includes consideration of the transportation distance to hospitals, size of the ambulance service area, the number of ambulance runs, and contributing factors that may affect the number of patient care providers on the ambulance service. Contributing factors considered may include age, population, service's location, size of the service area, and other personal commitments.

North Dakota Century Code Chapter 23-40 requires the State Department of Health to develop a strategic plan for an integrated EMS program in North Dakota which includes a comprehensive statewide EMS system. Based on state needs identified in the strategic plan, the State Health Officer shall make the following determinations: eligibility, level of local matching funds, and distribution amounts. The department uses a sliding percent formula for determining the percentage of an applicant's local matching fund obligation. The sliding percent formula is based on the department's strategic plan and must include consideration of how the applicant fits into the strategic plan and consideration of the needs of EMS operations in the applicant's neighboring service areas. The State Health Officer may not distribute funds to an applicant unless the applicant has verified the existence of local matching funds at the level determined by the State Health Officer. Chapter 23-40 requires the local matching funds to be at least 10 percent but not more than 90 percent of the proposed distribution amount.

The chapter provides that during the first year of the biennium, the State Health Officer may not distribute more than one-half of the biennial legislative appropriation and during the second year of the biennium, the State Health Officer may distribute the remainder of the biennial legislative appropriation. A recipient of funds under this chapter shall use the funds in a manner consistent with rules adopted by the Health Council. A recipient of funds may not use funds for capital expenses such as emergency vehicles and EMS equipment.

A summary of staffing grants awarded in 2010 is attached as Appendix C. Of the 147 ambulance services licensed with the State Department of Health, the department determined that 107 met the above-mentioned eligibility requirements. Out of the 107 eligible ambulance services, the State Department of Health received 41 applications, 2 of which were denied. One application was denied because the ambulance service had recently changed ownership and did not meet the minimum 12-month licensing requirement. The other was denied because the ambulance service application failed to demonstrate financial need.

ATTACH:3

EMERGENCY MEDICAL SERVICES
PROPERTY TAX LEVY BY COUNTY DETAILS
2009 COLLECTIONS BASED ON 2008 ASSESSMENTS

1228 - County - Emergency medical service - Maximum rate is 10 mills. Levies are in addition to the general fund levy enacted upon a majority of qualified electors of the county voting on the question. A taxing district that levies a special emergency medical services or ambulance service levy shall ensure that every ambulance service that has portions of its service area in that taxing district receives a portion of the revenue from this tax.

Source: North Dakota Century Code Sections 57-15-50, 57-15-06.7(23), and 23-27-04.7.

Levy No.	County Name	District Name	Mills	Property Tax Collections
1228	Traill	County	10.00	$298,635
	Sargent	Emergency medical	8.90	147,880
	Rolette	Ambulance	7.72	81,356
	Oliver	County	6.04	50,642
	Grand Forks	County	6.00	1,120,286
	Benson	County	5.00	77,772
	Golden Valley	County	5.00	30,701
	Kidder	County	5.00	58,527
	Logan	County	5.00	39,665
	Pembina	County	5.00	169,480
	Towner	Ambulance north	5.00	24,495
	Towner	Ambulance south	5.00	38,760
	Sioux	County	4.28	9,991
	Eddy	County	4.00	27,962
	Dickey	County	3.50	77,265
	LaMoure	County	3.29	65,872
	Cavalier	County	3.00	82,848
	McIntosh	County	3.00	32,354
	Emmons	County	2.00	29,372
	Grant	County	2.00	18,527
	Pierce	County	2.00	29,474
	Ransom	County	1.90	37,962
	Griggs	County	1.00	10,025
	Barnes	Ambulance	0.97	45,671
	Foster	County	0.17	2,385
Total				$2,607,907

1522 - Civil township - Emergency medical service - Maximum rate is 10 mills. Levies are in addition to the general fund levy enacted upon 60 percent majority vote of qualified electors. A taxing district that levies a special emergency medical services or ambulance service levy shall ensure that every ambulance service that has portions of its service area in that taxing district receives a portion of the revenue from this tax.

Source: North Dakota Century Code Sections 57-15-51.1 and 57-15-20.2(7).

Levy No.	County Name	District Name	Mills	Property Tax Collections
1522	Burke	Cleary	1.47	$250
Total				$250

1629 - City - Emergency medical service - Maximum rate is 10 mills. Levies are in addition to the general fund levy enacted upon a majority of qualified electors of the county voting on the question. A taxing district that levies a special emergency medical services or ambulance service levy shall ensure that every ambulance service that has portions of its service area in that taxing district receives a portion of the revenue from this tax.

Source: North Dakota Century Code Section 57-15-51.

Levy No.	County Name	District Name	Mills	Property Tax Collections
1629	Stark	Richardton	10.00	$8,104
	Mountrail	Stanley	4.27	7,992
	McIntosh	Ashley	2.13	1,808
	Hettinger	New England	1.30	599
	McIntosh	Wishek	1.16	1,161
Total				$19,664

1801 - Rural ambulance service district - Emergency medical service - Maximum rate is 10 mills. Requires majority vote to form or dissolve ambulance district or to increase mills (Attorney General Letter Opinion 2002-L-43). Local area levying for ambulance service is exempt from county levy.

Source: North Dakota Century Code Sections 11-28.3-03, 11-28.3-04, 11-28.3-09, and 57-15-26.5.

Levy No.	County Name	District Name	Mills	Property Tax Collections
1801	Richland	Lidgerwood	10.00	$35,220
	Sargent	Rural ambulance	10.00	13,598
	Burleigh	Rural ambulance - Wilton	8.87	36,618
	McLean	Wilton	8.87	15,120
	Wells	Ambulance	6.05	34,664
	Burke	Ambulance	5.00	20,682
	McLean	Turtle Lake	5.00	29,551
	Richland	Hankinson	5.00	55,861
	Sheridan	McClusky	5.00	16,129
	McLean	Underwood	4.75	22,594
	McLean	Washburn	4.43	28,894
	Dunn	Killdeer	4.00	32,724
	Richland	Barney	3.91	8,348
	Richland	Wyndmere	3.91	17,375
	Divide	Grenora	3.86	7,110
	Williams	Grenora	3.86	14,557
	Nelson	Ambulance	3.44	17,851
	McLean	Garrison	3.00	33,900
	Renville	Ambulance	3.00	14,147
	Divide	Ray	2.92	997
	Williams	Ray	2.92	17,564
	McLean	Parshall	2.74	2,035
	Mountrail	Parshall	2.74	7,970
	Divide	Divide County ambulance district	2.60	21,921
	Bottineau	Bottineau	2.00	38,490
	Bottineau	Lansford	2.00	10,797
	Bottineau	Westhope	2.00	15,190
	Bottineau	Willow City	2.00	3,828
	McKenzie	Ambulance	1.82	344
	Mountrail	New Town	1.82	7,753
Total				$581,832

1808 - Rural ambulance service district - Old-age and survivors' insurance, federal Social Security, and employee retirement - Maximum rate is 30 mills. Levies are in addition to the general fund levy.

Source: North Dakota Century Code Sections 52-09-07(3) and 57-15-28.1(5).

Levy No.	County Name	District Name	Mills	Property Tax Collections
1808	Divide	Divide County ambulance district	0.29	$2,445
Total				$2,445
Grand total				$3,212,098

SUMMARY OF EMERGENCY MEDICAL SERVICES
PROPERTY TAX LEVY BY COUNTY
2009 COLLECTIONS BASED ON 2008 ASSESSMENTS

County Name	Levy No. 1228 County	Levy No. 1522 Civil Township	Levy No. 1629 City	Levy No. 1801 Rural Ambulance Service District - Emergency Medical Services	Levy No. 1808 Rural Ambulance Service District - Old-Age and Survivors' Insurance, Federal Social Security, and Employee Retirement	Total
Barnes	$45,671					$45,671
Benson	77,772					77,772
Bottineau				$68,306		68,306
Burke		$250		20,682		20,932
Burleigh				36,618		36,618
Cavalier	82,848					82,848
Dickey	77,265					77,265
Divide				30,028	$2,445	32,473
Dunn				32,724		32,724
Eddy	27,962					27,962
Emmons	29,372					29,372
Foster	2,385					2,385
Golden Valley	30,701					30,701
Grand Forks	1,120,286					1,120,286
Grant	18,527					18,527
Griggs	10,025					10,025
Hettinger			$599			599
Kidder	58,527					58,527
LaMoure	65,872					65,872
Logan	39,665					39,665
McIntosh	32,354		2,970			35,324
McKenzie				344		344
McLean				132,094		132,094
Mountrail			7,992	15,723		23,715
Nelson				17,851		17,851
Oliver	50,642					50,642
Pembina	169,480					169,480
Pierce	29,474					29,474
Ransom	37,962					37,962
Renville				14,147		14,147
Richland				116,804		116,804
Rolette	81,356					81,356
Sargent	147,880			13,598		161,478
Sheridan				16,129		16,129
Sioux	9,991					9,991
Stark			8,104			8,104
Towner	63,255					63,255
Traill	298,635					298,635
Wells				34,664		34,664
Williams				32,121		32,121
Total	$2,607,907	$250	$19,665	$581,833	$2,445	$3,212,100

EMERGENCY MEDICAL SERVICES INSURANCE TAX DISTRIBUTION PER 2009 SENATE BILL NO. 2004
FISCAL YEAR 2010

Ambulance Service	Grant Award	Contractor Share	Contractor Percentage	Total Costs
Billings County Ambulance Service	$45,000	$30,000	40%	$75,000
Bottineau Ambulance Service	21,000	31,500	60%	52,500
Bowman Ambulance Service	45,000	11,250	20%	56,250
Casselton Volunteer Ambulance Service	35,000	35,000	50%	70,000
Community Volunteer EMS of LaMoure	7,300	10,950	60%	18,250
Divide County Ambulance District	45,000	5,000	10%	50,000
Emmons County ALS Ambulance	20,000	8,571	30%	28,571
Flasher Ambulance Service	13,000	1,444	10%	14,444
Gackle Ambulance Service	45,000	5,000	10%	50,000
Grenora Ambulance Service	45,000	5,000	10%	50,000
Hillsboro Ambulance Service	9,800	39,200	80%	49,000
Kidder County Ambulance	35,000	8,750	20%	43,750
Killdeer Area Ambulance	27,000	3,000	10%	30,000
Kindred Area Ambulance Service	33,000	22,000	40%	55,000
Lidgerwood Ambulance Service	20,000	20,000	50%	40,000
Maddock Ambulance Service	45,000	11,250	20%	56,250
McKenzie County Ambulance Service	45,000	5,000	10%	50,000
McVille Community Ambulance Service	26,646	39,969	60%	66,615
Medina Ambulance Service	45,000	5,000	10%	50,000
Mohall Ambulance Service	29,000	29,000	50%	58,000
Napoleon Ambulance Service	25,000	6,250	20%	31,250
New England Ambulance	33,280	8,320	20%	41,600
Northwood Deaconess Health Center	19,000	28,500	60%	47,500
Page Ambulance Service	11,000	11,000	50%	22,000
Parshall Ambulance Service	15,800	23,700	60%	39,500
Pembina Ambulance Service	45,000	19,286	30%	64,286
Richardton-Taylor Ambulance, Inc.	24,500	10,500	30%	35,000
Rock Lake Ambulance Service	9,000	6,000	40%	15,000
Rolette Community Ambulance Service	34,923	52,385	60%	87,308
Sargent County Ambulance - Forman	43,000	43,000	50%	86,000
Sargent County Ambulance - Milnor	2,080	8,320	80%	10,400
Towner County Ambulance	21,330	9,141	30%	30,471
Turtle Lake Ambulance Service	27,000	11,571	30%	38,571
Velva Ambulance Service	35,000	35,000	50%	70,000
Walhalla Ambulance Service	9,600	14,400	60%	24,000
Westhope Ambulance	44,000	11,000	20%	55,000
Wilton Rural Ambulance District	32,000	32,000	50%	64,000
Wing Rural Ambulance	22,000	2,444	10%	24,444
Wishek Ambulance	14,000	9,333	40%	23,333
Total 2010 distributions	$1,104,259	$669,034		$1,773,293

#3

January 19, 2011 House Bill 1152 Miller, Marlene (testimony)

Chairman Pollert and Chairman Weisz and members of the human service sub section of appropriations committee and members of the house human services committee.

My name is Marlene Miller and I am a program director at the UND Center for Rural Health - I have been in this position for eight years. I am a licensed master's prepared social worker and have had the opportunity and honor of working with ND hospitals (large and small) as well as many clinics and long term care facilities that are associated with them. I serve as the program director for two federally funded grants which are both designed to maintain access to quality health care in rural and frontier areas of North Dakota. The programs I am referring to are the Medicare Rural Hospital Flexibility Program (aka Flex) and the Small Hospital Improvement Program (aka SHIP). Both programs are funded through the federal Office of Rural Health Policy, Health Services and Research Administration.

My testimony today comes from two avenues:

1. My own experience, which comes from having been in each of North Dakota's hospitals and having ongoing contact with hospital administrators, directors of nursing, quality improvement coordinators, and chief financial officers, for the past eight years. I provide direct technical assistance to CAHs such as strategic planning, community needs assessments, staff surveys, network development and manage small grants provide to hospitals through the programs.
2. Information shared today also comes from objective data from a variety of sources such as the Flex Monitoring Team, federal Office of Rural Health Policy, economic impact studies using IMPLAN data and the hospitals themselves through anonymous surveys conducted over the years.

Today I will provide:

1. An overview of critical access hospitals in North Dakota including data that explains the age of our rural hospitals and the impact this has on the delivery of healthcare in our rural areas;
2. Challenges that our critical access hospitals are experiencing;
3. The results of economic impact studies completed on behalf of 13 critical access hospitals; and
4. Rural hospitals successes in meeting the health care needs of North Dakota's rural residents.

I. Critical Access Hospital (CAH) Overview

North Dakota's rural hospitals are one very important component to the state's health care delivery system. The system is comprised of critical access hospitals (CAHs), large referral hospitals, rural health clinics, community health centers, public health units, home health, long term care, emergency medical services, and a statewide trauma system.

Nationally, ND is known for its networking which is evident from the collaboration across our health system. Of the state's 36 CAHs, 26 of them operate within an integrated system – meaning they own or operate other components of the delivery system such as EMS, clinics, and long term care. This has implications related to financial viability and maintaining continued access to care for rural residents.

As of September 2010 there are 1320 CAHs in the nation – 36 located in ND. All of North Dakota's CAHs are non-profit/non-governmental entities. A CAH is a small, rural, acute care facility that provides outpatient, emergency and limited inpatient services. The primary benefit of designation as a CAH is exemption from the prospective payment system, and receiving cost-based reimbursement for services based on 101 percent of reasonable costs. (I do not plan on detailing the financial model and its implications as it is my understanding that Darrold Bertsch will speak to this and its impact on the viability of our facilities next).

Geographic criteria that CAHs must meet include being at least 35 miles from the nearest hospital. Of the state's 36 CAHs all but 2 are located at least 35 miles from one another – this has significant impact if we think about a hospital closing.

Most rural hospitals were built in the 1940s and 1950s and used funding from the Hill-Burton Grant Program of 1946. Nationally, over the past 60 years, numerous CAHs have made renovations, expansions, and/or major rehabilitations while about 100 facilities have replaced their entire hospital.

A national study completed in 2008 explained that hospital leaders reported improvement in tangible measures of hospital performance and operational efficiency after replacing their facility. They also reported greater success in physician and staff recruitment and improved customer and employee satisfaction. Additionally, the majority of replaced CAHs have documented that expenses are lower (on a unit cost basis) than pre-replacement. Other intangible benefits include improved work culture, better quality of care and a significant boost to the local economy.

A national research team called the Flex Monitoring Team is comprised of rural health experts from the Universities of Maine, South Carolina and Minnesota. Each year this research team reviews Medicare cost report data to determine the "average age of plant" for all CAHs in the nation. The average age of plant is measured by the average accounting age in years of the fixed assets of an organization – this may differ from the average chronological age because of depreciation practices. The most recent data from the Flex Monitoring Team indicates that North Dakota facilities are some of the oldest in the nation – the average age of plant for ND CAHs is 12.45 years; compared to the national average of 10.33 years. Current data shows the range of ND facilities by age of plant from 3 to 23 years.

North Dakota's rural hospitals are aging – many are outdated in the midst of a changing health care system. A national study of 10 CAHs found that renovations cost between $1 and 17

million and will likely result in increased physician referrals, increased market share, physician recruitment and retention, community satisfaction as well as improved operating margins.

II. CHALLENGES

The ND Flex Program conducted a statewide survey of all CAHs in 2008 to inform its strategic planning. Hospitals were asked to identify their most pressing challenges. From a lengthy list of potential issues:

- 100% of CAHs identified physician and nursing supply as their most significant challenge
- 100% also said third party reimbursement was the most significant problem they were facing
- 96% are experiencing issues with providing or maintaining access to mental health services.
- 92% are having difficulties with workforce in general (lab techs, coders, HIT assistance)
- 92% indicating significant difficulties with uninsured
- 67% said their most significant issues was their physical plant
- 58% said it was accessing capital
- 25% said it was addressing life/safety code issues

We are scheduled to repeat this survey in 2011, however based on my interactions with hospital leaders I do not foresee a change to these needs.

III. ECONOMIC IMPACT

While the hospital is vital in that it provides medical services to all residents, it typically is also the largest or second largest employer in the county. Health care facilities are a source of external dollars, because most of their funding comes from sources outside the community such as the federal and state government. For many communities, the hospital is a source of millions of dollars in outside revenue.

Hospitals are a significant employer, hiring both professional and nonprofessional staff in order to provide the care needed in the community. Those employees, in turn, buy goods and services from local businesses. Over 18,800 people were employed by community hospitals in 2008 as either part-time or full-time employees, according to the North Dakota Hospital Association. North Dakota has 38 rural hospitals: 36 Critical Access Hospitals and two Indian Health Services hospitals. The payroll and benefit dollars that these hospitals expend cycle through the local economy to generate additional dollars of income in other industries. Thus the healthcare system is a vital component of the county's fiscal well-being, providing not only much needed medical services but also a significant contribution to the county's economy. A strong case exists for the economic benefits that rural hospitals provide.

In 2010 the Flex Program (at the Center for Rural Health) completed 13 individual economic impact studies for critical access hospitals. Studies referenced are for those hospitals located in

Wishek, Tioga, Hazen, Bowman, Bottineau, Garrison, Turtle Lake, Mayville, McVille, Elgin, Watford City, Valley City, and Harvey.

- On average the 13 CAHs employ 122 full time equivalent positions; and create an additional 33 full time non health care positions within their respective communities.
- Together the 13 CAHs created 459 additional jobs and together had an economic impact of $65 million to ND.
- On average, CAHs from this study have an economic impact of $4.65 million to their communities. The range is from $2.5 to $8.7 million.
- Extending the averages to all 36 critical access hospitals, a conservative figure is: $167 million economic impact – we know it's much higher though. For example, large critical access hospitals such as St. Joseph's in Dickinson have an economic impact of $16.4 million (much higher than the $4.65 million used as an average for small rural hospitals).

IV. CAH use of GRANT FUNDING – SUCCESSES in MAINTAINING ACCESS TO CARE

As I've mentioned my frame of reference comes from managing two federally funded programs – the Flex and SHIP grants; both designed to support rural communities in preserving access to primary and emergency health care services. The Flex Program specifically helps sustain the rural healthcare infrastructure by strengthening critical access hospitals (CAHs) and helping them operate as the hub of a collaborative delivery system in those communities where they exist. Together these federal grants bring over $1 million each year to ND. CAHs have access to direct funding from both grants, however the funds are not allowed for bricks and mortar needs.

The SHIP grant allocates funds to each CAH on an annual basis – the focus is narrow and prescriptive. Funds average approximately $7,000 per CAH per year and have been used in recent years to support HIPAA compliance, quality improvement and health information technology. The Flex program allocates grant funds to CAHs on a competitive basis each year – the average award is $14,000.

My point in sharing this information is to convey that ND's CAHs have had and do have access to external funding – however the funding, such is the case with the Flex and SHIP grants, are small in comparison to the significant needs, and funding has limitations in terms of how it may be allocated. Since 1999 over $10 million have been subcontracted by the UND Center for Rural Health to CAHs – as a result of this funding I can speak to many successes that have been realized on behalf of ND's rural communities. A few examples include: 9 CAHs have utilized funding to develop local cardiac rehabilitation programs which allows for residents to return "home" for their care after major cardiac care at a large referral center; over half of ND CAHs are accessing information technology solutions to maintain care for rural residents such as e-emergency, telemedicine for wound care and mental health; and funds have been used to invest in staff and provider education to ensure those who care for us are equipped with knowledge of ongoing advancements and maintaining their skills.

It is my opinion that ND CAHs are extremely resourceful – all 36 of the CAHs came together to form a statewide quality network and have worked to streamline processes and improve care. A significant number of CAHs belong to one or more networks which allows them to negotiate as a group and save on costs associated with supplies, equipment purchases and consultant time.

V. OVERVIEW

In rural America, the local hospital exists to meet the emergent and non-emergent needs of the community. North Dakota's health care system is affected by demographic, social, and economic factors. With urban clusters and a small, geographically rural and frontier population, the state faces a unique set of challenges and opportunities that confront the population's health, the types of health care services needed, and the financial viability of health care systems.

We can be assured that providers in North Dakota want to do the right thing – rural hospitals especially are in a position to implement changes quickly but face significant systematic challenges: supply of health shortages, aging physical plants, reimbursement issues, aging equipment, medical advancement, demographic changes, and yet to be determined implications of health reform.

The confluence of issues facing rural health care is significant with cost, access and quality being overarching themes. Maintaining adequate staffing and competent providers impact access to quality of care. Recruiting health professionals, providers and others; retaining current staffing by offering competitive wages and benefits; and, investing in health information technology all come at a high cost. The financial constraints currently facing the majority of North Dakota's small rural hospitals severely limit their investment in the future of the health care delivery system as it exists today.

Chairmans Pollert and Weisz and members of the human service sub section of appropriations committee and house human services committee thank you for your time.

Testimony on HB 1152
Before House Human Services Committee
and
Human Services Subsection of Appropriations
January 19, 2011

Good morning Chairman Weisz and committee members. My name is Darrold Bertsch and I am the CEO of Sakakawea Medical Center in Hazen, North Dakota. I am here to testify in support of HB 1152.

Sakakawea Medical Center is a 25 bed Critical Access Hospital that provides local access to a variety of healthcare services to area residents including hospital services, 2 Rural Health Clinics, a 34 bed Basic Care facility, home health services and hospice. As is the case with the majority of the Critical Access Hospitals (CAH) in the state, we contribute positively to our local economy.

I would like to share three different types of information with you today. First of all, as *Appendix A,* I have included a map of the hospitals in North Dakota, with the Critical Access Hospitals being highlighted in yellow. The map shows that North Dakota has 6 larger acute care hospitals located in Bismarck (2), Minot, Grand Forks, and Fargo (2). There are also 36 Critical Access Hospitals located throughout the state. *(Comments)*

A Critical Access Hospital is designated as such by meeting the licensing requirements of the Centers for Medicare and Medicaid Services (CMS). As you may well know, CAHs can have no more that 25 licensed beds and must provide emergency services 24 hours per day. CAHs are reimbursed by Medicare, allowable cost plus 1% for the services provided to Medicare beneficiaries. Allowable costs however don't include such things as advertising, patient telephones, patient television, association/membership fees, the increasing bad debt expense we are experiencing and other operating expenses. Also not allowed are expenses that we are required to allocate to non cost based services that we provide such as Assisted Living, Home Health, Hospice, independent apartments, ambulance, meals on wheels, etc. Often the local hospital provides

these needed services, though it may negatively impact the reimbursement received from Medicare for the services provided at the hospital.

Payments received by North Dakota CAHs from commercial insurance companies for services provided to their subscribers are generally reimbursed based on charges submitted or on a fee schedule, as is the case with BCBS of North Dakota, the largest insurer in the state. For many of the smaller CAHs in North Dakota the cost of providing services to BCBS subscribers exceeds the reimbursement received from BCBS of North Dakota. Reimbursement from North Dakota Medicaid has been improved in the last couple of years, but cost based reimbursement for lab and clinic services would be beneficial as well for those who serve a large Medicaid population.

I feel HB 1152 would provide important grant funding to Critical Access Hospitals in North Dakota, to address their specific facility needs. These facilities are part of an important healthcare delivery network in North Dakota and provide important services to the communities in which they are located. In many cases, these facilities provide a variety of services, including hospital, clinic, nursing home, home health, hospice, ambulance services, basic care, assisted living and meals on wheels. Often they are also the largest local employer and are an important social and economic contributor to their local communities. *Appendix B* provides a list of the Critical Access Hospitals and the services that they provide. You will see the number of licensed hospital beds and the diversity of the services provided. Note that 27 of the Critical Access Hospitals also own and operate a total of 56 clinics. Without these local clinics, many of which are subsidized by the hospital, local residents would need to travel great distances to access basic primary care services. *(Comments)*

The second set of information that I would like to share with you validates the financial struggles experienced by North Dakota's Critical Access Hospitals. In *Appendix C* you are able to see data compiled annually for all CAHs in the U.S. by a consortium of the University of Minnesota, North Carolina and Southern Maine. The most recent information available from this source is for calendar year 2008. These financial indicators are taken from Medicare Cost Reports submitted

annually by hospitals to CMS. The information that I am providing shows that the Critical Access Hospitals in North Dakota lag well behind the national average and in comparison with other states in our region for the majority of the financial indicators presented. It is especially important to note the comparisons of median net margin, days of cash on hand and average age of plant. These indicators illustrate some of the financial challenges experienced by the state's CAHs. In *Appendix D*, you will find the 5 year historical median net margin comparison. Again you will see the North Dakota Critical Access Hospitals have negative margins and compare poorly with the national average and with the states in our region. *(Comments)*

The third set of information that I would like to share begins with Appendix E. Though the financial analysis I previously mentioned provided good information, North Dakota Critical Access Hospitals felt that we needed to have more current financial information from our facilities to analyze and use for our advocacy with our payers and stakeholders. In order to do so, annually I requested that all CAHs in North Dakota provide me with a copy of their most recent fiscal year financial statement. I have compiled this information annually for each of the past 4 years, with the most recent information being gathered in May of 2010. *Appendix E* provides a historical snapshot of the statement of operations for the CAHs reporting and the number of facilities reporting in each year. You will notice that facilities consistently experience operating and net margin losses. There has been slight improvement in the margins over the 4 year period that we feel is due in large part to the hard work done by Critical Access Hospitals to improve operations, increased local financial support and the increased reimbursement that we have received from BCBS of North Dakota, as a result of our advocacy efforts. *Appendixes F*-1 and F-2 are graphs of the operating margins for the CAHs reporting in 2006 – 2009. You will notice that in all 4 years there have been 21 – 23 facilities that have experienced negative operating margins. *(Comment)*

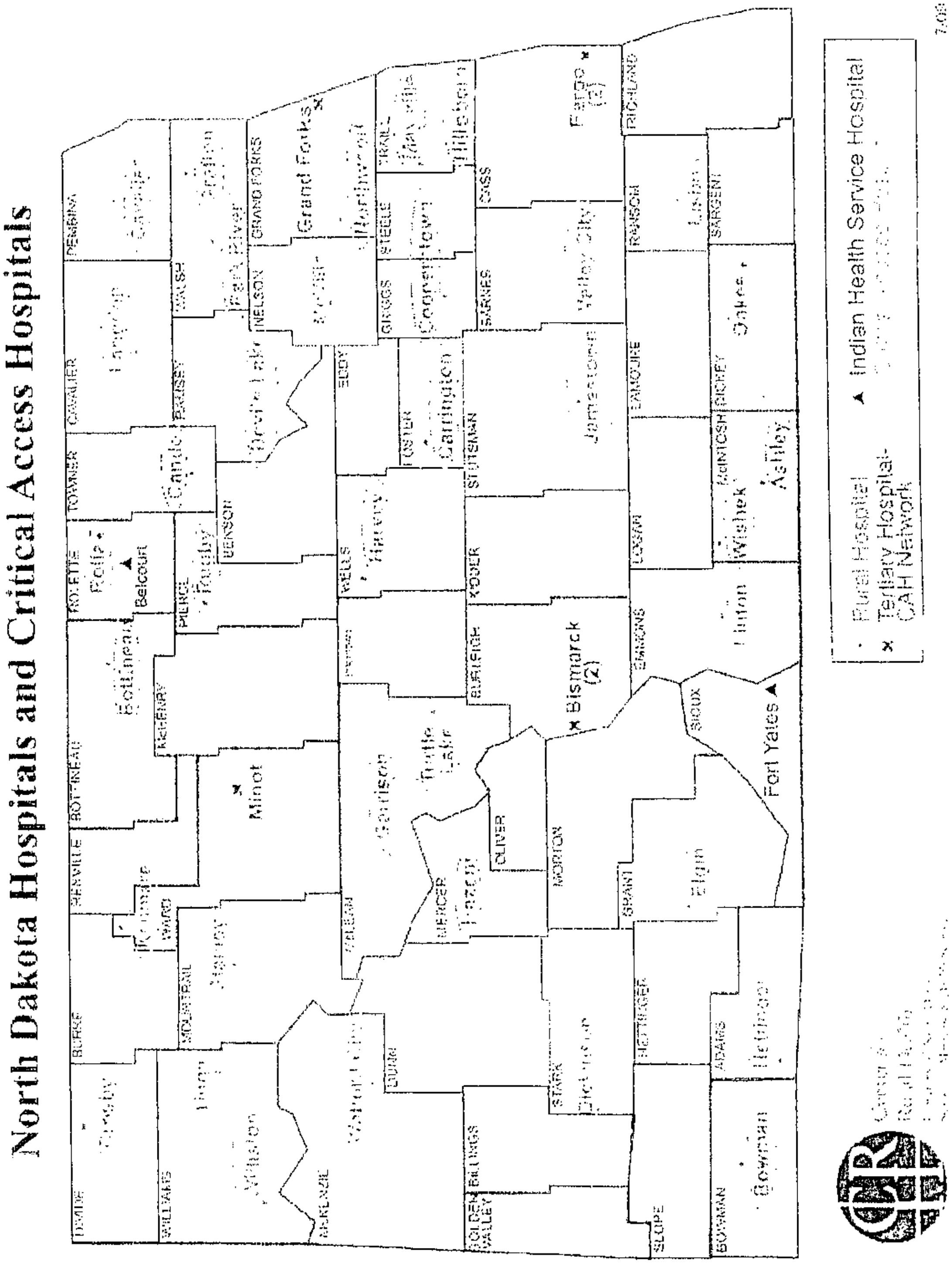
The losses being experienced by the state's Critical Access Hospitals makes it difficult for facilities to make ends meet, let alone have the cash on hand or borrowing capacity to make the needed facility improvements or service enhancements. HB 1152 will provide funding for the state's CAHs to address

individual facility specific needs. This legislation is not the total solution to the financial challenges being faced by the state's CAHs, but can provide much needed financial support that will benefit the patients being served. It will take a continued collaborative effort of many stakeholders in order for the rural health delivery network in North Dakota to remain viable.

Thank you to those who introduced this legislation and thank you all for your consideration of HB 1152. If you have any questions, I would be happy to answer them at this time.

Darrold Bertsch, CEO
Sakakawea Medical Center
510 8th Ave NE
Hazen, North Dakota 58545
Email address: dbertsch@sakmedcenter.org,
Telephone 701-748-7240, Cell phone 701-880-1440

APPENDIX A



North Dakota Hospitals and Critical Access Hospitals
Grand Forks
Fargo (2)
Bismarck (2)
Minot
Jamestown
Fort Yates
Belcourt
Carrington
Wishek
Ashley
Elgin
Valley City
Rural Hospital
Tertiary Hospital-CAH Network
Indian Health Service Hospital

APPENDIX B

North Dakota Critical Access Hospitals & Dickinson
Services That Are Owned/Operated

10/1 1/2010

Margin 6 7 8 9	Community	CAH Hospital	Nursing Home Beds	Basic Care	Assisted Living	Apartments	Clinic	Ambulance	Home Care
	Ashley	20 Beds	44 Beds			30 Units	RHC - 2		Yes
	Bottineau	25 Beds				15 Units	Jointly Own		
	Bowman	23 Beds	66 Beds		12 Units	16 Units	RHC	Yes	
	Cando	20 Beds	40 Beds	10 Beds		10 Units	RHC - 1 of 2		
	Carrington	25 Beds		24 Beds			RHC - 3	Yes	
	Cavalier	25 Beds	60 Beds				RHC		
	Crosby	25 Beds					RHC - 3		
	Cooperstown	18 Beds	48 Beds		12 Units		RHC		
	Devils Lake	25 Beds							
	Dickinson	25 Beds					RHC - 4		Yes
	Elgin	21 Beds	25 Beds				RHC - 2		
	Garrison	22 Beds	28 Beds				RHC		
	Grafton	17 Beds					RHC		
	Harvey	25 Beds	106 Beds			16 Units			
	Hazen	25 Beds		30 Beds			RHC - 2		Yes
	Hettinger	25 Beds					RHC - 5 of 7	Yes	
	Hillsboro	20 Beds	36 Beds					Yes	
	Jamestown	25 Beds							Yes
	Kenmare	25 Beds					RHC		
	Langdon	25 Beds					RHC - 2	Yes	
	Linton	14 Beds			11 Units		RHC - 3 of 4	Yes	
	Lisbon	25 Beds							Yes
	Mayville	25 Beds							
	McVille	19 Beds	39 Beds				RHC - 2		
	Northwood	12 Beds	61 Beds		6 Units	10 Units		Yes	
	Oakes	20 Beds					Yes		
	Park River	14 Beds					RHC		
	Rolla	25 Beds							
	Rugby	25 Beds	80 Beds	68 Beds	37 Units		Yes	Yes	
	Stanley	11 Beds					RHC		
	Tioga	25 Beds	30 Beds			22 Units	RHC - 3		
	Turtle Lake	25 Beds					RHC		
	Valley City	25 Beds		25 Beds					Yes
	Watford City	24 Beds	47 Beds	8 Beds	16 Units	7 Units	RHC		
	Williston	25 Beds					Yes 3		Yes
	Wishek	24 Beds					RHC - 4	Yes	Yes
6 5 10 13	**Facilities**	36	14	6	6	9	27	9	8
27 27 34 36	**Total**	799	706	185	94	146	56 46 RHCs		

CAH Financial Indicators 2008

Description	*National*	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
2008						
# of CAHs Included	1,247	**31**	36	77	42	65
Median Net Margin 2008	2.40%	**-0.95%**	3.32%	3.62%	3.12%	4.82%
Days Cash on Hand	61.0	**27.2**	42.2	99.6	72.3	111.8
Medicare Inpt Cost/Day	$1,633	**$1,145**	$1,431	$1,946	$1,580	$1,647
Average Age of Plant	10.4	**13.2**	10.8	9.7	14.0	9.4

Flex Monitoring Team, Fall 2010

APPENDIX C

CAH Financial Indicators 2008

	National	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
Median Net Margin						
2004	2.32%	**-2.07%**	2.70%	5.19%	1.25%	2.56%
2005	2.63%	**-.06%**	-.31%	3.06%	2.86%	4.24%
2006	3.58%	**-1.65%**	3.39%	4.40%	3.22%	5.08%
2007	3.64%	**-1.54%**	3.54%	5.13%	2.99%	5.75%
2008	2.40%	**-0.95%**	3.32%	3.62%	3.12%	4.82%

Flex Monitoring Team, Fall 2010

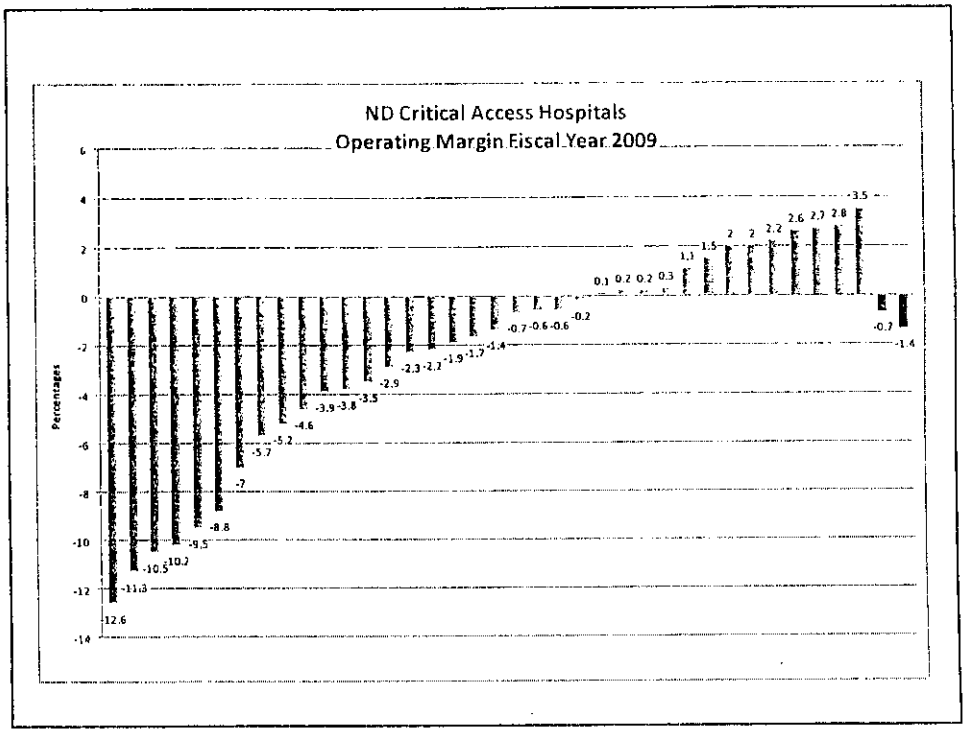
APPENDIX D

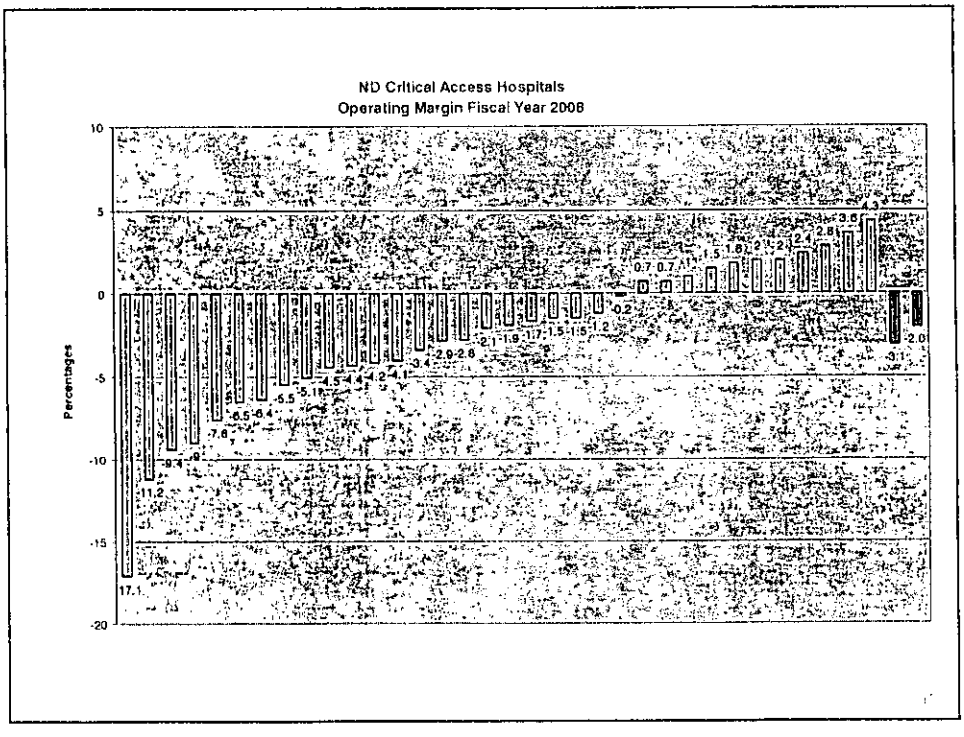
North Dakota Critical Access Hospitals
Financial Analysis By Bertsch

	27 Facilities 2006 Average	27 Facilities 2007 Average	34 Facilities 2008 Average	36 Facilities 2009 Average
Patient Revenue	$7,207,616	$7,781,546	$13,274,587	$14,927,825
Deductions	$1,447,925	$1,693,319	$ 4,326,888	$ 4,788,112
Net Revenue	$5,759,691	$6,088,227	$ 8,947,699	$10,139,712
Expenses	$5,980,217	$6,351,698	$ 9,356,405	$10,240,384
Operating Margin	- $220,526	- $263,470	- $408,706	-$100,672
Operating Margin%	*-3.1%*	*-3.4%*	*-3.1%*	*-0.7%*
Non Operating Rev.	$152,317	$194,617	$159,262	-$73,331
NET Income/Loss	-$68,209	- $68,854	-$249,444	-$174,003
Net Margin % Mean	*-0.9%*	*-0.9%*	*-1.9%*	*-1.2%*
Net Margin % Median	*-1.7%*	*-2.0%*	*-0.6%*	*-0.7%*

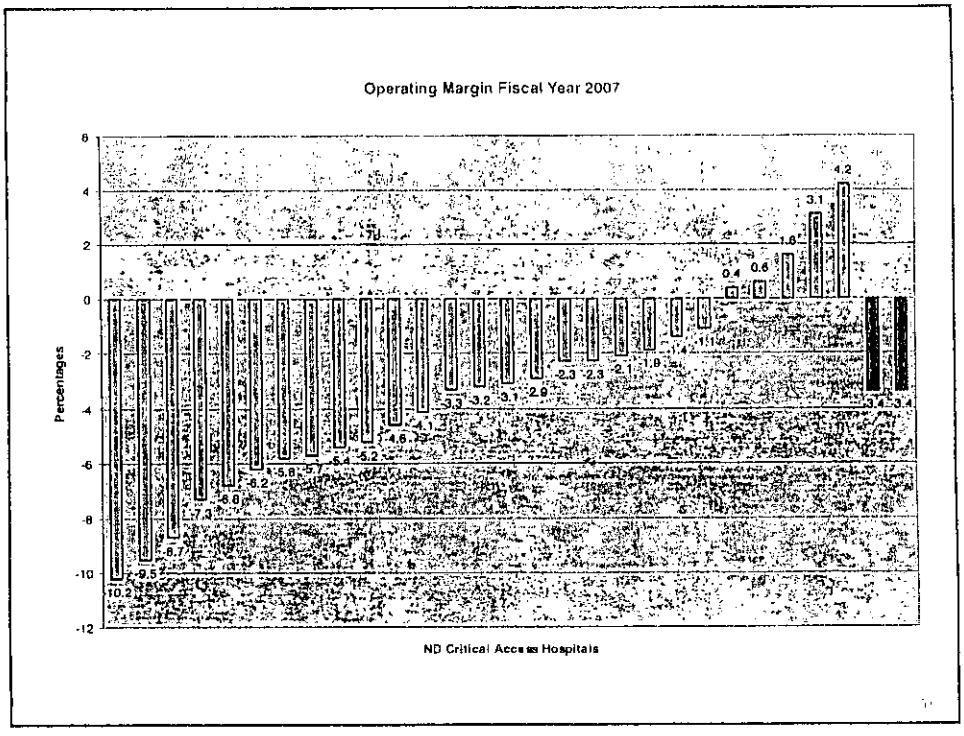
APPENDIX E

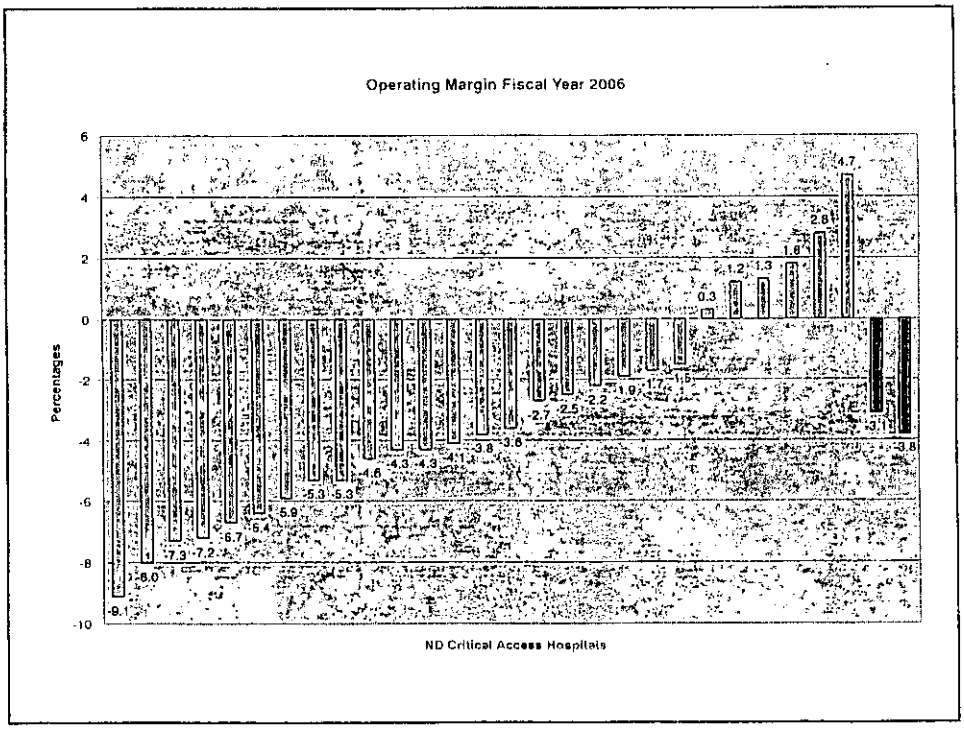
APPENDIX F-1


ND Critical Access Hospitals
Operating Margin Fiscal Year 2009
Percentages


ND Critical Access Hospitals
Operating Margin Fiscal Year 2008
Percentages

APPENDIX F-2


Operating Margin Fiscal Year 2007
Percentages
ND Critical Access Hospitals


Operating Margin Fiscal Year 2006
Percentages
ND Critical Access Hospitals

#5

January 19, 2011

Committee Hearing Notes: HB 1152
Members of the House Human Services Committee

Good morning and thank you for the opportunity to provide this testimony.

Introduction:
Pete Antonson, CEO, Northwood Deaconess Health Center. (NDHC) CFO 1983-2000. CEO to present.
Licensure: Nursing Home Administration, CPA
President North Dakota Rural Health Association since inception 2008
Past Chair ND Board of Examiners
Past board member NDHA and NDLTCA

NDHC formed in 1902 by 15 area Lutheran churches, 11 now surviving.
501 c 3 non profit.
Services provided: Hospital, nursing home, asst living, independent living, ambulance, rehab, emergency room with attached clinic run by independent organization. 2 physicians and 2 mid-levels.

Item / description	Statistic	Comment if any
Employment	173 employees	Largest employer in Northwood
Payroll	$4,600,000	Community of just under 1,000
Fixed assets	$4,887,000	68% of total assets. Business that doesn't provide great liquidity and requires significant capital investments.
Recent projects	Assisted living	$900,000 in 2008
	Electronic health record	$275,000 in 2007 and 2008
	Ambulance	$128,200 in 2009
Current needs	Replacement boilers, air handlers, air conditioning.	Plant size – 90 K sq. ft. Capital needs $1 million plus.
Current indebtedness	$3,000,000	USDA and private banks with guaranteed loans
Energy grant opportunities	Limited	Due to 501 c 3 status
Financing options	USDA or USDA signing off.	Last operating profit 2003. Last overall profit 2007.

North Dakota's economy is the envy across the country. Two major parts of that are agriculture and energy. Significant parts of both of those industries are located in rural parts of the state. Without health care services, those industries will struggle to maintain, much less continue to grow. Health care becomes part of the necessary infrastructure to maintain those significant parts of our economy and why we are asking for your support of this bill.

Thank you for your time. Questions?

Testimony on HB 1152
House Human Services Committee
House Appropriations Sub-Committee

Chairman Weisz, Chairman Pollert, and members of the House Human Services Committee and the House Appropriations Sub-Committee: Thank you for the opportunity to testify on HB 1152. My name is Cathy Swenson, and I am a nurse and the CEO of Nelson County Health System in McVille, ND – a 19 bed Critical Access Hospital (CAH), a 39 bed LTC facility, two Rural Health Clinics, and a soon to be finished 12 unit Assisted Living facility. I am testifying in support of HB 1152.

It was an exciting day when Governor Dalrymple gave his state of the state address on January 4th. He spoke about a variety of economic indicators and how we are setting our own course. He spoke about progress, population growth, the creation of new jobs, the low unemployment rate in the state, and how ND is strong and growing stronger. He specifically spoke about improvements to infrastructure and additional funding for a variety of areas – including health and other quality of life improvements, and he talked about working cooperatively together to achieve common goals – things that certainly apply to Critical Access Hospitals in North Dakota.

You've already heard about the financial status and the effects of years of inadequate reimbursements to rural facilities. This is not "news" – it has been included in the research studies by the NDHA in 1997, 2002, 2006, and the last one completed in 2008 called the Economic Pulse of ND. This information has been utilized for legislative testimony as well as utilized by various groups in the state. ND CAH have and continue to experience lower net returns than other hospitals across the nation.

Net returns represent the bottom line dollars that are needed to improve their facilities, purchase new equipment, expand services to meet the healthcare needs of the people they serve and keep pace with inflationary factors such as rate increases for employees to remain competitive and the increased costs they experience in purchasing supplies and services.

When net returns are decreased, CAH's are forced to tap into returned earnings to sustain their operations and facilities – essentially digging themselves into a hole. Year after year of decreased reimbursements, have now made that hole a crater for many CAH facilities, and CAH's across the state are asking for your help.

I've been told there are concerns re: some CAH's in the state showing a positive bottom line. Those CAH's with a positive bottom line have just begun to dig themselves out of that crater, due to increased utilization and an increase in population in the state, economic development, and continuing to provide the most cost efficient quality care to their patients. Having a positive bottom line is a positive thing – but it doesn't begin to make up for the losses they have incurred in the past. They are clearly demonstrating the practices that were often discussed during the Congressional hearings regarding Health Care Reform Whether you agree with the proposals for Health Care Reform or not, the one consistent message repeated time and again was how other states should learn from ND – a state that despite it's low reimbursement, continues to provide a high level of quality care when compared to all of the other states.

I've also been told there are also concerns re: not being "specific" enough. When CAH's were requested re: the top three concerns they needed to address in their facilities, what you see listed in the bill were the results - Because, when you see one CAH, then you've seen one CAH, and in order to make their needs known – all were listed as they requested

Using my facility as an example, a 13 bed Hospital was completed in McVille in 1917. In 1957, a 6 bed addition was added. In 1974, that 1957 addition was "modernized", the original 1917 building razed, and a replacement built in its place. Both the modernization and replacement portion occurred due to community involvement, loans, and Hill Burton funding. We continue to operate out of the "modernized" 1957 addition which houses our Business office, Medical Records, Lab/Xray, and Hospice/Home Health. The 1974 replacement continues to function as our CAH, with our nurses station, a two bed ER, a nursing office, Physical – Occupational- and Speech therapy, utility rooms, a CSR, supply and linen rooms and a reception area. We have pictures of the open house held in 1974, and the only changes to the facility include interior paint, a wall paper border, and additional equipment – such as cardiac monitors, security cameras, and State Radio receivers at the nurses station.

Our windows and our heating system are original – meaning 37 years old this year- and they need to be replaced – as they are not energy efficient, and should be converted from steam to hot water. They are wearing out and actually quit functioning for 22 hours early this winter, as repairs were being made. They are wearing out. We were able to obtain a grant for our LTC facility (which is City owned) to replace the boilers and upgrade our LTC heating system at a cost of $44,352.00. The costs for the hospital would be at least double that amount, because it would require two boilers, include the hot water conversion, and removal of the old boilers. Our electrical and heating system expenses for the CAH last year was over $54,000. A very basic energy audit indicates we could decrease those expenses by at least 1/3, but more importantly, it would improve our patients comfort during their hospitalization. We just don't have the funds.

In June of 2007, one of our J-1 physicians resigned to return to the east coast to be near other family and friends who lived there. We began our recruitment efforts and worked with a physician to provide occasional coverage at our facility. In January 2008, our second J-1 physician resigned after fulfilling his commitment to our community and returned to the east coast to work in research. We continued our recruitment efforts and paying for 24 hour locum coverage until September 2009, when we hired one physician with a second physician being hired in October 2009. The total cost to our facility? $1,447,947.60.

The cardiac monitoring equipment I mentioned earlier was replaced in the fall of 2010, as replacement and maintenance parts were no longer available. We could not afford to purchase a new system, and now are leasing a used and older cardiac monitoring system that provides just the basic EKG monitors. That is expected to be obsolete as well in another 5 years, but it currently meets our basic needs and it's something we can afford.

There are CAH facilities in this state who have or are about to be cut off from their medical suppliers. Due to additional expenses they have incurred, they been unable to completely pay their bills every month, and are making partial payments. Their long time suppliers are requiring a complete payment in order to continue receiving supplies. As a result, they have opened a new account with another supplier in order to have the basic items necessary to provide care. They still owe the money to their "old" supplier and continue to generate additional expenses with their "new" supplier.

Other facilities have the same upgrades that are needed to provide basic needs, such as heat, window replacements, sidewalk replacements, recruitment of staff, and the list goes on. The needs are varied, but they are needed. The grant application could require specific documentation to allay any fears of the legislators, and you could name one or more legislators to participate in the committee to review those applications if you continue to have concerns.

Then and now – Health Care and Social Assistance represent the state's largest non-government employment section. CAH's also rank as either the largest or second largest employer in their community with their presence having a primary and secondary effect for employment and economic impact. In addition, many CAH's operate a Rural Health Clinic (RHC) in order to retain and utilize their current medical provider(s).

The Center for Rural Health started posting CAH profiles on their web page at http://ruralhealth.und.edu. It lists information about each facility and their services, along with their economic impact – including the primary and secondary jobs generated as a result of their presence. Thirty (30) of the 36 CAH's in the state currently have a listing. The total primary and secondary jobs for these 30 facilities totals 6,057. The primary and secondary financial impact generated by these 30 facilities totals 193.7 million.

Although the population of each of these communities ranges from 408 to over 14,000 – it clearly demonstrates if you have seen one CAH, you have seen one CAH. These facilities are a diverse group, but they all provide access to primary health care acute and emergency health care services for the rural citizens of this state.

As the only CAH in our county, NCHS has employees who live in our county, as well as Benson, Ramsey, Eddy, Grand Forks and Griggs counties. We also impact and provide care to rural residents in these 6 counties, and 3 LTC facilities in Nelson County.

In November 2010, I contacted the administrators of all the CAH's in ND to get current information re: their viability. Twenty-two of 36 facilities (61%) responded.

The responses of these 22 facilities:

1. Do you currently have an EMR?
   *18/22 indicated they do not.

2. If not, do you currently have the funds to pay for an EMR?
   *3/18 indicated they have arranged for/or currently have the finances to pay for the software, hardware, training costs, conversion, and 1 year of maintenance.
   *Two facilities indicated this expense depleted their organizations foundation and/ or a trust given to them.

3. For those who had not implemented an EMR, what was their projected expense to acquire and implement an EMR?
   *18/22 responded with projected expense amounts ranging from $500,000 to $1.5 million dollars.

4. How many of you have a medical provider shortage?
   *16/22 indicated they currently had a medical provider shortage.
   *Two additional written comments indicated their facilities did not have a current shortage, but will have openings in 2-3 years due to the retirement of their current providers.

5. For your provider vacancies, how much money could you spend on a high scale recruitment effort?
   *Amounts ranged from $0.00 to $200,000
   *One written comment indicated "I don't have the answer to this question because we recruited for 24 months with no success."
   *One written comment indicated "I don't have the money to do any recruitment except local papers and utilizing the options available to us through the physician recruitment services (3R Net) at the UND Medical School.

6. Of those who answered "yes" to needing a medical provider, the total expenses they incurred as a result of their locum staffing for their FYE 2009 totaled $8,057,225.00 .

7. How much is your annual payroll?
   *The total for all 22 facilities was $916,075,102.00

8. What is the dollar amount of benefits you provide to your employees?
   *20 of the 22 original replied with $16,338,361.00 total
   *The remaining 2 facilities did not complete this portion

9. Have you tried to access capital in the past fiscal year?
   *8 of the original 22 respondents marked "yes"
   *2 did not complete this portion
   *12 marked "no"

10. If your answered "yes" to accessing capital in the past fiscal year, have you had any difficulties due to your financial position/balance sheet?
   *5 of the 8 who tried to access capital answered "yes"
   *Written comments included: "No, I didn't even try as I knew it would not fly"; "We had to actually increase our loan amount in order for financing to be approved under the USDA, as it improved our financial status"., and "No, but it's razor thin".

11. How many days of cash do you currently have on hand?
   *Less than 10 days = 8/22
   *11-20 days = 7/22
   *21-30 days = 1/22
   *31-40 days = 2/22
   *41-50 days = 1/22
   *51-99 days = 2/22
   *100 + days = 1/22

12. Does your facility face potential "closure" in 5 years or less if improvements in reimbursement, joining another larger facility, sale of your facility, closing one or more of your rural health clinics does not occur?
    *2/22 responded yes
    *2/22 wrote "?" besides the yes
    *18/22 indicated "no"

13. Has "closure" been discussed with your Board of Directors?
    *4 of the facilities indicated this has occurred

14. If you answered yes to #12 or #13, how many miles from your facility is the next CAH/ healthcare facility that would be able to provide 24 hr. emergency care?
    *22 replies indicate distances ranging from 30 -80 miles one way.

ND CAH's are at a crisis point in ND. I hope this testimony has provided you with information you need to make your decision. When I sent out the survey above, I noted that the information would be collated together and no identifying information would be included.

I am not sure if you realize this, but the makeup of these two committees actually represents legislative districts having 50% or 18 of the 36 CAH's in ND. I have to believe the CAH administrators in each of your legislative districts would share their facility specific information with you.

Access to quality rural care is vital to the health of the citizens of this state, the overall economy, and the vitality of the communities we are located in. None of us wants to become a "mini upper Midwest Mayo", but simply do what's been done for 100's of years so far, and that's to take care of our community.

Thank you for your patience and this opportunity. I would be happy to try and address any questions you may have.

#7

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1152

Human Service Committee
Critical Access Hospital Grant
January 19, 2011

Chairman Weisz and members of the Human Services Committee.

I am Tim Blasl, Vice President of the North Dakota Hospital Association (NDHA). I am presenting testimony put together by Jerry Jurena, President of the North Dakota Hospital Association (NDHA). Jerry is in Washington, D.C. visiting with our congressional delegation.

The North Dakota Hospital Association (NDHA) is made up of forty-five hospitals. There are thirty-six critical access hospitals (CAH) in the state; thirty-four are members. There are six large tertiary hospitals in the four major cities all members of NDHA. Other member hospitals include: two long-term acute care hospitals, one psychiatric hospital, one state hospital, and one VA hospital. Attachment one.

The hospitals across the state of North Dakota make up the largest non-government employer. If a community has a hospital it's typically the largest employer. Hospitals employ over 22,000 people within the state. Also, hospitals are a primary source of jobs and fuel economic activity throughout communities.

Currently, the Medicare and Medicaid reimbursement system for critical access hospitals is based on Medicare allowable costs. This payment system does not take into consideration the actual or total cost of providing service. Based on the current system critical access hospitals receive about ninety-two to ninety-three percent of their actual costs for services provided to patients. This means for every Medicare or Medicaid patient that comes through the doors of a hospital the provider loses seven to eight percent. No business can sustain a viable operation with these types of loses. When you combine both Medicare and Medicaid utilization numbers this makes up sixty to seventy percent of the business in a critical access hospital.

Please find attached to this testimony a graph displaying the profitability of critical access hospitals in North Dakota. From the information provided in the graph, you can see the operating margin for most hospitals was negative in 2009. This means most of them lost money. Attachment two.

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Also, critical access hospitals have been using their funded depreciation funds on daily operations to cover operating costs. The result of this process to maintain their operations using funded depreciation puts the hospitals in a challenging position. This results in not having funds available for construction and equipment upgrades.

Based on my testimony, you can see the critical access hospitals in North Dakota face many challenges. These same hospitals rank very high compared to other parts of the country in providing great quality outcomes. However, rank near the bottom in reimbursement.

NHDA supports any additional funding for hospitals. This concludes my testimony and would be happy to address any questions.

NDHA
MEMBER HOSPITALS BY REGION

Critical Access Hospitals

Northwest (11)

Bottineau	St. Andrew's Health Center	Jodi Atkinson
Crosby	St. Luke's Hospital	Les Urvand
Harvey	St. Aloisius Medical Center	Rocky Zastoupil
Kenmare	Trinity Kenmare Comm. Hosp.	Shawn Smothers
Minot	Trinity Health	John Kutch
Rolla	Presentation Med Center	Mike Pfeifer
Rugby	Heart of America Med. Center	Jeff Lingerfelt
Stanley	Mountrail Co. Med. Center	Mitch Leupp
Tioga	Tioga Medical Center	Randy Pederson
Watford City	McKenzie Co. Healthcare Sys	Daniel Kelly
Williston	Mercy Medical Center	Matthew Grimshaw

Northeast (11)

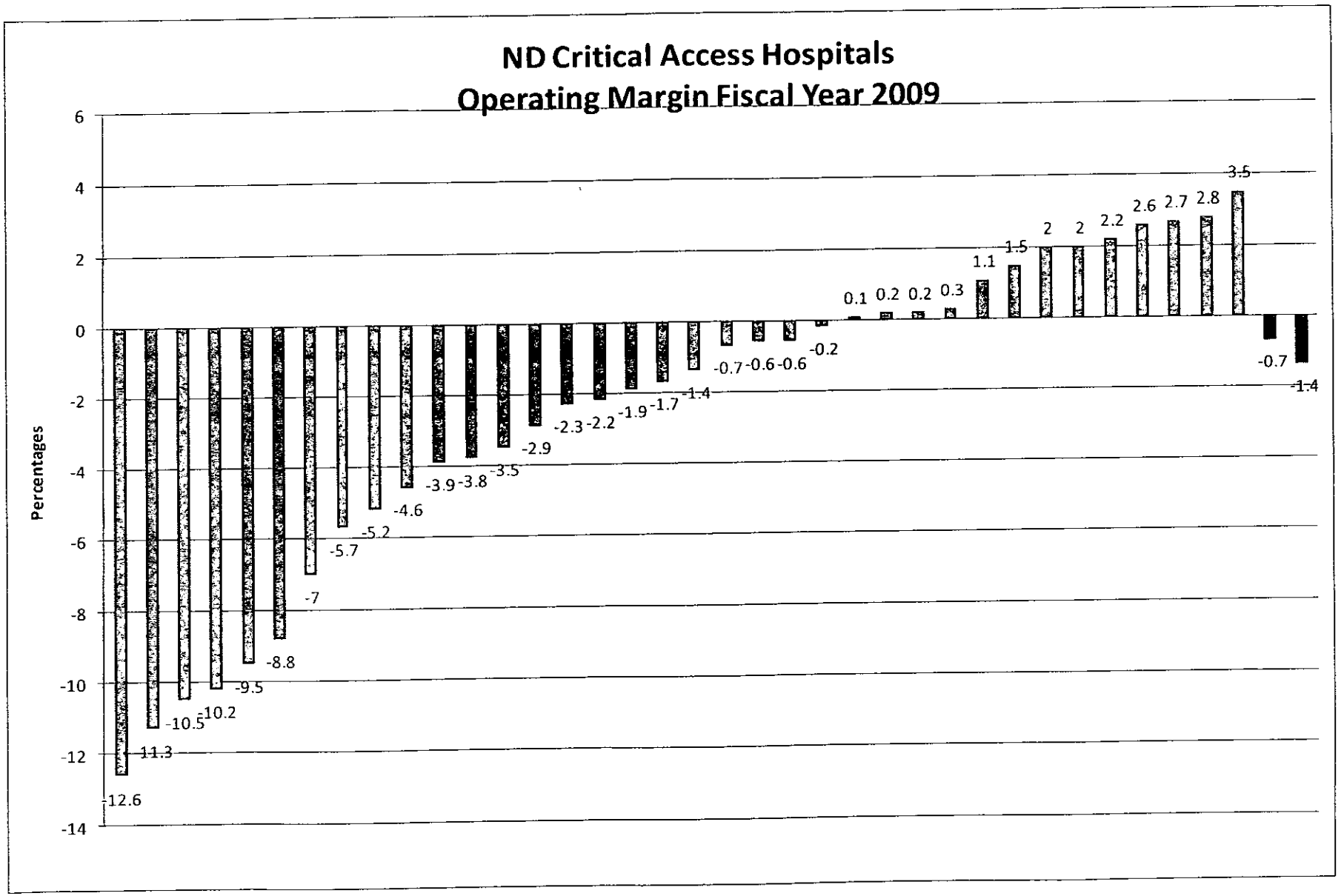
Cando	Towner Cnty Med. Center.	Jac McTaggart
Carrington	Carrington Health Center	MariAnn Doeling
Cavalier	Pembina Cnty Mem. Hospital	Everett Butler
Cooperstown	Cooperstown Medial Center	Greg Stomp
Devils Lake	Mercy Hospital	James Marshall
Grafton	Unity Med. Center	Everett Butler
Grand Forks	Altru Health System	Dave Molmen
Mayville	Sanford Medical Center – Mayville	Roger Baier
Langdon	Cavalier County Memorial Hosp.	Lawrence Blue
Northwood	Northwood Deaconess Health	Pete Antonson
Park River	First Care Health Center	Louise Dryburgh

Southwest (12)

Ashley	Ashley Medical Center	Kathy Hoeft
Bismarck	Medcenter One Health System	Craig Lambrecht, MD
Bismarck	St. Alexius Medical Center	Andrew Wilson
Bowman	Southwest HC Services	Dennis Goebel
Dickinson	St. Joseph's Hospital	Reed Reyman
Elgin	Jacobson Memorial Hosp	Jim Opdahl
Hazen	Sakakawea Medical Center	Darrold Bertsch
Hettinger	West River Health Services	Jim Long
Garrison	Garrison Memorial Hospital	Dean Mattern
Linton	Linton Hospital	Roger Unger
Mandan	Triumph Hosp. Central Dakota	April Bishop
Wishek	Wishek Comm. Hospital	Trina Schilling

Southeast (11)

Fargo	Essentia Health	Kevin Pitzer
Fargo	Sanford Medical Center	Dennis Millirons
Fargo	Prairie St. Johns	Emmet Kenney, MD
Fargo	Triumph Healthcare-Fargo	Custer Huseby
Fargo	VA Hospital	Michael Murphy
Jamestown	Jamestown Hospital	Martin Richman
Lisbon	Lisbon Area Health Services	Peggy Larson
Jamestown	ND State Hospital	Alex Schweitzer
Hillsboro	Hillsboro Medical Center	John Rieke
Oakes	Oakes Community Hospital	Lee Boyles
Valley City	Mercy Hospital	Keith Heuser


ND Critical Access Hospitals
Operating Margin Fiscal Year 2009
Percentages
6
4
2
0
-2
-4
-6
-8
-10
-12
-14
-12.6
-11.3
-10.5
-10.2
-9.5
-8.8
-7
-5.7
-5.2
-4.6
-3.9
-3.8
-3.5
-2.9
-2.3
-2.2
-1.9
-1.7
-1.4
-0.7
-0.6
-0.6
-0.2
0.1
0.2
0.2
0.3
1.1
1.5
2
2
2.2
2.6
2.7
2.8
3.5
-0.7
-1.4

#1

Chairman Lee and esteemed members of the Senate Human Service Committee.

For the record I am Rep. Bill Devlin of Finley. I represent District 23 in the Legislature. District 23 is a rural District that encompasses all or part of five rural counties in eastern North Dakota.

I am here to introduce HB 1152 which is a critical bill for health care as we know it in our state.

The bill will provide $3.454.061 million in state and federal funding to Critical Access Hospitals across our state. The bill was heavily amended in the House to change from an original plan for grants to a plan that will provide supplemental payment funding for Lab and Certified Registered Nurse Anesthetist (CRNA) coverage to the Critical Access Hospitals across the state, subject to the Upper Payment Limits.

As now written, the payments are based on the methodology approved by the Centers for Medicare and Medicaid Services. It is the same methodology that was used previously when the legislature provided funding for Presentation Medical Hospital in Rolla. It will provide additional funding to 34 of the 36 hospitals.

There are several speakers and other sponsors that will follow me that will explain the technical aspects of the bill. Rep. Jon Nelson will provide the financial details of what was done in the House Appropriations Committee, with the permission of the Policy Committee and the Prime Sponsor.

The term Critical Access Hospitals speaks for itself and the term is defined in federal code. The Hospital in that area of the nation has been deemed critical to providing accessibility to health care to the residents of a state. It is critical to the citizens of our state that we provide not only emergency care but making sure they have accessibility to primary health care to meet their needs for chronic care, preventive care and emergency care.

These hospitals have not gotten anywhere close to the reimbursements for the costs of operating their facilities. We hear the term Medicare allowable costs a lot when dealing with hospitals. What we don't hear on the actual costs. By leaving 6 to 8 percent or more of the actual costs we leave hospitals with the option of trying to recoup actual costs from other consumers.

Hence there is a vital need for this bill. Should people across North Dakota be denied accessibility to health care because their hospitals bottom line has fallen into negative territory through no fault of their own?

We talk a lot about infrastructure needs in this body. But, in my humble opinion, infrastructure means more than roads, bridges, water and sewer systems and other things normally

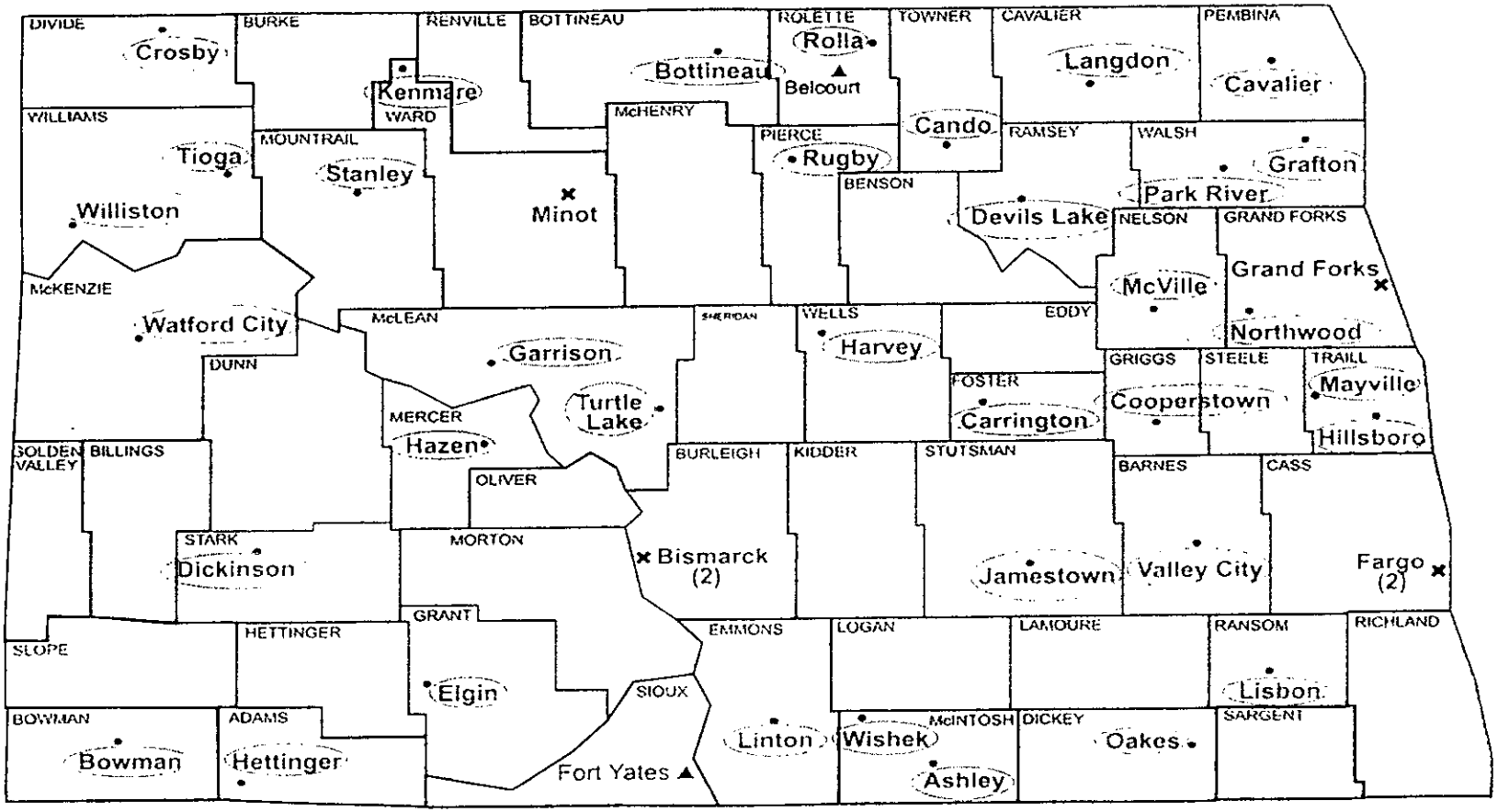
associated with the term. To me infrastructure means the things people need to live and work in our state and that includes the access to health care facilities.

There are 36 critical access hospitals in our state. The last report on saw was for 2009 which showed that 23 of them lost money. There was a lot of talk in the media about the frontier amendment and what good things it did for hospitals in the state. However, what wasn't said was that not one dime of that went to the rural hospitals it all went to the large city hospitals in the state. I don't begrudge them one dime of that money but also know that if the federal government doesn't step to the plate for rural hospitals the state must do that. Every one of them needs help and I believe there is an obligation to provide these dollars to as many facilities as possible through the state and federal dollars laid out in this bill.

I provided a map of where the hospitals are located across the state. I think this map shows a chain of life for our citizens. If the chain breaks, people in one or more areas do not have the accessibility they need to health care. We are all connected to this issue and can't afford to lose any of these hospitals in any part of the state.

Chairman Lee and members of the Committee I urge a do pass on HB 1152. This concludes my testimony. I am certainly willing to try to answer any questions you might have but know that the experts that will follow me have all the answers you need to make the right decision for the people of our state by giving this bill a do pass recommendation. Thank you for allowing me to appear here today.

North Dakota Hospitals and Critical Access Hospitals



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

- Rural Hospital
- ▲ Indian Health Service Hospital
- × Tertiary Hospital-CAH Network
- Critical Access Hospital

7/09

#2

ND Department of Human Services

Medical Services Division

Estimate of Critical Access Hospital Supplemental Payment

January 2011

	Lab	Certified Registered Nurse Anesthetist (CRNA)
Ashley	9,226	-
Bottineau	14,178	579
Bowman	8,059	-
Cando	15,216	2,967
Carrrington	16,314	26,431
Cavalier	10,977	-
Cooperstown	8,896	-
Crosby	-	-
Devils Lake	223,819	8,741
Dickinson	198,389	1,875
Elgin	22,438	-
Garrison	15,955	-
Grafton	23,426	495
Harvey	41,002	-
Hazen	14,615	-
Hettinger	19,686	340
Hillsboro	9,535	-
Jamestown	135,876	17,560
Kenmare	-	-
Langdon	18,604	-
Linton	9,399	-
Lisbon	49,379	1,161
Mayville	14,772	-
McVille	4,420	-
Northwood	7,852	-
Oakes	60,073	10,394
Park River	17,807	10,593
Rolla	167,461	-
Rugby	3,790	4,978
Stanley	15,708	-
Tioga	10,637	-
Turtle Lake	10,627	-
Valley City	33,094	12,730
Watford City	24,141	-
Williston	246,997	3,338
Wishek	4,522	173
Estimated Supplemental Payment *(Based upon 2009 data)*	1,486,890	102,355

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab		Certified Registered Nurse Anesthetist (CRNA)		
July 1, 2010 Inflationary Increase	44,607	*	6,141	^	
Estimated Supplemental Payment (SFY 2011)	1,531,497		108,496		
3% / 3% Inflation *(SFY 2012 / 2013)*	139,213		9,862		
Estimated Supplemental Payment for the 2011-2013 Biennium	3,202,206		226,855		
Administrative Cost				25,000	
					Totals
Total General	1,415,055		100,247	12,500	1,527,802
Total Federal	1,787,151		126,608	12,500	1,926,259
				Total 2011-2013 Estimated Cost	3,454,061

* July 1, 2010 lab inflation is 3%, as they are paid based upon Medicare fee schedule.

^ July 1, 2010 CRNA inflation is 6%, as services are paid on the Department's fee schedule.

Estimate is based on 2009 data, which is the latest year complete data is available. Actual payments made to facilities will not match these estimates.

Any supplemental payment is subject to the Medicaid Upper Payment Limit regulations and State Plan approval from the Centers for Medicare and Medicaid Services (CMS).

Estimate is based on the same criteria approved by the CMS for the supplemental payments authorized by the 2009 Legislative Assembly for Rolla. CMS has indicated that a similar supplemental payment would be available for all CAHs.

The Department currently has a contract in place with a vendor to do cost settlements of CAHs. This supplemental payment would be most efficiently handled in conjunction with those cost settlements. The estimated cost to complete these supplemental payment calculations for the biennium is $25,000.

#3

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1152

Senate Human Service Committee
Medicaid Supplemental Payments to Critical Access Hospitals
March 2, 2011

Chairman Lee and members of the Senate Human Services Committee; I am Jerry Jurena, President of the North Dakota Hospital Association (NDHA). I come before you today in support of HB 1152, Medicaid supplemental payments to Critical Access Hospitals.

The North Dakota Hospital Association (NDHA) is a trade association with forty-five member Hospitals. There are thirty-six Critical Access Hospitals (CAH) in the State; thirty-four are members of NDHA. There are six large Tertiary Hospitals in the four major cities all members of NDHA. Other member Hospitals include: two Long Term Acute Care Hospitals, one Psychiatric Hospital, one State Hospital, and one VA Hospital, see Attachment.

Again, there are two Critical Access Hospitals that are non-members of NDHA as well as two Governmental Hospital's (IHS) and one specialty Hospital.

Hospitals across the State of North Dakota make up the largest non-government employer in the State. In each community that has a Hospital the Hospital is the largest employer in that community. The largest percentage of each Hospital's revenue comes from Medicare; in most Hospitals it is well over fifty percent (50%) and in many Hospitals that revenue percentage is over sixty percent (60%).

Medicaid revenue ranges from a low of eight percent (8%) to almost thirty percent (30%).

Medicare reimburses Critical Access Hospitals based on their Medicare allowable costs; which is about ninety-two (92) to ninety-three (93) percent of their total or actual costs. Medicaid reimbursement to Critical Access Hospital followed Medicare reimbursement in 2007 with the exception of Lab and anesthesia services. They were capped by the Social Security Act at the Medicare fee schedule which is below the actual costs to provide these two services. The outcome of using the Medicare Allowable reimbursement system is; for every Medicare and Medicaid patient that presents to a Critical Access Hospital for services the Hospital takes a loss

of seven (7) to eight (8) percent. When you combine the Medicare and Medicaid utilization numbers they make up sixty (60) to seventy (70) percent of the total Hospital revenue. No business can sustain a viable operation with a seven (7) to eight (8) percent loss on sixty (60) to seventy (70) percent of its incoming revenue. Hospitals have had to raise their charges to the remaining patients to offset this ongoing loss. Many Critical Access Hospitals have also been using their funded depreciation dollars on daily operations to cover operating costs. The result of this process to maintain their operations, using Funded Depreciation, puts the Hospitals in a precarious position. They do not have funds available for upgrades or emergencies if and when they are needed.

I am in support of Critical Access Hospitals receiving reimbursement that will cover their actual costs to provide all services as required my Medicaid. HB 1152, a supplemental payment to Critical Access Hospitals for Lab and anesthesia services, is a start in this process by reimbursing some of our most vulnerable Hospitals at costs for these two services. Again this bill will not bring all services up to actual costs on all services but it will provide some needed relief.

I ask that you give HB 1152 a Do Pass and consider in the future a study on reimbursement for all Hospitals comparing Medicare Allowable Costs to their actual costs to provide services as required by Medicaid.

Thank you.

Jerry E. Jurena, President
North Dakota Hospital Association

NDHA
MEMBER HOSPITALS BY REGION

Critical Access Hospitals

Northwest (11)

Bottineau	St. Andrew's Health Center	Jodi Atkinson
Crosby	St. Luke's Hospital	Les Urvand
Harvey	St. Aloisius Medical Center	Rocky Zastoupil
Kenmare	Trinity Kenmare Comm. Hosp.	Shawn Smothers
Minot	Trinity Health	John Kutch
Rolla	Presentation Med Center	Mike Pfeifer
Rugby	Heart of America Med. Center	Jeff Lingerfelt
Stanley	Mountrail Co. Med. Center	Mitch Leupp
Tioga	Tioga Medical Center	Randy Pederson
Watford City	McKenzie Co. Healthcare Sys	Daniel Kelly
Williston	Mercy Medical Center	Matthew Grimshaw

Northeast (11)

Cando	Towner Cnty Med. Center.	Jac McTaggart
Carrington	Carrington Health Center	MariAnn Doeling
Cavalier	Pembina Cnty Mem. Hospital	Everett Butler
Cooperstown	Cooperstown Medial Center	Greg Stomp
Devils Lake	Mercy Hospital	James Marshall
Grafton	Unity Med. Center	Everett Butler
Grand Forks	Altru Health System	Dave Molmen
Mayville Sanford	Medical Center – Mayville	Roger Baier
Langdon	Cavalier County Memorial Hosp.	Lawrence Blue
Northwood	Northwood Deaconess Health	Pete Antonson
Park River	First Care Health Center	Louise Dryburgh

Southwest (12)

Ashley	Ashley Medical Center	Kathy Hoeft
Bismarck	Medcenter One Health System	Craig Lambrecht, MD
Bismarck	St. Alexius Medical Center	Gary Miller, Interim
Bowman	Southwest HC Services	Dennis Goebel
Dickinson	St. Joseph's Hospital	Reed Reyman
Elgin	Jacobson Memorial Hosp	Jim Opdahl
Hazen	Sakakawea Medical Center	Darrold Bertsch
Hettinger	West River Health Services	Jim Long
Garrison	Garrison Memorial Hospital	Dean Mattern
Linton	Linton Hospital	Roger Unger
Mandan	Triumph Hosp. Central Dakota	April Bishop
Wishek	Wishek Comm. Hospital	Trina Schilling

Southeast (11)

Fargo	Essentia Health	Kevin Pitzer
Fargo	Sanford Medical Center	Dennis Millirons
Fargo	Prairie St. Johns	Emmet Kenney Jr., MD
Fargo	Triumph Healthcare-Fargo	Custer Huseby
Fargo	VA Hospital	Michael Murphy
Jamestown	Jamestown Hospital	Martin Richman
Lisbon	Lisbon Area Health Services	Peggy Larson
Jamestown	ND State Hospital	Alex Schweitzer
Hillsboro	Hillsboro Medical Center	John Rieke
Oakes	Oakes Community Hospital	Lee Boyles
Valley City	Mercy Hospital	Keith Heuser

#4

Testimony on HB 1152
Senate Human Services Committee
March 2, 2011

Chairman Lee and members of the Senate Human Services Committee, I thank you for the opportunity to testify on HB 1152. My name is Daniel Kelly, Chief Executive Officer of the McKenzie County Healthcare Systems, Inc. in Watford City, North Dakota. I wish to go on record supporting HB 1152.

North Dakota has 42 hospitals providing acute medical services. Of that number, 36 are considered Critical Access Hospitals. I offer support for House Bill 1152 for three reasons:

Two/Thirds of North Dakota Critical Access Hospitals Experience an Operating Loss: For the past three years data has been gathered and assessed which reflect that many North Dakota Critical Access Hospital's lose money. This past year, 24 of North Dakota's 36 Critical Access Hospitals lost money. As it stands, some of these hospitals are destined to close in three to five years. We need to offer whatever assistance we can to sustain our healthcare system.

Rural Hospitals are Safety Net Providers: For many rural North Dakotans, Critical Access Hospitals are safety net providers of medical care. We provide the initial medical assessment and stabilization for routine emergencies as well as trauma cases. For many in rural North Dakota if their local hospital did not exist they might be anywhere from 30 to 60 minutes from healthcare services.

HB 1152 affords some relief for North Dakota's Critical Access Hospitals: While HB 1152 will not assure the viability of North Dakota's Critical Access Hospitals it is a fiscally prudent means to afford some relief. While many officials I have spoken to believe that Critical Access Hospitals are paid their cost by Medicare and Medicaid, this is not true. Medicare and Medicaid will not recognize the following when calculating reimbursement:

- Patient Telephones or Television
- Lobbying
- Advertising
- Physician Recruitment (except for Rural Health Clinics)

In addition, if a Critical Access Hospital operates any of the following, those costs are not recognized as part of the hospital Medicare and Medicaid Reimbursement.

- Wellness Centers
- Hospice
- Skilled Nursing Facility
- Assisted Living

- Meals on Wheels
- Day Care (Some costs may be reimbursable)
- Non-Provider Based Clinics

HB 1152 will result in $3,454,061 in incremental revenue while costing the state $1,527,802 (federal FMAP funding will contribute $1,926,259).

For the McKenzie County Healthcare System that will result in additional reimbursement for outpatient lab services in the amount of $26,525.00 annually.

Your support of HB 1152 will send a positive message of to our medical community and to the citizenship of North Dakota. Please support HB 1152.

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.
516 North Main Street
Watford City, North Dakota 58854
(701) 842-3000

#5

North Dakota
Critical Access Hospital
(CAH)

Financial Analysis!

March 2011

Presentation Objectives

- Request Support for HB1152
- National CAH Financial Indicator Info
  Flex Monitoring Information for 2008
- 2009/10 ND CAH Financials – 36 CAHs
- 4 Yr. Trended Financials for the ND CAHs
- 2009/10 Financials for Rural Health Clinics Owned/Operated by ND CAHs

CAH Financial Indicators 2008

Description	*National*	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
2008						
# of CAHs Included	1,247	31	36	77	42	65
Median Net Margin 2008	2.40%	-0.95%	3.32%	3.62%	3.12%	4.82%
Days Cash on Hand	61.0	27.2	42.2	99.6	72.3	111.8
Medicare Inpt Cost/Day	$1,633	$1,145	$1,431	$1,946	$1,580	$1,647
Average Age of Plant	10.4	13.2	10.8	9.7	14.0	9.4

Flex Monitoring Team, Fall 2010

CAH Financial Indicators 2008

	National	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
Median Net Margin						
2004	2.32%	-2.07%	2.70%	5.19%	1.25%	2.56%
2005	2.63%	-.06%	-.31%	3.06%	2.86%	4.24%
2006	3.58%	-1.65%	3.39%	4.40%	3.22%	5.08%
2007	3.64%	-1.54%	3.54%	5.13%	2.99%	5.75%
2008	2.40%	-0.95%	3.32%	3.62%	3.12%	4.82%

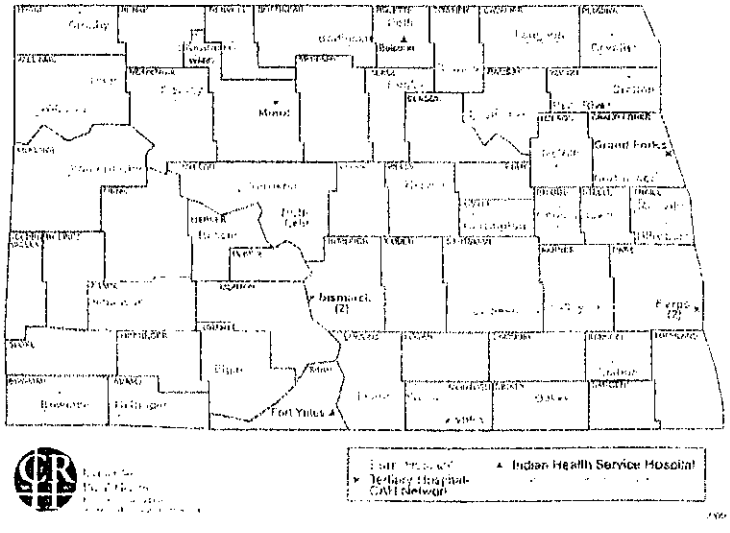
Flex Monitoring Team, Fall 2010

ND CAH Financial Analysis

All ND CAHs

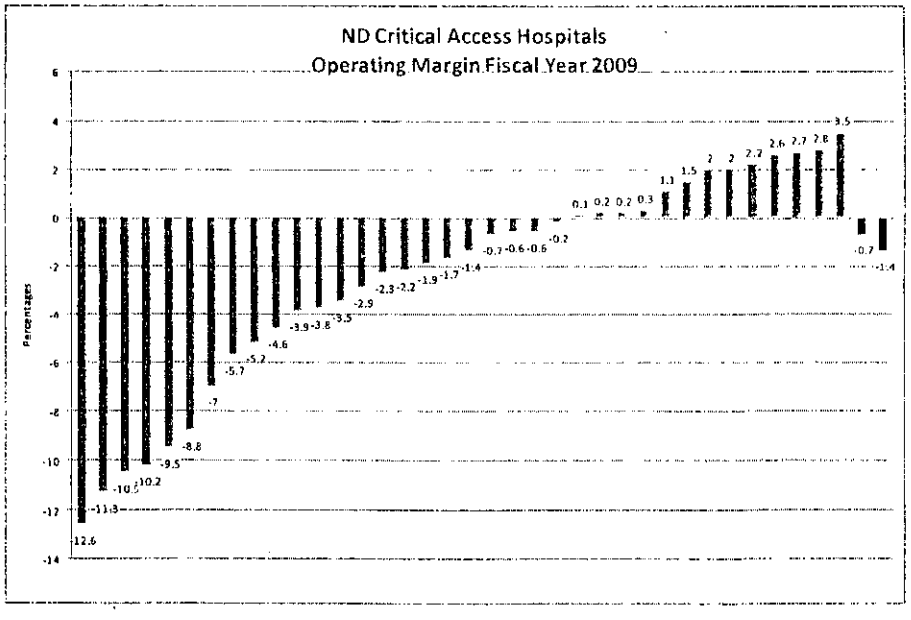
2010

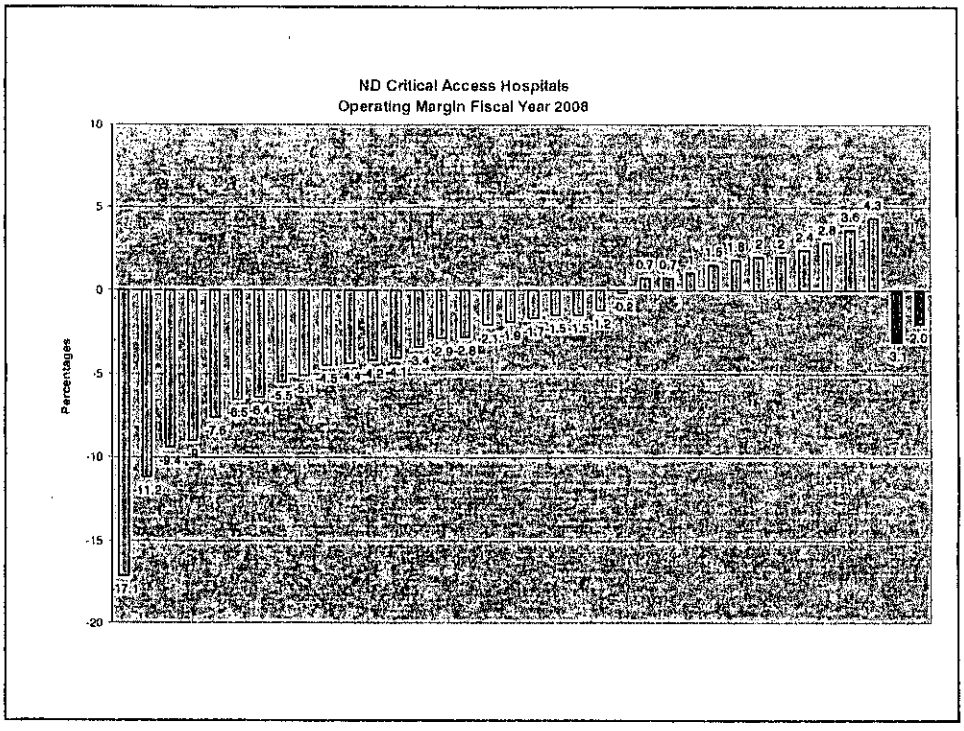
North Dakota Hospitals and Critical Access Hospitals

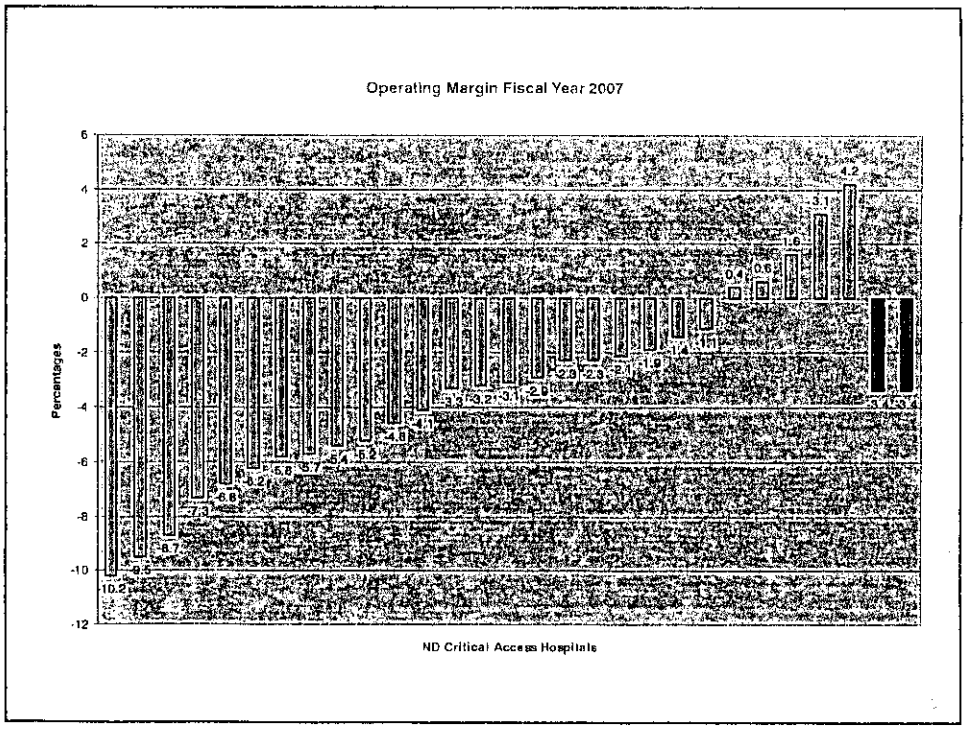


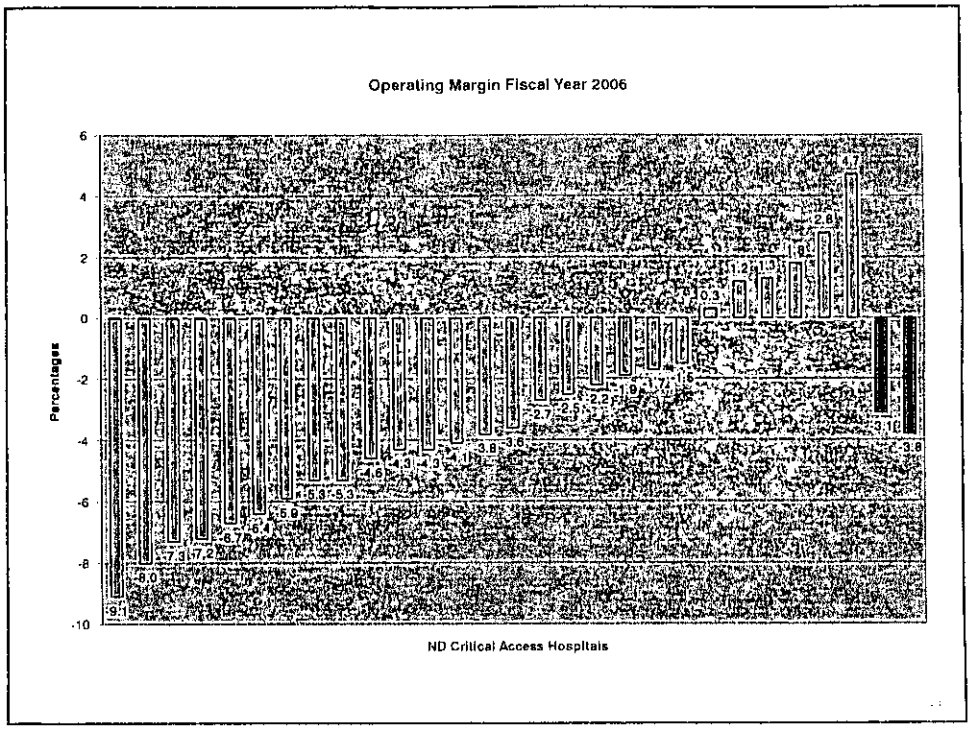
North Dakota CAH Financial Analysis

- Observations
  - 36 of 36 Facilities Reported Their Financial Information
  - 27 of 36 Facilities Own/Operate a Primary Care Clinic
  - 27 Facilities Who Own/Operate Clinics, Operate 56 Clinics, 46 RHCs
    - There are 59 RHCs in North Dakota
  - 14 of 36 Facilities Own/Operate a Nursing Home
  - 9 Facilities Own and Operate the Local Ambulance
  - 8 Facilities Provide Home Health, some Visiting Nurse Services
  - 23 of 36 Facilities had Negative Operating Margins




ND Critical Access Hospitals
Operating Margin Fiscal Year 2008
Percentages
10
5
0
-5
-10
-15
-20

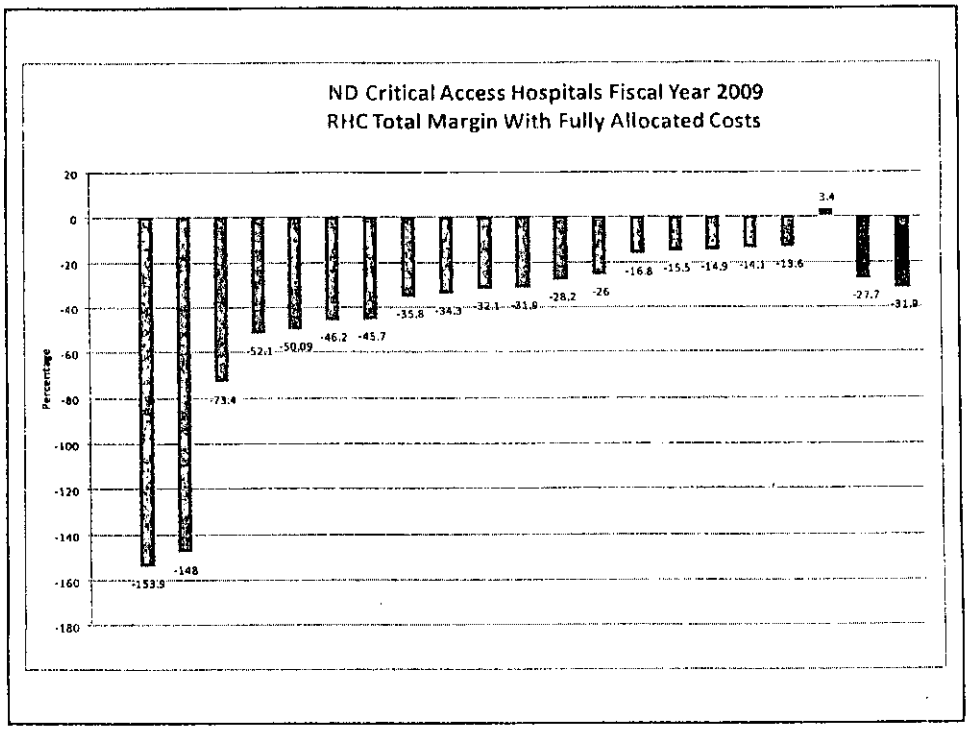

Operating Margin Fiscal Year 2007
Percentages
6
4
2
0
-2
-4
-6
-8
-10
-12
ND Critical Access Hospitals



ND CAH Financial Analysis

Rural Health Clinics (RHC) Owned by CAHs

2010



Closing Thoughts...

- Continue to Create Awareness of the Challenges Experienced by ND CAHs
- Request Support of HB1152
- Questions

- ***Thanks For Listening!!***

North Dakota Critical Access Hospitals & Dickinson
Services That Are Owned/Operated

10/11/2010

.rgin 6 7 8 9	Community	CAH Hospital	Nursing Home Beds	Basic Care	Assisted Living	Apartments	Clinic	Ambulance	Home Care
	Ashley	20 Beds	44 Beds			30 Units	RHC - 2		Yes
	Bottineau	25 Beds				15 Units	Jointly Own		
	Bowman	23 Beds	66 Beds		12 Units	16 Units	RHC	Yes	
	Cando	20 Beds	40 Beds	10 Beds		10 Units	RHC - 1 of 2		
	Carrington	25 Beds		24 Beds			RHC - 3	Yes	
	Cavalier	25 Beds	60 Beds				RHC		
	Crosby	25 Beds					RHC - 3		
	Cooperstown	18 Beds	48 Beds		12 Units		RHC		
	Devils Lake	25 Beds							
	Dickinson	25 Beds					RHC - 4		Yes
	Elgin	21 Beds	25 Beds				RHC - 2		
	Garrison	22 Beds	28 Beds				RHC		
	Grafton	17 Beds					RHC		
	Harvey	25 Beds	106 Beds			16 Units			
	Hazen	25 Beds		30 Beds			RHC - 2		Yes
	Hettinger	25 Beds					RHC - 5 of 7	Yes	
	Hillsboro	20 Beds	36 Beds					Yes	
	Jamestown	25 Beds							Yes
	Kenmare	25 Beds					RHC		
	Langdon	25 Beds					RHC - 2	Yes	
	Linton	14 Beds			11 Units		RHC - 3 of 4	Yes	
	Lisbon	25 Beds							Yes
	Mayville	25 Beds							
	McVille	19 Beds	39 Beds				RHC - 2		
	Northwood	12 Beds	61 Beds		6 Units	10 Units		Yes	
	Oakes	20 Beds					Yes		
	Park River	14 Beds					RHC		
	Rolla	25 Beds							
	Rugby	25 Beds	80 Beds	68 Beds	37 Units		Yes	Yes	
	Stanley	11 Beds					RHC		
	Tioga	25 Beds	30 Beds			22 Units	RHC - 3		
	Turtle Lake	25 Beds					RHC		
	Valley City	25 Beds		25 Beds					Yes
	Watford City	24 Beds	47 Beds	8 Beds	16 Units	7 Units	RHC		
	Williston	25 Beds					Yes 3		Yes
	Wishek	24 Beds					RHC - 4	Yes	Yes
6 5 10 13	**Facilities**	36	14	6	6	9	27	9	8
27 27 34 36	**Total**	799	706	185	94	146	56 46 RHCs		8

BCBS Reimbursement Workgroup
Facility Statement of Operations Summary

Description	*27 Facilities* Fiscal 2006 Average	*27 Facilities* Fiscal 2007 Average	*34 Facilities* Fiscal 2008 Average	*36 Facilities* Fiscal 2009 Average
Patient Revenue				
Inpatient	1,169,588	1,241,801	2,815,005	3,103,545
Outpatient	3,067,613	3,420,277	6,611,378	7,641,840
Clinic	756,213	856,810	1,325,311	1,629,600
Swingbed	429,137	406,733	585,439	527,468
Long Term Care	1,407,598	1,449,804	1,241,033	1,245,146
Basic Care	90,522	102,040	105,513	93,770
Ambulance	82,704	84,408	90,451	93,397
Home Care	29,446	30,438	143,679	162,256
Independent Apartments	40,996	42,141	36,638	27,235
Assisted Living	18,205	19,817	19,623	42,239
Total Patient Revenue	7,092,022	7,654,269	12,974,070	14,566,496
Other Operating Revenue	115,594	127,277	300,517	361,328
Total Operating Revenue	**7,207,616**	**7,781,546**	**13,274,587**	**14,927,825**
Contractual Deductions				
Medicare Contractuals	709,690	871,770	2,173,069	2,297,310
Blue Cross Contractuals	327,313	366,189	941,019	1,106,897
Medicaid Contractuals	156,068	159,956	389,415	435,701
[redacted]r Contractuals	124,389	155,569	413,628	504,282
[redacted] Debt/Charity Expense	130,465	139,835	409,757	443,923
[redacted]otal Deductions	1,447,925	1,693,319	4,326,888	4,788,112
NET PATIENT REVENUE	**5,759,691**	**6,088,227**	**8,947,699**	**10,139,712**
Operating Expenses				
Salaries, Wages, Benefits	3,527,392	3,708,759	5,304,081	5,662,822
Purchased Service/Other	900,083	956,472	1,992,000	2,418,429
Supply Expense	1,096,002	1,179,344	1,275,223	1,285,802
Utilities	126,994	132,754	250,679	240,376
Depreciation & Amortization	276,790	310,915	437,718	527,506
Interest Expense	52,955	63,454	96,703	105,450
Total Expenses	5,980,217	6,351,698	9,356,405	10,240,384
Net Operating Margin	**(220,526)**	**(263,470)**	**(408,706)**	**(100,672)**
Operating Margin % (Mean)	*-3.1%*	*-3.4%*	*-3.1%*	*-0.7%*
Operating Margin % (Median)	*-3.8%*	*-3.2%*	*-2.0%*	*-1.4%*
Non Operating Revenue				
Governmental Subsidies	4,228	14,841	17,547	25,623
Foundation Gifts	18,396	25,216	33,831	30,441
Grants	27,739	45,021	41,434	29,072
Other Donations	53,543	59,412	48,669	40,230
[redacted]er Non Operating Revenue	48,411	50,126	17,781	(198,697)
[redacted]Non Operating Rev.	152,317	194,617	159,262	(73,331)
NET INCOME/LOSS	**(68,209)**	**(68,854)**	**(249,444)**	**(174,003)**
Net Margin % (Mean)	*-0.9%*	*-0.9%*	*-1.9%*	*-1.2%*
Net Margin % (Median)	*-1.7%*	*-2.0%*	*-0.6%*	*-0.7%*

11.0346.04001
Title.

Prepared by the Legislative Council staff for
Senator Mathern
March 3, 2011

#6

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

Page 1, line 1, after the semicolon insert "to provide for a legislative management study;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakotans experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

#7

NORTH DAKOTA HEALTH CARE REVIEW, INC.

March 3, 2011

Senator Tim Mathern
State Capitol
600 E. Boulevard Ave.
Bismarck, ND 58701

Dear Senator Mathern:

Thank you for taking time out of your busy day to be a part of the Strategic Planning Session for the Patient-Centered Medical Home (PCMH) meeting on Wednesday afternoon, March 2, 2011, at the Kelly Inn in Bismarck.

Enclosed are the two packets from the PCMH meeting on Wednesday that Barb Groutt, MSA, CEO of North Dakota Health Care Review, Inc. (NDHCRI), asked me to mail to you.

If we can be of any further assistance, please don't hesitate to contact us at 701-852-4231.

Sincerely,

Debbie Hoover

Debbie Hoover, MSA, ASCP, CNMT, RDMS, LPN, RAC-CT
Quality Improvement Specialist

Enclosures

Strategic Planning Session for

Patient-Centered Medical Home (PCMH)

KELLY INN, BISMARCK, ND
MARCH 2, 2011
1:00 – 4:30 P.M.

AGENDA:

A.	1:00 – 1:15	WELCOME AND INTRODUCTION – BARB GROUTT
B.	1:15 – 2:00	SHARING CURRENT INITIATIVES IN NORTH DAKOTA – ALL
C.	2:00 – 2:20	SUMMARIZING OTHER STATE INITIATIVES – BARB GROUTT
D.	2:20 – 2:35	BREAK
E.	2:35 – 3:30	GATHERING FEEDBACK – BEV RANSTROM, ALL
F.	3:30 – 4:30	DECIDING FUTURE ACTIONS - ALL

Objectives:

1. Become aware of existing PCMH – related activities in North Dakota.
2. Increase awareness of PCMH initiatives underway in other states.
3. Identify issues, opportunities, barriers, strengths for implementing PCMH in ND.
4. Determine interest for further action.

Medical Home Strategic Planning Participant List

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Sparb Collins, Executive Director NDPERS 400 E Broadway Ave. Suite 505, PO Box 1657 Bismarck N.D. 58502-1657 Ph: 701-328-3900; Toll free: 1-800-803-7377 Email: ndpers-info@state.nd.us	**Terry Dwelle, MD** ND Department of Health 600 East Boulevard Avenue Bismarck, N.D. 58505-0200 Ph: 701-328-2372 Email: tdwelle@nd.gov
Joann Gaul, MD Altru Health System 1000 S. Columbia Road Grand Forks, N.D. 58206 Ph: 701-780-6000 Email: jgaul@altru.org	**David Hanekom, MD, FACP, CMPE** Chief Medical Officer, Blue Cross Blue Shield of North Dakota 4510 13th Ave. S. Fargo, N.D. 58121-0001 Ph: 701-282-1350; Cell: 701-540-2769 Email: david.hanekom@bcbsnd.com
Hellman, Tania, Admin. Mgd Care,RN, BSN, MM, CCM **Cindy Sheldon**, Deputy Director N.D. Dept of Human Services 600 East Boulevard Ave. – Dept 325 Bismarck, N.D. 58505-0250 Ph: 701-328-3598 Email: thellman@nd.gov Email: csheldon@nd.gov	**Jurena, Jerry** ND Hospital Association PO Box 7340, 1622 E. Interstate Ave. Bismarck, N.D. 58503-0512 Ph: 701-224-9732 Email: jjurena@ndha.org
Sen. Judy Lee State Capitol, 600 E. Boulevard Ave. Bismarck, N.D. 58505 Ph: 701-237-5031; 701-282-6512 Email: jlee@nd.gov	**Bruce Levi,** Executive Director ND Medical Association PO Box 1198, 1622 East Interstate Avenue Bismarck, N.D. 58502-1198 Ph: 701-223-9475 Email: blevi@ndmed.com
Jody Ward, RN, BSN ND CAH Quality Network Coordinator UND School of Medicine and Health Sciences 1201 11th Ave. S.W. Minot, N.D. 58701 Ph: 701-858-6729 Email: jody.ward@med.und.edu	**Mark Grove** Great Plains Clinic 33 9th St. W. Dickinson, N.D. 58601 Ph: 701-483-6017 ext. 161 Email: markgrove@greatplainsclinic.com
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Eunah Fischer, MD, BCBS Medical Director, Medical Management Blue Cross Blue Shield of North Dakota 4510 13th Ave. S. Fargo, N.D. 58121-0001 Ph: 800.342.4718 (main BCBS number) Email: eunah.fischer@bcbsnd.com	**Bev Ranstrom, RHIA, CPHQ** 41178 260th St. N.W. Warren, Mn. 56762 Ph: 218-201-0009 Email: bev@hcqconsult.com
Liz Rindel, RN Crosby Clinic 112 1st Ave. N.W. Crosby, N.D. 58730 Ph: 701-965-6349 Email: lrindel@dcstlukes.org	**Karen Larson** Deputy Director, Community Healthcare Association of the Dakotas 1003 E. Interstate Ave., Suite 1 Bismarck, N.D. 58503 Ph: 701-221-9824 Email: Karen@communityhealthcare.net
Ann Skoglund Clinical Quality Specialist Community Healthcare Assn of the Dakotas 1003 E. Interstate Avenue, Suite 1 Bismarck, N.D. 58503 Ph: 701-221-9824 Email: askoglund@communityhealthcare.net	**Marlene Miller, MSW, LCSW** Program Director| Center for Rural Health The University of North Dakota School of Medicine and Health Sciences 501 N Columbia Road, Stop 9037 | Room 4101 | Grand Forks, N.D. 58202-9037 Ph: 701-777-4499 direct |701-777-3848 main Email: marlene.miller@med.und.edu
Barbara Groutt, MSA CEO/Director of QI and Communications North Dakota Health Care Review, Inc. 800 31st Ave. S.W. Minot, N.D. 58701 Ph: 701-852-4231 Email: bgroutt@ndhcri.org	**Debra Hoover, MSA, ASCP, CNMT, RDMS, LPN** Quality Improvement Specialist North Dakota Health Care Review, Inc. 800 31st Ave. S.W. Minot, N.D. 58701 Ph: 701-852-4231 Email: dhoover@ndhcri.org

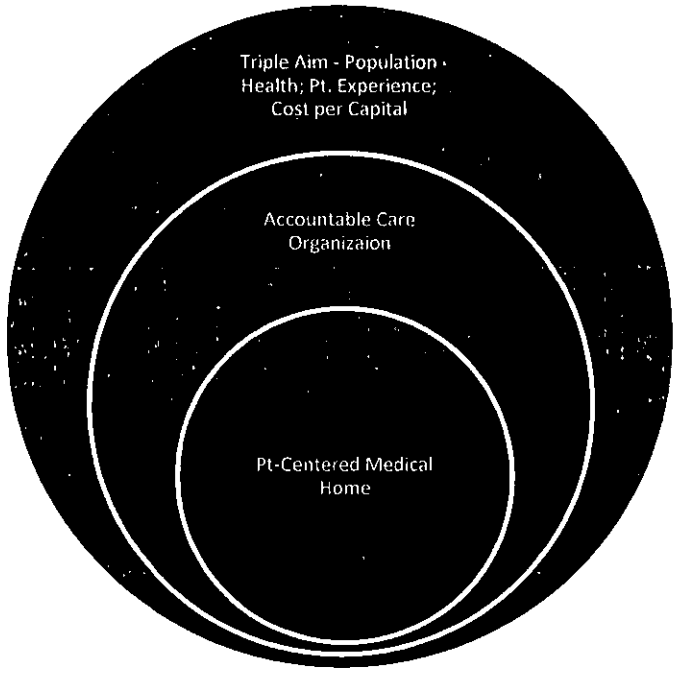
Findings *from A Consensus for Operational Definition of Patient Centered Medical Home (PCMH)*[1]

Ten key paradigms considered crucial in a PCMH:

0 - Patients/citizens identify a primary care practitioner and team	Goal: Everyone has identified with a health care practitioner and team.
1 - Routinely acting from a patient-centered whole-person orientation	Goal: Includes healing relationships that address health behaviors and mental health/substance abuse.
2 – Aiming for population health outcomes	Goal: An effect on the population, not just small segments of it.
3 – Through a practice team tailored to needs of each patient and situation	Goal: To produce a broad range of outcomes for which no one provider/patient can achieve on his/her own.
4 – Carrying out practice-based care coordination or care management	Goal: Documented personal care plans, formed with engaged patient, responsive to changes & preferences.
5 – Coordinating with other healthcare neighborhood of other teams and community	Goal: Keeping the care plan coordinated with, reinforced by, supported in other venues.
6 – With patients actively participating in quality improvement & practice development	Goal: PCMH goals, operations and habits are shaped by patient perspective.
7 – Demonstrating capacity for continuous learning and practice improvement	Goal: Organizations and practices intentionally improve themselves and learn from others.
8 – Supported by a sustainable business model and leadership alignment	Goal: PCMH model is sustainable within large or small organizations with appropriately aligned incentives.
9 – Accountable to achieving a set of clinical, experience and financial outcomes	Goal: Achievements in care, patient experience, affordability, & ability to keep pace with rapid change.

[1] ***A Consensus for Operational Definition of Patient Centered Medical Home (PCMH) – Also known as Health Care Home*** – A joint product of the University of minnesota and the Institute for Clinical Systems Improvement. Peek CJ, Oftedahl G, December 17, 2010. http://www.icsi.org/health_care_redesign_/health_care_home_/health_care_home_operational_definition/.

Developing Consensus for an Operational Definition of Patient Centered Medical Home



Triple Aim – A national initiative to measure population health based on three dimensions: 1) population health, 2) patient experience or satisfaction, 3) cost per capita.

Accountable Care Organizations - A regional network of physicians & hospital who share responsibilities for delivering health care. Reimbursement is shared and based on quality of care outcomes, keeping patients healthy and out of the hospital rather than fee-for-service.

Patient-Centered Medical Homes – A re-design of how primary care is delivered. PCMHs are considered a key strategy in achieving the outcomes desired in Accountable Care Organizations.

The Patient-Centered Medical Home (PCMH) is a re-design of primary care delivery services and "structures". States and health systems have high hopes that this redesign will transform how primary care is delivered and that it will mitigate rising health care costs.

There is no agreed-upon operation definition for PCMH, even with recognized certification criteria sets developed by Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Different stakeholders, such as primary care providers, health system administrators, insurers, payers and policy-maker understand or embrace the elements of a PCMH differently.

In 2009, Minnesota's Institute for Healthcare Improvement (ICSI) and University of Minnesota Medical School convened a national network of medical home implementers to learn from each other and to develop "*an operational definition that is specific enough to be useful in practice.*"

This work is important if the concept of PCMH is to be implemented and measured on a national rather than local scale. It should also help policymakers, patients, and payers understand medical homes "in action" more consistently, form more specific expectations and become clearer on the policies needed to sustain it.

"To become a transformative model of care delivery, patient-centered medical homes must make a significant dent in the cost trend even more than make another incremental gain in quality and experience." (Peek, Oftedahl, 2010)

Appendix A: Multiple Definitions of Medical Home

Joint Statement "Patient-Centered Medical Home"[16]	**AAFP "TransforMED model"**[59]	**ACP "Advanced Medical Home"**[17]	**AAP** *"Medical Home"*[15]	**OPCA "Primary Care Home"**[60]	**Commonwealth** *"Medical Home"*[19]
Personal physician	Personal Medical Home	Personal Physician	Long-term continuity	First point of access	Regular source of care
Physician-directed team practice	Team approach	Team Approach	Team-based care	Team-based care	
Whole person orientation – (comprehensive)	• Patient-centered care • Whole-person orientation • Consistent set of services	• Partnership with patients/families • Range of medical services	Comprehensive set of primary care services	Comprehensive and integrated care	• Patient-centered care
Integrated/Coordinated care across the health system, patient's community and culture	Integrated approach to care	Chronic Care model of care for all patients	• Coordination of subspecialty care and community resources • Cultural/developmental competence • Family-centered care	• Sustained patient/family-provider partnerships • Health system navigation and coordination • Cultural competence	
Improved access	• Elimination of access barriers • Re-designed offices	Improved access	24/7 Accessibility	Immediate access	• Evening/weekend access • Phone accessibility
Focus on Quality and Safety	• Focus on Quality and Safety • Data-based information systems • Electronic health record	• POC Evidence-based medicine and tools • Health information technology • Quality improvement programs	Confidential health record	Identifying and measuring process and outcomes measures	Efficient, well-organized, on-time visits
Payment that reflects value of services	Sustainable reimbursement	Revised reimbursement system		Working on multiple solutions	

[59] American Academy of Family Physicians. The New Model. TransforMed. www.transforMED.com. Accessed 7/3/07.
[60] Hostetler C. Testimony to the Oregon Senate Committee on Health Policy and Public Affairs. March 12, 2007

Appendix B: Comparison of Primary Care Financing Models*

	Pay for Performance	Pay for Process	Global Prospective Payments	FFS Payment for Non-Visit Services	One-Time Grants and Technical Assistance	Carved-Out Case Management	Mixed Models
Incentives and Impacts[†]							
Includes Monthly per-patient payments	+/-	+/-	+	-			+
Includes Visit-based payments	+	+	-	+			+
Encourages providers to improve quality	+	+	+/-	-		+	+
Encourages providers to limit practice size	-	-	-	+		-	-
Encourages providers to care for complex patients	-	-	+	+		+	+/-
Encourages providers to re-design their practices	+/-	+	+/-	+	+		+/-
Supports adoption of infrastructure improvements (e.g. EHRs)	+	+	+	-	+		+
Increases requirements and responsibility of PCPs	+	+	+	-	-	-	+
Support of the Medical Home Principles[‡]							
Personal Physician	-	-	+	-	-	-	+/-
Physician-directed Team Practice	+	+	++	++	-	+	+
Whole-person Orientation to Care	+/-	+	++	++	-	+/-	+
Care Coordination/Integration	-	++	+	+	+/-	+	+
Quality and Safety Improvement	++	+	+/-	-	+/-	+/-	+

* This table was compiled by the author based on reviewed literature and discussions with experts about the impact of various financing models.

† + Indicates that the financing model would encourage a certain provider/practice behavior, – indicates that the financing model would not encourage the behavior, and +/- indicates that the financing model may or may not do so, depending on specific policies adopted in designing the payment structure.

‡ + indicates that the financing model would support or strongly support (++) the development of a medical home characteristic in primary care practices, - indicates that the financing model would not have a strong impact on the development of a medical home characteristic, and +/- indicates that the model may or may not impact the development of a medical home characteristic, depending on specific policies adopted in designing the payment structure.

Joint Principles

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. The American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA), representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Principles

- Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- Physician directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- Whole person orientation—the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- Quality and safety are hallmarks of the medical home:
  - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
  - Evidence-based medicine and clinical decision-support tools guide decision making.
  - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
  - Patients actively participate in decision making and feedback is sought to ensure patients' expectations are being met.
  - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
  - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
  - Patients and families participate in quality improvement activities at the practice level.

- Enhanced access to care is available through systems such as open scheduling, expanded hours and new

options for communication between patients, their personal physician, and practice staff.

- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
  - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
  - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
  - It should support adoption and use of health information technology for quality improvement.
  - It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
  - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
  - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
  - It should recognize case mix differences in the patient population being treated within the practice.
  - It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
  - It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

Endorsers

- The American Academy of Family Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American Academy of Pediatrics
- The American College of Cardiology
- The American College of Chest Physicians
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American College of Physicians
- The American Geriatrics Society
- The American Medical Directors Association
- The American Osteopathic Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Infectious Diseases Society of America
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine

For More Information

- American Academy of Family Physicians
  http://www.aafp.org/pcmh
- American Academy of Pediatrics
  http://aappolicy.aappublications.org/policy_statement/index.dtl#M
- American College of Physicians
  http://www.acponline.org/advocacy/where_we_stand/medical_home/
- American Osteopathic Association

The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009

Prepared by Kevin Grumbach, MD, Thomas Bodenheimer, MD MPH and Paul Grundy MD, MPH

Abundant research comparing nations, states and regions within the U.S., and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.[i, ii] However, some policy analysts have questioned whether these largely cross-sectional, observational studies are adequate for making inferences about whether implementing major policy interventions to strengthen primary care as part of health reform would in the relatively short term "bend the cost curve" at the same time as improving quality of care and patient outcomes.

Is there research using prospective, controlled study designs which shows what happens to quality, access and costs as a result of investments to enhance and improve primary care? Have recent evaluations documented the outcomes of interventions in the U.S. promoting primary care patient centered medical homes (PCMHs)?

The answer to these questions is, *Yes*. Although some major evaluations of the PCMH are only now getting off the ground, including the evaluation of the Medicare Medical Home Demonstrations, evaluations of other primary care initiatives are much farther along, and the findings of some of these evaluations are starting to emerge in peer-reviewed journals and other publications.

This briefing document summarizes key findings from recent PCMH evaluation studies. These studies have investigated a variety of PCMH models, in a variety of settings ranging from integrated delivery systems to community-based office practices. Some evaluations examine interventions focused on general primary care patient populations, and others on high risk subsets. The evaluations span privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured.

Across these diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment:

- Quality of care, patient experiences, care coordination, and access are demonstrably better.
- Investments to strengthen primary care result within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.

This summary provides a review of recent PCMH evaluations. The initial section of the summary provides a concise view of the key data on cost outcomes. The subsequent section provides more information about each PCMH model and includes data on quality and access in addition to costs, as well as reference citations.

I. Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- Additional investment in primary care of $16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients (the total net cost trend was a savings of $17 per patient per year, which was not statistically significant). Unpublished data from the 24 month evaluation reportedly show a statistically significant decrease in total costs.

Community Care of North Carolina

- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population.

HealthPartners Medical Group BestCare PCMH Model

- 39% decrease in emergency room visits, 24% decrease in hospital admissions.
- Overall costs in the PCMH clinics decreased from being 100% of the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average.

Geisinger Health System ProvenHealth Navigator PCMH Model

- Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months.
- Estimated $3.7 million net savings; for a return on investment of greater than 2 to 1.

Genesee Health Plan HealthWorks PCMH Model

- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors.

Colorado Medicaid and SCHIP

- Median annual costs $785 for PCMH children compared with $1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

continued

Intermountain Healthcare Medical Group Care Management Plus PCMH Model

- 10% relative reduction in total hospitalizations, with even greater reductions among the subset of patients with complex, chronic illnesses. Net reduction in total costs $640 per patient per year ($1,650 savings per year among highest risk patients)

Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days
- Annual net Medicare savings of $1364 per patient and $75,000 per Guided Care nurse deployed in a practice

II. Full Summaries of PCMH Interventions and Outcomes

Group Health Cooperative of Puget Sound

Group Health Cooperative of Puget Sound, a large, consumer owned integrated delivery system in the Northwest, is rolling out a major transformation of its primary care practices. In 2007, Group Health piloted a PCMH redesign at one of its Seattle clinic sites. The redesign included substantial workforce investments to reduce primary care physician panels from an average of 2,327 patients to 1,800, expand in-person visits from 20 to 30 minutes and use more planned telephone and email virtual visits, and allocate daily "desktop medicine" time for staff to perform outreach, coordination, and other activities. The redesign emphasized team-based chronic and preventive care and 24/7 access using modalities including EHR patient portals.

A 12-month controlled evaluation of the pilot clinic redesign, published in a peer-reviewed journal,[iii] found the following:

- **Better quality:** the pilot clinic had an absolute increase of 4% more of its patients achieving target levels on HEDIS quality measures, significantly different from the control clinic trend; pilot clinic patients also reported significantly greater improvement on measures of patient experiences, such as care coordination and patient activation.
- **Better work environment:** Less staff burnout, with only 10% of pilot clinic staff reporting high emotional exhaustion at 12 months compared to 30% of staff at control clinics, despite being similar at baseline; Group Health has seen a major improvement in recruitment and retention of primary care physicians.
- **Reduction in ER and inpatient hospital costs:** 29% reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- **Better value proposition:** an additional investment in primary care of $16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients (the total net cost trend was a savings of $17 per patient per year, which was not statistically significant). Unpublished data from the 24 month evaluation reportedly show a statistically significant decrease in total costs.

As a result of the success of the pilot clinic redesign, Group Health is currently implementing the PCMH model at all 26 of its primary care clinics serving 380,000 patients.

Community Care of North Carolina

Community Care of North Carolina has more than a decade of experience with innovations in the delivery of primary care to Medicaid and SCHIP beneficiaries. Community Care linked these beneficiaries to a primary care medical home, provided technical assistance to practices to improve chronic care services, directly hired a cadre of nurses to collaborate with practices in case management of high risk patients, and added a $2.50 (now $3.00) per member per month care coordination fee for each patient registered with the practice, contingent on practices reporting clinical tracking data. The Community Care PCMH program now involves more than 1,300 community-based practice sites with approximately 4,500 primary care clinicians throughout North Carolina.

An external evaluation[iv, v] concluded that the Community Care of North Carolina PCMH model resulted in:

- **Better quality:** 93% of asthmatics received appropriate maintenance medications; diabetes quality measured improved by 15%
- **Lower costs:** 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total annual savings to the Medicaid and SCHIP programs are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population.

continued

HealthPartners Medical Group

HealthPartners Medical Group, a 700 physician group that is part of a consumer-governed health organization in Minnesota, implemented a PCMH model in 2004 as part of its "BestCare" model of delivery system redesign. The BestCare model invested in better care coordination centered in the primary care medical home, including proactive chronic disease management through phone, computer, and face-to-face coaching. The program also emphasized more convenient access to primary care through online scheduling, test results, email consults, and post-visit coaching.

A 5-year prospective evaluation of the PCMH approach used in the HealthPartners BestCare model, as reported by the Institute for Healthcare Improvement, found the following results:

- **Better quality:** 129% increase in patients receiving optimal diabetes care, 48% increase in patients receiving optimal heart disease care
- **Better access:** 350% reduction in appointment waiting time
- **Reduction in ER and inpatient hospital costs:** 39% decrease in emergency room visits, 24% decrease in admissions
- Overall costs in the BestCare clinics decreased from being equal to the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average.

Geisinger Health System ProvenHealth Navigator PCMH Model

The Geisinger Health System, a large integrated delivery system in Pennsylvania, implemented a PCMH redesign in 11 of its primary care practices beginning in 2007. Their ProvenHealth Navigator model focuses on Medicare beneficiaries, emphasizing primary care-based care coordination with team models featuring nurse care coordinators, EHR decision-support, and performance incentives.

Two-year follow-up results from an as-yet unpublished controlled evaluation[vii] show:

- **Better quality:** Statistically significant improvements in quality of preventive (74.0% improvement), coronary artery disease (22.0%) and diabetes care (34.5%) for PCMH pilot practice sites.
- **Reduction in costs:** Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months.

Geisinger estimates a $3.7 million net savings from the implementation of its PCMH model, for a return on investment of greater than 2 to 1, and is spreading the ProvenHealth Navigator PCMH model throughout the Geisinger Health System.

Genesee Health Plan

The Genesee Health Plan based in Flint, Michigan developed a PCMH model for its health plan serving 25,000 uninsured adults. The Genesee PCMH model, called Genesys HealthWorks, invested in a team approach to improve health and reduce costs, including a Health Navigator to work with primary care clinicians to support patients to adopt healthy behaviors, improve chronic and preventive care, and provide links to community resources.

A 4-year longitudinal evaluation of the PCMH approach used in the Genesys HealthWorks model, as reported by the Institute for Healthcare Improvement,[viii] found the following results:

- **Improved access:** 72% of the uninsured adults in Genesee County now identify a primary care practice as their medical home.
- **Better quality:** 137% increase in mammography screening rates; 36% reduction in smoking and improvements in other healthy behaviors.
- **Reduction in ER and inpatient costs:** 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors.

Colorado Medicaid and SCHIP

The Colorado Department of Health Care Policy and Financing has implemented a PCMH program for low-income children enrolled in the state's Medicaid and SCHIP programs. To qualify as medical homes, primary care practices must have 24/7 access, open access systems or similar convenient scheduling of appointments, and provide care coordination, which make practices eligible for extra pay for performance payments indexed to EPSDT metrics. As of March 2009, 150,000 children were enrolled in Colorado PCMH practices, involving 97 different community-based practices and 310 physicians.

The Colorado Department of Health Care Policy and Financing has performed an internal evaluation of its PCMH program,[ix] comparing children in PCMH practices to those care for in usual care practices, and found:

- **Better quality:** 72% of children in the PCMH practices have had well-child visits, compared with 27% of controls.
- **Lower costs:** Median annual costs were $785 for PCMH children compared with $1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

continued

Intermountain Healthcare Medical Group Care Management Plus PCMH Model

Intermountain Healthcare Medical Group, part of an integrated delivery system in Utah, began implementing a PCMH redesign model in 2001. The Care Management Plus PCMH model focuses on primary care-based care coordination of high risk elders, embedding RN care managers in primary care practices and enhancing EHR functionality in support of chronic care and care coordination.

A well-designed controlled 2-year evaluation published in peer-reviewed journals[x] documented:

- **Better quality:** absolute reduction of 3.4% in 2-year mortality (13.1% died in PCMH group, 16.6% in controls)
- **Lower costs:** a 10% relative reduction in total hospitalizations, with even greater reductions among the subset of patients with complex chronic illnesses. Net reduction in total costs was $640 per patient per year ($1,650 savings per year among highest risk patients).

Based on these evaluation results, the Care Management Plus PCMH model is now being implemented at more than 75 practices in more than six states. (Dorr et al., 2007a; Dorr et al., 2008).

Johns Hopkins Guided Care PCMH Model

The Guided Care PCMH model, developed by an interdisciplinary team at the Johns Hopkins Bloomberg School of Public Health, features care coordination by RN-primary care physician teams working in community-based practices. Guided Care RNs are trained to coordinate care, monitor patients and teach patients and families self-management skills, including early identification of worsening symptoms that can be addressed before an emergency department or hospital admission becomes necessary. The RNs focus on Medicare beneficiaries in the top quartile of health risk.

A preliminary evaluation after eight months of a cluster randomized trial of this model involving 904 patients has been published in a peer-reviewed journal.[xi] The trends indicate, on average:

- 24% reduction in total hospital inpatient days
- 15% fewer ER visits
- 37% decrease in skilled nursing facility days
- Annual net Medicare savings of $75,000 per Guided Care nurse deployed in a practice
- The Guided Care patients were more than twice as likely as usual care patients to rate the quality of their care highly.

Erie County PCMH Model

- In the 1990s, Erie County, NY implemented a primary care medical home program for dual eligible Medicaid-Medicare patients with chronic disabilities, including substance abuse. A key part of the intervention was a per-member/per-month care coordination fee to primary care practices to support enhanced team-based chronic care management. An evaluation published in a peer-reviewed journal found that the intervention improved quality of care, decreased duplication or services and tests, lowered hospitalization rates, and improved patient satisfaction while saving $1 million for every 1000 enrollees.[xii]

Geriatric Resources for Assessment and Care of Elders

The Geriatric Resources for Assessment and Care of Elders (GRACE) program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolled low-income seniors with multiple diagnoses, one-fourth of whom were at high risk for hospitalization. The GRACE PCMH model included a nurse practitioner/social worker care coordination team, working closely with primary care physicians and a geriatrician. At two years, the use of the emergency department was significantly lower in the group receiving the GRACE intervention compared with controls. The subgroup defined at the start of the study as having a high risk of hospitalization was found to have a significantly lower hospitalization rate compared with high-risk usual care patients.[xiii]

Endnotes

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[v] Mercer. Executive Summary, 2008 Community Care of North Carolina Evaluation. Available at http://www.communitycarenc.com/PDFDocs/Mercer%20ABD%20Report%20SFY08.pdf.

[vi] Health Partners uses "BestCare" practices to improve care and outcomes, reduce costs. Institute for Healthcare Improvement. Available at http://www.ihi.org/NR/rdonlyres/7150DBEF-3853-4390-BBAF-30ACDCA648F5/0/IHITripleAimHealthPartnersSummaryofSuccessJul09.pdf

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[viii] Genesys HealthWorks integrates primary care with health navigator to improve health, reduce costs. Institute for Healthcare Improvement. Available at http://www.ihi.org/NR/rdonlyres/2A19EFDB-FB9D-4882-9E23-D4845DC541D8/0/.

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[xii] Rosenthal, T. C., M. E. Horwitz, et al. Medicaid Primary Care Services in New York State: Partial Capitation vs. Full Capitation." J Fam Practice 1996;42(4):362-368.

[xiii] Counsell SR, Callahan CM, Clark DO, et al. Geriatric care management for low-income seniors: a randomized controlled trial. JAMA. 2007;12;298(22):2623-33.

Demonstration/Pilot Program Guidelines

PCPCC Endorsed—March 2009

The following chart outlines the guidelines for PCMH demonstration projects developed by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), which the PCPCC endorsed in March 2009. These guidelines are designed to help ensure that demonstration projects purporting to test the PCMH model are broadly consistent with the Joint Principles.[2] In addition, the standardization promoted by the acceptance of these guidelines will help facilitate more meaningful interpretation and understanding of the "lessons learned" from the different PCMH demonstration projects.

Collaboration and Leadership	1. The project is open to input from all relevant stakeholders. Examples of relevant stakeholders include professional societies, payers, local large employers/purchasers, health care-oriented community groups including patient advocacy groups, and representatives from local/regional quality improvement programs. 2. The project ensures that the leaders of local/regional primary care professional organizations are adequately briefed about the project. 3. The project identifies an entity that is responsible for convening all participants and coordinating the activities of the project.
Practice Recognition	4. The project uses the National Committee for Quality Assurance (NCQA) Physicians Practice Connections (PPC) PCMH tool, or a similar, consensus-based recognition process that includes validation of PCMH practice attributes defined in the "Joint Principles."[3] 5. The project includes participation of a range of practice sizes, and is representative of the area in which the project is taking place. 6. The project clearly outlines the responsibilities of all participating parties, including providers, payers, patients/families and other relevant stakeholders.

[2]American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association. *Joint Principles of the Patient Centered Medical Home.* March 2007. Accessible at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

[3]Ibid.

Practice Support

7. The project provides participating practices with sufficient financial and non-financial support to at least cover the costs of the PCMH recognition approval process; additional physician, clinical staff, and administrative staff work associated with the project; and implementation of the practice infrastructure required to provide services consistent with the PCMH care model.

8. The project encourages the incorporation of and support for Health Information Technology (HIT) solutions to facilitate: Care Management and Care Coordination by the medical team; Patient and Family Access to educational material and electronic communications; and/or Performance Reporting (including the Patient/Family Experience, Quality Outcomes and Improvement, and Healthcare Resource Utilization).

9. The project design maximizes the number of patients in each participating practice covered by the demonstration project. This can be accomplished in multiple ways, including the participation of multiple payers and the use of broad criteria for patient participation (e.g., child, adult, and elderly participants; patients with chronic and non-chronic conditions).

Reimbursement Model

10. The project's payment model is broadly consistent with the following:
    - A prospective, bundled component that covers physician and administrative staff work and practice expenses linked to the delivery of services under the PCMH model not covered by the most current Medicare RBRVS system.
    - A visit-based fee component for services delivered as part of a face-to-face visit and that are already recognized by the most current Medicare RBRVS system.
    - A performance-based component based on the achievement of defined quality and efficiency goals as reflected by evidence-based quality, cost of care and patient experience measures.
    - The payment model should recognize differences in the level of PCMH care provided and patient case mix/complexity.

Assessment and Reporting of Results

11. The project provides evidence supporting that it is of sufficient duration to reasonably expect the impact of the model to be demonstrated.

12. The project contains a commitment to an external evaluation to ensure the integrity and credibility of the project's data and reports.

13. The project contains a commitment to transparency of the data set, including the selection, use and reporting of results from clinical metrics, financial measures and the application of proprietary measures of performance.

continued

(continued)

Assessment and Reporting of Results

14. The project includes, at a minimum, the following data collection categories:
    - Descriptive data of the participating patients and practices.
    - Process and outcome measures of clinical quality with preference for those measures approved by the AQA and the National Quality Forum (NQF).
    - Measures of resources used, which can include cost of care to the payer and patient, and net effect of the care model on the financial performance of the participating practices.
    - Measures of patient/family experience of care with a preference for nationally recognized measures.
    - Measures of the experience and/or satisfaction of participating physicians, practice staff, and payers with the model.

15. The project measures the qualitative and quantitative (i.e., resource utilization) effects of the PCMH delivery and payment model on the broader health care community, e.g., subspecialty and specialty practices, hospital/emergency room care.

16. The project includes a process to broadly and publicly disseminate its results.

NCQA Scoring Criteria

Standard 1: Access and Communication	Pts.
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts.
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts.
A. Adopts and implements evidence-based guidelines for three conditions**	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts.
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts.
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

continued

Standard 6: Test Tracking	**Pts.**
A. Tracks tests and identifies abnormal results systematically**	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	**Pts.**
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	**Pts.**
A. Has written standards for patient access and patient communication**	3
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician**	3
D. Sets goals and takes action to improve performance	2
E. Produces reports using standardized measures	1
F. Transmits reports with standardized measures electronically to external entities	
	15

Standard 9: Advanced Electronic Communications	**Pts.**
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

PPC-PCMH™ Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 -100	10 of 10
Level 2	50 –74	10 of 10
Level 1	25 –49	5 of 10
Not Recognized	0 –24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass," Elements do not Qualify.

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'Health care home' is a Minnesota way

● As America squabbles, an '08 law brings a new system to many clinics that aims to improve care and cut costs.

By WARREN WOLFE
wolfe@startribune.com

STAPLES, MINN. – Strapped to his oxygen supply and pushing a walker, 73-year-old Keith Ford doesn't look like the solution to a fractured health care system.

But he is — at least in an ambitious new effort that Minnesota is rolling out to transform how hospitals and clinics deliver care.

health care
THE GREAT DEBATE

While the national health care debate has become mired in an acrimonious mix of ideas and insults, Minnesota is moving ahead, putting in place the building blocks of a landmark 2008 state law designed to improve medical care, keep Minnesotans healthier and ultimately trim soaring costs.

The first of the big changes — the "health care home" — will debut July 1 and then spread across the state, with perhaps one-fourth of the state's 700 clinics certified to offer their sickest patients this new model of care by 2012.

Go to Staples, 150 miles northwest of the Twin Cities, and you can glimpse at the medical future now.

That's where 11 family-practice doctors at Lakewood Health System are using the approach to see whether they can offer better and sometimes cheaper care for 524 patients with the most complex

Health continues on A8 ▸

KYNDELL HARKNESS • kyndell.harkness@startribune.com
Lakewood's Dr. Christine Albrecht asked Keith Ford how he was feeling. Lakewood is among the state's first health care homes.

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Vol. XXVIII • No. 330 • Minneapolis, St. Paul • February 28, 2010

health care the great debate

Minnesota rolls out own change in health care

◂ HEALTH FROM A1

conditions.

"Instead of paying for tests and visits when people get sick, we're starting to pay to coordinate care, to keep people well and out of the hospital," Health Commissioner Sanne Magnan said in an interview last week.

What's different is Niki

The idea is that good things happen when a medical team — including the patient — collaborates to form and execute an individualized care plan to help patients cope, even thrive, with multiple ailments.

The care coordinator is key.

"What's different from before? Having Niki is different," Ford said last week as he waited to see Dr. Christine Albrecht for shortness of breath.

Niki is care coordinator Nicole Worden, who monitors Ford's treatment, answers the phone when he has questions and can schedule him to see the doctor in a moment's notice.

Because of Albrecht and Worden, Ford said, he hasn't been hospitalized since he joined the program in November 2008 — saving him and the government money.

If the same model were adopted nationally, health care costs could drop by 15 to 20 percent per year, without a drop in quality, according to a study published recently in the journal Health Affairs.

More changes are coming this year for Minnesota: a statewide campaign to reduce smoking and obesity, public measures of care quality and costs in clinics and hospitals, and set-fee "baskets of care" covering such conditions as lower back pain.

"But health care homes, that's the big dog, the big thing most people are going to see first," said Dr. Jeff Schiff, a pediatrician and medical director at the state Department of Human Services.

A three-ring patient buy-in

At Lakewood, physicians decide which patients go into the health care home — generally, those with three or more chronic ailments, four or more prescriptions, severe or complex conditions and who agree to be active participants. Most are over 65, but they come in all ages.

To cement patient buy-in, each gets a three-ring binder with medical records, contact information and educational materials, updated at each clinic visit.

"I feel more ownership of my care now, and the binder is kind of like the proof," said Clarice (Jollie) Ricke, 78. She has volunteered to join a Patient Advisory Council that will start this year, funded partly by a $2,000 state grant announced last week.

Every medical home patient gets a doctor visit of at least 30 minutes, double the usual time. All 11 primary care doctors reserve several slots a day for medical home patients who need immediate care.

"We were getting frustrated. We didn't seem to have enough time for the patients who needed us most," said Dr. John Halfen, 60, medical director at the Staples clinic and the driving force behind the new system, now 16 months old. "I'm not working less now, but I feel like I'm accomplishing more."

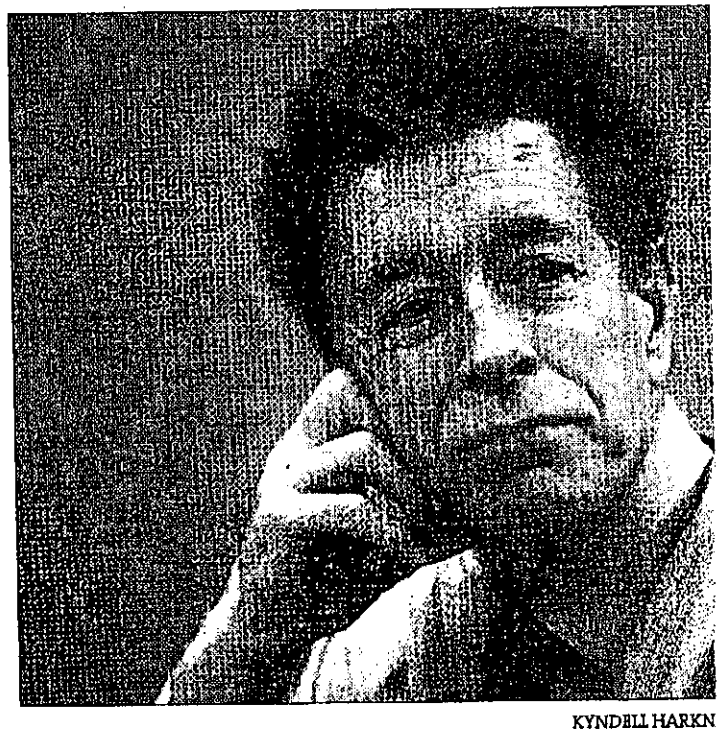
Depending on the patient, the health team might include a pharmacist, a psychologist, a specialist, a physical therapist, a home health nurse, the patient's spouse, even a hospice coordinator or nursing home worker.

But it's the care coordinator — a registered nurse and the first point of contact — who keeps the system humming.

A huge advantage of the medical home, many patients say, is that instant help. Bypassing the normal triage nurses, they call Worden — or her replacement while she's on maternity leave, Arloa Bauch.

"A lot of times I can just help them, reassure them, right there on the phone," Worden said. "I have the electronic records, and I pretty much know everyone, their family stuff, because I ask. The more I know, the more I can help."

Recently, a patient with congestive heart failure called,

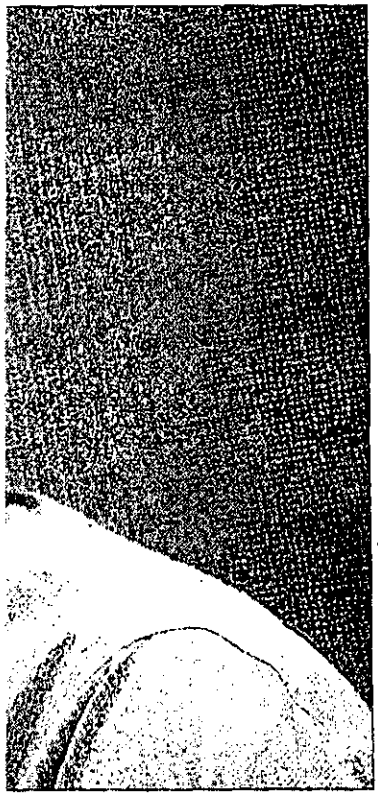


KYNDELL HARKN

John Halfen is medical director at Lakewood Hospital in Staples. Lakew as one of the state's first health care homes, a pioneering approach to n costs and improve patient care. Halfen helped create the program.

« A LOT OF TIMES I CAN JUST HELP THEM, REASSURE THEM, RIGHT THERE ON THE PHONE. »

Nicole Worden, Lakewood Hospital care coordinator



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ood will be certified this spring
nedicine that promises to reduce

nervous that a 2-pound weight gain might signal a crisis.

"Two years ago, that guy would have rushed to the emergency room," Worden said. "This time, the doctor and I calmed him down, monitored him closely for a few days and helped him lose that weight — patient happy, doctor happy, no unnecessary ER visit."

System doesn't come cheap

Lakewood already has invested more than $500,000 in its medical home, not counting about $4 million for its computerized medical record system, a critical tool.

"So far we've eaten the cost, and it's been worth it," said Lakewood CEO Tim Rice. "We can't keep that up forever, but I don't think we could go back. Our patients wouldn't let us."

Starting July 1, the state will begin paying a range of care coordination fees, based on a patient's care needs — amounts that Health Commissioner Magnan will announce Friday.

While the state will pay to coordinate care of the sickest people on Medical Assistance and other state programs, insurers such as HealthPartners, Medica, and Blue Cross and Blue Shield of Minnesota will begin paying the fee for some of their clients.

"Ultimately, what we really want is for this integrated, patient-centered team approach to become the standard for all patients," said Dr. Pat Corneya, associate medical director for care delivery systems at HealthPartners.

Not covered for now, however, will be most people on Medicare — roughly one in seven Minnesotans.

Lakewood and 78 other "critical access" rural hospital systems will get some Medicare reimbursement because they are paid for their overall costs. Some Medicare Advantage plans, managed by insurers, may negotiate care coordination fees with clinics.

But state officials are waiting for Medicare to start pilot programs so doctors can add more of their 760,000 Medicare patients to the new model.

Old-fashioned medicine

Ford developed a chronic lung disease and in 1996 retired as an over-the-road trucker. He and his wife, Carol, returned home to Staples after 50 years in Coon Rapids.

"I've done a lot of doctoring, been in a lot of hospitals, and we thought hard about the health care stuff before coming back," he said. "So far, this is good, real good. It's like they actually know who I am."

Halfen said patients stop him on the street with similar testimonials.

"What we're doing is practicing medicine the way it used to be in the old days," he said, "but with a lot more colleagues and a lot more tools."

Warren Wolfe • 612-673-7253

Medical Home Resources and Bibliography

- List of articles and resources that serves as a starting point for learning about the medical home and its components: http://pchm.ahrq.gov/portal/server.pt/community/pcmh_home/1482/foundational_articles.
- An overview of the PCMH, including key features, discussion of federal, state and private sector medical home models, and considerations for hospitals interested in developing a PCMH. http://www.hret.org/patientcentered/resources/patient-centered -medical-home.pdf .
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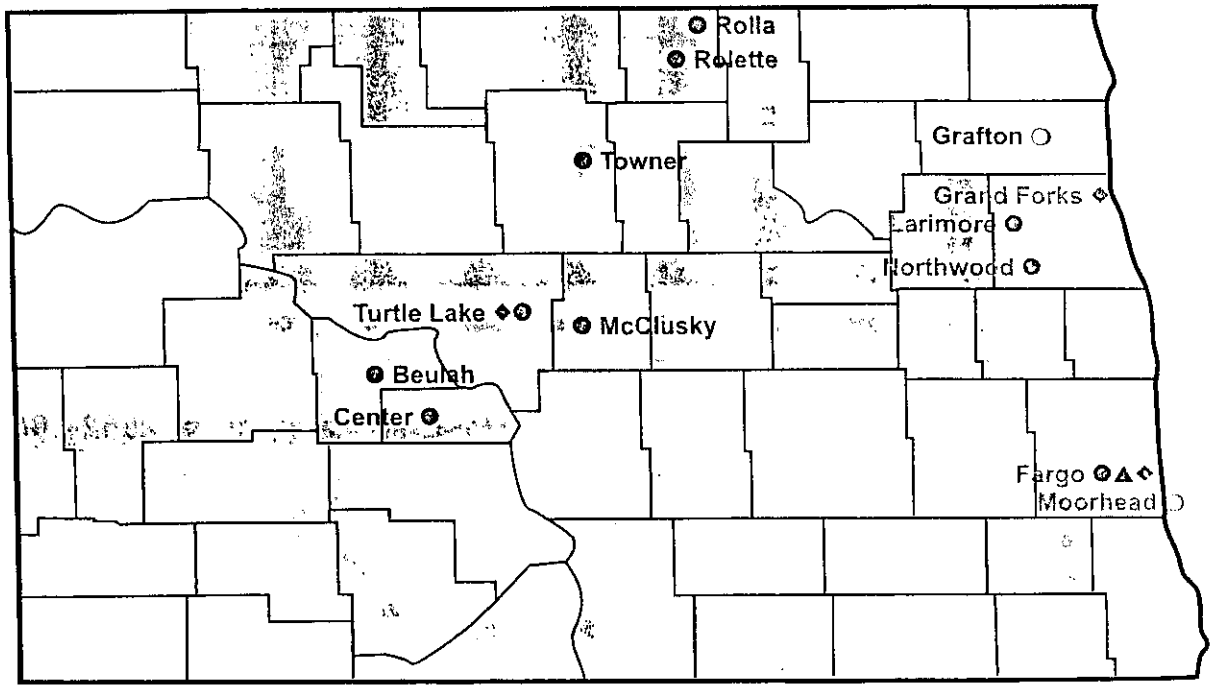
- American Osteopathic Association: http://www.osteopathic.org

Community Health Center Sites in North Dakota



☐ Medically Underserved Areas

NORTH DAKOTA
Coal Country Community Health Centers
Family HealthCare Center
Migrant Health Service, Inc.
Northland Community Health Center
Valley Community Health Centers

- ● Federally Qualified Health Centers
- ○ Migrant Health
- ◆ Dental Clinic
- ■ School-based Health Centers
- ▲ Healthcare for the Homeless

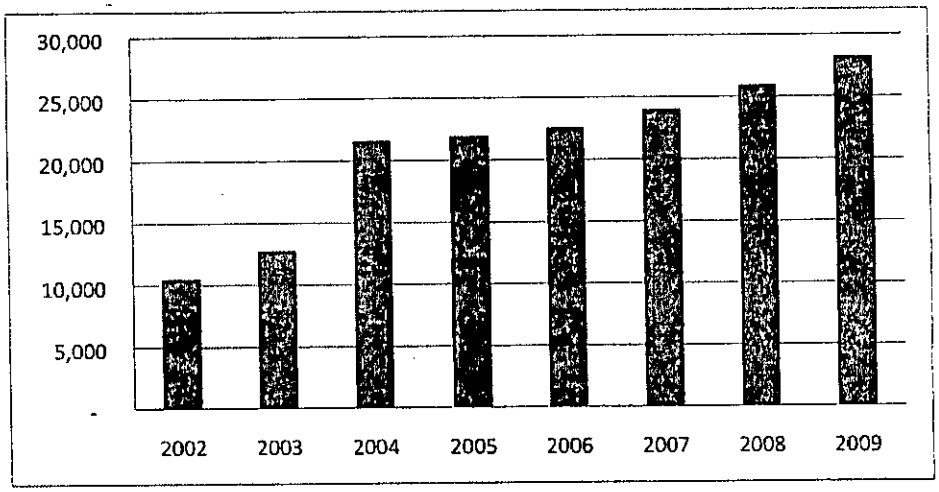
2009 Patient Demographics

Total Patients	**28,215**
Total Encounters	
Medical	67,356
Dental	17,273
Patients by Age	
Under Age 5	2,320
Age 5-19	6,484
Age 20-64	16,369
Ages 65+	3,042

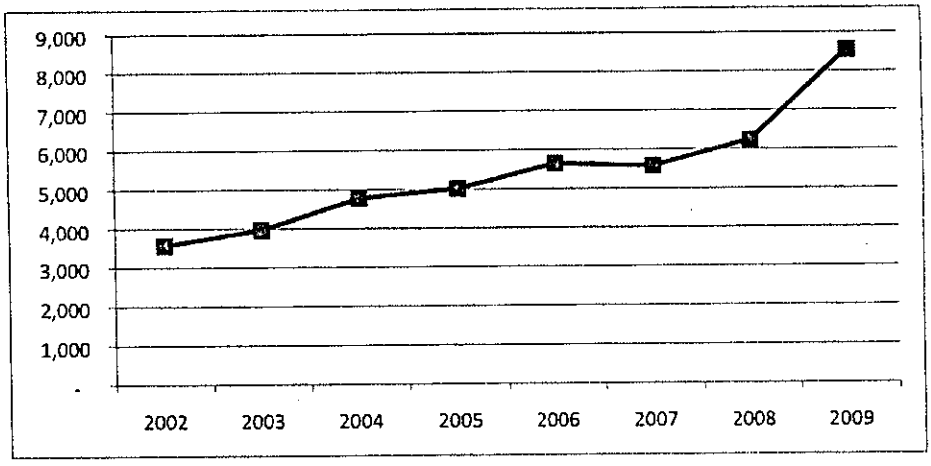
Patients by Race	
White	26,186
American Indian/Alaska Native	1,560
Black/African American	1,914
Asian/Pacific Islander	694
Native Hawaiaan	76
More than one race	226
Income as a percent of Poverty Level	
100% and Below	10,709
101-150%	2,347
151-200%	1,115
Over 200%	739
Unknown	13,305

Source: 2009 Uniform Data System

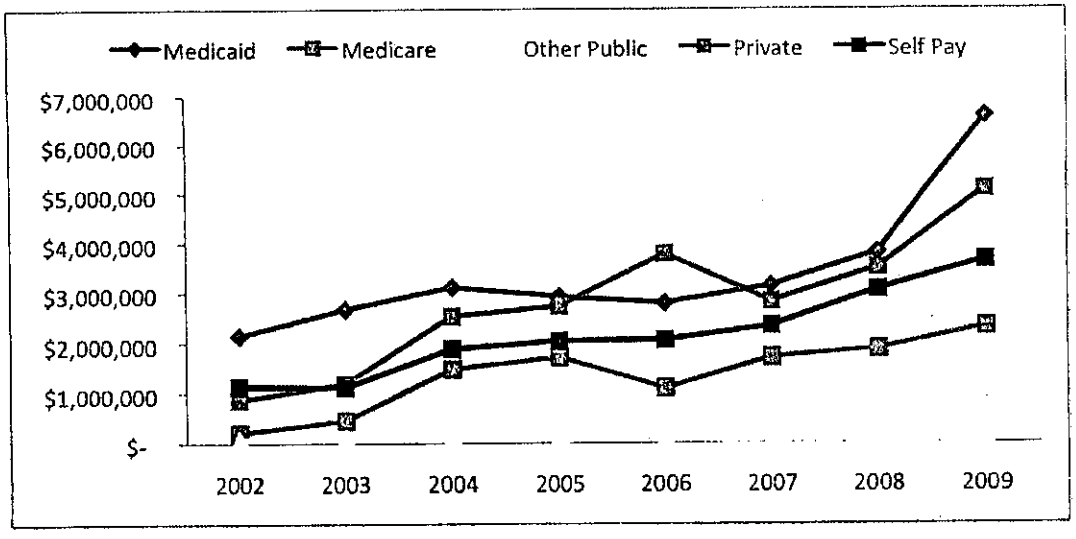
Patient Numbers for 2002-2009



Uninsured Patients for 2002-2009



Patient Revenue by Source for 2002-2009



Source for all graphs: 2009 Uniform Data System

CHAD
Community HealthCare Association of the Dakotas

NCQA

Patient Centered Medical Home

March 2, 2011

The Community HealthCare Association of the Dakotas (CHAD) and its Health Center Controlled Network (HCCN) have reached consensus to strive for Patient Centered Medical Home (PCMH) recognition with the goal of all registering with an "Intent to Apply" to the National Committee for Quality Assurance (NCQA)* by August 2012. The HCCN will learn the NCQA 6 standards, find tools to assess the Health Center's current practice, apply gap analysis' to find areas for improvement, and provide over-reads of NCQA applications. The Network members will be able to submit applications for Level 1, 2, or 3. The Network will document progress and best practices, with the goal that fully implemented improvements are retained at the sites.

Possible Resources:

NCQA standards tutorial:

There is a possibility of combining efforts with MT, CO, UT, and WY to engage NCQA, or a consultant, to teach the standards on webinars. Community Health Association of Mountain/Plains States (CHAMPS) would be willing to house the archived webcasts and make them available as 6 modules for the 6 standards: Standard 1: Enhance Access & Continuity, Standard 2: Identify and Manage Patient Populations, Standard 3: Plan and Manage Care, Standard 4: Provide Self-Care Support and Community Resources, Standard 5: Track and Coordinate Care, and Standard 6: Measure & Improve Performance.

NCQA trainings for CHC staff and CHAD staff:

- Facilitating PCMH recognition April 28-29 in New Orleans $850 registration fee
- Facilitating PCMH recognition May 19-20 in Baltimore $850 registration fee
- Facilitating PCMH recognition September 13-14 in Denver $850 registration fee
- http://www.ncqa.org/tabid/1295/Default.aspx

Primary Care Development Corporation as a consultant to do a CHAD Collaborative:

- Toolkit ready to go, has been tested with CHCs through the NY 12 team Collaborative.
- http://www.pcdcny.org/

TransforMED as a consultant for individual CHCs:

- Tools for assessment, education, evaluations, and the ability to benchmark a CHC against the standards.
- http://www.transformed.com/PPC/NCQA/PPC_ncqa.cfm?gclid=CI71wvjOq6cCFQcBbAod0nCYBg

***The NCQA definition of a Primary Care Medical Home is a health care setting that provides patients with:**

-well-organized and on-time visits
-enhanced access with their own provider and care team for continuity
-proactive care management
-care coordination across all health care settings
-patient activation, engagement and participation in decisions on care
-focus on health outcomes
-use of Health IT as a tool

100% of Stage 1 Meaningful Use objectives are incorporated into the 2011 NCQA PCMH program.

MU & PCMH Overviews / HCCN Strategic Planning Meeting

February 16, 2011

Patient-Centered Medical Homes: An Overview

Presentation by:
Regina Neal & Carl Reiner
Primary Care Development Corp.

CHAD
Community HealthCare Association of the Dakotas

PRIMARY CARE DEVELOPMENT CORPORATION

Agenda

- Setting the Context: An Overview of the Patient Centered Medical Home (PCMH)
- PCMH Recognition Programs
- Overview of Process for Becoming a PCMH/ Obtaining Recognition
- Available Assistance

Key Decisions to Consider

- Do you want to obtain PCMH recognition?
  - If so, using which program?
  - By when?
- Do you want to go for CMS MU incentives?
  - If so, Medicaid or Medicare?
  - By when?
- What type of assistance might you need to do either or both of these?

I. Overview of PCMH Concept

Setting the Context

- What is the medical home
- Why is it important
- Is there evidence that it works
- What's happening around the country
- Why are standards important (e.g., NCQA, TJC)
- Why the standards can be useful even if you're not going to pursue recognition

Terminology

- Patient-Centered Medical Home (NCQA, PCPCC)
- Health Home or Health Care Home (NACHC)
- Advanced Primary Care Practice
- Primary Medical Care Home
- Primary Care Home (Joint Commission)
- Mental Health Home

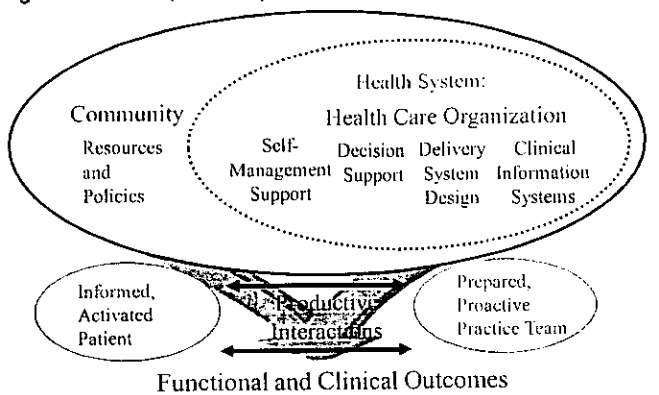
Principles for the Patient-Centered Medical Home

- Personal physician/clinician
- Team-based care
- Whole person orientation
- Enhanced access (with continuity)
- Coordinated & integrated care
- Quality & safety prioritized
- Payment for the value provided

The Medical Home: What Is It?

- A health care setting that provides patients with:
  - ***well-organized*** & ***on-time*** visits
  - ***enhanced access*** with their own provider & care team for ***continuity*** (same day appointment availability, 24/7 telephone access, alternatives to the 1:1 visit)
  - ***proactive care management*** (evidence base clinical care, panel management, reminder systems, registries)
  - ***care coordination*** across settings (assistance with referrals, tracking for tests & referrals; care during transitions)
  - ***patient activation, engagement & participation*** in decisions on care (patient centered → customer driven)
  - focus on ***health outcomes*** & goals for improvement
  - use of ***Health IT*** as tool to support the achievement of advanced primary care practice

Aligned with the (Chronic) Care Model



What's Driving the Need for Transformation?

- High costs & low quality (especially compared to cost)
- Poor access & continuity
- Low satisfaction for patients, staff
- Current models of care are not working to achieve quality, cost & patient experience goals

The Medical Home: Closing the Gap in Disparities

- Disparities in terms of access to care and quality of care largely disappear when adults have a medical home (CMWF, 2006, Closing the Divide)
- Key features of Medical Home in this study
  - Not difficult to contact provider by phone
  - Not difficult to get care or medical advice after hours or on weekends
  - Office visits available, well-organized and on-time
- Key Findings
  - when adults have a medical home, their access to needed care, receipt of routine preventive screenings and management of chronic conditions improve substantially

How is primary care performing on basic chronic and preventive care services?

- National study of physician performance
  - 439 process indicators for 30 medical conditions plus preventive care
- Physicians provided only 55% of recommended care

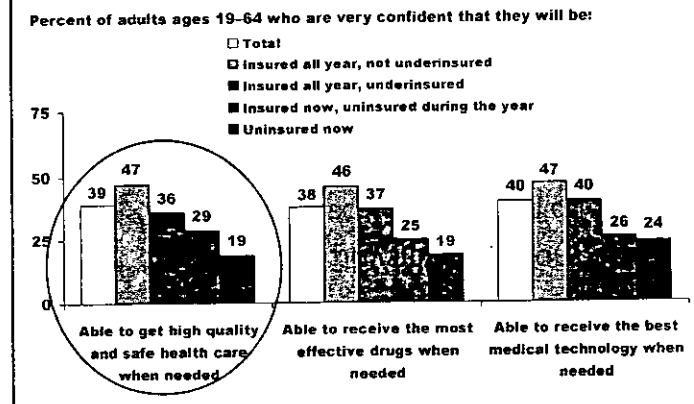
[McGlynn et al. NEJM 2003; 348:2635]

How is primary care performing on the most prevalent chronic care conditions?

- Despite well-designed guidelines for hypertension, hyperlipemia, and diabetes
- Despite widespread guideline dissemination to physicians for years
  - 65% of people with HBP are poorly controlled
  - 62% with elevated LDL have not reached lipid-lowering goals
  - 63% of people with diabetes have HbA1c > 7

Roumie et al. Ann Intern Med 2006;145:165, Afonso et al. Am J Manag Care 2006;12:583, Saydah et al. JAMA 2004;291:335.

Only Four of Ten Adults Are Very Confident In Their Ability to Get Safe, Effective Care



Source. The Commonwealth Fund Biennial Health Insurance Survey (2007).

Data on Practice: Are We There Yet?

- 2009 Commonwealth Fund Survey
  - national survey of all FQHCs to assess capacity to function as high-performing sites of care, i.e., medical homes
  - 80% response rate

Exhibit 14. Indicators of a Medical Home

INDICATORS OF MEDICAL HOME	Total
Medical Home Capacity—Total Number of NCQA Domains	
Capacity in All 5 Domains	29%
Capacity in 3 to 4 Domains	55%
Capacity in 0 to 2 Domains	16%
1) NCQA Domain—Patient Tracking and Registry Functions: Can easily generate a list of patients by diagnosis with the current patient medical records system	69%
2) NCQA Domain—Test Tracking: Provider usually receives an alert or prompt to provide patients with test results; or laboratory test ordered are usually tracked until results reach clinicians	60%
3) NCQA Domain—Referral Tracking: When clinic patients are referred to specialists or subspecialists outside largest site, center usually or often tracks referrals until the consultation report returns to the referring provider	70%
4) NCQA Domain—Enhanced Access and Communication: Patients usually are able to receive same- or next-day appointments, can get telephone advice on clinical issues during office hours or on weekends/after hours	71%
5) NCQA Domain—Performance Reporting and Improvement: Performance data are collected on clinical outcomes or patient satisfaction surveys and reported at the provider or practice level	99%

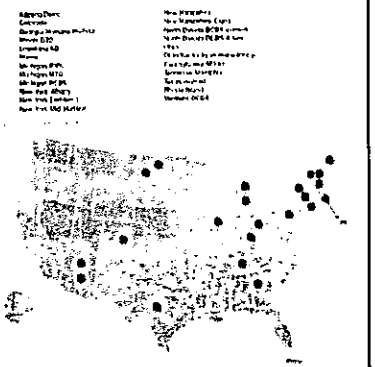
Notes: Easily means they can generate information about the majority of patients in less than 24 hours.
Usually means 75% to 100% of the time and Often means 50% to 74% of the time
Source: The Commonwealth Fund National Survey of Federally Qualified Health Centers (2009).

The Medical Home Is A Movement Developing Traction And Urgency

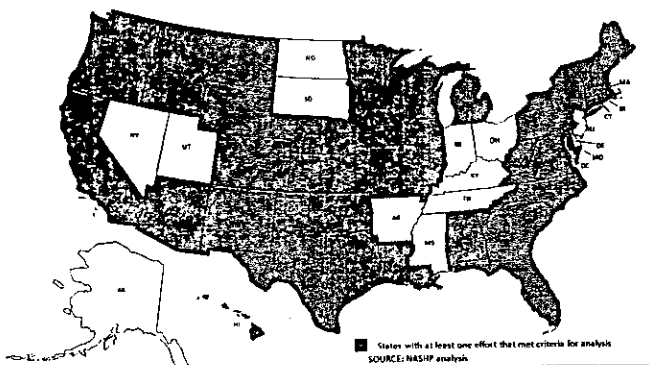
Patient-Centered Primary Care COLLABORATIVE

Overview of Activity

- 23 Multi-stakeholder Pilots
- 8 State Medicare Pilots Planned for 2009
- 44 States and the District of Columbia Have Passed over 330 Laws and/or Have PCMH Activity



There are 37 States Working to Advance Medical Homes for Medicaid or CHIP Beneficiaries



Findings from PCMH Evaluations

- Investments to redesign the delivery of care around a primary care patient-centered medical home yield an excellent return on investment:
  - demonstrably better
    - quality of care
    - patient experiences
    - care coordination
    - access.
  - reductions that produce savings in total costs:
    - emergency department visits
    - inpatient hospitalizations
  - savings at minimum offset new investments in primary care in a cost-neutral manner; in many cases appear to produce a reduction in total costs per patient.

Grumach K, Bodenheimer T & Grundy P. 2009. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies. Review of data & key findings from PCMH evaluation studies from eight systems http://test.pcpcc.net/files/pcmh_evidence.pdf

Summary of Key Data from PCMH Interventions

	Better Quality	Better Work Environment	Reduction in ER & Inpatient Hospital Costs	Better Patient Satisfaction & Access
Group Health Cooperative	X	X	X	X
Community Care of North Carolina	X		X	
HealthPartners Medical Group	X		X	X
Geisinger Health System	X		X	
Genesee Health Plan	X		X	X
Colorado Medicaid & SCHIP	X		X	
Intermountain Healthcare	X		X	
Johns Hopkins	X		X	

Source: Grumbach K, Bodenheimer T & Grundy P. (2009) The Outcomes of Implementing PCMH Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies.

PCPCC November 16,2010 PCMH Outcomes Update

Pilot Name	Total Lives Covered	Cost Redux	Hosp Redux	ER Redux	ROI	Quality Outcomes
[redacted]	7,018	$10pmpm	16%	29%	$1.69/Pt	4% increase HEDIS 20% Decrease staff burnout
[redacted]	8,634	7%	18%		2:1	22% improvement CAD 34.5% improvement Diabetes Care
[redacted]	10,847 CDM	$593/pt				Composite outcome for HSP and ED visits reduced 27% COPD
[redacted]	350,000	8%	29%	39%		350% reduction in Appointment wait times
[redacted]	1,144	$640/pt	3%			3.4% reduction in 2yr mortality
BCBS NC	809	Rx 6%pmpm	10% in days	32.2%		Improved 6/10 DM quality measures
BCBS ND	192 DM	$530/pt	6%	24%		18% increase in complete care pts
Metropolitan Health Pla		(5.2%)	3%			Screening rates up/Vaccinations up
Community Care NC	970,000		40%	16%		93% asthmatics appropriate meds
Colorado Medd & SCHIP	150,000	$215/child				46% increase in well child visits
[redacted]		$75k saved per CCN	24% in days	15%		
[redacted]	25,000		15%	50%		72% uninsured have PCP PCMH
[redacted]						Saved $1M/1000 enrollees

Excellent Care by Design

"[Better] performance is not simply a matter of effort; it is a matter of design"

Don Berwick

NCQA standards form a framework that can be used as a guide for our improvement work.

II. PCMH Recognition Programs

MH Recognition Programs

- NCQA's programs
  - 2008 PPC-PCMH (expires in Dec 2011)
  - 2011 PCMH (standards released Jan 31, 2011; survey tool available on Mar 28, 2011)
  - More info available at www.ncqa.org
- The Joint Commission Primary Care Home (draft criteria released Jan 31, 2011)
- AAAHC
- URAC
- State-specific programs

Joint Commission

- Developing **Primary Care Home (PCH)** designation as an **optional add-on** to Joint Commission ambulatory **Accreditation Program**
- Offers opportunity for both accreditation & PCH designation through one on-site evaluation process
- **Release of standards:** Spring 2011
- **Implementation** for accredited organizations: July 2011 (target date)

NCQA PCMH RECOGNITION PROGRAMS: COMPARISON OF 2008 & 2011 REQUIREMENTS

Who is Eligible for 2011 PCMH Recognition?

YES (or likely)

- CHCs, including FQHCs and FQHC look-alikes
- Solo & group practices
- Hospital-based primary care practices
- Clinicians that can be selected by patients/ families as a "Personal Clinician"
- NPs and PAs practicing in Internal Med, Family Med or Peds (pts must be able to choose them as their primary care practitioner)

NO (or not likely)

- Rehabilitation facility
- Hospital
- Specialty physicians
- NPs and PAs who don't have their own panel of pts or don't practice in primary care

Goals of 2011 NCQA Standards

- Increase patient-centeredness
- Align the requirements with processes that improve quality and eliminate waste
- Increase the emphasis on patient feedback
- Enhance the use of clinical performance measure results
- Integrate behaviors affecting health, mental health and substance abuse
- Enhance coordination of care
- Enhance applicability to pediatric practices
- Better alignment with CMS Meaningful Use requirements
- More emphasize on language and other culturally sensitive aspects

Source: Table 2 in NCQA's Standards for PCMH 2011 Standards available at: http://ncqa.org/tabid/1302/Default.aspx and NCQA's PCMH 2011 FAQs available at: http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH_2011_FAQs_1.20.11.pdf

Transitioning to 2011 NCQA PCMH Program

- PPC-PCMH 2008 survey tool will be sold until PCMH 2011 is released March 28, 2011
  - Can submit using 2008 standards until Dec 31, 2011
- 2011 PCMH Survey Tool will be available Mar 28, 2011
  - PCMH CAHPS Clinician Group Survey Tool anticipated to be released in July 2011 and will not be required until January 2012

Definitions

- **Standard:** consist of several specific elements; evaluate a practice's ability to function as a PCMH
- **Element:** consist of factors; scored component of a standard that provides details about performance expectations
- **Must pass element (MPE):** specific type of element; designated elements that a practice must pass at a score of ≥50% to achieve NCQA recognition
- **Factor:** score item in an element
- **Critical factor:** specific type of factor; these factors identified as central to the concept being assessed within particular elements

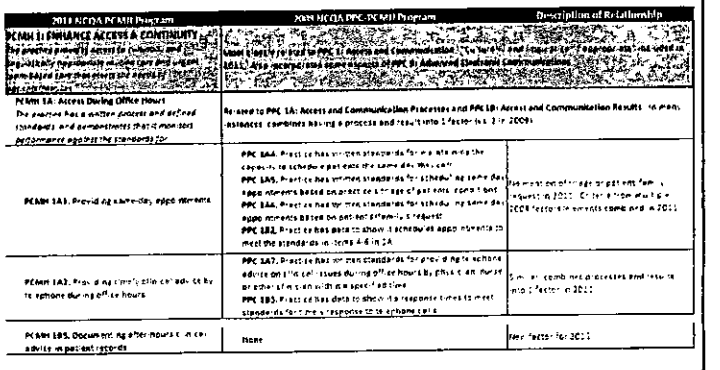
2008 vs. 2011 NCQA PCMH Program

Domain	Item	2008	2011
	# Standards	9	6
	# Elements	30	27
	# Must Pass Elements	10	6
	# Factors	166	149
	# Critical Factors	0	8
Scoring Requirements	Level 1	≥25 points & 5 of 10 MPE at 50% level	≥35 points & all 6 MPE at 50% level
	Level 2	≥50 points & all 10 MPE at 50% level	≥60 points & all 6 MPE at 50% level
	Level 3	≥75 points & all 10 MPE at 50% level	≥85 points & all 6 MPE at 50% level
	Recognition Period	3 years	3 years
HIT/MU	HIT Required	Similar. Can accomplish majority of factors w/ little or no HIT (e.g., PM5). Achieving higher levels of recognition requires more advanced HIT (e.g., registry, eRx, EMR, patient portals, lab interfaces)	
	Relationship to MU	Indirect	Includes 25 MU objectives directly in requirements

What's New in 2011 NCQA Program

- Critical factors
  - Total of eight, two of which fall in MPE
  - Play large role in scoring, especially if they fall in a MPE
- Includes all 25 Stage 1 MU Requirements
  - *Core MU Requirement (15)
  - **Menu MU Requirement (10 of which a practice chooses 5)
- PCMH version of CAHPS Group Clinician Survey Tool
  – Anticipated to be released in July 2011

PCDC's 2008-2011 NCQA Crosswalk: An Excerpt



2011 NCQA PCMH STANDARDS & REQUIREMENTS

2011 NCQA PCMH Standards

1. Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Self-Care
5. Track and Coordinate Care
6. Performance Measurement and Quality Improvement

2011 NCQA PCMH Standards & Content Summary

Standard	Content Summary
Enhance Access/Continuity	• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours • The practice provides electronic access • Patients may select a clinician • The focus is on team-based care with trained staff
Identify/Manage Patient Populations	• The practice collects demographic and clinical data for population management • The practice assesses and documents patient risk factors • The practice identifies patients for proactive and point-of-care reminders
Plan/Manage Care	• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems • Care management emphasizes – Pre-visit planning – Assessing patient progress toward treatment goals – Addressing patient barriers to treatment goals • The practice reconciles patient medications at visits and post-hospitalization • The practice uses e-prescribing
Provide Self-Care Support/ Community Resources	• The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) • The practice follows up with discharged patients
Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

Source: Table 1 in NCQA's Standards for PCMH 2011 Standards available at: http://mcqa.org/tabid/1302/Default.aspx

PCMH 1: Enhance Access/Continuity (20 points)

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- The practice provides electronic access
- Patients may select a clinician
- The focus is on team-based care with trained staff

PCMH 2: Identify/Manage Patient Populations (16 points)

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

PCMH 3: Plan/Manage Care (17 points)

- The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
- Care management emphasizes:
  - Pre-visit planning
  - Assessing patient progress toward treatment goals
  - Addressing patient barriers to treatment goals
- The practice reconciles patient medications at visits and post-hospitalization
- The practice uses e-prescribing

PCMH 4: Provide Self Care Support/ Community Resources (9 points)

- The practice assesses patient/family self-management abilities
- The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
- Practice clinicians counsel patients on healthy behaviors
- The practice assesses and provides or arranges for mental health/substance abuse treatment

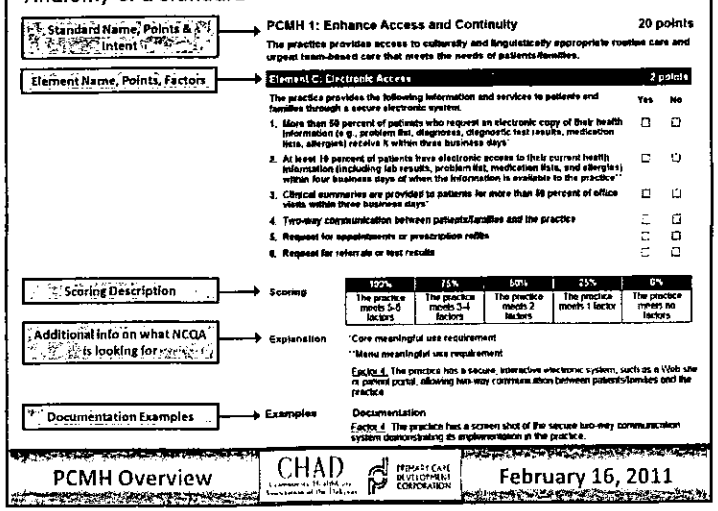
PCMH 5: Track/Coordinate Care (18 points)

- The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
- The practice follows up with discharged patients

PCMH 6: Measure/Improve Performance (20 points)

- The practice uses performance and patient experience data to continuously improve
- The practice tracks utilization measures such as rates of hospitalizations and ER visits
- The practice identifies vulnerable patient populations
- The practice demonstrates improved performance

Anatomy of a Standard



NCQA Materials

TO DO: Access a free, electronic copy of NCQA standards at http://ncqa.org/tabid/1302/Default.aspx

2011 materials include:

- Standards for PCMH 2011 (aka "Front Matter")
- PCMH 2011 Standards
- PCMH 2011 Scoring (Appendix 1)
- NCQA PCMH 2011 & CMS Stage 1 MU Reqs (Appendix 2)
- Glossary (Appendix 3)

2011 NCQA Must Pass Elements (MPE)

- 1A: Access During Office Hours (4 points)
- 2D: Use Data for Population Management (5 points)
- 3C: Care Management (4 points)
- 4A: Support Self-Care Processes (6 points)
- 5B: Referral Tracking and Follow-Up (6 points)
- 6C: Implement Continuous Quality Improvement (4 points)

2011 NCQA PCMH Critical Factors

- **1A1:** Providing same day appointments [MPE]
- **1B3:** Providing timely clinical advice by phone when office is not open
- **1G2:** Having regular team meetings and communication processes
- **3D1:** Reviews and reconciles medications with patients/families for more than 50% of care transitions**
- **3E2:** Generates at least 75% of eligible prescriptions*
- **4A3:** develops and documents self-management plans and goals in collaboration w/ at least 50% of patients/families** [MPE]
- **5A1:** Tracks lab until results are available, flagging and following-up on overdue results
- **5A2:** Tracks imaging tests until results are available, flagging and following-up on overdue results

NCQA Recognizes "Practices"

- **Practice:** 1 or more clinicians who practice together and provide patient care at a single geographic location
- **Practice together:** All clinicians in a practice:
  - Follow the same ***procedures and protocols***
  - ***Medical records*** for all patients treated at the practice site are available to and ***shared*** by all clinicians
  - The ***same systems***—electronic and paper-based—and procedures ***support both clinical and administrative functions***

2011 NCQA Survey Types

- **Standard Survey:** Used when submitting for 1-2 locations
- **Multi-Site Survey:** Used when part of a network with at least 3 locations
- **Add-On Survey:** Used when trying to get a higher level of recognition within the 3 year recognition period

2011 NCQA PCMH Application Components

- Account Info
- NCQA Legal Documents
- Practice Site Info
- Multi-Site Group Self-Assessment Questionnaire
- Clinician Info
- Application
- Important Conditions (select 3)

2011 NCQA PCMH Submission Process: High-Level Overview

1. Order PCMH 2011 online application from NCQA
2. Access the PCMH online application system
3. Sign and submit legal documents
4. Complete and submit online application to NCQA
5. Submit application fee
6. Complete survey tool, incl. required documentation

⚠ IMPORTANT NOTE: You can begin this step while completing steps 1-5 BUT you cannot complete submission UNTIL steps 1-5 are complete

Refer to NCQA's Standards for PCMH 2011 Standards for more detailed info: http://ncqa.org/tabid/1302/Default.aspx

Types of Documentation to Demonstrate Performance of Requirements

- **Documented process**, e.g., policy, checklists, work flows
- **Reports**, from either electronic or manual processes
- **Record or files**, aka "chart review"
- **Other Materials**, e.g., brochures, pamphlets

2011 NCQA PCMH & CMS STAGE 1 MU COMPARISON

Relationship of Joint PCMH Principles & MU Policy Priorities

MH Principle	MU Policy Priority
Patient-centered, whole-person orientation	Engage patients and families
Coordinated care	Improve care coordination
	Not specified
	Improve quality, safety, and efficiency and reduce health disparities
	Adequate private & security protection for personal health info

2011 NCQA PCMH & Stage 1 MU

- 100% of Stage 1 MU objectives (all 25) directly incorporated into 2011 NCQA PCMH program
  - Refer to NCQA's crosswalk for more detailed info
- MU objectives fall in:
  - All 6 standards
  - 12 of the 27 elements
  - 34 of the 149 factors
- In several cases, multiple PCMH factors relate to 1 MU objective
  - E.g., MU C8 incorporates 5 PCMH factors

2011 NCQA PCMH & Stage 1 MU: Key Areas of Overlap

I. PATIENT COMMUNICATION
- Providing patients with electronic access to health related info *[PCMH 1C]*
- Providing patients with ability to make electronic health requests (e.g., eRx refill, test results) *[PCMH 1C]*

II. CARE MANAGEMENT
- Electronically storing patient info (demo and clinical) *[PCMH 2A & 2B]*
- Use of evidence-based guidelines *[PCMH 3A]*
- Self-management support *[PCMH 4A]*

III. CARE COORDINATION – INTERNAL & EXTERNAL
- Medication management *[PCMH 3D]*
- Electronic prescribing *[PCMH 3E]*
- Test and referral tracking and follow-up *[PCMH 5A & 5B]*
- Coordination with facilities/care transitions *[PCMH 5C]*

IV. POPULATION & PUBLIC HEALTH
- Population management *[PCMH 2D]*
- Reporting data externally *[PCMH 6F]*

2011 NCQA & Stage 1 MU: Factor Level

PCMH 1C: Electronic Access • PCMH 1C1 & MU C12 • PCMH 1C2 & MU M5 • PCMH 1C3 & MU C13	PCMH 3E: Use Electronic Prescribing • PCMH 3E1 & MU C4 • PCMH 3E2 & MU C1 • PCMH 3E4 & MU C2 • PCMH 3E6 & MU M1
PCMH 2A: Patient Information • PCMH 2A1 5 & MU C7	PCMH 4A: Support Self-Care Processes • PCMH 4A2 & MU M6
PCMH 2B: Clinical Data • PCMH 2B1 & MU C3 • PCMH 2B2 & MU C6 • PCMH 2B3 7 & MU C8 • PCMH 2B8 & MU C9 • PCMH 2B9 & MU C5	PCMH 5A: Test Tracking and Follow-Up • PCMH 5A9 & MU M2
PCMH 2D: Use Data for Pop Management • PCMH 2D1 & MU M4 • PCMH 2D2 & MU M3	PCMH 5C: Coordinate w/ Facilities/Care Transitions • PCMH 5C7 & MU C14 • PCMH 5C8 & MU M8
PCMH 3A: Implement Evidence-Based Guidelines • PCMH 3A1 & MU C11	PCMH 6F: Report Data Externally • PCMH 6F1 & MU C10 • PCMH 6F2 & MU M9 • PCMH 6F3 & MU M10
PCMH 3D: Manage Medications • PCMH 3D1 & MU M7	

2011 NCQA & Stage 1 MU Comparisons

Standard	Element (total points possible)	Points	Standard	Element (total points possible)	Points
PCMH 1: Enhance Access & Continuity	*A: Access During Office Hours (4)	0	PCMH 4: Provide Self-Care Support & Community Resources	*A: Support Self-Care Process (6)	1.5
	B: After-Hours Access (4)	0		B: Provide Referrals to Community Resources (3)	0
	C: Electronic Access (2)	0.5	PCMH 5: Track & Coordinate Care	A: Test Tracking and Follow-Up (6)	0
	D: Continuity (2)	0		**B: Referral Tracking and Follow-Up (6)	1.5
	E: Medical Hours Responsibilities (2)	0		C: Coordinate with Facilities and Care Transitions (6)	3
	F: Culturally & Linguistically Appropriate Services (2)	0	PCMH 6: Measure & Improve Performance	A: Measure Performance (4)	0
	G: The Practice Team (4)	0		B: Measure Patient/Family Experience (4)	0
PCMH 2: Identify & Manage Patient Populations	A: Patient Information (3)	1.5		**C: Implement Continuous Quality Improvement (4)	0
	B: Clinical Data (4)	4		D: Demonstrate Continuous Quality Improvement (3)	0
	C: Comprehensive Health Assessment (4)	0		E: Report Performance (3)	0
	**D: Use of Data for Population Management (6)	2.5		F: Report Data Externally (2)	2
PCMH 3: Plan & Manage Care	A: Implement Evidence-Based Guidelines (4)	1			
	B: Identify High Risk Patients (3)	0			
	**C: Care Management (4)	0			
	D: Medication Management (3)	0.75			
	E: Use Electronic Prescribing (3)	2.25			

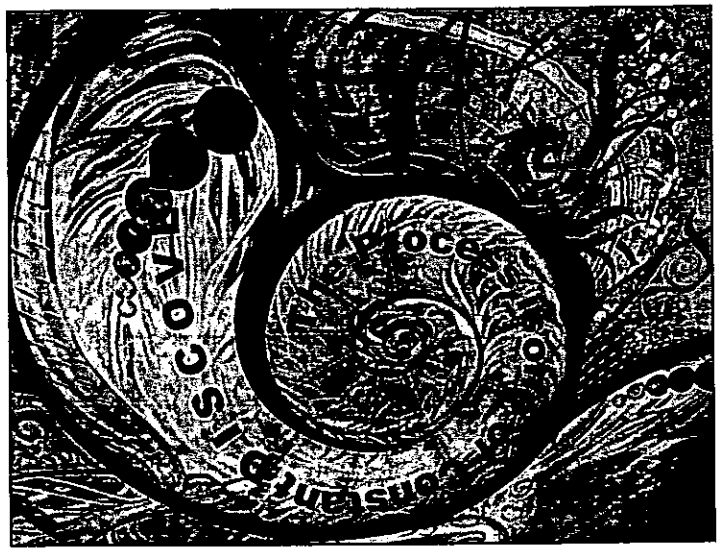
Total Score: 20.5 points, 1 MPE @ 50%, No Recognition

MPE & Stage 1 MU Comparison

Standard	Must Pass Elements	Points	Pts needed to pass @ 50%	Passed at 50%? (Yes/No)
PCMH 1: Enhance Access & Continuity	**A: Access During Office Hours	0	2	NO
PCMH 2: Identify and Manage Patient Populations	**D: Use of Data for Population Management	2.5	2.5	YES
PCMH 3: Plan and Manage Care	**C: Care Management	0	2	NO
PCMH 4: Provide Self-Care Support and Community Resources	**A: Support Self-Care Process	1.5	3	NO
PCMH 5: Track and Coordinate Care	**B: Referral Tracking and Follow-Up	1.5	3	NO
PCMH 6: Measure and Improve Performance	**C: Implement Continuous Quality Improvement	0	2	NO

Total Score: 20.5 Points, 1 MPE @ 50%, No Recognition

III. Obtaining PCMH Recognition

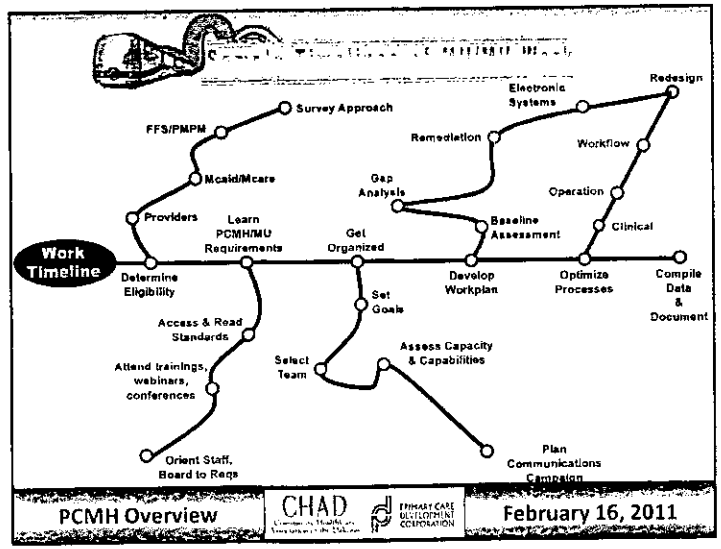


Ingredients for success

- Committed and visible leadership
  - Supports team in accomplishing work
  - Removes barriers
  - Provides required time and resources to accomplish the work
- Clear and frequent communication with key stakeholders (Board, Staff, Providers, Patients, EHR vendors, etc.)
  - Messages should be appropriately crafted for each audience
- Clearly defined goals
  - Stretches the organization, yet realistic
  - Aligned with organization's vision, mission, and strategy
  - Agreed upon by all key stakeholders

Ingredients for success, cont'd

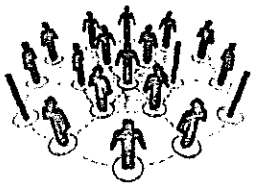
- The Right Team
  - Right knowledge and skills
  - Protected time for all team members
- Accurate assessment of PCMH readiness
- Organized and accurate workplans
  - Clearly outlines major activities to achieve goals, including required resources, timeline
  - Adjusted as needed over course of project
- Identification of areas of overlap (e.g., between NCQA PCMH & CMS Stage 1 MU) of initiatives to avoid make the most effective and efficient use of your resources



TEAMS

Team Composition

- Organizational factors to consider:
  - Size
  - Number of sites
  - Culture
  - Management style
  - Project goals

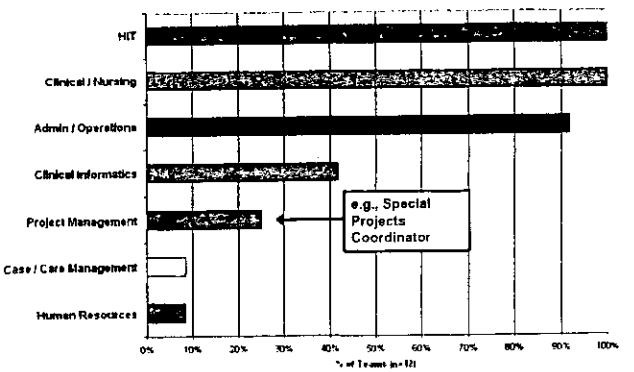


Team Needs – Knowledge & Skills

HIT	Clinical	Admin/ Operational	Project Mgmt
• Analytical • Standards Translation • Systems Troubleshooting • Technical Policy and Procedure • Technical Lifecycle Experience (Readiness, Implementation, Effective use) • Vendor Relations	• Medical • Patient Interaction • Clinical Guidelines and Decision Making • Clinical Documentation • Results Interpretation, Data analysis • Application Adoption	• Decision Making • Enthusiasm • Communications • Team Coordination • Goal Congruence • Resource Allocation • Policy & Procedure	• Coordination/ Mgmt of tasks and resources • Driver • Monitor/ evaluator • Vendor Relations

Team Composition

Departments Represented on Team



Team size ranged from 3 to 11 members, with the majority of teams comprised of 5 to 7 people

Meeting Duration, Frequency & Topics

- Meet weekly, ranging from 1 to 5 hours / week;
- Majority of teams meet for ***2 to 3 hours / week***
- Meeting Topics
  - Discuss goals
  - Develop high-level workplans and action items
  - Provide status updates
  - Identify and discuss challenges / barriers
  - Review PCMH & MU requirements, including opportunities for improvement (based on gaps)
    - Workflows
    - Policies
    - HIT (e.g., EMR) enhancements
    - Tools (e.g., patient registration form)

Tips for Developing Your Team

- Have a ***core team*** and bring in others as needed
- Time required can vary across team
  - Project lead: up to ***10 hrs / week***
  - Other team members: approx. ***4-6 hrs / week***
- If network is looking to get multiple locations recognized, need ***knowledge of on-the-ground operations for ALL locations included***

GOALS

Things to Consider in Setting Goals

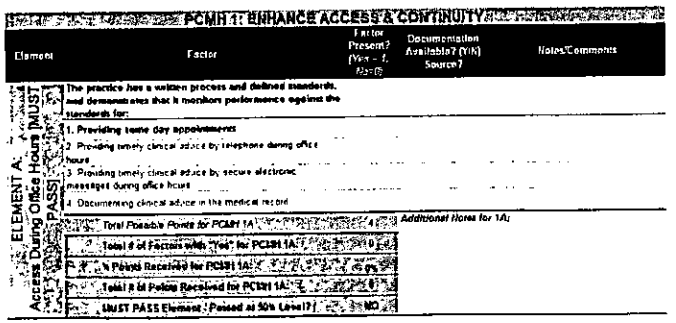
- Competing priorities
- Available resources
- Can be (and probably should be) revised throughout process since you will continually learn more info which may seriously impact timeline, resources, etc.

BASELINE ASSESSMENTS

Scoring

- For each Level of Recognition need to have:
  - Minimum number of total points; ***AND***
  - Obtain at least 50% of the points for all 6 must pass elements
- Factors in place (= can be documented) contribute to percent of total points earned for each Element
  - Scoring approach for each Element is the same
  - Specific number of factors contribute to the percent of points earned for each Element (from 0% to 100%)
  - Total points for Element = % of points from Factors X total number of points for the Element

Excerpt from PCDC's PCMH Self Assessment Tool *(Excel-based)*



PCMH 1: ENHANCE ACCESS & CONTINUITY

Element	Factor	Factor Present? (Yes = 1, No = 0)	Documentation Available? (Y/N) Source?	Notes/Comments
ELEMENT A: Access During Office Hours [MUST PASS] (1 of 6)	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:			
	1. Providing same day appointments			
	2. Providing timely clinical advice by telephone during office hours			
	3. Providing timely clinical advice by secure electronic messages during office hours			
	4. Documenting clinical advice in the medical record			
	Total Possible Points for PCMH 1A	4		Additional Notes for 1A:
	Total # of Factors with "Yes" for PCMH 1A?	0		
	% Points Received for PCMH 1A:	0%		
	Total # of Points Received for PCMH 1A:	0		
	MUST PASS Element: Passed at 50% Level?	NO		

Scoring Ex: PCMH 1A (4 points)

- Formula for Scoring is:
  - Total points for Element = % of points for # of Factors X total number of points for the Element
- Practice determines they have 2 of 4 factors for PCMH 1A in place, including factor 1 (which is a critical factor)
- Calculation:
  - **Total points = 50% x 4**
    - **Total points = 2**
    - This score will contribute 2 points for Element 1A and create a "pass" for this must-pass Element

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

2011 NCQA Scoring Methodology

Level	Points	Must-Pass Elements
Level 1	35-59	6 of 6, with a performance level of at least 50%
Level 2	60-84	6 of 6, with a performance level of at least 50%
Level 3	85-100	6 of 6, with a performance level of at least 50%

Tips for Conducting Assessments

- Use relevant PCMH reference tools when conducting assessments
  - NCQA standards and guidelines: http://ncqa.org/tabid/1302/Default.aspx
- If you don't know, investigate...
  - Spot checks *(e.g. mini-chart review, coach, sample your data, regulations etc)*
  - Reports
  - Policy and procedure review

TO DO: Conduct baseline assessments

WORKPLANS

Workplans

- Based on gaps between desired and current state
- Types of Gaps/Areas of work
  - Process and workflow redesigns
  - Electronic system enhancements/upgrades
  - Data and documentation

Process & Workflow Redesigns

- Consider overlap between MH and MU requirements
- How will these redesigns impact…
  - Goals?
  - Timeline?
  - Resource requirements?
- Consider short and long-term solutions?

2011 NCQA PCMH & Stage 1 MU: Key Areas of Overlap

I. PATIENT COMMUNICATION •Providing patients with electronic access to health related info *[PCMH 1C]* •Providing patients with ability to make electronic health requests (e.g., eRx refill, test results) *[PCMH 1C]*	**III. CARE COORDINATION – INTERNAL & EXTERNAL** •Medication management *[PCMH 3D]* •Electronic prescribing *[PCMH 3E]* •Test and referral tracking and follow-up *[PCMH 5A & 5B]* •Coordination with facilities/care transitions *[PCMH 5C]*
II. CARE MANAGEMENT •Electronically storing patient info (demo and clinical) *[PCMH 2A & 2B]* •Use of evidence-based guidelines *[PCMH 3A]* •Self-management support *[PCMH 4A]*	**IV. POPULATION & PUBLIC HEALTH** •Population management *[PCMH 2D]* •Reporting data externally *[PCMH 6F]*

Electronic System Upgrades

- What needs to be upgraded/enhanced?
- Do you need vendor assistance?
  - Consider how this will impact goals and timeline
- Key questions to ask vendor
  - What training, materials, and technical assistance is available to achieve PCMH & MU?
  - Is there a demo of the version to be certified for MU and when is it expected to be available in General Release?
  - Can I have contract provisions re: PCMH & MU
  - Can I have a contact in Product Management who can answer more in-depth questions about functionality?

Documentation & Data Needs

- Polices and procedures *(PCMH)*
- Screenshots demonstrating capability in electronic systems *(PCMH)*
- Other materials describing your processes and protocol – both clinical and operational *(PCMH)*
- Reports *(PCMH & MU)*
- Calculations *(MU)*

Tips for Developing Policies & Procedures (PCMH)

- Should be written for benefit of staff and/or patient, ***not*** NCQA
- Should be specific and measurable (e.g., policy should state "within 30 minutes" as opposed to "immediately")
- When reviewing policies, NCQA is assessing:
  - If the policy meets the intent of the element/ factor
  - If the policy is consistently implemented across the practice
- Policies and procedures should be in place for at least 3 months by the time of submission

Tips for Producing Screen Shots (PCMH)

- Use real patient information, not information from a test system
- De-identify all PHI
- Use textboxes to explain what the screen shot is displaying

Tips for Producing Reports (PCMH & MU)

- Create clear summary reports of key information
- Clearly label all column and row headers
- Include a brief descriptions of:
  - Methodology for how the data was gathered
  - Analysis of the results

IV. Available Assistance & Resources

PCDC Services & Resources

- Conducting baseline assessments to provide recommendation on workplan
- Facilitating process to obtain PCMH recognition, incl. reviewing documentation against requirements
- Assistance around process and workflow redesign and HIT implementations

NCQA Trainings & Workshops

- PCMH 2011 Standards Workshops
  - Free webinars (Call-in # 866-262-1846, Rm # *3865358*)
  - Stds 1 – 3: Feb 24, 2011; 1- 2:30 pm EST
  - Stds 4 – 6: Mar 3, 2011 ; 1- 2:30 pm EST
- Facilitating PCMH 2011 Recognition
  - Two-day workshops ranging from $850 – 995
    - Mar 17-18: Philadelphia, PA
    - Apr 28-29: New Orleans, LA
    - May 19-20: Baltimore, MD
    - Sept 13-14: Denver, CO
- For more info, call 888-275-7585 or go to http://www.ncqa.org/tabid/631/Default.aspx

Selection by HRSA

- HCs will provide Notice of Intent to HRSA
  - Progress to date on achieving medical home principals
  - Initial, renewal or add-on survey designation
  - Timeline for Recognition
- HRSA will confirm HC is eligible for program
- HRSA will notify NCQA on a weekly basis as HCs are approved

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal11014)

PCMH Process for FQHCs

- NCQA will contact the HC with Survey Tool and on-line application access information
  - Create draft timeline for survey completion
- Refer HCs to NCQA web site for information on PCMH process
- HCs complete readiness evaluation in Survey Tool
  - Applies when ready

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal11014)

Technical Assistance

- Three types of TA available
  - Training
  - Mock surveys
  - Consultant advice

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal1101/)

Training

- NCQA regularly provides web-based training on PCMH program
  - One session includes overview of the Survey Tool and the Interactive Survey System (ISS)
  - Other session includes overview of standards and requirements
- Each training offered once/month
  - Likely additional sessions added
  - Free of charge to all participants

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal1101/)

Mock Surveys

- Practice surveys for organizations who face challenges with achieving PCMH requirements
- Must complete readiness evaluation first
- Mock survey steps are same as if actually applying
  - No decision results
- Reviewer on mock survey will review all documentation and provide advice on how to improve documentation

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal1101/)

Consultants

- Most intensive form of TA for HCs
  - Limited numbers of centers can benefit
- Consultants will review all documentation prior to any survey, provide advice on:
  - Improved documentation
  - Better templates for policies and procedures
  - Design and implementation of new processes for the practice
  - Creation of monitoring systems
  - Data analysis processes; data analyses

Source: HRSA Patient Centered Medical/Health Home Initiative (http://www.bphc.hrsa.gov/policy/pal1101/)

V. Additional Reference Materials

COMPARISON OF 2008 & 2011 NCQA PCMH PROGRAMS

2011-2008 Standard Comparison

2011 PCMH Standards	2008 PPC-PCMH Standards
PCMH 1: Enhance Access & Continuity	• PPC 1: Access and Communication • PPC 9: Advanced Electronic Communications
PCMH 2: Identify and Manage Patient Populations	• PPC 2: Patient Tracking and Registry Functions • PPC 3: Care Management • PPC 4: Patient Self-Management Support
PCMH 3: Plan and Manage Care	• PPC 3: Care Management • PPC 5: Electronic Prescribing
PCMH 4: Provide Self-Care Support and Community Resources	• PPC 4: Patient Self-Management Support
PCMH 5: Track and Coordinate Care	• PPC 6: Test Tracking • PPC 7: Referral Tracking • PPC 3: Care Management
PCMH 6: Measure And Improve Performance	• PPC 8: Performance Reporting and Improvement

Refer to 2008-2011 crosswalk for more detailed description of relationships

2011 Must Pass Elements (MPE)

2011 MPE	# Points	Relationship to 2008 MPE
1A: Access During Office Hours	4	Related to PPC 1A and 1B (Access and Communication Processes and Results) but more focused on having access during office hours; requires that practices provide patients same day appointments (critical factor)
2D: Use Data for Population Management	5	Instead of just having to collect clinical data, practices need to use this data for population management purposes
3C: Care Management	4	New, in 2008 the related must pass element (PPC 3A) focused on the consistent implementation of evidence-based guidelines for the 3 clinically important conditions
4A: Support Self-Care Processes	6	Similar to 2008 PPC 4B but more closely aligned with Stage 1 MU requirements and thresholds have been increased
5B: Referral Tracking and Follow-Up	6	Similar to 2008 PPC 7A but more specific and comprehensive
6C: Implement Continuous Quality Improvement	4	New, in 2008 the related must pass elements (PPC 8A & 8B) focused on collecting and reporting measures vs. setting goals and taking action based on current status as well as involving patients in process

What's Different in 2011: PCDC's Perspective

- Approx. 60 new factors introduced in 2011 and 60 factors were omitted from 2008
  - Removed factors that weren't as relevant for primary care practices, weren't clear or weren't feasible given current infrastructure/technologies
  - Refer to handout for list of omitted 2008 factors
  - New 2011 elements/factors in blue on 2008-2011 crosswalk handout
- Descriptions and examples much clearer in 2011
  - Provide them at factor level (vs. element level in 2008)
- Some requirements were broadened to allow for flexibility and nuances among practices
- Some requirements were made more specific to provide better guidance
- Some elements/factors combined to reduce redundancies
- Some elements/factors separated to clarify and be more comprehensive

PCMH & MU CHECKLIST / DECISION CATALOG

PCMH/MU Checklist/Decision Catalog

1. Assessing the Scope
2. Assessing Capacity to do the Work
3. Getting Organizational Backing
4. Doing the Work
5. Applying for Certification/Recognition

1. Assessing the Scope

- PCMH First? MU First? PCMH/MU Together?
- Which providers are eligible for PCMH? For MU?
- For MU, do I meet the threshold for Medicaid? Medicare? Both?
  - If both, which one do I want to do?
  - I can switch once. Should I? When? Why?
- For MU, by when for Adopt/Implement/Upgrade? Stage 1 MU?
- Do I want to obtain PCMH recognition from NCQA or another source (e.g., Joint Commission)?
  - If NCQA, do I want to use the 2008 or 2011 standards?
  - If NCQA, what Level of PCMH recognition do I want to obtain? By when?
- What HIT upgrades/enhancements do I need for MU? PCMH? Both?

2. Assessing Capacity to do the Work

- Who should be on the team?
- Will team composition change over course of project?
- Do we need to hire new staff, engage consultants?
- Does our organization have the adaptive reserve to accomplish these projects over the next 5 years?

3. Getting Organizational Backing

- What is the estimated return on investment (ROI) of PCMH? MU? Both?
- What should I be communicating regarding this initiative?
  - To whom?
  - How do the messages vary by audience?

4. Doing the Work

- For Stage I MU, which 5 of the 10 discretionary / menu objectives do I want to select? What are my gaps?
- For Stage I MU, which clinical quality measures will I select?
  - 3 core / alternate core measures
  - 3 from remaining pool of 38 discretionary measures
- For PCMH, which standards, elements and factors will I select?
- For PCMH, what are my 3 clinically important conditions?
- What optimizations (clinical and operational processes) are necessary to meet the requirements for PCMH and MU?

5. Applying for Certification/ Recognition

- What applications/registrations, attestations, data, reports and documentation do I need to compile for PCMH and MU?

#8

From: Dan Kelly [mailto:dkelly@mckenziehealth.com]
Sent: Monday, March 07, 2011 2:10 PM
To: Lee, Judy E.
Cc: Jerry Jurena
Subject: Follow up from Dan Kelly relative to bad debt

Senator Lee,

Do to my travel schedule I could not be present to offer support for HB 1152 and thus Jerry Jurena read my testimony into the record. Jerry noted that you asked of him, what is driving the increase in bad debt. For the McKenzie County Healthcare System, year-to-date our bad debt has increased 300%. The two overarching factors driving this increase are:

1. Oil field activity. We are used to dealing with our hometown personnel and when they supply us with an address and contact information that historically was accurate. With somewhat transient oil field workers they are giving my admitting staff wrong information and when we try and contact them to secure payment we cannot track them down. We are putting into place up front insurance verification mechanisms that should afford some relief to this problem but I anticipate my bad debt will be higher than it historically was.
2. The second factor is our native customers. We have a long term problem collecting from the Three Affiliated Tribes for services provided. Typically when this becomes intolerable we contact our federal representatives who in turn schedule a meeting amongst the parties and the problem improves for a period of a few months.

I realize my answers are brief but I suspect you do not want to read a detailed answer to a very precise question.

Stating the above, if you do have additional questions please feel free to email me or call me at 701-842-3000.

Sincerely,

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.

HB 1152
Feb. 10, 2011
Attachment 1

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab	Certified Registered Nurse Anesthetist (CRNA)
Ashley	9,226	-
Bottineau	14,178	579
Bowman	8,059	-
Cando	15,216	2,967
Carrrington	16,314	26,431
Cavalier	10,977	-
Cooperstown	8,896	-
Crosby	-	-
Devils Lake	223,819	8,741
Dickinson	198,389	1,875
Elgin	22,438	-
Garrison	15,955	-
Grafton	23,426	495
Harvey	41,002	-
Hazen	14,615	-
Hettinger	19,686	340
Hillsboro	9,535	-
Jamestown	135,876	17,560
Kenmare	-	-
Langdon	18,604	-
Linton	9,399	-
Lisbon	49,379	1,161
Mayville	14,772	-
McVille	4,420	-
Northwood	7,852	-
Oakes	60,073	10,394
Park River	17,807	10,593
Rolla	167,461	-
Rugby	3,790	4,978
Stanley	15,708	-
Tioga	10,637	-
Turtle Lake	10,627	-
Valley City	33,094	12,730
Watford City	24,141	-
Williston	246,997	3,338
Wishek	4,522	173
Estimated Supplemental Payment *(Based upon 2009 data)*	1,486,890	102,355

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab		Certified Registered Nurse Anesthetist (CRNA)		Administrative Cost		Totals
July 1, 2010 Inflationary Increase	44,607	*	6,141	^			
Estimated Supplemental Payment (SFY 2011)	1,531,497		108,496				
3% / 3% Inflation *(SFY 2012 / 2013)*	139,213		9,862				
Estimated Supplemental Payment for the 2011-2013 Biennium	3,202,206		226,855				
Administrative Cost					25,000		
Total General	1,415,055		100,247		12,500		1,527,802
Total Federal	1,787,151		126,608		12,500		1,926,259
						Total 2011-2013 Estimated Cost	3,454,061

* July 1, 2010 lab inflation is 3%, as they are paid based upon Medicare fee schedule.

^ July 1, 2010 CRNA inflation is 6%, as services are paid on the Department's fee schedule.

Estimate is based on 2009 data, which is the latest year complete data is available. Actual payments made to facilities will not match these estimates.

Any supplemental payment is subject to the Medicaid Upper Payment Limit regulations and State Plan approval from the Centers for Medicare and Medicaid Services (CMS).

Estimate is based on the same criteria approved by the CMS for the supplemental payments authorized by the 2009 Legislative Assembly for Rolla. CMS has indicated that a similar supplemental payment would be available for all CAHs.

The Department currently has a contract in place with a vendor to do cost settlements of CAHs. This supplemental payment would be most efficiently handled in conjunction with those cost settlements. The estimated cost to complete these supplemental payment calculations for the biennium is $25,000.

Good afternoon Chairman Holmberg and esteemed members of the Senate Appropriations Committee.

For the record I am Rep. Bill Devlin of Finley. I represent District 23 in the Legislature. District 23 is a rural District that encompasses all or part of five rural counties in eastern North Dakota.

I am here to introduce HB 1152 which is a critical bill for health care as we know it in our state.

The bill will provide $3.454.061 million in state and federal funding to Critical Access Hospitals across our state. The bill was heavily amended in the House to change from an original plan for grants to a plan that will provide supplemental payment funding for Lab and Certified Registered Nurse Anesthetist (CRNA) coverage to the Critical Access Hospitals across the state, subject to the Upper Payment Limits.

As now written, the payments are based on the methodology approved by the Centers for Medicare and Medicaid Services. It is the same methodology that was used previously when the legislature provided funding for Presentation Medical Hospital in Rolla. It will provide additional funding to 34 of the 36 hospitals.

Rep. Jon Nelson will provide the complete financial implications of what was done in the House Appropriations Committee

The term Critical Access Hospitals speaks for itself and the term is defined in federal code. The Hospital in that area of the nation has been deemed critical to providing accessibility to health care to the residents of a state. It is critical to the citizens of our state that we provide not only emergency care but making sure they have accessibility to primary health care to meet their needs for chronic care, preventive care and emergency care.

These hospitals have not gotten anywhere close to the reimbursements for the costs of operating their facilities. We hear the term Medicare allowable costs a lot when dealing with hospitals. What we don't hear on the actual costs. By leaving 6 to 8 percent or more of the actual costs we leave hospitals with the option of trying to recoup actual costs from other consumers.

Hence there is a vital need for this bill. Should people across North Dakota be denied accessibility to health care because their hospitals bottom line has fallen into negative territory through no fault of their own?

We talk a lot about infrastructure needs in this body. But, in my humble opinion, infrastructure means more than roads, bridges, water and sewer systems and other things normally

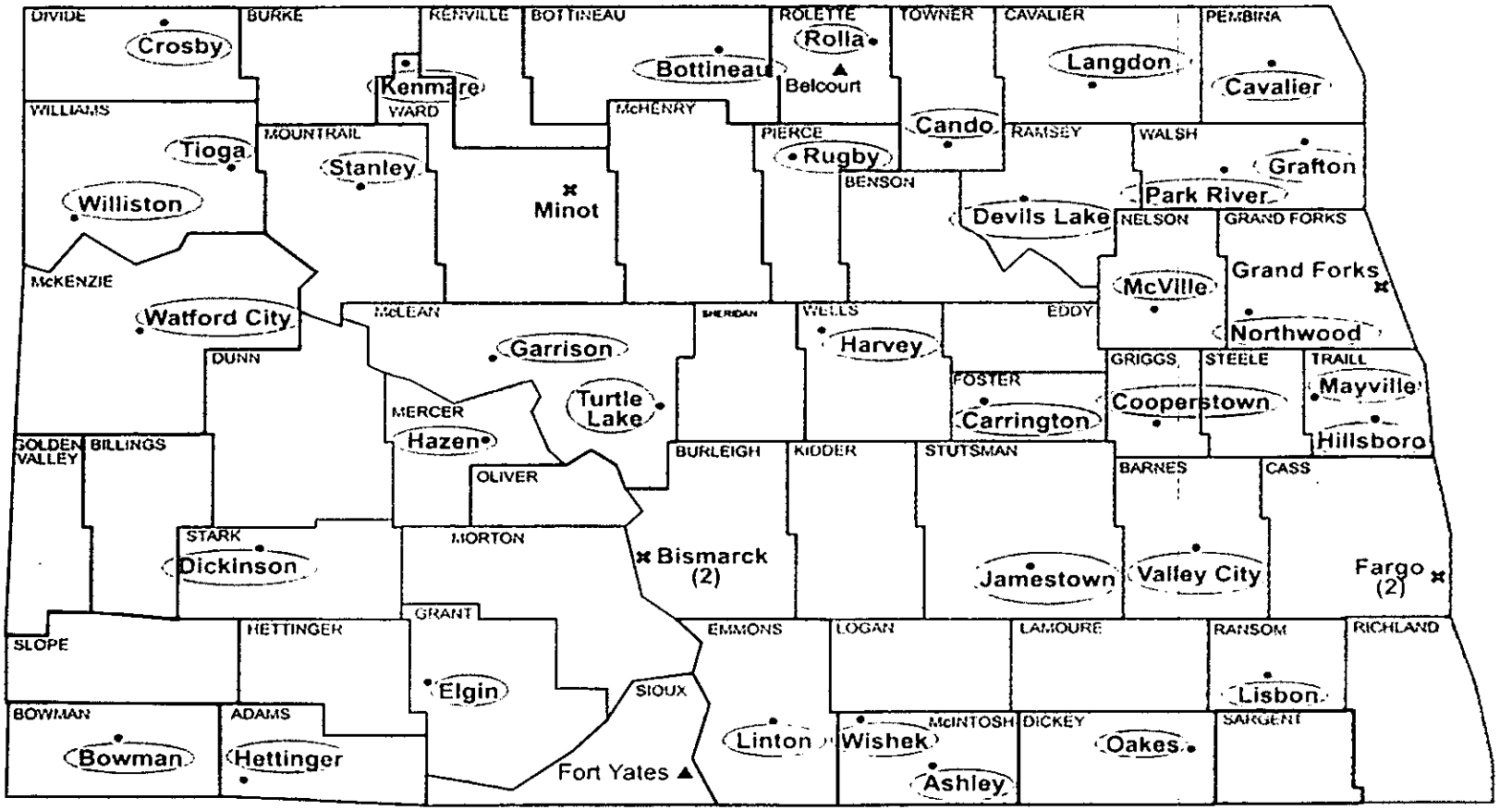
associated with the term. To me infrastructure means the things people need to live and work in our state and that includes the access to health care facilities.

There are 36 critical access hospitals in our state. The last report on saw was for 2009 which showed that 23 of them lost money. There was a lot of talk in the media about the frontier amendment and what good things it did for hospitals in the state. However, what wasn't said was that not one dime of that went to the rural hospitals it all went to the large city hospitals in the state. I don't begrudge them one dime of that money but also know that if the federal government doesn't stop to the plate for rural hospitals the state must do that. Every one of them needs help and I believe there is an obligation to provide these dollars to as many facilities as possible through the state and federal dollars laid out in this bill.

I provided a map of where the hospitals are located across the state. I think this map shows a chain of life for our citizens. If the chain breaks, people in one or more areas do not have the accessibility they need to health care. We are all connected to this issue and can't afford to lose any of these hospitals in any part of the state.

Chairman Holmberg and members of the Appropriations Committee I urge a do pass on HB 1152. This concludes my testimony. I am certainly willing to try to answer any questions you might have but know that others who will follow me have all the answers you need to make the right decision for the people of our state by giving this bill a do pass recommendation. Thank you for allowing me to appear here today.

North Dakota Hospitals and Critical Access Hospitals



Center *for* Rural Health
University of North Dakota
School of Medicine & Health Sciences

- Rural Hospital
- Tertiary Hospital-CAH Network
- Indian Health Service Hospital
- Critical Access Hospital

7/09

HB 1152

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Elgin	22,438	-
Garrison	15,955	-
Grafton	23,426	495
Harvey	41,002	-
Hazen	14,615	-
Hettinger	19,686	340
Hillsboro	9,535	-
Jamestown	135,876	17,560
Kenmare	-	-
Langdon	18,604	-
Linton	9,399	-
Lisbon	49,379	1,161
Mayville	14,772	-
McVille	4,420	-
Northwood	7,852	-
Oakes	60,073	10,394
Park River	17,807	10,593
Rolla	167,461	-
Rugby	3,790	4,978
Stanley	15,708	-
Tioga	10,637	-
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2

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The Department currently has a contract in place with a vendor to do cost settlements of CAHs. This supplemental payment would be most efficiently handled in conjunction with those cost settlements. The estimated cost to complete these supplemental payment calculations for the biennium is $25,000.

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1152

Senate Appropriations Committee
Medicaid Supplemental Payments to Critical Access Hospitals
March 15, 2011

Chairman Holmberg and Members of the Senate Appropriations Committee; I am Jerry Jurena, President of the North Dakota Hospital Association (NDHA). I come before you today in support of HB 1152, Medicaid Supplemental Payments to Critical Access Hospitals.

The North Dakota Hospital Association (NDHA) is a Trade Association with forty-five member Hospitals. There are thirty-six Critical Access Hospitals (CAH) in the State; thirty-four are members of NDHA. There are six large Tertiary Hospitals in the four major cities all members of NDHA. Other member Hospitals include: two Long Term Acute Care Hospitals, one Psychiatric Hospital, one State Hospital, and one VA Hospital, see Attachment.

Again, there are two Critical Access Hospitals that are non-members of NDHA as well as two Governmental Hospital's (IHS) and one specialty Hospital.

Hospitals across the State of North Dakota make up the largest non-government employer in the State. In each community that has a Hospital the Hospital is the largest employer in that community. The largest percentage of each Hospital's revenue comes from Medicare; in most Hospitals it is well over fifty percent (50%) and in many Hospitals that revenue percentage is over sixty percent (60%).

Medicaid revenue ranges from a low of eight percent (8%) to almost thirty percent (30%).

Medicare reimburses Critical Access Hospitals based on their Medicare allowable costs; which is approximately ninety-two (92) to ninety-three (93) percent of their total or actual costs. In 2007 the State adopted the Medicare reimbursement methodology for Medicaid reimbursement to Critical Access Hospitals. However, CAHs are capped by the Social Security Act at the Medicare fee schedule for Lab and anesthesia services which is below the actual costs to provide these two services and less than the Medicare Allowable Costs. The outcome of using the Medicare Allowable reimbursement system is; for every Medicare and Medicaid

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

3

patient that presents to a Critical Access Hospital for services the Hospital takes a loss of seven (7) to eight (8) percent and even greater for Lab and anesthesia services.

When you combine the Medicare and Medicaid utilization numbers for CAHs the total percentage is sixty (60) to seventy (70) percent of the total Hospital revenue. No business can sustain a viable operation with a seven (7) to eight (8) percent loss on sixty (60) to seventy (70) percent of its incoming revenue.

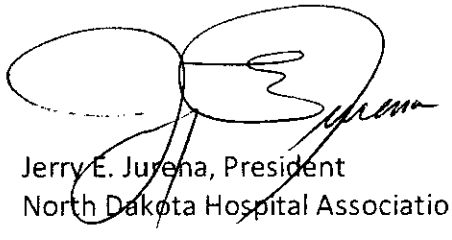
Hospitals have had to raise their charges to the remaining patients to offset this ongoing loss. Many Critical Access Hospitals have also been using their funded depreciation dollars on daily operations to cover their operating costs. The result of using Funded Depreciation to maintain their operations puts the Hospitals in a precarious position. They do not have funds available for upgrades or emergencies if and when they are needed.

I am in support of Critical Access Hospitals receiving reimbursement that will cover their actual costs to provide all services as required my Medicaid. HB 1152, a Supplemental Payment to Critical Access Hospitals for Lab and anesthesia services, is a start in this process by reimbursing some of our most vulnerable Hospitals at costs for these two services.

Again this bill will not bring all services up to actual costs on all services but it will provide some needed relief in two of their services.

I ask that you give HB 1152 a Do Pass and consider in the future a study on reimbursement for all Hospitals comparing Medicare Allowable Costs to their actual costs to provide services as required by Medicaid.

Thank you.



Jerry E. Jurena, President
North Dakota Hospital Association

NDHA
MEMBER HOSPITALS BY REGION HB 1152

Critical Access Hospitals

Northwest (11)

Bottineau	St. Andrew's Health Center	Jodi Atkinson
Crosby	St. Luke's Hospital	Les Urvand
Harvey	St. Aloisius Medical Center	Rocky Zastoupil
Kenmare	Trinity Kenmare Comm. Hosp.	Shawn Smothers
Minot	Trinity Health	John Kutch
Rolla	Presentation Med Center	Mike Pfeifer
Rugby	Heart of America Med. Center	Jeff Lingerfelt
Stanley	Mountrail Co. Med. Center	Mitch Leupp
Tioga	Tioga Medical Center	Randy Pederson
Watford City	McKenzie Co. Healthcare Sys	Daniel Kelly
Williston	Mercy Medical Center	Matthew Grimshaw

Northeast (11)

Cando	Towner Cnty Med. Center.	Jac McTaggart
Carrington	Carrington Health Center	MariAnn Doeling
Cavalier	Pembina Cnty Mem. Hospital	Everett Butler
Cooperstown	Cooperstown Medial Center	Greg Stomp
Devils Lake	Mercy Hospital	James Marshall
Grafton	Unity Med. Center	Everett Butler
Grand Forks	Altru Health System	Dave Molmen
Mayville Sanford	Medical Center – Mayville	Roger Baier
Langdon	Cavalier County Memorial Hosp.	Lawrence Blue
Northwood	Northwood Deaconess Health	Pete Antonson
Park River	First Care Health Center	Louise Dryburgh

Southwest (12)

Ashley	Ashley Medical Center	Kathy Hoeft
Bismarck	Medcenter One Health System	Craig Lambrecht, MD
Bismarck	St. Alexius Medical Center	Gary Miller, Interim
Bowman	Southwest HC Services	Dennis Goebel
Dickinson	St. Joseph's Hospital	Reed Reyman
Elgin	Jacobson Memorial Hosp	Jim Opdahl
Hazen	Sakakawea Medical Center	Darrold Bertsch
Hettinger	West River Health Services	Jim Long
Garrison	Garrison Memorial Hospital	Dean Mattern
Linton	Linton Hospital	Roger Unger
Mandan	Triumph Hosp. Central Dakota	April Bishop
Wishek	Wishek Comm. Hospital	Trina Schilling

Southeast (11)

Fargo	Essentia Health	Kevin Pitzer
Fargo	Sanford Medical Center	Dennis Millirons
Fargo	Prairie St. Johns	Emmet Kenney Jr., MD
Fargo	Triumph Healthcare-Fargo	Custer Huseby
Fargo	VA Hospital	Michael Murphy
Jamestown	Jamestown Hospital	Martin Richman
Lisbon	Lisbon Area Health Services	Peggy Larson
Jamestown	ND State Hospital	Alex Schweitzer
Hillsboro	Hillsboro Medical Center	John Rieke
Oakes	Oakes Community Hospital	Lee Boyles
Valley City	Mercy Hospital	Keith Heuser

North Dakota

Critical Access Hospital (CAH)

Financial Analysis!

March 2011

Presentation Objectives

- Request Support for HB1152
- National CAH Financial Indicator Info
  Flex Monitoring Information for 2008
- 2009/10 ND CAH Financials – 36 CAHs
- 4 Yr. Trended Financials for the ND CAHs
- 2009/10 Financials for Rural Health Clinics Owned/Operated by ND CAHs

5

CAH Financial Indicators 2008

Description	*National*	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
2008						
# of CAHs Included	1,247	**31**	36	77	42	65
Median Net Margin 2008	2.40%	**-0.95%**	3.32%	3.62%	3.12%	4.82%
Days Cash on Hand	61.0	**27.2**	42.2	99.6	72.3	111.8
Medicare Inpt Cost/Day	$1,633	**$1,145**	$1,431	$1,946	$1,580	$1,647
Average Age of Plant	10.4	**13.2**	10.8	9.7	14.0	9.4

Flex Monitoring Team, Fall 2010

CAH Financial Indicators 2008

	National	*ND*	*SD*	*Minn.*	*Mont*	*Neb.*
Median Net Margin						
2004	2.32%	**-2.07%**	2.70%	5.19%	1.25%	2.56%
2005	2.63%	**-.06%**	-.31%	3.06%	2.86%	4.24%
2006	3.58%	**-1.65%**	3.39%	4.40%	3.22%	5.08%
2007	3.64%	**-1.54%**	3.54%	5.13%	2.99%	5.75%
2008	2.40%	**-0.95%**	3.32%	3.62%	3.12%	4.82%

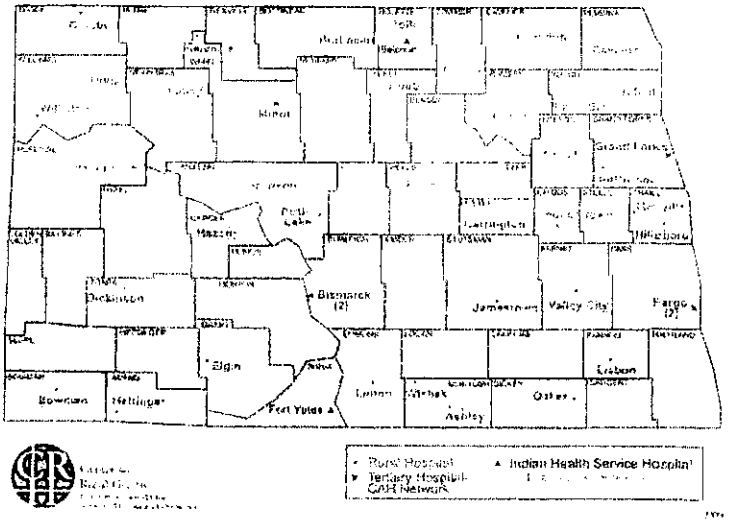
Flex Monitoring Team, Fall 2010

ND CAH Financial Analysis

All ND CAHs

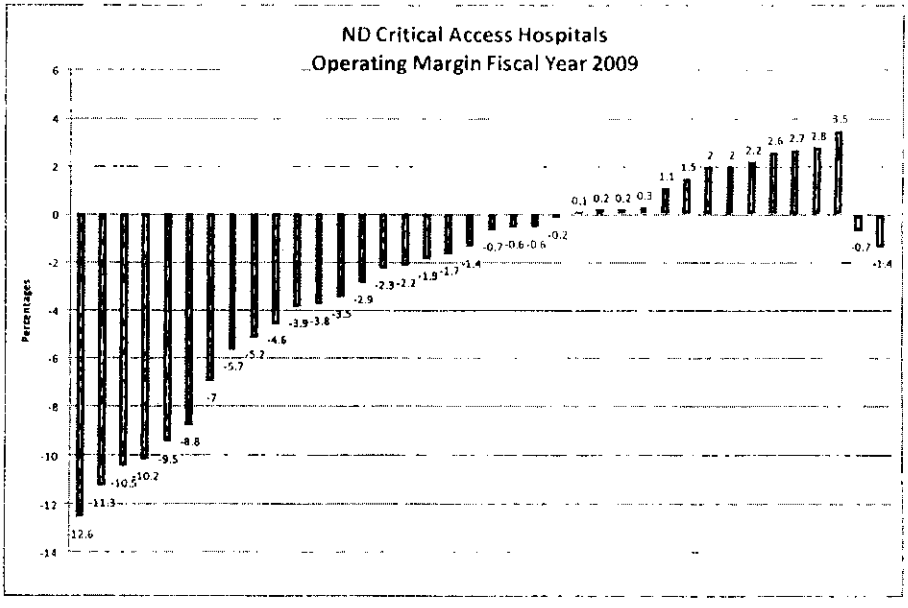
2010

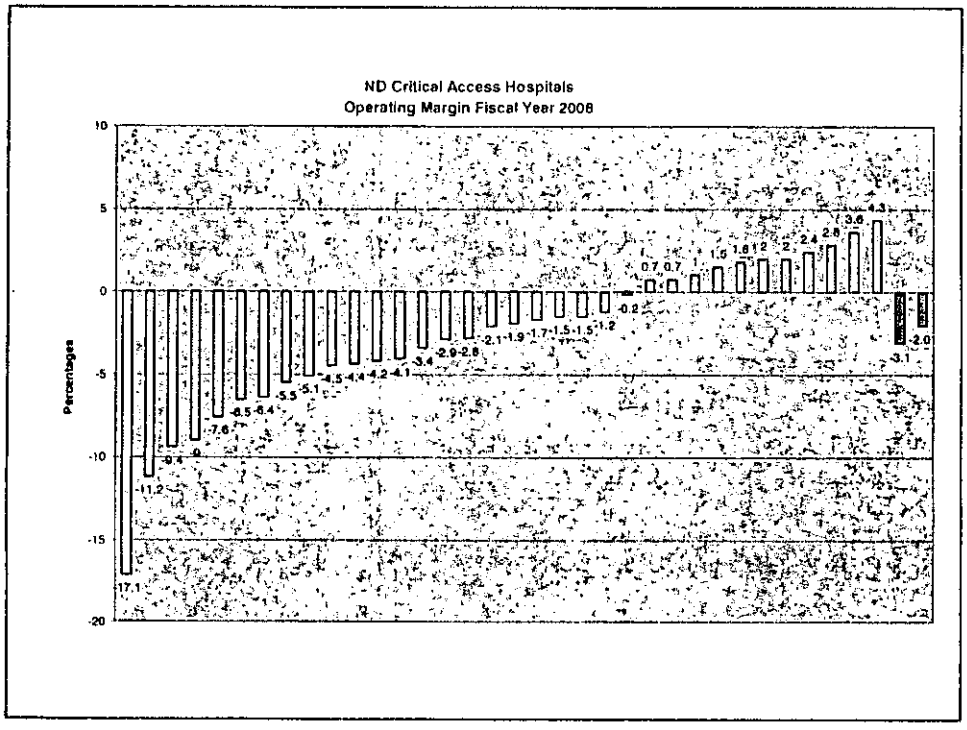
North Dakota Hospitals and Critical Access Hospitals

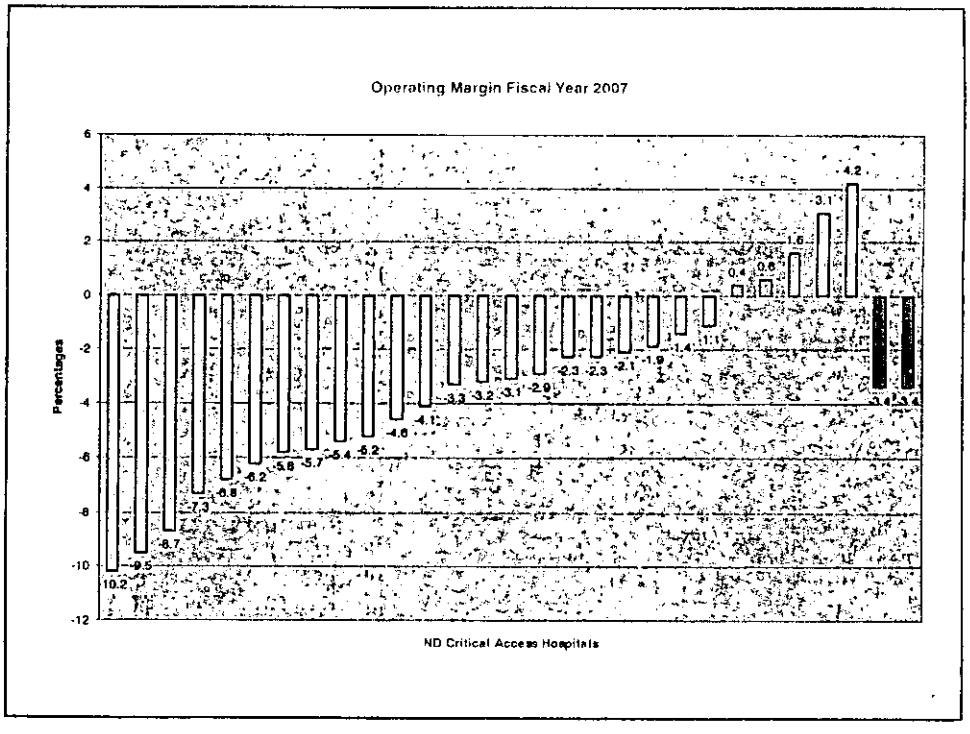


North Dakota CAH Financial Analysis

- Observations
  - 36 of 36 Facilities Reported Their Financial Information
  - 27 of 36 Facilities Own/Operate a Primary Care Clinic
  - 27 Facilities Who Own/Operate Clinics, Operate 56 Clinics, 46 RHCs
    - There are 59 RHCs in North Dakota
  - 14 of 36 Facilities Own/Operate a Nursing Home
  - 9 Facilities Own and Operate the Local Ambulance
  - 8 Facilities Provide Home Health, some Visiting Nurse Services
  - 23 of 36 Facilities had Negative Operating Margins




ND Critical Access Hospitals
Operating Margin Fiscal Year 2008
Percentages
10
5
0
-5
-10
-15
-20
-17.1
-11.2
-9.4
-9
-7.6
-6.5
-6.4
-5.5
-5.1
-4.5
-4.4
-4.2
-4.1
-3.4
-2.9
-2.8
-2.1
-1.9
-1.7
-1.5
-1.5
-1.2
-0.2
0.7
0.7
1.5
1.8
2
2
2.4
2.8
3.6
4.3
-3.1
-2.9


Operating Margin Fiscal Year 2007
Percentages
6
4
2
0
-2
-4
-6
-8
-10
-12
-10.2
-9.5
-8.7
-7.3
-6.8
-6.2
-5.8
-5.7
-5.4
-5.2
-4.6
-4.1
-3.3
-3.2
-3.1
-2.9
-2.3
-2.3
-2.1
-1.9
-1.4
0.4
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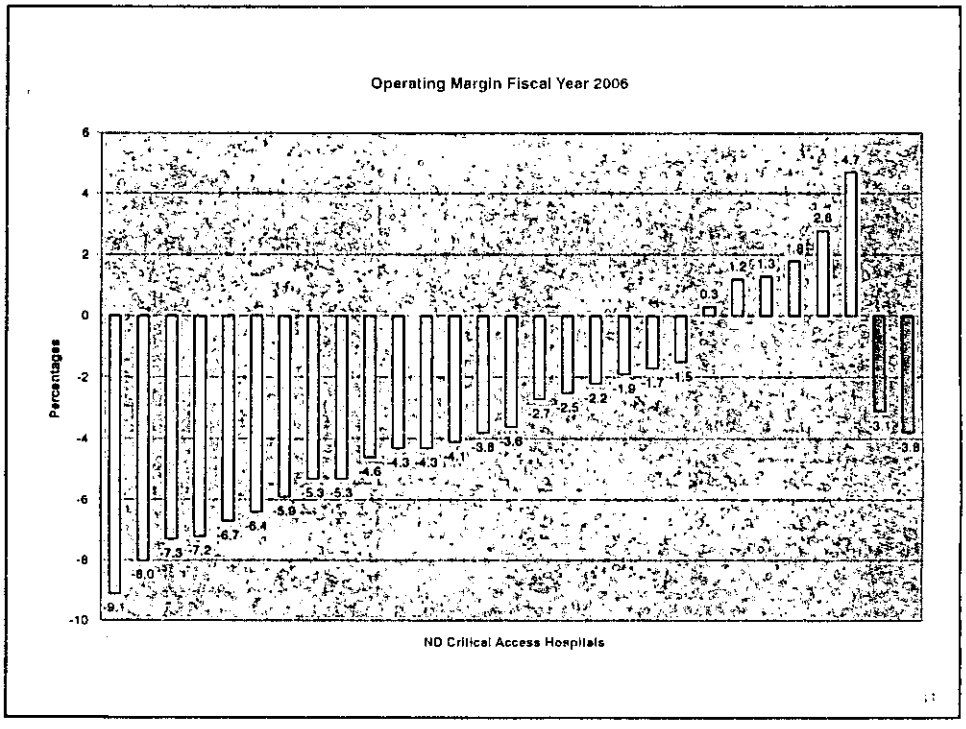
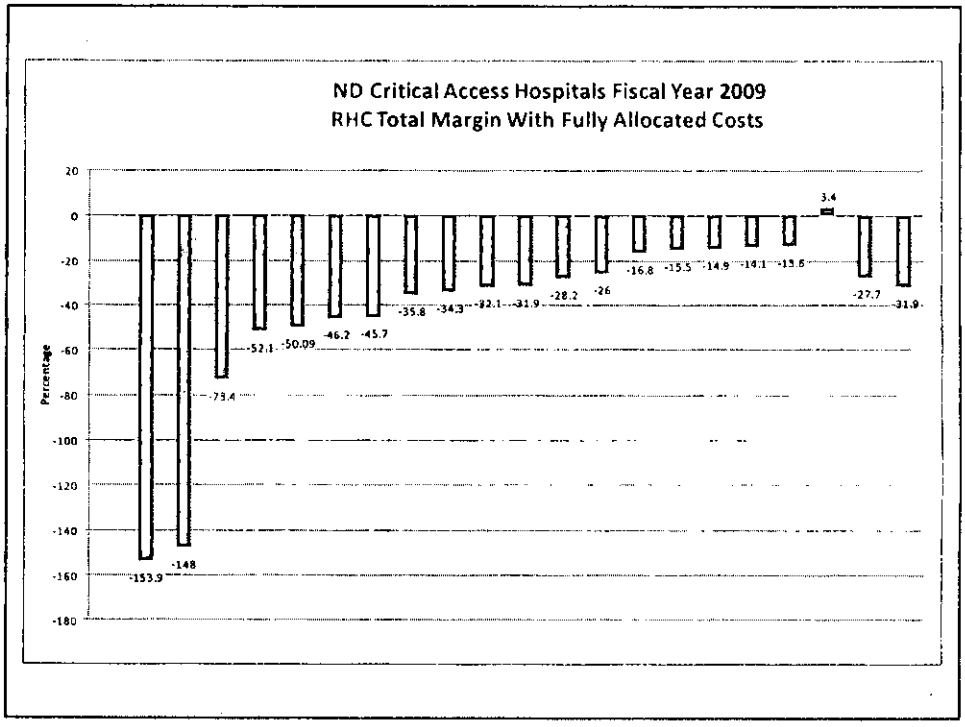
1.6
3.1
4.2
-3.4
-3.4
ND Critical Access Hospitals



ND CAH Financial Analysis

Rural Health Clinics (RHC) Owned by CAHs

2010



Closing Thoughts…

- Continue to Create Awareness of the Challenges Experienced by ND CAHs
- Request Support of HB1152
- Questions

- ***Thanks For Listening!!***

North Dakota Critical Access Hospitals & Dickinson
Services That Are Owned/Operated

10/11/2010

Margin 6 7 8 9	Community	CAH Hospital	Nursing Home Beds	Basic Care	Assisted Living	Apartments	Clinic	Ambulance	Home Care
	Ashley	20 Beds	44 Beds			30 Units	RHC - 2		Yes
	Bottineau	25 Beds				15 Units	Jointly Own		
	Bowman	23 Beds	66 Beds		12 Units	16 Units	RHC	Yes	
	Cando	20 Beds	40 Beds	10 Beds		10 Units	RHC - 1 of 2		
	Carrington	25 Beds		24 Beds			RHC - 3	Yes	
	Cavalier	25 Beds	60 Beds				RHC		
	Crosby	25 Beds					RHC - 3		
	Cooperstown	18 Beds	48 Beds		12 Units		RHC		
	Devils Lake	25 Beds							
	Dickinson	25 Beds					RHC - 4		Yes
	Elgin	21 Beds	25 Beds				RHC - 2		
	Garrison	22 Beds	28 Beds				RHC		
	Grafton	17 Beds					RHC		
	Harvey	25 Beds	106 Beds			16 Units			
	Hazen	25 Beds		30 Beds			RHC - 2		Yes
	Hettinger	25 Beds					RHC - 5 of 7	Yes	
	Hillsboro	20 Beds	36 Beds					Yes	
	Jamestown	25 Beds							Yes
	Kenmare	25 Beds					RHC		
	Langdon	25 Beds					RHC - 2	Yes	
	Linton	14 Beds			11 Units		RHC - 3 of 4	Yes	
	Lisbon	25 Beds							Yes
	Mayville	25 Beds							
	McVille	19 Beds	39 Beds				RHC - 2		
	Northwood	12 Beds	61 Beds		6 Units	10 Units		Yes	
	Oakes	20 Beds					Yes		
	Park River	14 Beds					RHC		
	Rolla	25 Beds							
	Rugby	25 Beds	80 Beds	68 Beds	37 Units		Yes	Yes	
	Stanley	11 Beds					RHC		
	Tioga	25 Beds	30 Beds			22 Units	RHC - 3		
	Turtle Lake	25 Beds					RHC		
	Valley City	25 Beds		25 Beds					Yes
	Watford City	24 Beds	47 Beds	8 Beds	16 Units	7 Units	RHC		
	Williston	25 Beds					Yes 3		Yes
	Wishek	24 Beds					RHC - 4	Yes	Yes
6 5 10 13	**Facilities**	36	14	6	6	9	27	9	8
27 27 34 36	**Total**	799	706	185	94	146	56 46 RHCs		

BCBS Reimbursement Workgroup
Facility Statement of Operations Summary

Description	*27 Facilities* Fiscal 2006 Average	*27 Facilities* Fiscal 2007 Average	*34 Facilities* Fiscal 2008 Average	*36 Facilities* Fiscal 2009 Average
Patient Revenue				
Inpatient	1,169,588	1,241,801	2,815,005	3,103,545
Outpatient	3,067,613	3,420,277	6,611,378	7,641,840
Clinic	756,213	856,810	1,325,311	1,629,600
Swingbed	429,137	406,733	585,439	527,468
Long Term Care	1,407,598	1,449,804	1,241,033	1,245,146
Basic Care	90,522	102,040	105,513	93,770
Ambulance	82,704	84,408	90,451	93,397
Home Care	29,446	30,438	143,679	162,256
Independent Apartments	40,996	42,141	36,638	27,235
Assisted Living	18,205	19,817	19,623	42,239
Total Patient Revenue	7,092,022	7,654,269	12,974,070	14,566,496
Other Operating Revenue	115,594	127,277	300,517	361,328
Total Operating Revenue	**7,207,616**	**7,781,546**	**13,274,587**	**14,927,825**
Contractual Deductions				
Medicare Contractuals	709,690	871,770	2,173,069	2,297,310
Blue Cross Contractuals	327,313	366,189	941,019	1,106,897
Medicaid Contractuals	156,068	159,956	389,415	435,701
Other Contractuals	124,389	155,569	413,628	504,282
Bad Debt/Charity Expense	130,465	139,835	409,757	443,923
Total Deductions	1,447,925	1,693,319	4,326,888	4,788,112
NET PATIENT REVENUE	**5,759,691**	**6,088,227**	**8,947,699**	**10,139,712**
Operating Expenses				
Salaries, Wages, Benefits	3,527,392	3,708,759	5,304,081	5,662,822
Purchased Service/Other	900,083	956,472	1,992,000	2,418,429
Supply Expense	1,096,002	1,179,344	1,275,223	1,285,802
Utilities	126,994	132,754	250,679	240,376
Depreciation & Amortization	276,790	310,915	437,718	527,506
Interest Expense	52,955	63,454	96,703	105,450
Total Expenses	5,980,217	6,351,698	9,356,405	10,240,384
Net Operating Margin	**(220,526)**	**(263,470)**	**(408,706)**	**(100,672)**
Operating Margin % (Mean)	***-3.1%***	***-3.4%***	***-3.1%***	***-0.7%***
Operating Margin % (Median)	***-3.8%***	***-3.2%***	***-2.0%***	***-1.4%***
Non Operating Revenue				
Governmental Subsidies	4,228	14,841	17,547	25,623
Foundation Gifts	18,396	25,216	33,831	30,441
Grants	27,739	45,021	41,434	29,072
Other Donations	53,543	59,412	48,669	40,230
Other Non Operating Revenue	48,411	50,126	17,781	(198,697)
Total Non Operating Rev.	152,317	194,617	159,262	(73,331)
NET INCOME/LOSS	**(68,209)**	**(68,854)**	**(249,444)**	**(174,003)**
Net Margin % (Mean)	***-0.9%***	***-0.9%***	***-1.9%***	***-1.2%***
Net Margin % (Median)	***-1.7%***	***-2.0%***	***-0.6%***	***-0.7%***

Testimony on HB 1152
Senate Appropriations Committee
March 15, 2011

Chairman Holmberg and members of the Senate Appropriations Committee, I thank you for the opportunity to testify on HB 1152. My name is Daniel Kelly, Chief Executive Officer of the McKenzie County Healthcare Systems, Inc. in Watford City, North Dakota. I wish to go on record supporting HB 1152.

North Dakota has 42 hospitals providing acute medical services. Of that number, 36 are considered Critical Access Hospitals. I offer support for House Bill 1152 for three reasons:

Two/Thirds of North Dakota Critical Access Hospitals Experience an Operating Loss: For the past three years data has been gathered and assessed which reflect that many North Dakota Critical Access Hospital's lose money. This past year, 24 of North Dakota's 36 Critical Access Hospitals lost money. As it stands, some of these hospitals are destined to close in three to five years. We need to offer whatever assistance we can to sustain our healthcare system.

Rural Hospitals are Safety Net Providers: For many rural North Dakotans, Critical Access Hospitals are safety net providers of medical care. We provide the initial medical assessment and stabilization for routine emergencies as well as trauma cases. For many in rural North Dakota if their local hospital did not exist they might be anywhere from 30 to 60 minutes from healthcare services.

HB 1152 affords some relief for North Dakota's Critical Access Hospitals: While HB 1152 will not assure the viability of North Dakota's Critical Access Hospitals it is a fiscally prudent means to afford some relief. While many officials I have spoken to believe that Critical Access Hospitals are paid their cost by Medicare and Medicaid, this is not true. Medicare and Medicaid will not recognize the following when calculating reimbursement:

- Patient Telephones or Television
- Lobbying
- Advertising
- Physician Recruitment (except for Rural Health Clinics)

In addition, if a Critical Access Hospital operates any of the following, those costs are not recognized as part of the hospital Medicare and Medicaid Reimbursement.

- Wellness Centers
- Hospice
- Skilled Nursing Facility
- Assisted Living

- Meals on Wheels
- Day Care (Some costs may be reimbursable)
- Non-Provider Based Clinics

HB 1152 will result in $3,454,061 in incremental revenue while costing the state $1,527,802 (federal FMAP funding will contribute $1,926,259).

For the McKenzie County Healthcare System that will result in additional reimbursement for outpatient lab services in the amount of $26,525.00 annually.

Your support of HB 1152 will send a positive message of to our medical community and to the citizenship of North Dakota. Please support HB 1152.

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.
516 North Main Street
Watford City, North Dakota 58854
(701) 842-3000

Testimony on HB 1152

Chairman Holmberg and Members of the Appropriations Committee:

I would like to thank you for giving me the opportunity to speak with you today in support of House Bill 1152. My name is Paula Wilkie and I am the Chief Financial Officer of Presentation Medical Center which is located in Rolla. I am here today speaking on behalf of my facility.

Presentation Medical Center is a 25 bed critical access hospital that provides services to the citizens of Rolette and Towner Counties. Presentation Medical Center has the highest percentage of Medicaid beneficiaries in the state. During 2010, 50.87% of the patients who received services at Presentation Medical Center had Medicaid as their primary insurance. In the last biennium Presentation Medical Center was the only facility in the state that received cost for lab and anesthesia services from Medicaid due the high number of Medicaid beneficiaries that we serve. It is vital to our facility to continue to receive cost based reimbursement from Medicaid for lab and anesthesia so that we can continue to meet the medical needs of our community.

I would also like to make you aware that in 2008 the average income from operations was a negative -2.08% for all hospitals in North Dakota. Even though other critical access facilities do not have the Medicaid volume that Presentation Medical Center has, they also cannot continue to cover the cost for Medicaid beneficiaries for lab and anesthesia services. The critical access hospitals in North Dakota need to be able to cover their cost to continue to fulfill medical services in their region. HB 1152 will meet this objective and let all critical access hospitals in North Dakota receive reimbursement at cost for lab and anesthesia services.

I appreciate your attention and would be happy to answer any questions that you have.

Prepared by the Legislative Council staff for
Senator Kilzer
March 29, 2011

A

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

In lieu of the amendments adopted by the Senate as printed on page 698 of the Senate Journal, Reengrossed House Bill No. 1152 is amended as follows:

Page 1, line 1, after the semicolon insert "to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 3. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

B

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab	Certified Registered Nurse Anesthetist (CRNA)
Ashley	9,226	-
Bottineau	14,178	579
Bowman	8,059	-
Cando	15,216	2,967
Carrrington	16,314	26,431
Cavalier	10,977	-
Cooperstown	8,896	-
Crosby	-	-
Devils Lake	223,819	8,741
Dickinson	198,389	1,875
Elgin	22,438	-
Garrison	15,955	-
Grafton	23,426	495
Harvey	41,002	-
Hazen	14,615	-
Hettinger	19,686	340
Hillsboro	9,535	-
Jamestown	135,876	17,560
Kenmare	-	-
Langdon	18,604	-
Linton	9,399	-
Lisbon	49,379	1,161
Mayville	14,772	-
McVille	4,420	-
Northwood	7,852	-
Oakes	60,073	10,394
Park River	17,807	10,593
Rolla	167,461	-
Rugby	3,790	4,978
Stanley	15,708	-
Tioga	10,637	-
Turtle Lake	10,627	-
Valley City	33,094	12,730
Watford City	24,141	-
Williston	246,997	3,338
Wishek	4,522	173
Estimated Supplemental Payment *(Based upon 2009 data)*	1,486,890	102,355

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab		Certified Registered Nurse Anesthetist (CRNA)			
July 1, 2010 Inflationary Increase	44,607	*	6,141	^		
Estimated Supplemental Payment (SFY 2011)	1,531,497		108,496			
3% / 3% Inflation *(SFY 2012 / 2013)*	139,213		9,862			
Estimated Supplemental Payment for the 2011-2013 Biennium	3,202,206		226,855			
Administrative Cost					25,000	
						Totals
Total General	1,415,055		100,247		12,500	1,527,802
Total Federal	1,787,151		126,608		12,500	1,926,259
				Total 2011-2013 Estimated Cost		3,454,061

* July 1, 2010 lab inflation is 3%, as they are paid based upon Medicare fee schedule.

^ July 1, 2010 CRNA inflation is 6%, as services are paid on the Department's fee schedule.

Estimate is based on 2009 data, which is the latest year complete data is available. Actual payments made to facilities will not match these estimates.

Any supplemental payment is subject to the Medicaid Upper Payment Limit regulations and State Plan approval from the Centers for Medicare and Medicaid Services (CMS).

Estimate is based on the same criteria approved by the CMS for the supplemental payments authorized by the 2009 Legislative Assembly for Rolla. CMS has indicated that a similar supplemental payment would be available for all CAHs.

The Department currently has a contract in place with a vendor to do cost settlements of CAHs. This supplemental payment would be most efficiently handled in conjunction with those cost settlements. The estimated cost to complete these supplemental payment calculations for the biennium is $25,000.

C

North Dakota Department of Human Services
Medical Services Division
2011 HB 1152
Information on Financing the non-Federal Share of the Medicaid Supplemental Payment for CAHs

Per the Centers for Medicare and Medicaid Services (CMS): it is permissible that the cities/counties Inter-Governmental Transfer (IGT) the non-Federal share to the State so that the State can use those funds to draw down Federal Financial Participation in order to make Medicaid payments to both private and public facilities. The city/county must be a legitimate unit of government.

The State must use the entire IGT payment toward the non-Federal share and cannot retain any of the city/county funds. CMS would need to review the IGT arrangement between the City (or County)/State prior to approving the state plan amendment. Items for review would include (at a minimum) ensuring that the city/county transfers the funds directly to the State, the funds are transferred prior to draw down of FFP, the State transfers payment directly to the providers, the providers retain the full total computable payment and do not redirect any portion back to the State and/or any other entity.

It would be permissible for the city/county to pay a portion of the non-Federal share and for the remainder to be paid with general funds.

Considerations:

Per the information provided by the North Dakota Hospital Association: there are eight CAHs that currently receive some level of funding from a city sales tax, one that receives a portion of a county tax and one that receives an annual stipend from the county. (See attached)

If the above financing mechanism would be adopted, the communities that have a CAH, but do not have a current city or county tax, would need to implement a city or county tax to qualify for the supplemental payment. According to information from the ND Tax Department, prior to the implementation of a tax, each city/county would potentially have to have two votes; one for the establishment of a home rule charter and the second to vote on the implementation of a tax.

While CMS has indicated this methodology would be approvable, the Department expects a more lengthy approval of the state plan amendment, as we would need to develop and execute IGT agreements with each city/county.

Options:

1. Retain the Medicaid supplemental payment methodology as is in 2011 HB 1152. Add language that requires or provides legislative intent that each city/county with a CAH is expected to help financially support the health care operations of the CAH. Each CAH would submit to the Department a written explanation of what support is provided by the city/county – prior to the issuance of an annual supplemental payment. (The financial support would NOT be used to provide the non-Federal share of the Medicaid supplemental payment; however, the Department would need to know if the Legislature had minimum "support" expectations.)

2. Retain the Medicaid supplemental payment methodology as is in 2011 HB 1152. Add language to the study resolution section of the bill that indicates the study will include a comprehensive review of the current city/county tax support provided to CAHs and the feasibility of each community with a CAH implementing or increasing the amount of city/county tax designated. (If the supplemental payment is continued into future bienniums, a future decision could be made about the use city/county tax funds to support the non-Federal share of the supplemental payment.) This would also allow the cities/counties to have adequate time to plan for a city/county tax and secure approval through a vote of their constituents.

North Dakota Hospital Association
December 2010

Does your hospital receive funding from a City Sales Tax Provision?	What percentage is devoted to your hospital?	Hospital	City
Yes	0.5%	Unity Medical Center	Grafton
Yes	1 %	First Care Health Center	Park River
Yes	1%	Turtle Lake Community Hospital	Turtle Lake
Yes	1% after the City completes their match for our AL.	Nelson County Health System	McVille
Yes	1/2 percent for 5 years	Cavalier County Memorial Hospital	Langdon
Yes	100% (so far)	Southwest Healthcare Services	Bowman
No	have 5 mil county tax	Linton Hospital	Linton
Yes	no set amount-gave $100,000 for our bldg project	St. Lukes Hospital	Crosby
Yes	The sales tax is not specific to healthcare or hospital.	Jacobson Memorial Hospital Care Center	Elgin
No	We do however receive an annual stipend from the county.	McKenzie County Healthcare Systems, Inc	Watford City

11.0346.04001
Title.05000

Prepared by the Legislative Council staff for
Senator Mathern
March 3, 2011

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

Page 1, line 1, after the semicolon insert "to provide for a legislative management study;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakotans experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

Prepared by the Legislative Council staff for
Senator Kilzer

April 2, 2011

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

In lieu of the amendments adopted by the Senate as printed on page 698 of the Senate Journal, Reengrossed House Bill No. 1152 is amended as follows:

Page 1, line 1, after the semicolon insert "to provide legislative intent; to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. LEGISLATIVE INTENT - MEDICAL SUPPLEMENT PAYMENT - CRITICAL ACCESS HOSPITALS.** It is the intent of the sixty-second legislative assembly that any future requests for a medicaid supplemental payment to critical access hospitals include a local funding commitment equal to fifty percent of the nonfederal share of any payments.

SECTION 3. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly

11.0346.04006
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
April 13, 2011

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1152

That the Senate recede from its amendments as printed on pages 1424 and 1425 of the House Journal and page 1173 of the Senate Journal and that Reengrossed House Bill No. 1152 be amended as follows:

Page 1, line 1, after the semicolon insert "to provide for legislative management studies;"

Page 1, after line 7, insert:

"**SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakota residents experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 3. HEALTH CARE DELIVERY - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the university of North Dakota school of medicine and health sciences center for rural health, hospitals, and the medical community. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Page 1, line 13, after the period insert "This funding is considered to be one-time funding for the 2011-13 biennium and is not to be a part of the department's base budget for the 2013-15 biennium. The department shall report to the appropriations committees of the sixty-third legislative assembly on the use of this one-time funding."

Renumber accordingly