NORTH DAKOTA HOSPITAL ASSOCIATION

Value of Membership

Advocacy Highlights

WELCOME TO NDHA

The North Dakota Hospital Association (NDHA) is a voluntary trade organization of North Dakota's licensed hospitals committed to advancing public policy and fostering excellence in medical and health services.

Founded in 1934, NDHA has been representing hospitals and health-related member organizations for over 80 years. The NDHA is a voluntary, not-for-profit organization comprised of hospitals and health systems with a common interest in promoting the health of the people of North Dakota.

ADVOCACY

The North Dakota Hospital Association's government advocacy is one of the most important ways the Association serves its members. NDHA's efforts to communicate with and educate lawmakers on the issues that affect North Dakota hospitals have resulted in improved health care policy that better supports hospitals and patients.

STATE LEGISLATIVE ACCOMPLISHMENTS 2013-2015

HB1012

North Dakota Department of Human Service Budget provided a 4% inflator for each year of the biennium. Please see service lines and financial impacts below:

PPS Hospitals - IP & OP	**$11.9 million**
Physician Services	**$6.6 million**
Rebase RHC's	**$1.4 million**
CAH Lab/CRNA	**$1.3 million**
Total	**$21.2 million**

HB1358

$8.9 million

Provides **$8.9 million** for Critical Access Hospitals in oil-producing counties and contiguous counties to address the effects of oil and gas related economic development activities.

Bill allows **$700,000** to be used for developing a system to verify personal data and insurance information. **$700,000**

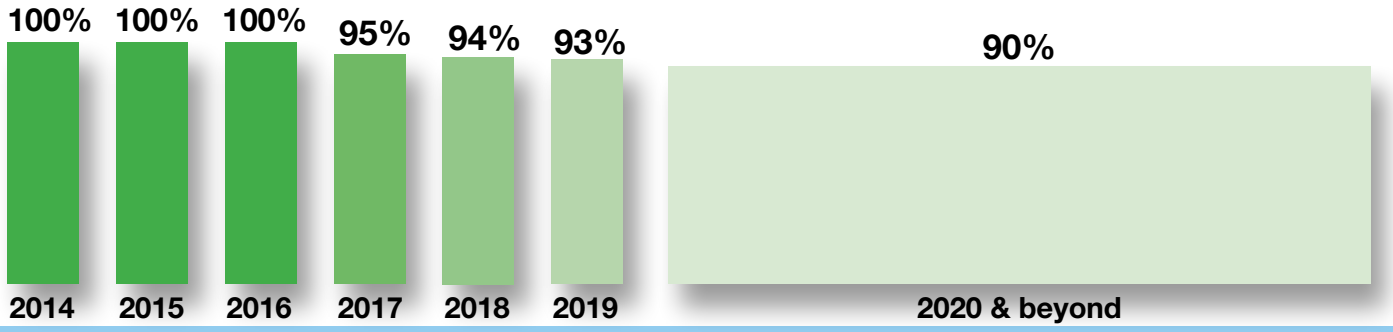
Total = $9.6 million

HB1362

Medicaid Expansion

- Reduces uncompensated care by **$68 million** for ND hospitals
- Effective January 2014, sunsets July 2017
- **100%** federally funded **until 2017**

$68 million



STATE LEGISLATIVE ACCOMPLISHMENTS 2013-2015

SB 2187

Medical Facility Infrastructure Program

1%	1% capital loans from Bank of North Dakota
$50 million	**$50 million** available for medical facilities to improve infrastructure.
+ $50 million	**Additional $50 million** available if money uncommitted from HB 1013
6	Six hospitals applied and received funding

STUDY RESOLUTION 2243

Study behavioral health needs, including consideration of behavioral health needs of youth and adults, access, availability, and delivery of services.

Study was completed and presented to legislative interim committee in July 2014.

NDHA will monitor activity in next legislative session.

NDHA PLATFORM 2015-2017 LEGISLATIVE SESSION

Medicaid Reimbursement

- 4% Inflator request for PPS Hospitals, Physicians, and Nursing Homes
- Rebase RHCs
- Maintain current CAH payment system (cost-based)

Legislative funding for Hospitals

Behavioral Health & Substance Abuse

FEDERAL LEGISLATIVE GOALS

96-HOUR PHYSICIAN CERTIFICATION REQUIREMENT

The Centers for Medicare & Medicaid Services (CMS) recently indicated it will begin enforcing a condition of payment for critical access hospitals that requires a physician to certify that a **beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission** to the CAH.

NDHA Message: *The 96-hour requirement for payment threatens access to medical services for North Dakota's seniors. It could force seniors to obtain medical treatment in communities away from their homes or force them to be transferred after 96 hours. In addition, the revenue CAHs will lose will make it difficult for already financially-strapped CAHs to survive.*

MEDICARE DIRECT SUPERVISION POLICY

In the 2009 Medicare outpatient prospective payment system rule, the Centers for Medicare & Medicaid Services (CMS) mandated new requirements for "direct supervision" of outpatient therapeutic services. North Dakota's critical access hospitals have expressed deep concerns about complying. The mandate begins in January 2015.

NDHA Message: *We are deeply disappointed that CMS has ignored the concerns voiced by CAHs about the impact of the direct supervision policy. We believe it is unnecessary, not warranted by clinical evidence and are concerned that it will result in reduced access to care. Without adequate numbers of physicians or other health care professionals, hospitals may limit their hours of operation or close certain programs.*

PREDICTABLE MEDICARE PAYMENTS

In the past few years, a number of harmful proposals have been considered by lawmakers as they debated ways to reduce the deficit. They were ultimately rejected, but still have some support and will almost surely be considered as offsets in the next round of deficit reduction talks. They include:

- **Site-neutral payment** policies for hospital outpatient departments
  - Estimated ND annual impact **$29 million**
- Reductions in payments for **graduate medical education**
- Additional Medicare **Bad Debt** reductions
- Additional across-the-board cuts to Medicare inpatient hospital rates through **coding adjustments**
- Payment **reductions for CAHs**
  - 101% to 100%
  - CAH mileage adjustment

NDHA Message: *We urge Congress to reject further cuts to Medicare and Medicaid funding. We need long-term solutions to strengthen our nation's health care system, not arbitrary cuts that undermine hospitals' ability to provide care for North Dakota's seniors and low-income residents.*

FEDERAL LEGISLATIVE GOALS

IHS REIMBURSEMENT DELAYS AND DENIALS

Hospitals that provide services to enrolled tribal members have historically raised concerns about the IHS reimbursement system – specifically, the lag between when bills are submitted and when they are paid and the denial rate for claims submitted. For hospitals, carrying this level of accounts payable often presents problems meeting cash flow needs.

The IHS budget was boosted in FY 2011 to help deal with these issues. But the agency continues to be underfunded and plagued by an antiquated bureaucracy.

NDHA Message: *We appreciate the congressional delegations' help in resolving these issues. However, we have much more work to do. The Indian Affairs Committee and the Appropriations Interior Subcommittee can play key roles in ensuring that these issues are ultimately resolved.*

EXPANSION OF THE 340B DRUG PRICING PROGRAM

The 340B program is a federal drug pricing program that requires pharmaceutical manufacturers participating in the Medicaid program – safety net hospitals – to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people.

The ACA expanded access to the 340B program to CAHs and certain sole community hospitals and rural referral centers. However, in the final hours of action on the ACA, Congress eliminated coverage for inpatient drugs from the program expansion.

NDHA Message: *The 340B program is essential to helping safety net providers stretch limited resources to better serve their communities. We oppose efforts to scale back the program and support extending 340B discounts to the purchases of drugs used during inpatient hospital stays. Such an expansion would provide significant cost savings for hospitals without any additional cost to taxpayers.*

WORKFORCE DEVELOPMENT

Our state continues to face a persistent shortage of health care professionals – a shortage that threatens to grow worse as our demographics change due to increased oil and gas production and growing numbers of seniors. We also face an aging health care workforce that must be replaced if we are to continue to provide access to medical treatment – especially in smaller communities.

A number of federal programs currently provide grants, scholarships and loan repayments aimed at encouraging students to pursue health professions and to locate in rural and underserved areas. The ACA expanded these.

NDHA Message: *In view of the amount of time it takes to train physicians and other health care professionals, we need to make a substantial investment in training new physicians, nurses and other mid-level practitioners to meet these impending needs. Failure to make this investment now will lead to reduced access to health care services in the future. Specifically, we urge ensuring that the Labor–Health and Human Services–Education appropriation fully fund health care training programs.*