North Dakota Health Care Task Force – Meeting Summary

Meeting #2

Roughrider – Main Floor Capitol

January 31, 2024

Attendees:

- Kyle Davison (Chair)
- Rep. Greg Stemen (Vice Chair)
- Sarah Aker, Executive Director, HHS Medical Services Division
- Rep. Bert Ander Sonja
- Sen. Ryan Braunberger
- Michael Delfs, CEO, Jamestown Regional Medical Center
- Sen. Dick Dever - Chairman of the Senate Appropriations Committee - Human Resources Division
- Todd Forkel, CEO, Altru Health System
- Jon Godfread, North Dakota Insurance Commissioner
- Ty Hegland, CEO, Universal Health Services Inc.
- Stacie Heiden, Blue Cross Blue Shield of North Dakota
- Alyson Kornele, CEO, West River Health Services
- Tiffany Lawrence, President & CEO, Sanford Health
- Sen. Judy Lee - Chairman of the Senate Human Services Committee (*virtually*)
- Rep. Mike Lefor, House Majority Leader
- Rep. Alisa Mitskog - Appointed by the House Minority Leader (*virtually*)
- Rep. Jon Nelson - Chairman of the House Appropriations Committee - Human Resources Division *(virtually)*
- Maria Neset, Senior Policy Advisory, Governor's Office
- Rep. Emily O'Brien
- Dr. Josh Ranum, President, ND Medical Association
- Reed Reyman, President & CEO, Common Spirit (CHI)
- Wayne Salter, North Dakota Health and Human Services Commissioner (*virtually*)
- Kurt Snyder, Executive Director, Heartview Foundation
- Sara Stolt, HHS Interim Commissioner (*virtually*)
- Dr. Richard Vetter, Chief Medical Officer, Essentia Health (*virtually*)
- Dr. Nizar Wehbi, (HHS) State Health Officer
- Rep. Robin Weisz - Chairman of the House Human Services Committee
- Dylan Wheeler, Sanford Health

Welcome and Introductions

Senator Kyle Davison (Chair) welcomed Task Force members to the second meeting. The new Health and Human Services Commissioner, Wayne Salter, introduced himself.

Beth Waldman of Bailit Health reviewed the meeting agenda.

Reminder of Task Force Goals and Follow-Up on Timeline and Stakeholder Engagement Plan

Beth reviewed the goals of the Task Force and a revised Task Force meeting timeline to better reflect the timing of North Dakota's next legislative session beginning in January 2025. She noted that the content over the next few meetings would focus on getting to possible solutions to recommend to the legislature, with recommendations finalized by October 2024.

Beth reminded everyone that members had expressed interest in engaging stakeholders for their perspectives on the topics that the Task Force was interested in and explained that the plan was to hold three separate meetings with each stakeholder group. She asked for input on additional groups (i.e., those who represent consumers and other provider groups not listed on the slide) to include.

- Task Force members suggested the following groups: PhRMA (Ty Hegland), the ND EMS Association (Alyson Kornele), the ND Behavioral Health Planning Council and Mental Health America (Kurt Snyder), and social workers broadly (Sen. Braunberger).
- There is no specific consumer group in ND; Commissioner Godfread noted that he utilized a national consumer group to support his office.

Presentation on Hospital Finances

Hospital Finance 101

Tim Blasl (President, ND Hospital Association) provided an overview of health insurance coverage in North Dakota. He noted that the 340B Drug Pricing Program and Medicaid Expansion provided lifelines to hospitals in the state.

- Commissioner Godfread noted that the lack of transparency into hospital data made it hard to understand why there was wide variability of hospitals' cost structures, and the differences between costs, charges, rates, and reimbursement. He was aware that commercial insurers and health care providers negotiated on payment rates in ND.
    - Sarah Stolt highlighted Task Force members' desire to ensure that there was common understanding on the terminology used, both within this group and for the public (for charges, rates and costs).
- Senator Nelson asked how the 340B Program and Medicaid Expansion improved affordability for consumers in terms of lower premiums. In response to Tim Blasl's reply that commercial insurers had less pressure to increase prices to make up for lower Medicaid prices, Commissioner Godfread stated that the "cost-shifting" theory that Tim alluded to had been dispelled. Commissioner Godfread suggested that it would be worthwhile to examine charity care qualifications in the state. Tiffany Lawrence supported this suggestion, and added that Sanford has presumptive charity care. Maria Neset also supported Commissioner Godfread's suggestion.

Kirk Christy (VP of Finance, Sanford Health Bismarck) presented on the basics of hospital finance. He explained that charges were what was put on a hospital bill. A payment was what a hospital contracted with a commercial payer to pay. Costs were what it cost the provider to

provide a service, irrespective of what it was paid. Hospitals aimed to set their prices above what insurers would pay, and that was the contracted amount for a particular procedure. Charge rates could not be modified to improve margin, although this could happen in very limited circumstances (e.g., a contract with a payer covers a small number of lives). He said that rates differed between payers, but that a single payer would pay similar rates across hospitals. Hospitals in the state, like in many other states, experienced workforce issues in 2022 and had to rely heavily on contract labor, which was a significant expense. The cost to recruit and retain physicians was high in the state, especially so for smaller clinics.

- Representative Lefor asked whether NDHA could provide hospital quality metrics. Kirk Christy said he could provide that data, although the state already had access to Medicaid hospital quality data.
- In response to Commissioner Godfread's question about breaking down labor costs into more specific categories, Kirk Christy said he could get at that data by resurveying the hospitals. In response to Senator Nelson's question on reproducing the "How payer mix impacts margin" slide for South Dakota, Kirk said he could share the charge and reimbursement information from the SD Hospital Association.
- In response to Sarah Aker's question on what could be done to drive down health care costs, Kirk responded that he knew that the highest costs for hospitals were for labor, supplies, and pharmaceuticals.

Critical Access Hospitals Financial Analysis

Darrold Bertsch (retired CEO) described his financial analysis of Critical Access Hospitals (CAHs) and Rural Health Clinics for 2023. Members asked for detail on items such as labor costs and daily censuses for CAHs. He summarized key findings of the analysis, highlighting that CAHs and RHCs were important for local access to healthcare for North Dakota residents, but that many of them have relied on external funds (i.e., Provider Relief Funds) for positive net margins.

Data Discussion

January Angeles of Bailit Health thanked NDPERS and Sanford for sharing their data and analyses that informed the presentation of NDPERS data (approximately 50K members). As for Medicaid data, January shared that Medicaid's current analyses were geared toward a legislative audience, and so were not appropriate for the Task Force's goals. However, Bailit Health was currently in conversations with Medicaid analysts for other data that the Task Force could use. She then reviewed two approaches to data analyses and acknowledged statewide analyses were, presently, not possible as North Dakota lacked an All-Payer Claims Database (APCD).

- Members asked whether there were other national data sources that could be used. January replied that those data were typically proprietary and expensive to purchase. Senator Kyle Davison reminded everyone that there was a budget allocated to the Task Force, so members could consider that route.

January reviewed the graphs and charts on health care spending in North Dakota, based on Sanford's analysis of NDPERS' data. Members were interested in benchmarking their data to other states and the role of price versus utilization in driving spending. January noted that with any cross-state comparisons, one should make sure the population represented is large enough to make fair comparisons. She reminded members that state comparisons may be misleading; as was explained during the last meeting, North Dakota performed better than other states on certain quality metrics, but North Dakota's absolute performance score was poor (e.g., ND may score in the 75th percentile for a measure, but its score might be only 30%).

- In response to members' desire to look at cost and quality outcomes together, January suggested that at a future meeting, Bailit Health could pull together both the quality outcomes data.
- In response to Commissioner Godfread's question on how the NDPERS plan design is accounted for in the analysis (given the differences between the PERS plan and other commercial plans), January replied that these analyses include allowed amounts, which include consumer cost sharing amounts. However, it did not account for level of coverage for services.

January noted that Bailit Health would continue to discuss with Sanford how to perform deep dives of the available NDPERS data, and asked for other reactions to the presentation.

- Members noted that data examining the Medicaid population would look different from the data for NDPERs, given that these beneficiaries had higher behavioral health and complex needs. January acknowledged this, and shared that Bailit Health plans to examine mental health data for the Medicaid population.

All-Payer Claims Database Discussion

Beth Waldman explained that APCDs allowed for the examination of longitudinal data and supported transparency of state health care spending data. Members wanted to know whether cross-state comparisons were truly comparable, about the level of detail available in an APCD, and whether an APCD was necessary to get the desired data. Beth explained that the APCD would provide a structure for insurers to report data on a regular basis, which allowed stakeholders to reliably study trends over time without ad hoc requests to insurers. This structure also eliminated biases in data reporting.

- Reed Reyman commented that it appeared that the Task Force needed more data beyond what an APCD could offer to target legislative policies. He suggested setting up subcommittees to investigate all health care spending and quality data available for North Dakota. One member supported this suggestion.
- In response to members' questions about the initial cost and maintenance of an APCD, Beth responded that she estimated the startup and maintenance costs to be around $1 to $4 million based on other state activities. Members expressed a strong desire to have access to a comprehensive set of data soon, but wanted to learn more about the value that states have found from using their APCDs. Beth pointed to the fact that states continued to fund these databases, which was telling of their perceived value in states.

She noted Bailit Health could follow up with more research on the perceived utility and value of APCDs across states.

Members expressed a strong desire to get access to a comprehensive set of data soon. Some explained that they could not see how the state could get more transparent about health care spending data without an APCD, while others were uncertain whether APCDs could provide enough value to be worth the state's investment. Members expressed interest in hearing from other provider groups and an informational session on health plan expenditures.

Rep. Mike Lefor suggested that before the next meeting, legislators provide their questions to the Chair ahead of the next meeting.

As for next steps, Beth Waldman noted that Bailit Health could research how North Dakota is represented in national data sets as a possible venue with which to explore ND costs, absent an APCD.