North Dakota Legislative Health Care Task Force Meeting #2

January 31, 2024

bailit health

Agenda

- Welcome and introductions
- Reminder of Task Force goals, and follow-up on timeline and stakeholder engagement plan
- Presentation on hospital finances
  - Hospital finance 101, Tim Blasl and Kirk Cristy
  - Critical Access Hospitals financial analysis, Darrold Bertsch
- Data discussion
- Break for lunch
- All-payer claims database discussion

REMINDER OF TASK FORCE GOALS, AND FOLLOW UP ON TIMELINE AND STAKEHOLDER ENGAGEMENT PLAN

Task Force Goals

- Understand the current health care costs and cost drivers in North Dakota
- Describe health care costs trends and cost drivers that the state should be prepared for
- Summarize the current status of health care cost transparency in North Dakota and develop a roadmap to improve transparency as needed

Revised Task Force Meeting Timeline and Agenda

Meeting #	Date	Tentative Agenda Topics
#1	Held 10/25/23	• Introduction to the Task Force's charge • Level-setting and discussion of process and meeting ground rules • High-level presentation of national trends in health care costs and cost containment strategies
#2	1/31/24	• Hospital finances • Health care cost trends in North Dakota • Presentation on APCD
#3	Mar/Apr 2024	• Health care cost trends in North Dakota, including feedback from stakeholders on costs and cost drivers in the State (cont.) • Criteria for selecting policy recommendations
#4	May/Jun 2024	• High level review of potential policy solutions to consider
#5	Aug/Sept 2024	• In-depth discussion of policy solutions to recommend to the Legislature, including feedback from stakeholders on potential recommendations
#6	Early Oct 2024	• Presentation of report to the Legislature and finalization of recommendations
#7	Jan/Feb 2025	• In-depth discussion of additional policy solutions to recommend to the Legislature, including feedback from stakeholders on potential recommendations
#8	May/Jun 2025	• Discussion of policy solutions supported by Legislature and implementation/next steps

Stakeholder Engagement Plan

- Goals and objectives:
  - Better understand stakeholder perspectives on health care spending and affordability.
  - Solicit potential recommendations to the Legislature to improve transparency on health care spending, reduce or contain spending growth, and improve health outcomes.
  - Obtain feedback on potential recommendations that will be shared with the Task Force.
- Specific stakeholders identified to date:
  - North Dakota Hospital Association
  - North Dakota Medical Association
  - Community HealthCare Association of the Dakotas
  - North Dakota Long Term Care Association
  - AARP
  - Center for Rural Health (UND)
  - Tribal Health Services
  - Local Public Health Association
  - Chamber of Commerce
- **Looking for additional consumer voices**

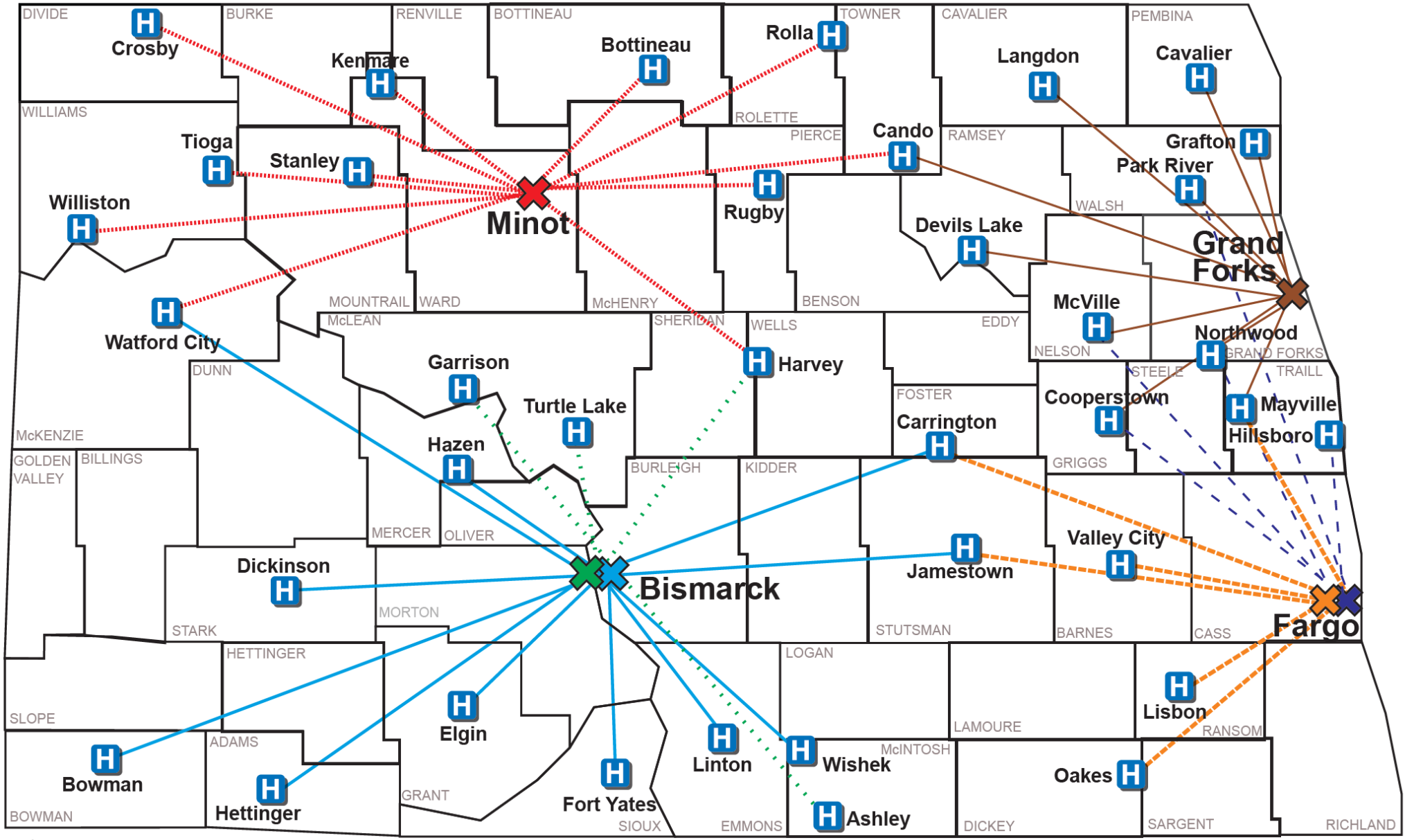
PRESENTATION ON HOSPITAL FINANCES

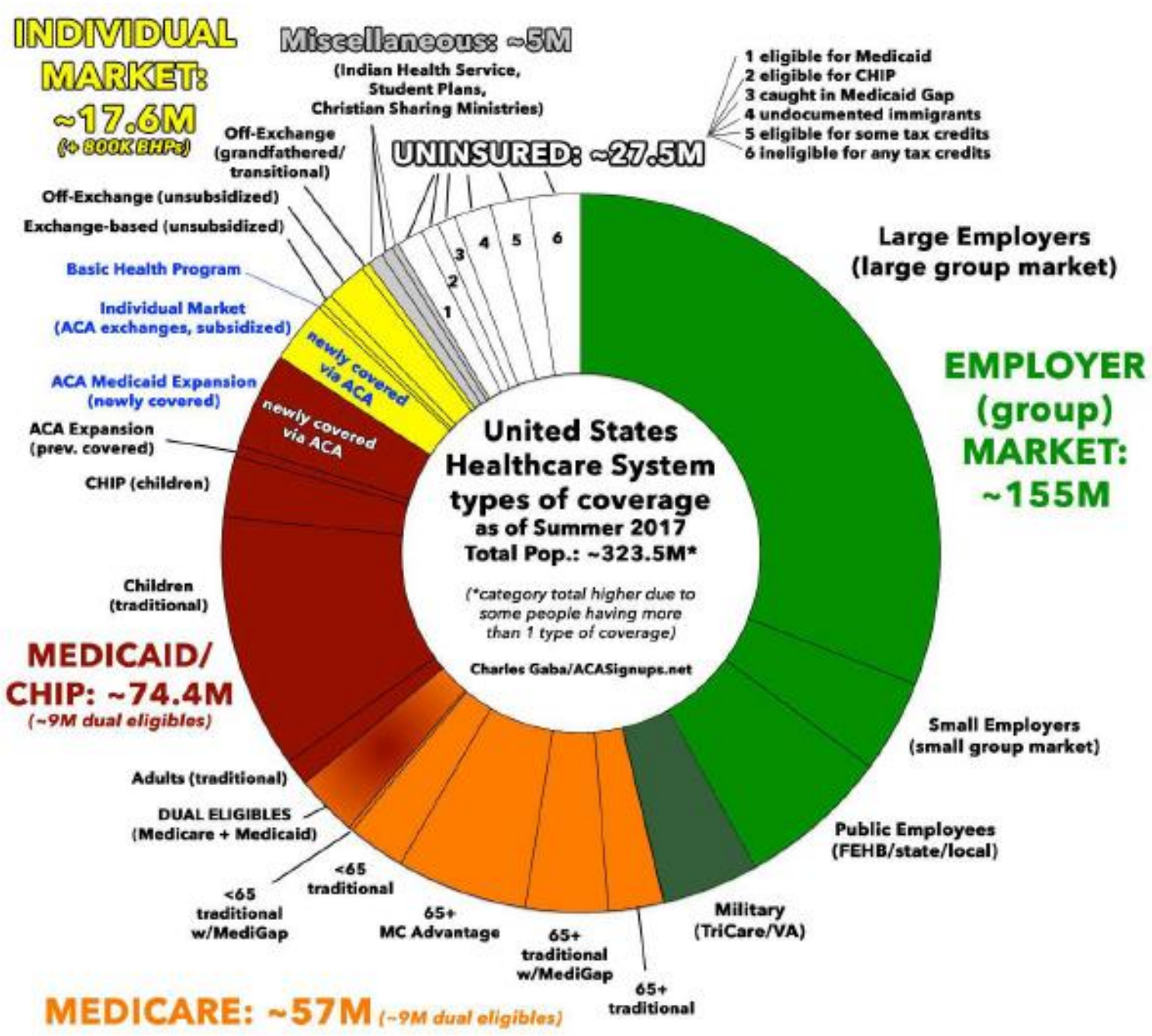
Healthcare Finance 101

Tim Blasl, President
N.D. Hospital Association

Kirk Cristy, VP Finance
Sanford Health Bismarck

North Dakota Critical Access Hospitals & Referral Centers




INDIVIDUAL MARKET: ~17.6M (+ BOOK BHPs)
Miscellaneous: ~5M
(Indian Health Service, Student Plans, Christian Sharing Ministries)
UNINSURED: ~27.5M
1 eligible for Medicaid
2 eligible for CHIP
3 caught in Medicaid Gap
4 undocumented immigrants
5 eligible for some tax credits
6 ineligible for any tax credits
Off-Exchange (grandfathered/ transitional)
Off-Exchange (unsubsidized)
Exchange-based (unsubsidized)
Basic Health Program
Individual Market (ACA exchanges, subsidized)
ACA Medicaid Expansion (newly covered)
ACA Expansion (prev. covered)
CHIP (children)
Children (traditional)
Adults (traditional)
DUAL ELIGIBLES (Medicare + Medicaid)
<65 traditional w/MediGap
<65 traditional
65+ MC Advantage
65+ traditional w/MediGap
65+ traditional
Military (TriCare/VA)
Public Employees (FEHB/state/local)
Small Employers (small group market)
Large Employers (large group market)
newly covered via ACA
newly covered via ACA
United States Healthcare System types of coverage
as of Summer 2017
Total Pop.: ~323.5M*
(*category total higher due to some people having more than 1 type of coverage)
Charles Gaba/ACASignups.net
EMPLOYER (group) MARKET: ~155M
MEDICAID/ CHIP: ~74.4M
(~9M dual eligibles)
MEDICARE: ~57M (~9M dual eligibles)

Healthcare Finance 101

N.D. healthcare coverage categories

Commercial Payers	Government Payers	Uninsured
• Blue Cross Blue Shield • Sanford Health Plan • United Healthcare • Health Partners • Medica • Aetna • Humana	• Medicare • Medicaid • Children's Health Insurance Program • Tricare • Indian Health Services	• Self-pay • Eligible for Medicaid or CHIP • Eligible for tax credits

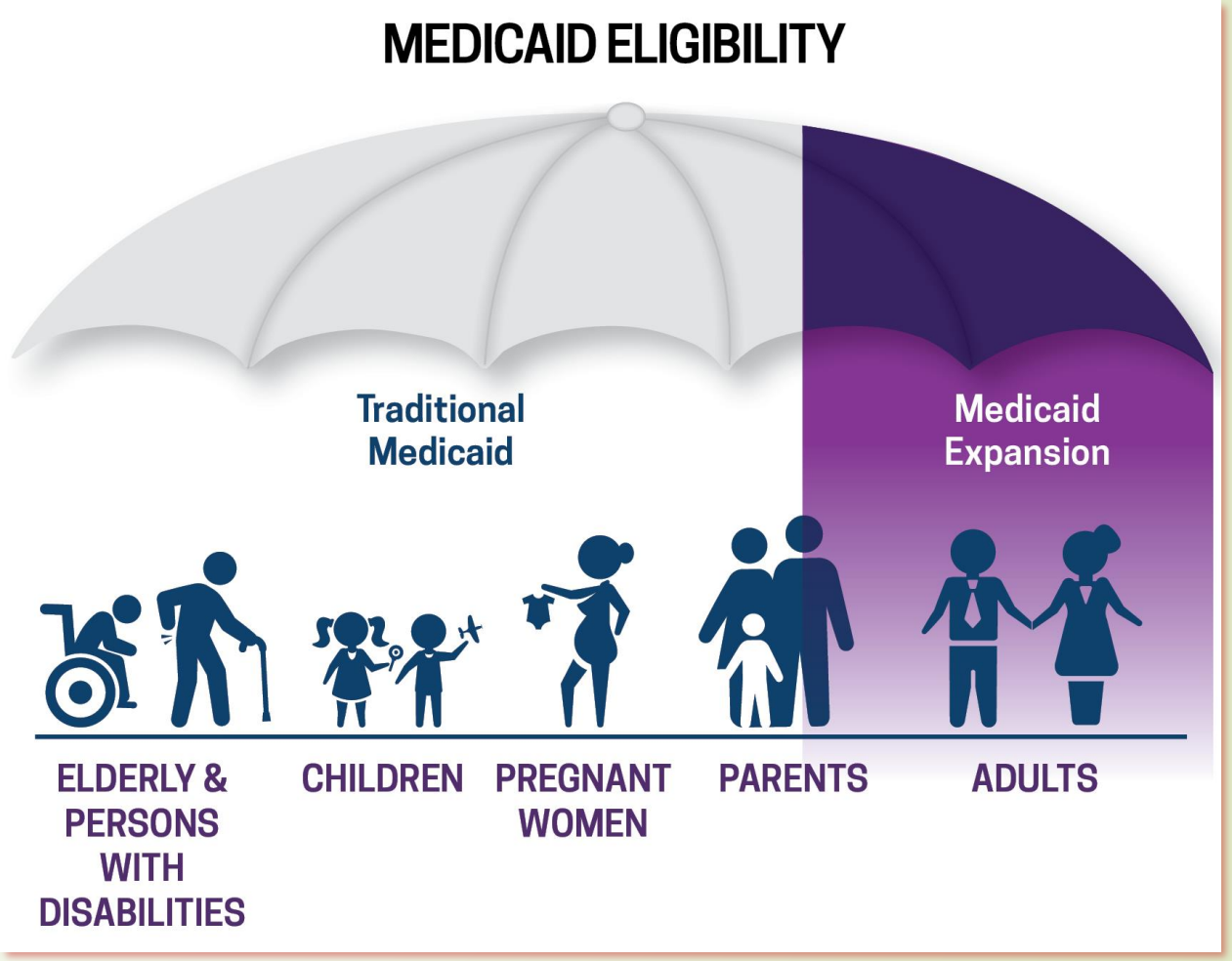
Medicaid: Protecting our most vulnerable population

Medicaid

- *Who does it cover?*
- *How is it funded?*

Medicaid Expansion

- *Who does it cover?*
- *How is it funded?*



North Dakota

Healthcare Finance 101

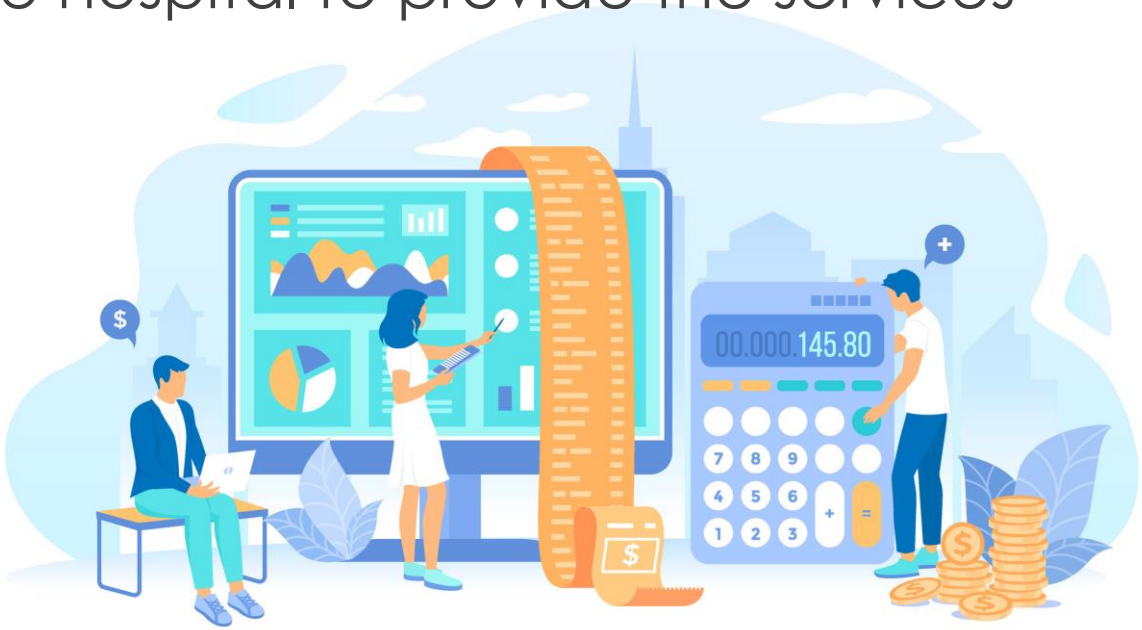
Key Points

- Hospitals are paid based on contracts with health insurance carriers
- Hospitals invest 97% of Payments into daily provision of care
  - 85% of these costs are for labor, pharmacy and supplies
- Remaining 3% necessary to reinvest in the future of North Dakota's rural healthcare delivery system

North Dakota

Healthcare Finance 101

- **Charges**: the amounts hospitals list as the price for services
- **Payment**: the amount the hospital receives for its service
- **Cost:** what it actually costs the hospital to provide the services



North Dakota Hospital Charges

$2.64

Source: NDHA October 2023 PPS hospital revenue/expense survey.

North Dakota Hospital Payment

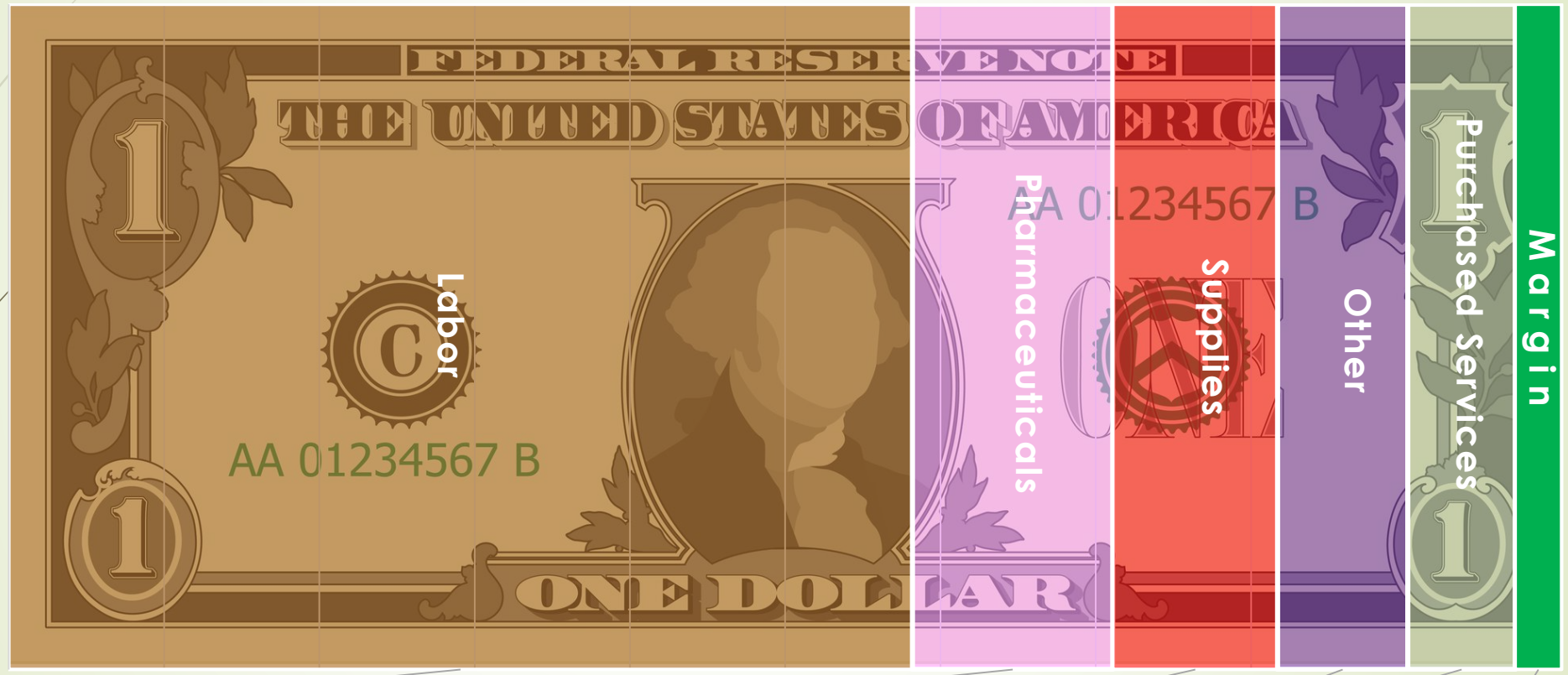
$1.00

37.9% Payment
62.1% Discount off Charge

- Payer Discounts
- Uncompensated Care
  - Charity
  - Bad Debt

Source: NDHA October 2023 PPS hospital revenue/expense survey.

North Dakota Hospital Operating Costs



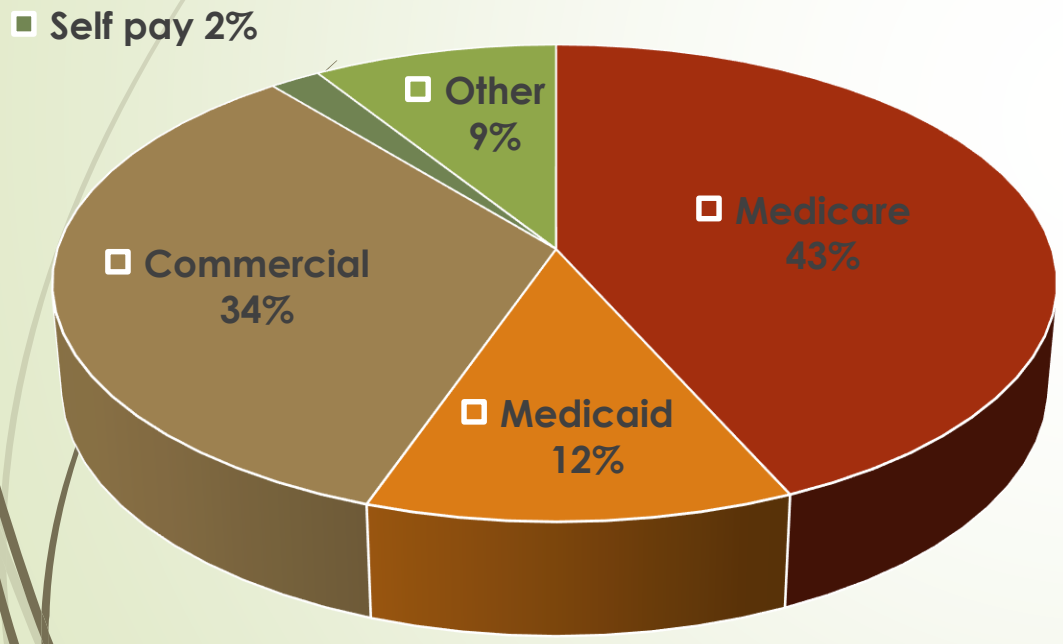
- Labor 58.2%
- Pharmaceuticals 12.9%
- Supplies 10.6%
- Other 8.4%
- Services 6.9%
- Margin 3.0%

Source: NDHA October 2023 PPS hospital revenue/expense survey.

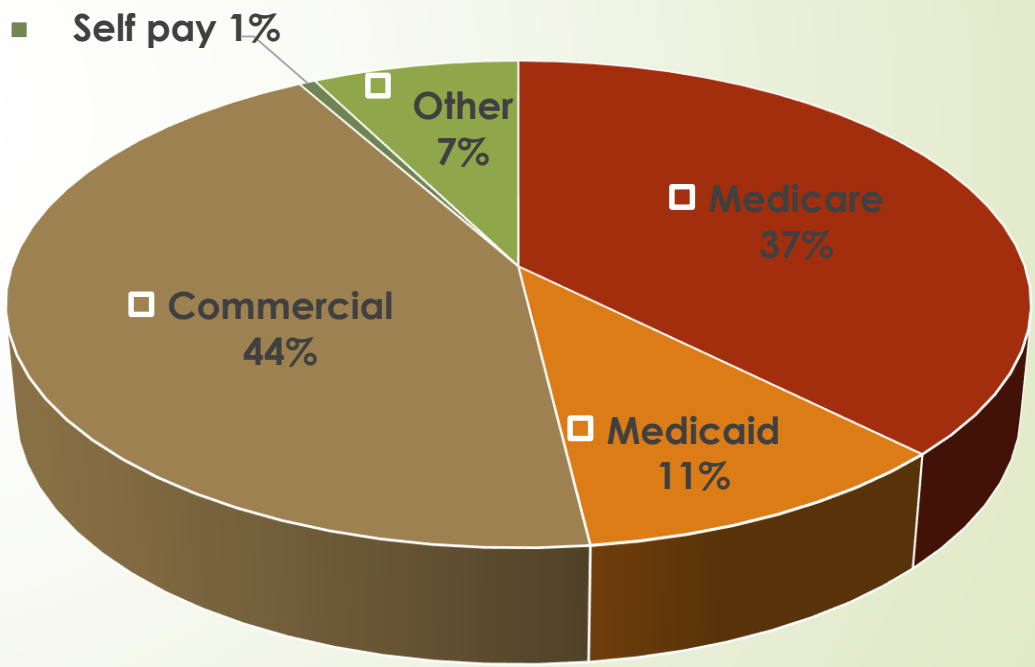
North Dakota

Hospital payer mix vs. net patient revenue

Charges



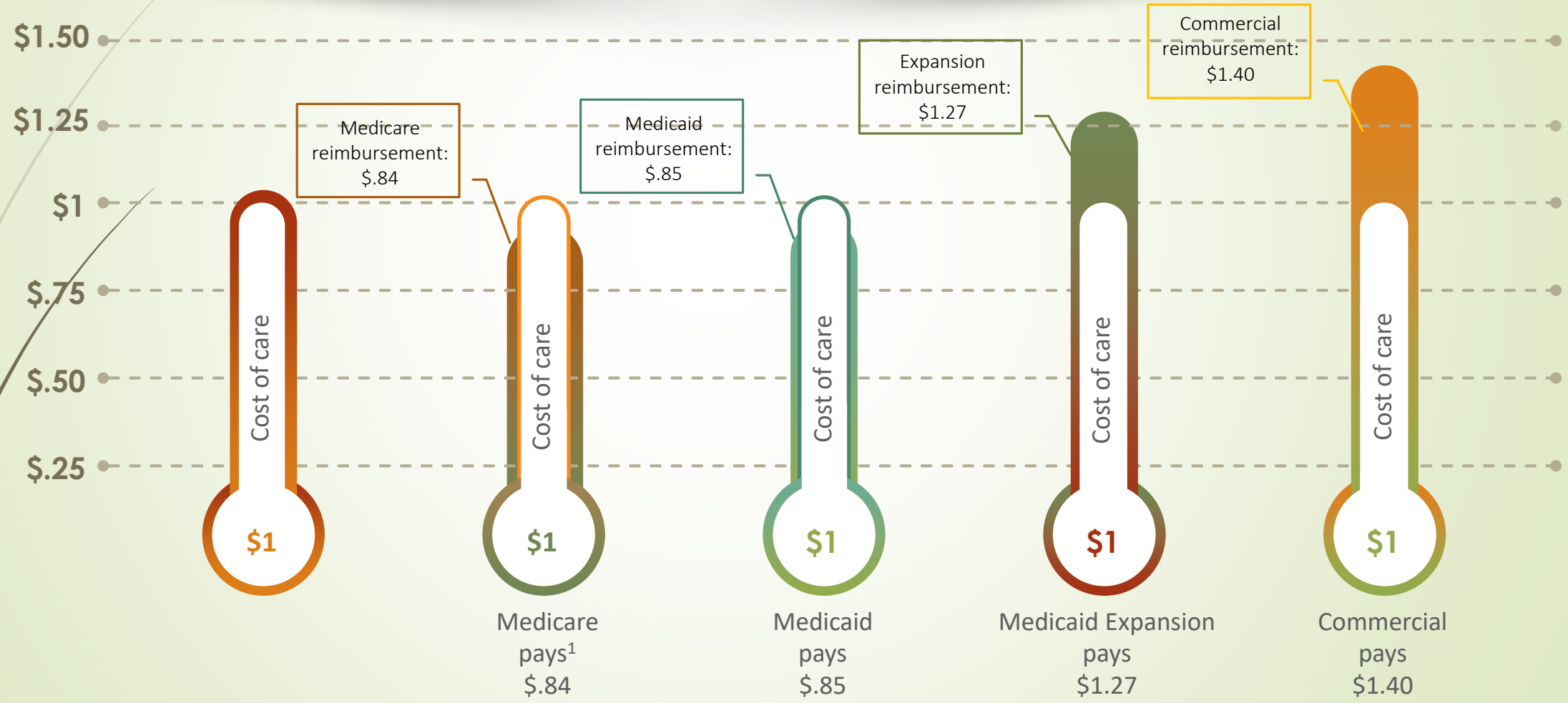
Payment



Source: NDHA October 2023 PPS hospital revenue/expense survey.

Payer mix

How payer mix impacts margin



[1] *AHA Underpayment by Medicare and Medicaid*

Healthcare Finance 101: Margins

- Health economists consider a positive 4% operating margin as the minimum necessary to ensure hospitals have sufficient funds to reinvest improving care and expanding access
- ND PPS hospitals average margin: 3%[1]
- How is margin used:
  - Maintain / Improve Access to care
    - Upgrade / Improve Equipment and Technology
    - Infrastructure upgrades / new facilities / expand locations
  - Invest in New Services
  - Community investments
  - Maintain viability

[1]*Source: NDHA October 2023 PPS hospital revenue/expense survey.*

Summary

- Hospitals are paid based on contracts with health insurance carriers
  - Charges do not materially drive payment
  - Hospitals are price takers for the majority of their business
  - Commercial business subsidizes the cost of care for government-sponsored and uncompensated care
- Hospitals invest 97% of Payments into daily provision of care
  - 85% of these costs are for labor, pharmacy and supplies
- Remaining 3% necessary to reinvest in the future of North Dakota's rural healthcare delivery system

Health Care Task Force
HHS Committee

Critical Access Hospital (CAH) & Rural Health Clinic (RHC) 101

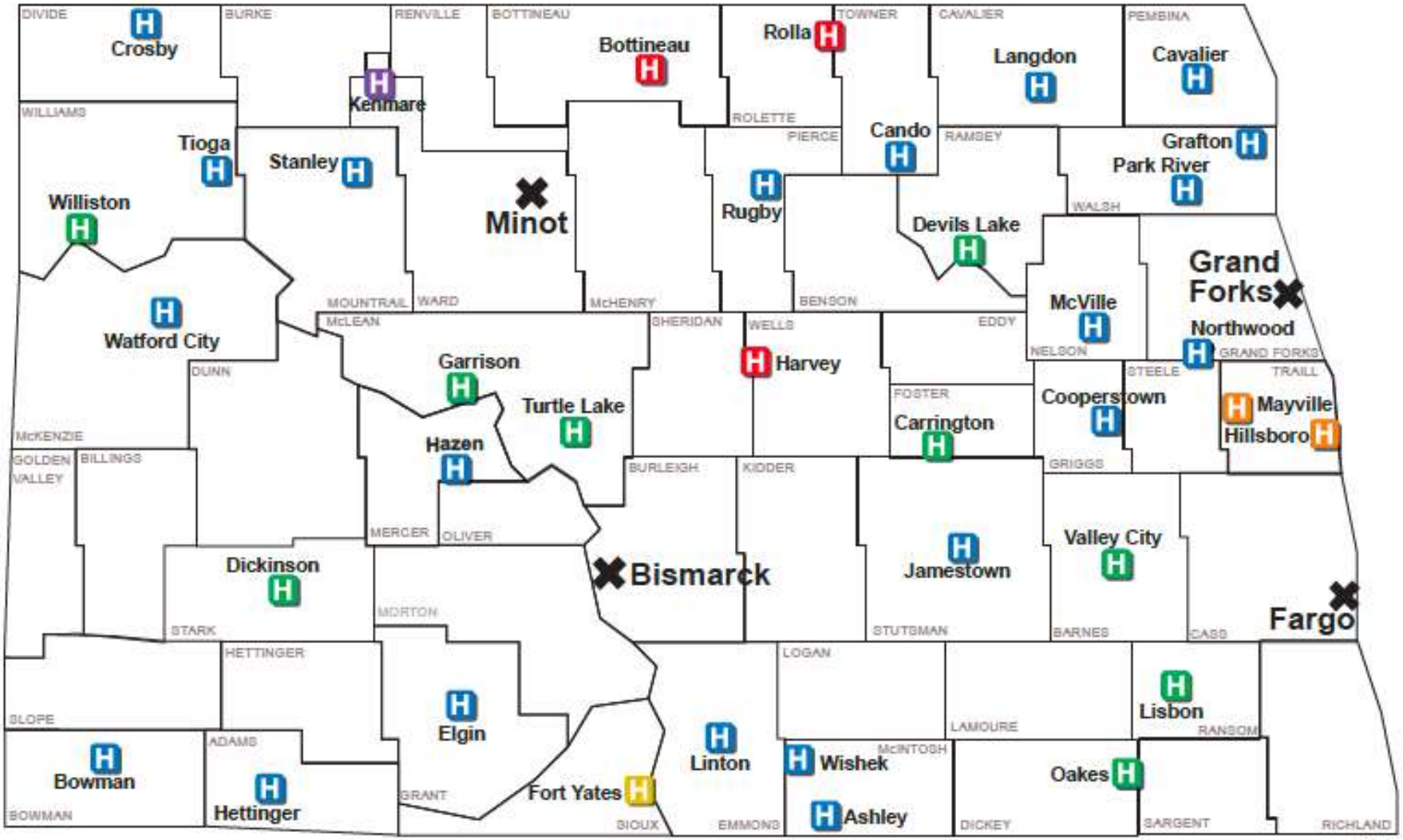
2023 Critical Access Hospital (CAH)
Financial Analysis

Darrold Bertsch, CEO Retired
January 31, 2024

Agenda

- Preface Slide Deck Content and Clinic Info
- North Dakota Acute Care Hospitals
- ND Rural Safety Net Providers
- CAH, RHC & FQHC Basics
- 2023 Financial Analysis for 36 CAHs

North Dakota Critical Access Hospital Ownership



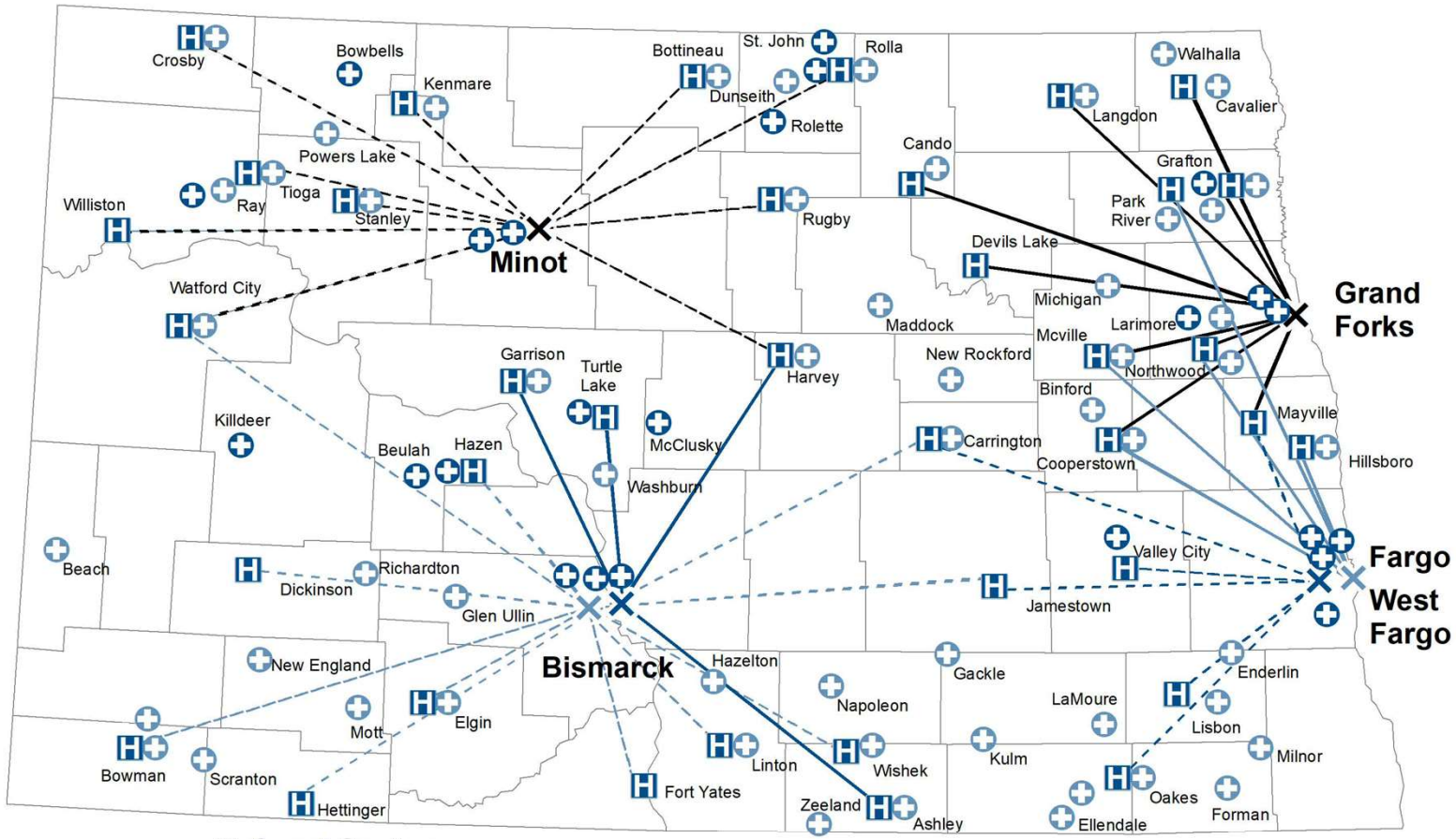
03/22

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

Hospital Ownership

- Independently owned
- CommonSpirit Health
- Sanford Health
- Sisters of Mary of the Presentation Health System
- Trinity
- Indian Health Services

Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers
North Dakota, 2022



Referral Centers

- Altru Health Systems Grand Forks
- CHI St. Alexius Bismarck
- Sanford Health and CHI St. Alexius Bismarck
- Sanford Health Fargo
- Sanford Health and Essentia Health Fargo
- Trinity Hospital Minot

- Referral Center
- Critical Access Hospital
- Federally Qualified Health Center
- Rural Health Clinic

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas.

Sources: data.HRSA.gov, April 2022

Created by the North Dakota Healthcare Workforce Group on 4/2022

UND School of Medicine & Health Sciences
University of North Dakota

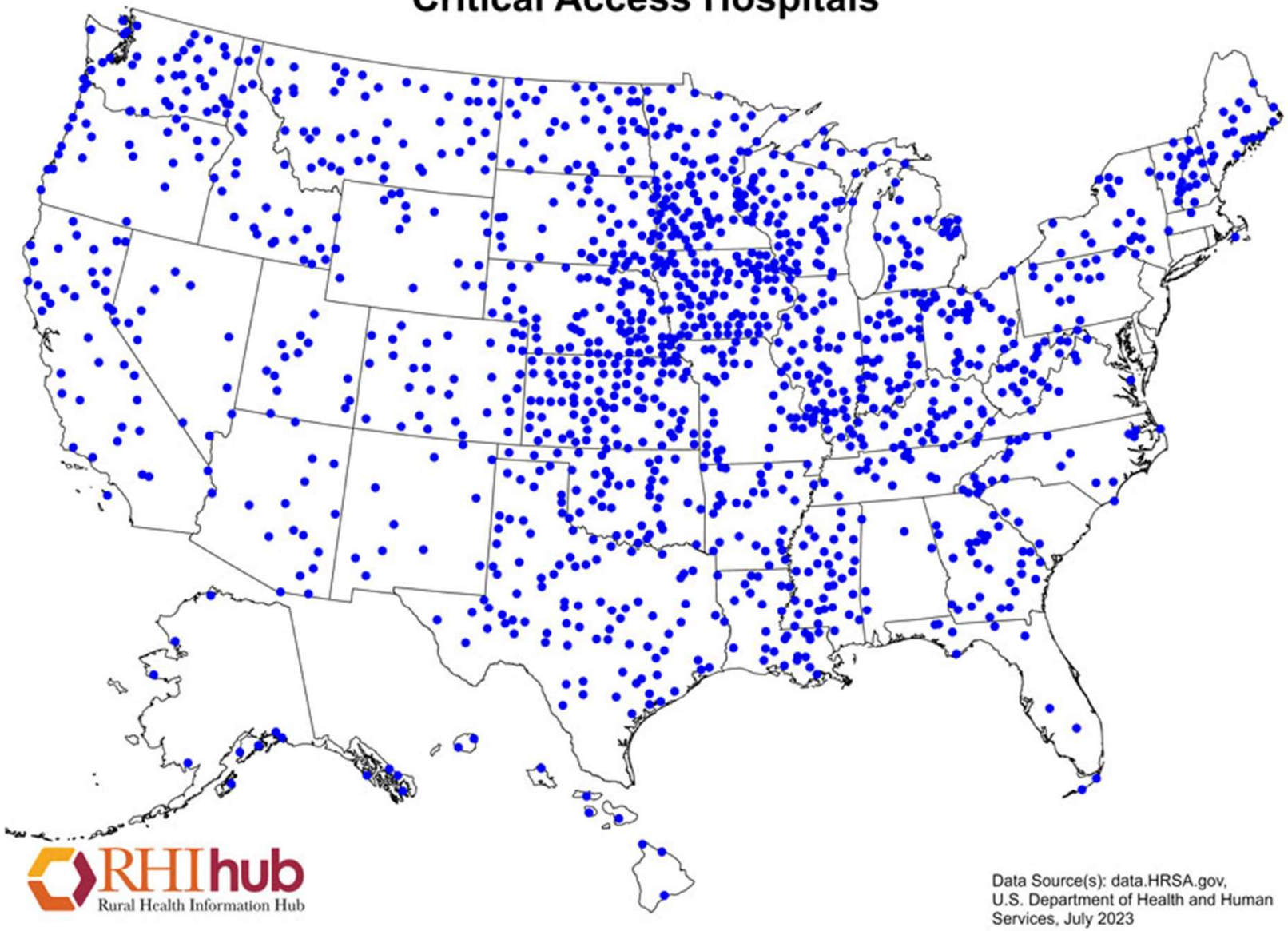
ND HEALTHCARE WORKFORCE GROUP

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

What is a CAH?

- **Critical Access Hospital (CAH)**
  - Enacted with the Balanced Budget Act of 1997
  - A CAH must be located in states that developed a rural health plan
  - Recognized the financial challenges of a rural hospital
  - Located more that 35 miles from another hospital (exemptions)
    - Necessary provider with Governor designation was available prior to January 2006.
  - Must provide 24/7 Emergency Room services
  - Must provide certain ancillary and support services
  - Licensed for 25 or fewer acute inpatient beds, some exceptions in certain states
    - Observation status not part of 25 bed requirement
  - Must meet Medicare Conditions of Participation (COPs)
  - Must have an Acute inpatient average length of stay < 96 hours
  - Must have a referral relationship with a tertiary provider
  - Reimbursed by Medicare 101% of ”allowed” cost for inpatient, outpatient and skilled swingbed service, less 2% sequestration
    - Allowed costs do not include phone, tv, marketing, recruitment, etc.

Critical Access Hospitals



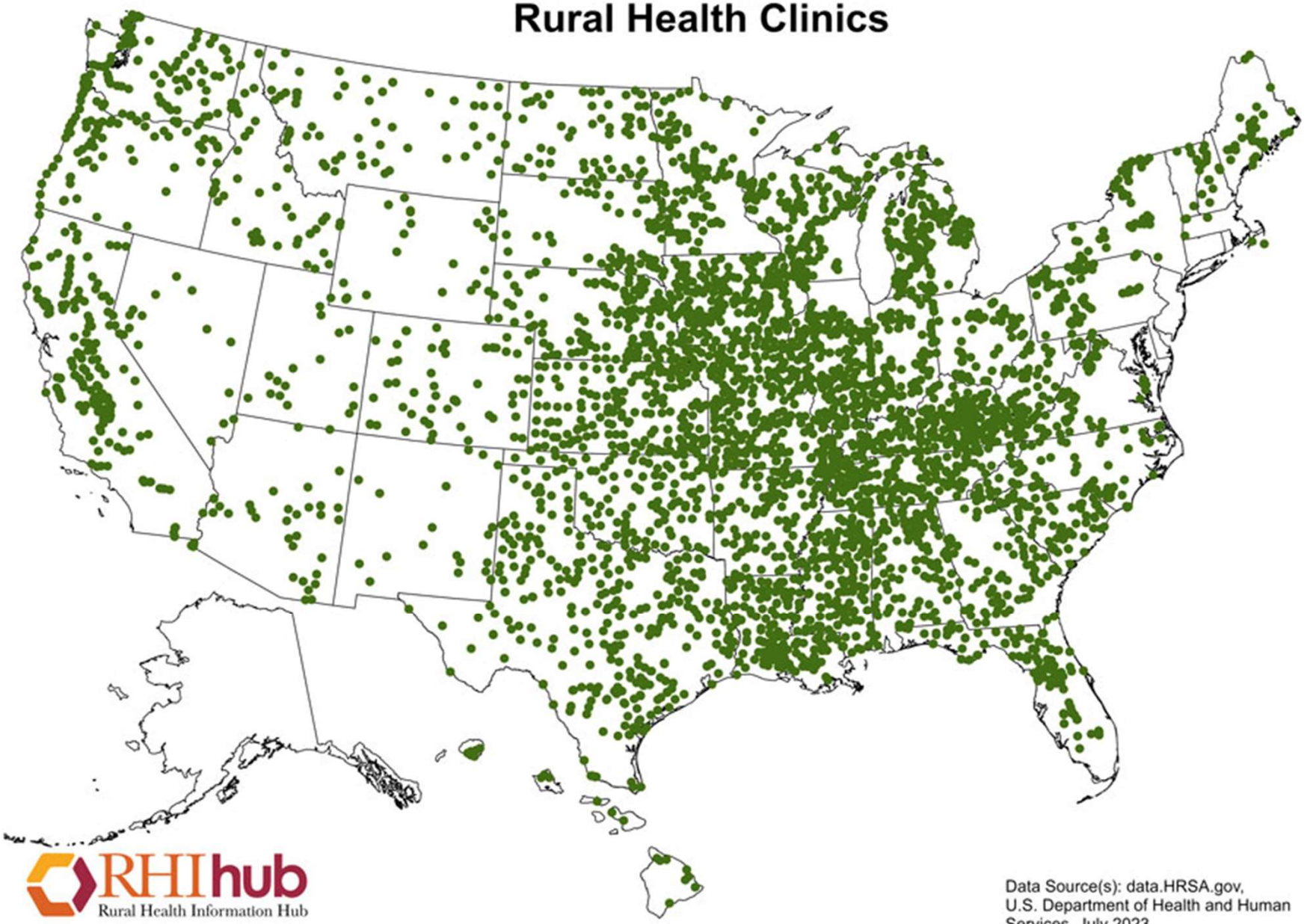
RHIhub
Rural Health Information Hub

Data Source(s): data.HRSA.gov,
U.S. Department of Health and Human Services, July 2023

What is a Rural Health Clinic (RHC)?

- **Rural Health Clinic (RHC)**
  - Most ND CAHs own and operative an RHC
  - Medicare designation for a rural Primary Care Clinic
  - Located in a non-urban area as designated by HRSA
    - Medically Underserved Area (MUA)
    - Primary Care Health Professional Shortage Area (HPSA)
  - Provide primary care and preventative visits
  - Must provide certain ancillary services (lab, x-ray, etc.)
  - Have an arrangement with a hospital for services it does not provide
  - Must employ or contract with a PA or Nurse Practitioner
  - Must be staffed at least 50% of the time with a PA or Nurse Practitioner
  - Reimbursed from Medicare based an all-inclusive rate or prior cost-based rate
  - May provide Visiting Nurse Services where a shortage of Home Health exists

Rural Health Clinics

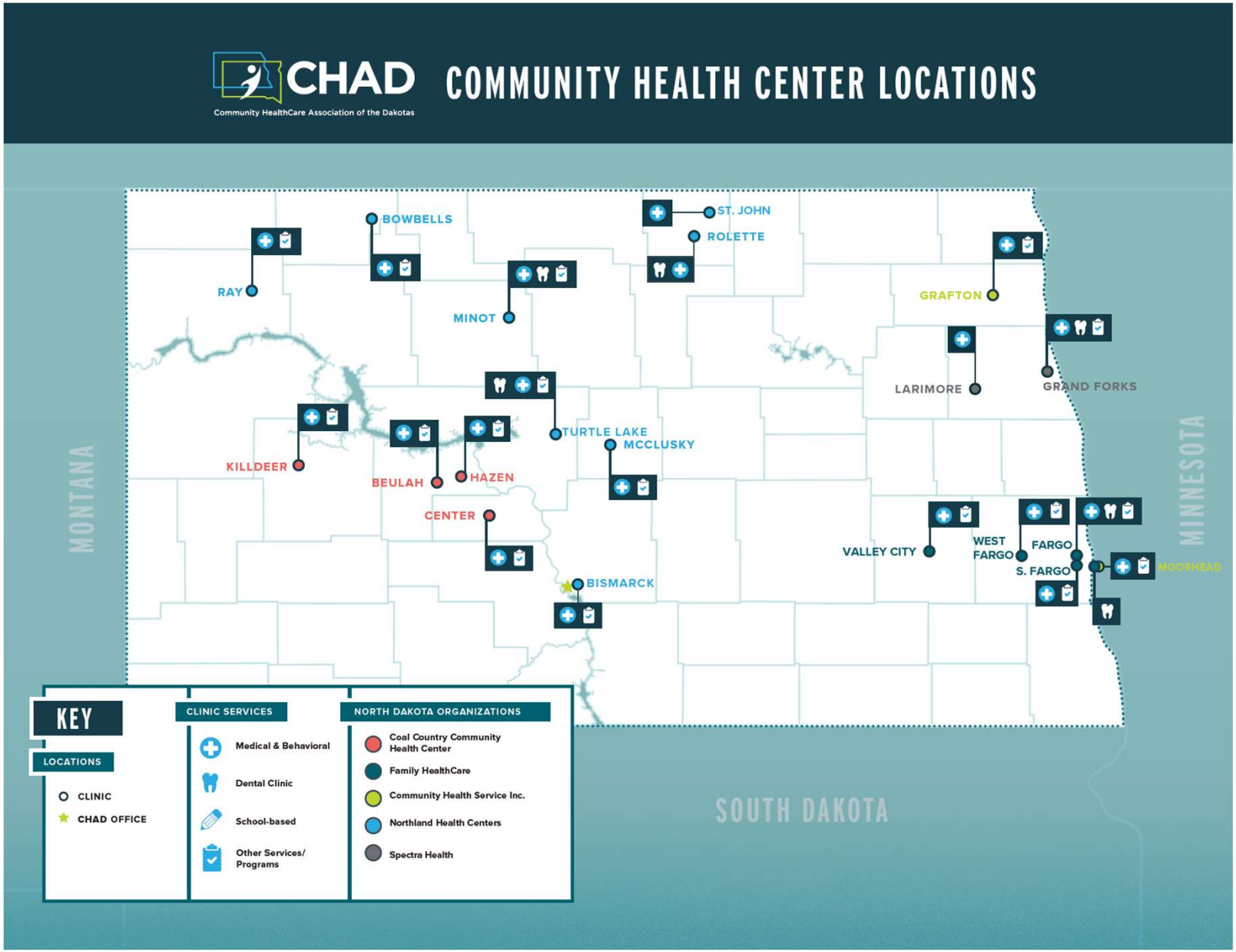


RHIhub
Rural Health Information Hub

Data Source(s): data.HRSA.gov,
U.S. Department of Health and Human Services, July 2023

What is a Federally Qualified Health Center?

- **Federally Qualified Health Center (FQHC)**
  - Federal reimbursement designation for a Community Health Center
  - Developed in the 1960's
  - 501(c)3 Not for Profit or Public Entity
  - Receive grant funds thru Section 330 of Public Health Services Act
    - Significant report and performance requirements
  - Treat Patients Regardless of their ability to pay
  - Located in a federally designated area (HRSA)
    - Medical Underserved Area (MUA)
    - Medically Underserved Population (MUP)
  - Must provide Primary Care and certain ancillary services
  - Often Provide Dental and Behavioral Health Services
  - Regulated through HRSA Bureau of Primary Health Care
  - May provide Visiting Nurse Services where a shortage of Home Health services exist


CHAD
Community HealthCare Association of the Dakotas
COMMUNITY HEALTH CENTER LOCATIONS
BOWBELLS
ST. JOHN
ROLETTE
RAY
MINOT
GRAFTON
LARIMORE
GRAND FORKS
TURTLE LAKE
MCCLUSKY
KILLDEER
BEULAH
HAZEN
CENTER
BISMARCK
VALLEY CITY
WEST FARGO
FARGO
S. FARGO
MOORHEAD
MONTANA
MINNESOTA
SOUTH DAKOTA
KEY
LOCATIONS
CLINIC
CHAD OFFICE
CLINIC SERVICES
Medical & Behavioral
Dental Clinic
School-based
Other Services/ Programs
NORTH DAKOTA ORGANIZATIONS
Coal Country Community Health Center
Family HealthCare
Community Health Service Inc.
Northland Health Centers
Spectra Health

Hospital and Clinic Reimbursement Methods Patient Care Provided

- Cost based reimbursement
  - Payment based on the cost of providing services
  - Determined though the submission of an annual cost report
- Fee Schedule
  - DRG (Diagnosis Related Group) for hospital services
    - Ex. DRG 194 Simple Pneumonia with complications
  - CPT (Common Procedural Terminology)
    - Ex. CPT 71010 chest x-ray, 80048 basic metabolic panel
- Charges
  - What the entity charges for services provided
  - Percent of what the entity charges for services provided
- Value based payments
  - Capitation
  - Two-sided risk
  - Shared savings
  - Pay for reporting (ND Medicaid)

CAH & RHC reimbursement methodologies

- Cost based reimbursement
  - Medicare
  - Medicaid
  - Medicare Advantage
- Fee Schedule
  - Medicare
  - Commercial insurance & others
  - Physician services
- Charges
  - Commercial payers
  - Self Pay patients
- Value based payments
  - Medicare
  - Commercial
  - Medicaid

CAH Medicare reimbursement

- CAH Medicare reimbursement
  - Paid 101% of for providing services to Medicare beneficiaries, less 2% sequestration
  - Medicare costs are determined by looking at % of Medicare patients versus total patients served
  - Must file an annual Medicare Cost Report
  - Interim payments are made throughout the year based prior year based on prior year cost report
  - Interim cost reports can be filed to updated interim payments
  - Final prior year reimbursement completed after submission of the cost report
  - Cost reimbursement for inpatient, outpatient and swingbed services
  - Professional services ie. Physician and APPs typically reimbursed based on the fee schedule
  - Many providers including hospitals, RHCs, FQHCs, SNF required to file a Medicare Cost Report

Financial Analysis

36 North Dakota CAHs

2023

ND CAH Financial Analysis

- Definition of Terms Used
  - Operating Revenue
    - Revenue generated from providing healthcare related services
  - Contractual Deductions
    - Difference between what is charged for services provided and what is actually paid
  - Bad Debt/Charity Care
    - Uncompensated care provided by facilities
  - Expenses
    - Operating expenses incurred
  - Operating Margin
    - Revenue from operations less contractuals, uncompensated care and expenses
  - Non-operating Revenue
    - Revenue realized from non-operational sources such as grants, donations, foundation, investments, government subsidies, etc.
  - Net Margin
    - Net income/loss realized from all sources of revenue and expense

2023 North Dakota CAH Financial Analysis

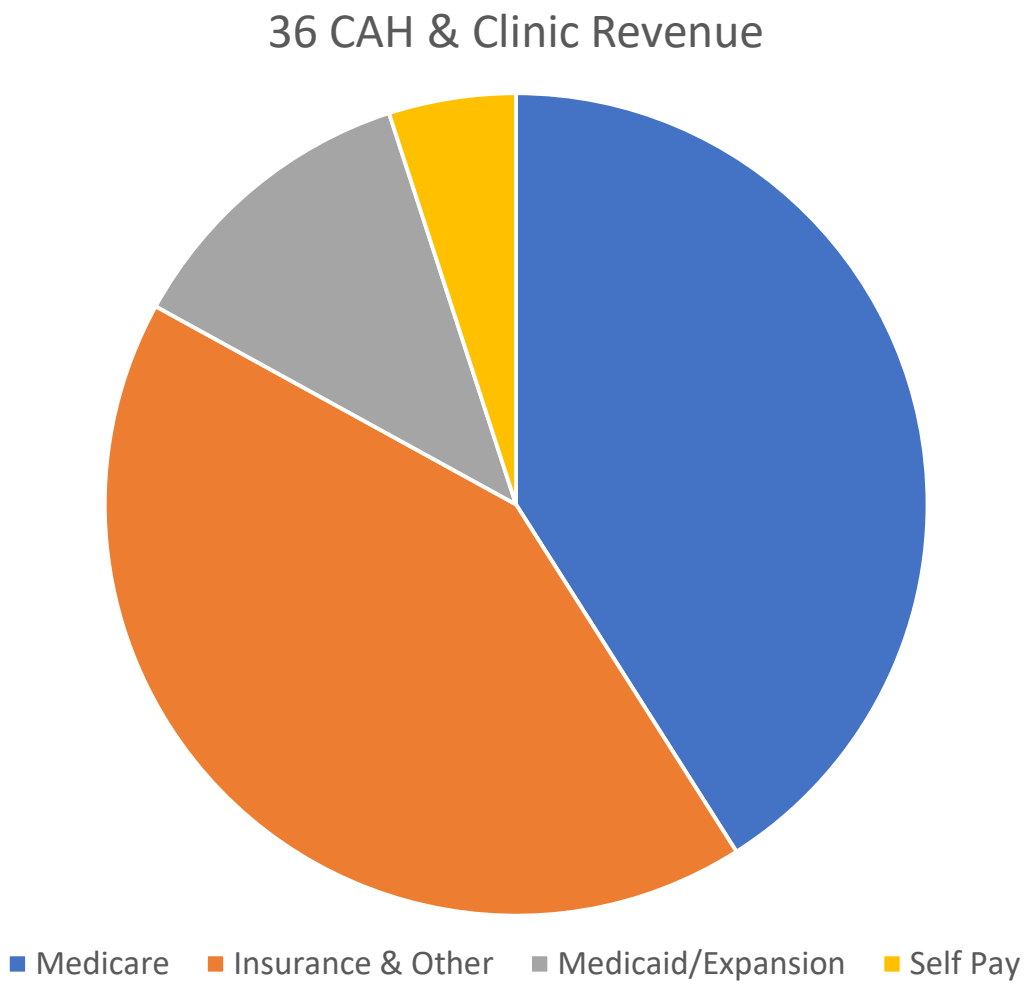
- Calendar 2022 Observations
  - Last analysis was done in the spring of 2023
  - Last analysis done prior to the COVID Pandemic (2019)
  - 13th year of the CAH Financial Analysis
  - Facilities were asked to report their most recent fiscal year end
  - All 36 CAHs reported financial information
  - 769 CAH Licensed Hospital beds
  - 34 of 36 Facilities Own/Operate a Clinic
  - 34 Facilities Who Own/Operate Clinics, Operate 65 Clinics
    - 55 of the Clinics Are Rural Health Clinics (RHCs)
  - 14 of 36 Facilities Own/Operate a Nursing Home (475 licensed beds)
  - 5 Facilities Operate Basic Care (109 beds)
  - 9 Facilities Operate Assisted Living (121 apartments)
  - 9 Facilities Own and Operate the Local Ambulance

North Dakota CAH Financial Analysis

- 2022 Observations (continued)
  - CAHs had 97,319 ER Visits, 272 per day
  - CAHs reported 359,125 Clinic Visits
  - CAHs spent $38,905,530 in Contract Nursing Costs
    - 2018 - $14,742,000 in contract nursing costs

  - Hospital and Clinic Revenue 36 CAHs
    - Medicare revenue (41%)
    - BCBS ND revenue (26%)
    - Other revenue (16%)
    - Medicaid/Expansion revenue (12%)
    - Self Pay revenue (5%)

Hospital and Clinic Revenue



North Dakota 2022 CAH Financial Analysis

- 36 CAH Observations

Description	2018	2022
# CAHs - Positive Operating Margin	18	17
Mean Operating Margin	1.4%	-0.5%
Median Operating Margin	.3%	-2.1%
CAHs - Positive Net Margin	28	27
Mean Net Margin	5.0%	3.7%
Median Net Margin	3.2%	5.5%

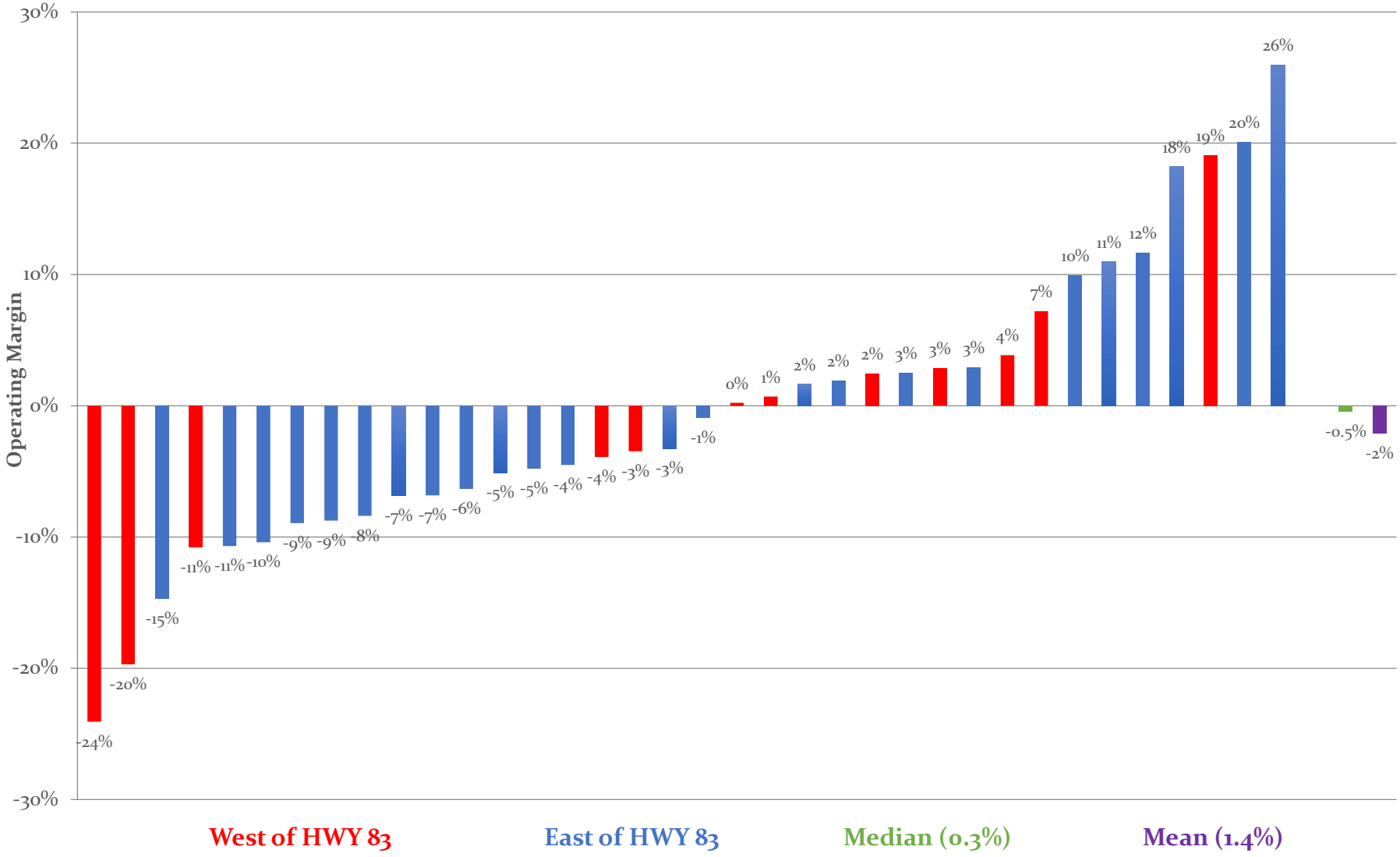
North Dakota Critical Access Hospitals
Statement of Operations, Comparing 2018 to 2022

	36 Facilities 2018 Total	36 Facilities 2022 Total	Variance % 2018 - 2022
Operating Revenue	$972,125,850	$1,128,270,531	+16%
Contractual Deductions	-$318,374,647	-$362,398,349	+14%
Bad Debt/Charity Expense	-$42,718,587	- $37,212,575	-13%
Net Revenue	$611,032,616	$728,659,607	+19%
Expenses	$602,579,437	$732,171,178	+21.5%
Operating Margin	$8,453,179	-$3,511,571	-141.5%
Operating Margin Mean %	*1.4%*	*-0.5%*	
Operating Margin Median %	*0.3%*	*-2.1%*	
Non-Operating Rev.	$22,307,416	$30,665,508	+37.5%
NET Income/Loss	$30,760,594	$27,153,936	-11.7%
Net Margin Mean %	*5%*	*3.7%*	
Net Margin Median %	*3.2%*	*5.5%*	

North Dakota Critical Access Hospitals
Statement of Operations, Comparing 2010 to 2022

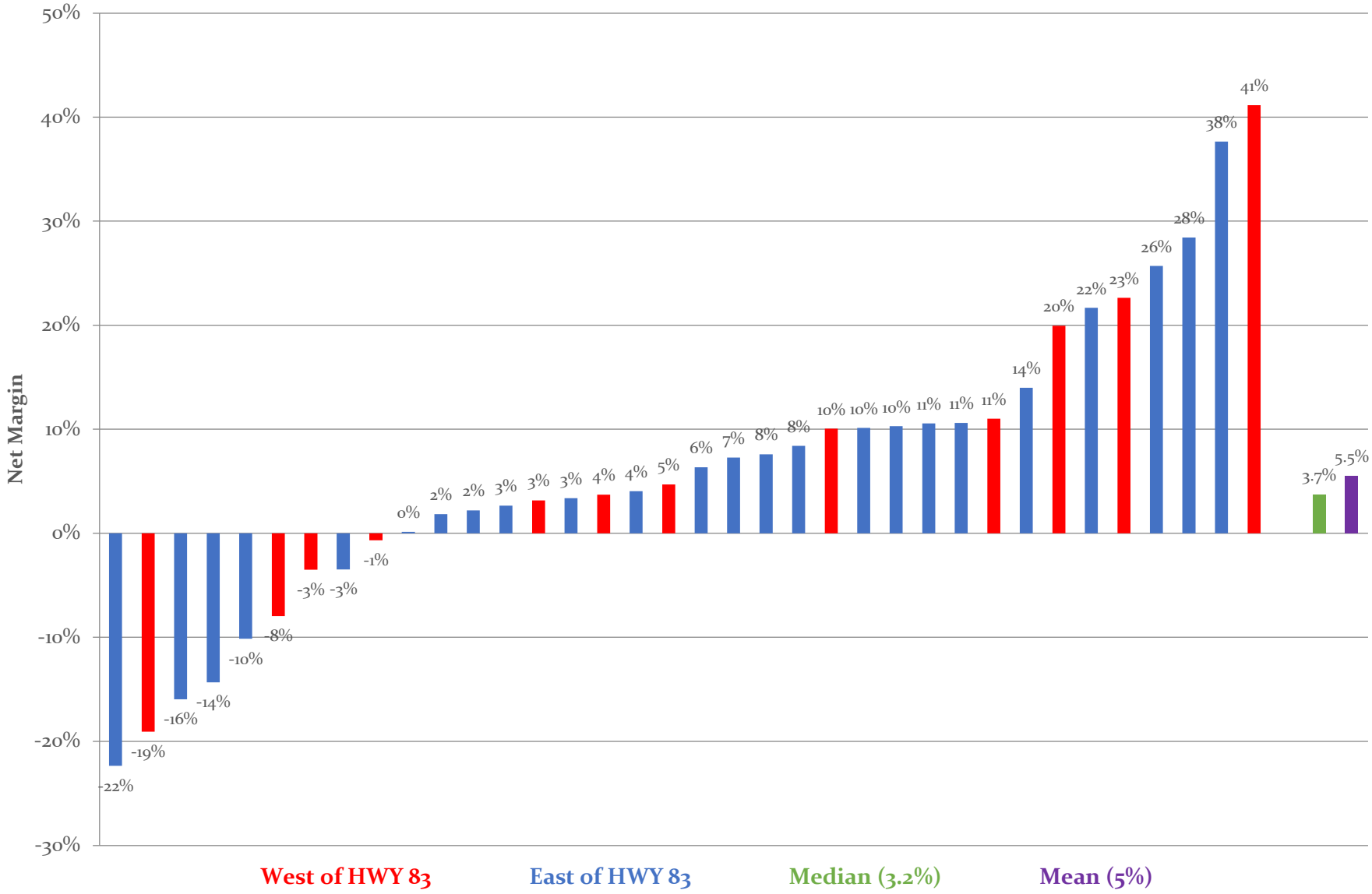
	36 Facilities 2010 Total	36 Facilities 2022 Total	Variance % 2010 - 2022
Operating Revenue	$537,401,689	$1,128,270,531	+110%
Contractual Deductions	-$156,390,822	-$362,398,349	+132%
Bad Debt/Charity Expense	- $15,981,219	- $37,212,575	+133%
Net Revenue	$365,029,648	$728,659,607	+100%
Expenses	$368,653,823	$732,171,178	+ 99%
Operating Margin	-$3,624,175	-$3,511,571	+ 3%
Operating Margin Mean%	***-0.7%***	***1.4%***	
Operating Margin Median%	***- 1.4%***	***0.3%***	
Non-Operating Rev.	- $ 2,639,921	$30,665,508	+1262%
NET Income/Loss	- $ 6,264,096	$27,153,936	+534%
Net Margin Mean %	***-1.2%***	***3.7%***	
Net Margin Median %	***-0.7%***	***5.5%***	

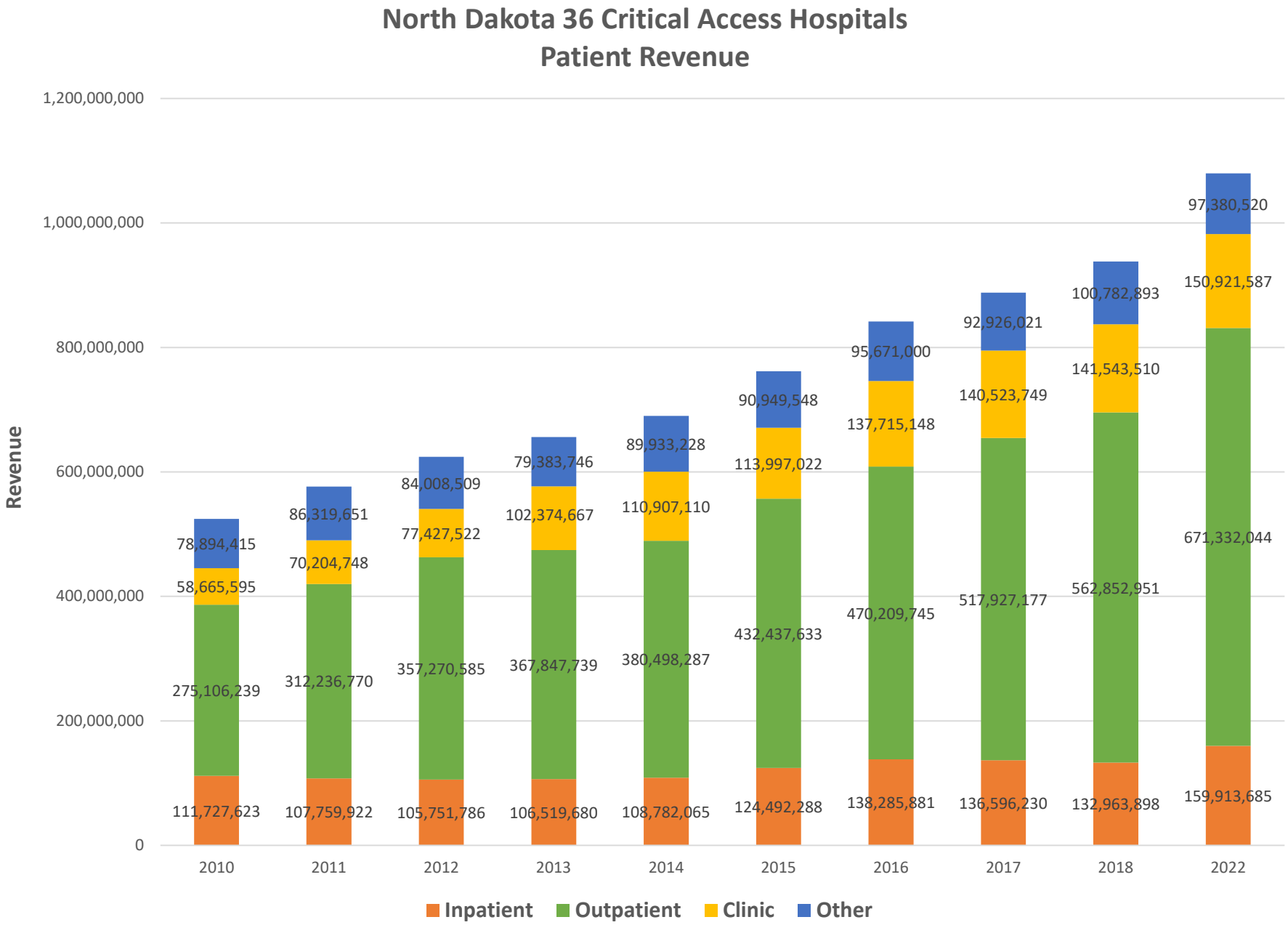
North Dakota Critical Access Hospitals
2022 Operating Margins

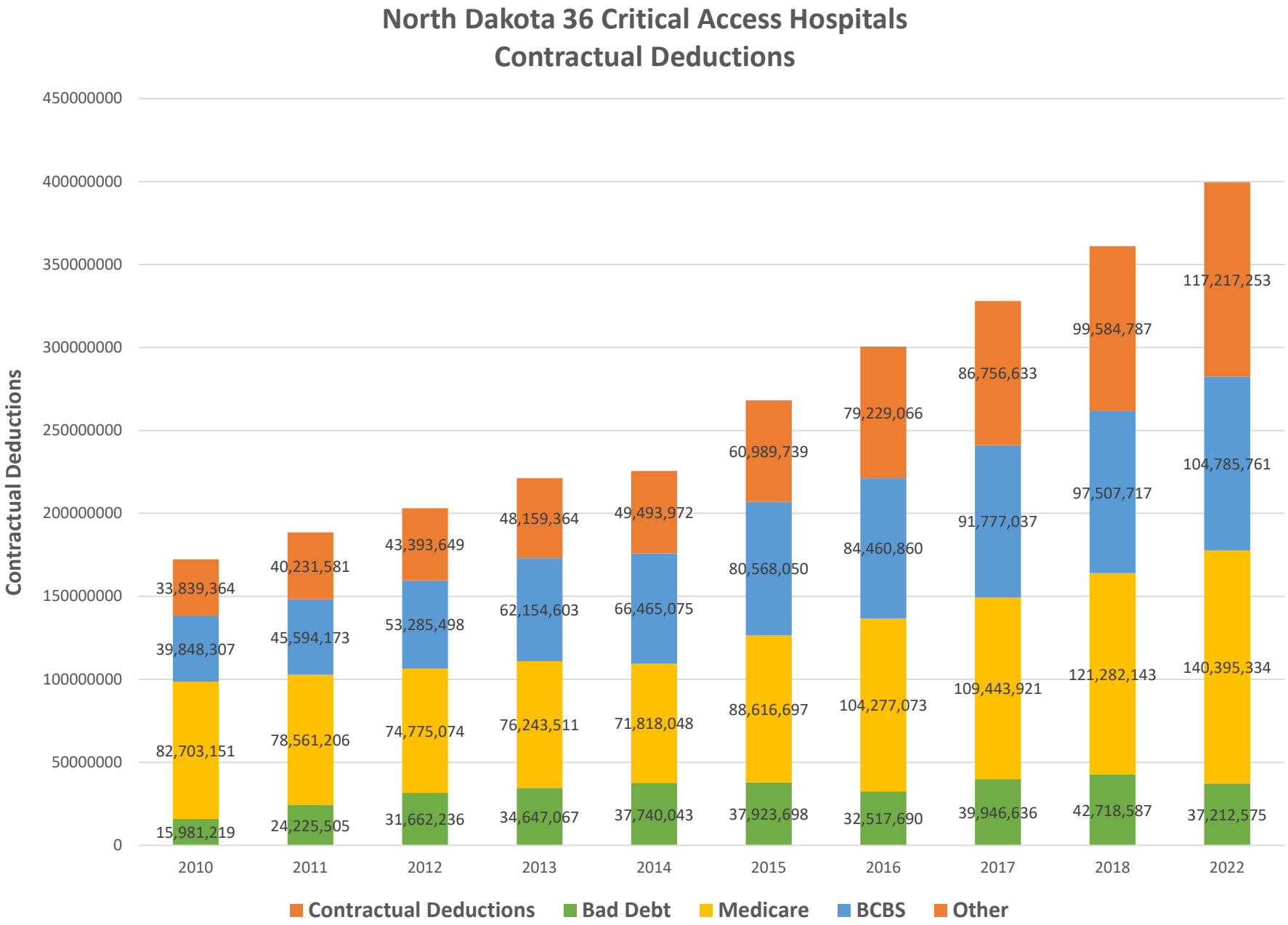


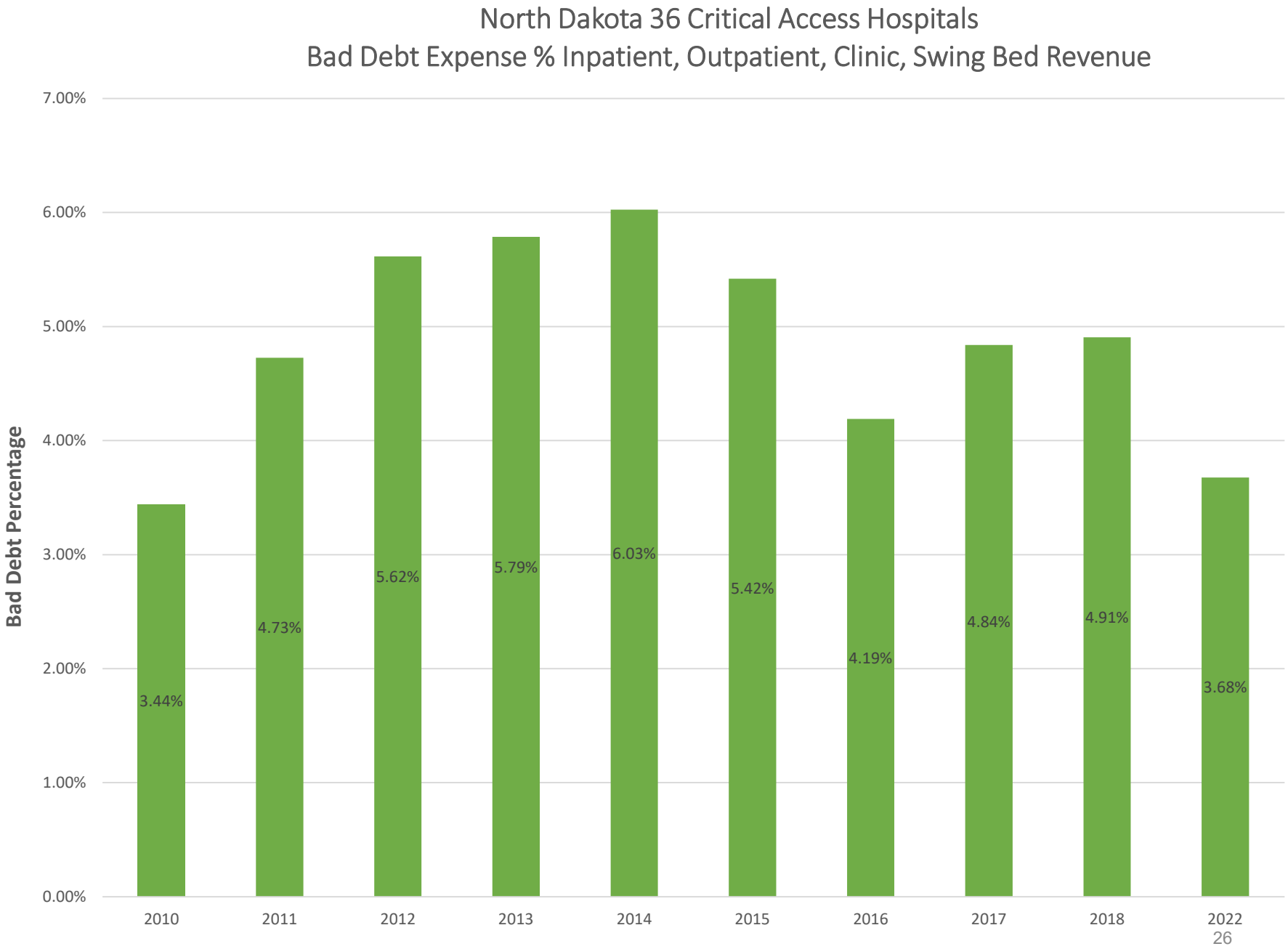
West of HWY 83 East of HWY 83 Median (0.3%) Mean (1.4%)

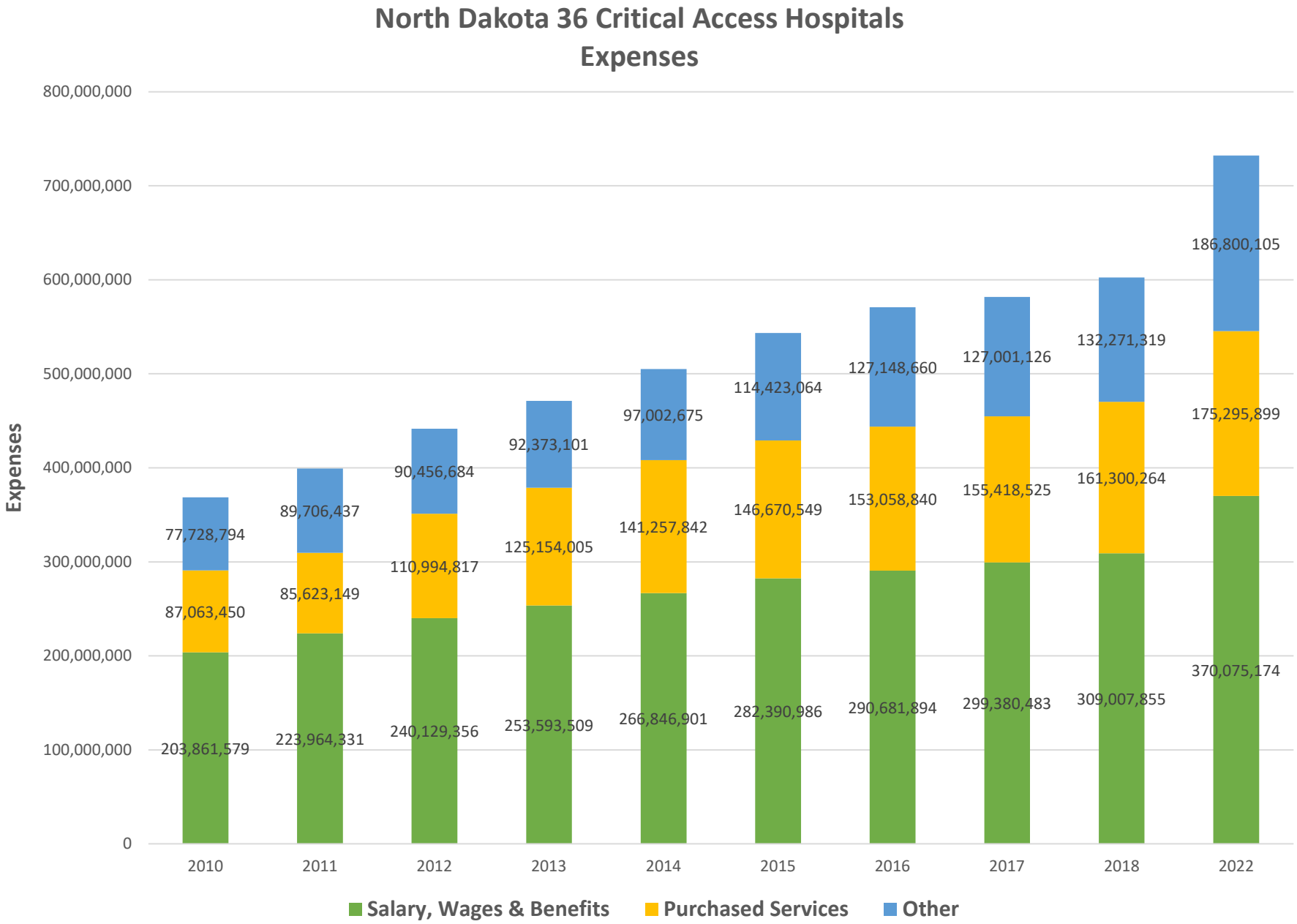
North Dakota Critical Access Hospitals
2022 Net Margins

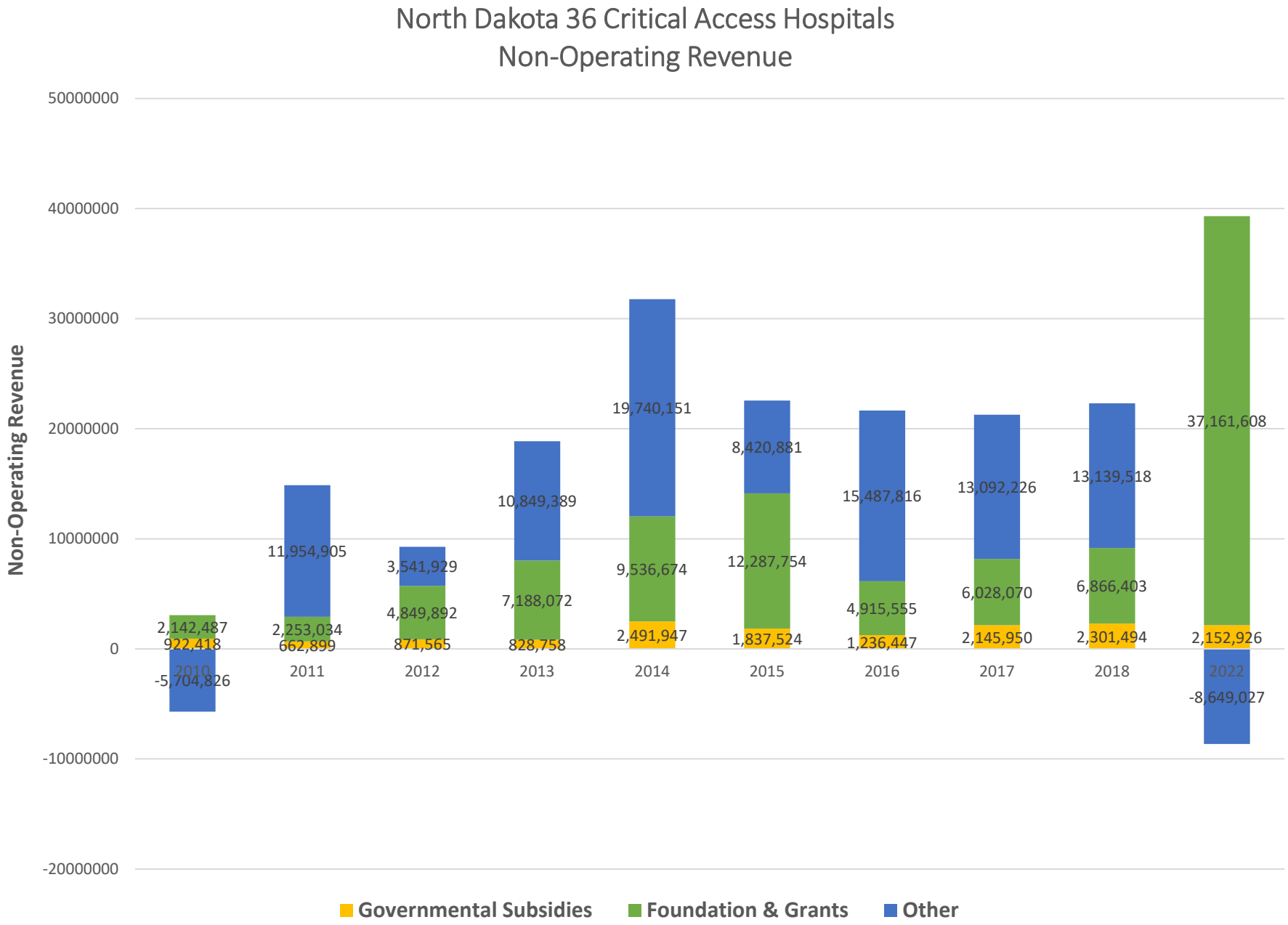



North Dakota 36 Critical Access Hospitals
Patient Revenue
Revenue
1,200,000,000
1,000,000,000
800,000,000
600,000,000
400,000,000
200,000,000
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2022
78,894,415
58,665,595
275,106,239
111,727,623
86,319,651
70,204,748
312,236,770
107,759,922
84,008,509
77,427,522
357,270,585
105,751,786
79,383,746
102,374,667
367,847,739
106,519,680
89,933,228
110,907,110
380,498,287
108,782,065
90,949,548
113,997,022
432,437,633
124,492,288
95,671,000
137,715,148
470,209,745
138,285,881
92,926,021
140,523,749
517,927,177
136,596,230
100,782,893
141,543,510
562,852,951
132,963,898
97,380,520
150,921,587
671,332,044
159,913,685
Inpatient
Outpatient
Clinic
Other


North Dakota 36 Critical Access Hospitals
Contractual Deductions
Contractual Deductions
450000000
400000000
350000000
300000000
250000000
200000000
150000000
100000000
50000000
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2022
33,839,364
39,848,307
82,703,151
15,981,219
40,231,581
45,594,173
78,561,206
24,225,505
43,393,649
53,285,498
74,775,074
31,662,236
48,159,364
62,154,603
76,243,511
34,647,067
49,493,972
66,465,075
71,818,048
37,740,043
60,989,739
80,568,050
88,616,697
37,923,698
79,229,066
84,460,860
104,277,073
32,517,690
86,756,633
91,777,037
109,443,921
39,946,636
99,584,787
97,507,717
121,282,143
42,718,587
117,217,253
104,785,761
140,395,334
37,212,575
Contractual Deductions
Bad Debt
Medicare
BCBS
Other


North Dakota 36 Critical Access Hospitals
Bad Debt Expense % Inpatient, Outpatient, Clinic, Swing Bed Revenue
Bad Debt Percentage
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
3.44%
4.73%
5.62%
5.79%
6.03%
5.42%
4.19%
4.84%
4.91%
3.68%
2010
2011
2012
2013
2014
2015
2016
2017
2018
2022


North Dakota 36 Critical Access Hospitals
Expenses
Expenses
800,000,000
700,000,000
600,000,000
500,000,000
400,000,000
300,000,000
200,000,000
100,000,000
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2022
77,728,794
87,063,450
203,861,579
89,706,437
85,623,149
223,964,331
90,456,684
110,994,817
240,129,356
92,373,101
125,154,005
253,593,509
97,002,675
141,257,842
266,846,901
114,423,064
146,670,549
282,390,986
127,148,660
153,058,840
290,681,894
127,001,126
155,418,525
299,380,483
132,271,319
161,300,264
309,007,855
186,800,105
175,295,899
370,075,174
Salary, Wages & Benefits
Purchased Services
Other


North Dakota 36 Critical Access Hospitals
Non-Operating Revenue
Non-Operating Revenue
50000000
40000000
30000000
20000000
10000000
0
-10000000
-20000000
2,142,487
922,418
-5,704,826
2010
11,954,905
2,253,034
662,899
2011
3,541,929
4,849,892
871,565
2012
10,849,389
7,188,072
828,758
2013
19,740,151
9,536,674
2,491,947
2014
8,420,881
12,287,754
1,837,524
2015
15,487,816
4,915,555
1,236,447
2016
13,092,226
6,028,070
2,145,950
2017
13,139,518
6,866,403
2,301,494
2018
37,161,608
2,152,926
-8,649,027
2022
Governmental Subsidies
Foundation & Grants
Other

Final Thoughts and Observations

- 17 CAHs had a positive operating margin in 2022
  - W/o Paycheck Protection Program only 11 would have had a positive margin
- CAHs provided $1.1 billion of healthcare services in 2022
- Contractual deductions and uncompensated care grew by 11% from prior analysis
- Expenses grew by 21%
  - Salaries and Wages grew by 20%
  - Contract staffing grew from $10 million to $38.9 million (nearly 4 times)
  - Federal reimbursement designation for a Community Health Center
- 27 CAHs had a positive net margin in 2022. However!!!
  - W/o Provider Relief Funds (PRF) only 18 would have had a positive net margin
  - Net Income from grants grew from $2.9 million to $35 million (PRF and other grants)
  - Remembering that only $27 million was the total net income for all CAHs
- CAHs are important for local access to healthcare for residents and visitors
- CAHS are important contributors to local economies
- Continued advocacy for adequate reimbursement, etc. is imperative
- Looking forward to the next CAH financial analysis in the summer of 2024

Thanks for Listening!

Questions?

DATA DISCUSSION

Two Approaches to Data Analyses

	Aggregate Data	Granular, Claims-level Data
What Is Included in the Data	• Aggregate information on overall and average and per member spending and utilization by service categories. • Distribution of population by demographic characteristics. • No Protected Health Information (PHI).	• Claims level data that include information, including PHI, such as member demographics, diagnostic and procedure codes at the claim line level, provider information, and payment amounts.
Analysis Process	• Request is made for payers to provide aggregate data according to specifications provided. • Process generally takes a few weeks to a month. • Limited ability to go back to payers for deep dives on trends identified from the first cut of data (additional time required).	• Request for claims-level data is made with specifications on what variables and fields to include. • Process for obtaining, cleaning and analyzing data takes several months, with data agreements needed in place. • Allows for deep dives into specific areas of interest.
Questions that Can Be Answered by Data	• How much is spent on different categories of services overall and on average per member? • How much has spending grown over time? • Is spending growth driven by price or utilization? • What percent of the population are high-cost and how much of overall spending do they account for?	• Who received care and why? • Who provided the care? • How much was paid for the care? • Which insurers paid for the care?
Types of Recommend-ations Allowed	• High level, system-wide recommendations. ◦ Leverage rate review to place price growth caps. ◦ Implement greater oversight of provider consolidation. ◦ Increase adoption of value-based payment models to incentivize efficiency while maintaining quality. ◦ Enact legislation on stricter oversight and regulation of pharmacy benefit managers.	• Program-specific recommendations. ◦ Implement a transitional care program to facilitate safe discharges to home or other facilities. ◦ Provide medically tailored meals to patients in the first month post-discharge. ◦ Implement a program to steer individuals towards non-hospital based facilities for outpatient services.

Request for Data

- Project Limitations:
  - No statewide all-payer claims database
  - Short timeframe for developing recommendations (October 2024) to the legislature
- Approach:
  - Leverage existing analyses of spending and utilization:
    - NDPERS as an indicator of spending levels and trends in the commercial market
    - DHS reports for Medicaid program spending and utilization
    - No readily available state-specific source for data on Medicare spending and utilization
- Findings:
  - For NDPERS, Sanford regularly conducts standard analyses of spending and utilization by categories of services for its contracts (presented later)
  - For Medicaid, DHS regularly produces financial reports for the legislature that are structured for FMAP claiming purposes and not suitable for the purposes of the Task Force

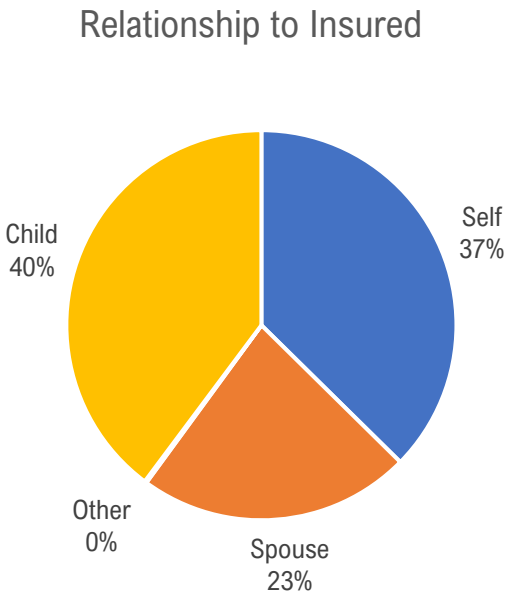
About the NDPERS Data

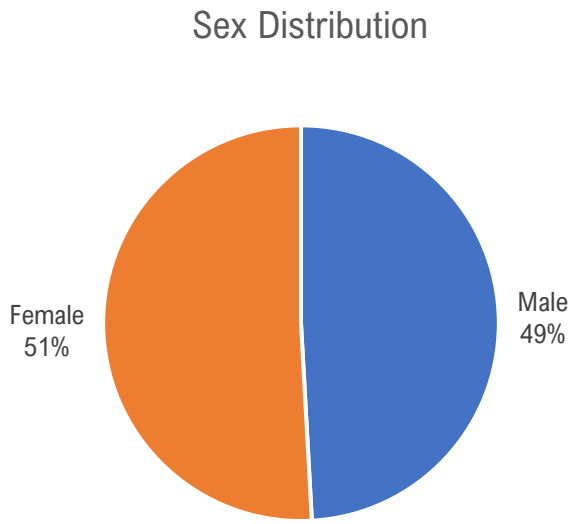
- Data source:
  - NDPERS claims analyzed by Sanford
- Population included:
  - State employees and colleges
  - Pre-Medicare retirees and COBRA
  - Political subgroups (e.g., schools, municipalities, counties, district health) that buy into NDPERS
- Timeframe:
  - Current period: July 2022 – June 2023
  - Prior period: July 2021 – June 2022

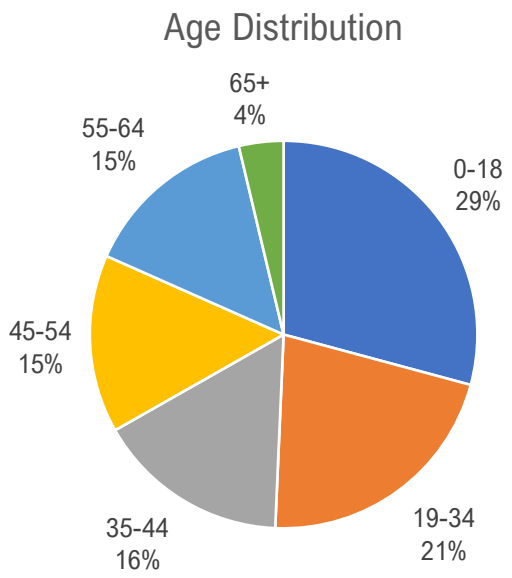
Important Definitions

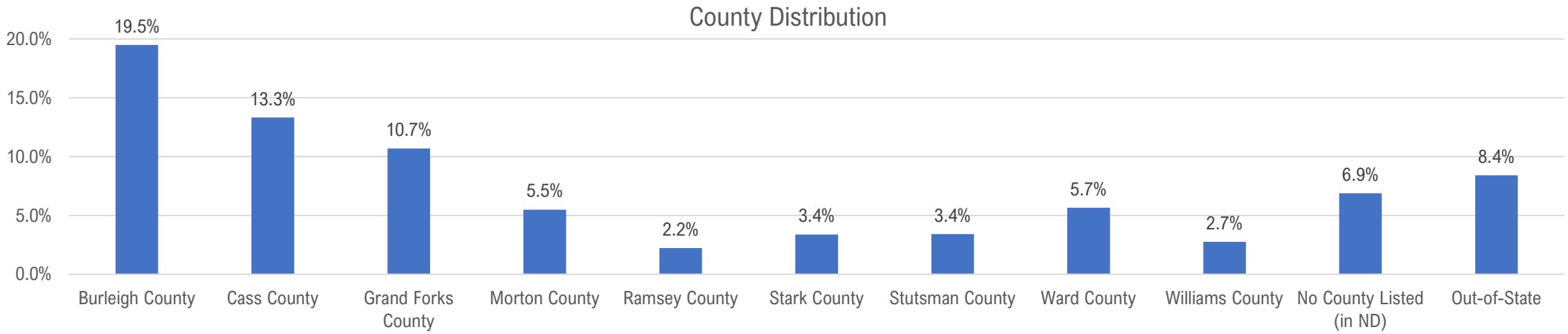
- Definition of amounts:
  - Allowed amount is the negotiated rate and includes the member cost-sharing
  - Paid amount is the insurer liability (allowed amount minus member cost-sharing)
- Encounters:
  - An encounter is a contact between an individual and the health care system for a related set of service(s) for one or more medical conditions that occur in a given day for a member
  - When calculating encounters per 1,000 by categories of service:
    - For the Outpatient Facility, Professional and Ancillary services, each related set of visits and services per day is a single encounter
    - For Retail Pharmacy, each service or prescription is a single encounter

Characteristics of the NDPERS Population as of November 2023







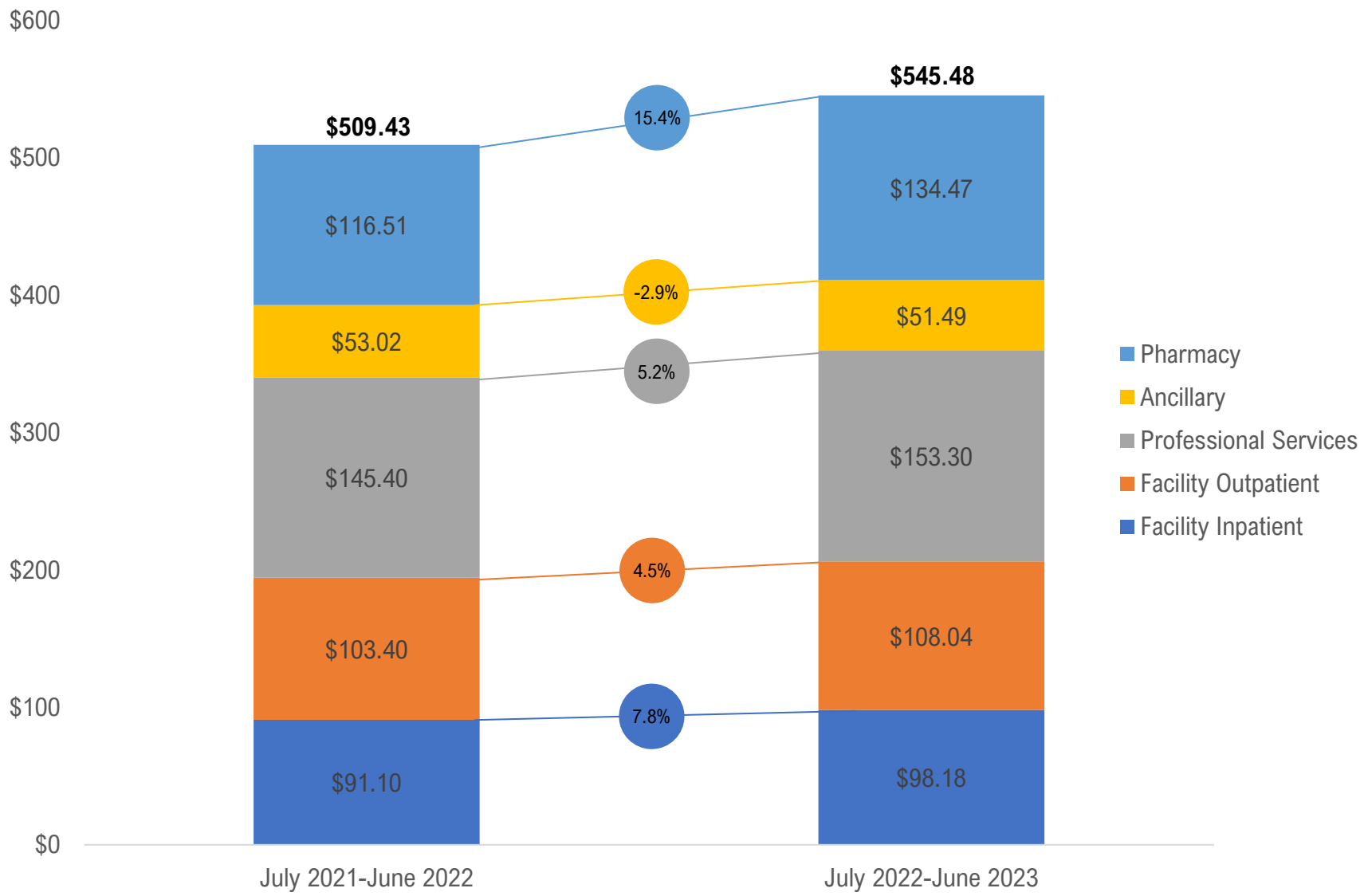


NOTE: Excludes counties in which less than 2% of the NDPERS population resides. Combined, these counties accounts for 18% of the NDPERS population.

Per Member Per Month Spending and Spending Growth by Service Category

Per member per month (PMPM) spending* grew 7.1% from 2022 to 2023.

This growth was driven by growth in pharmacy (15.4%) and inpatient hospital (7.8%) spending.



* Based on allowed amounts.

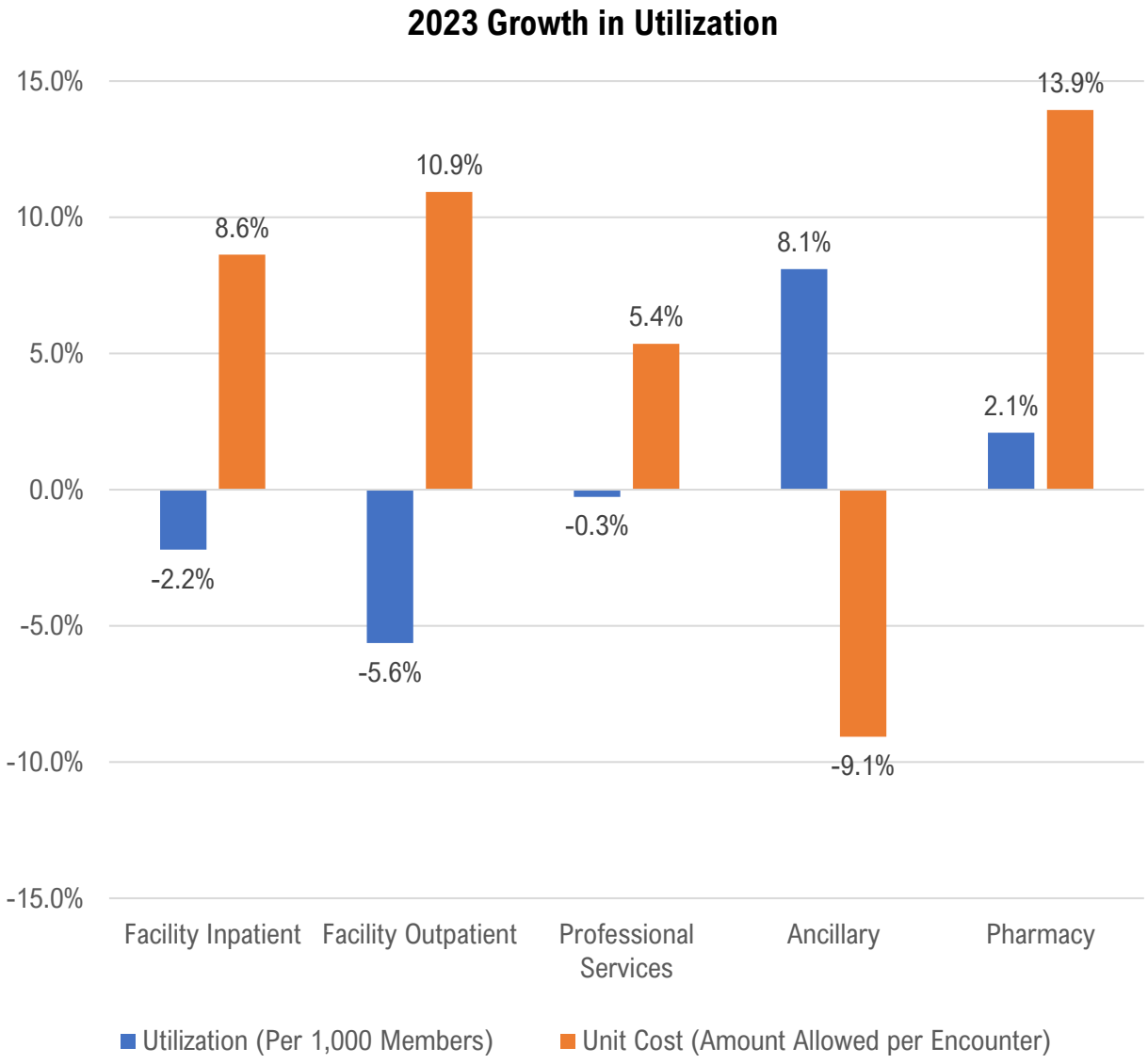
Utilization, Unit Cost and June 2022-June 2023 Growth in Utilization and Unit Cost by Service Category

Utilization is highest for professional and pharmacy services, while unit cost is highest for facility inpatient and outpatient services.

For all service categories except ancillary services, spending growth was driven by an increase in unit cost rather than utilization.

	2023 Utilization (Per 1,000 Members)	2023 Unit Cost (Allowed Amount per Encounter)
Facility Inpatient	51	$23,881
Facility Outpatient	2,515	$609
Professional Services	13,092	$177
Ancillary	1,706	$391
Pharmacy*	9,009	$152

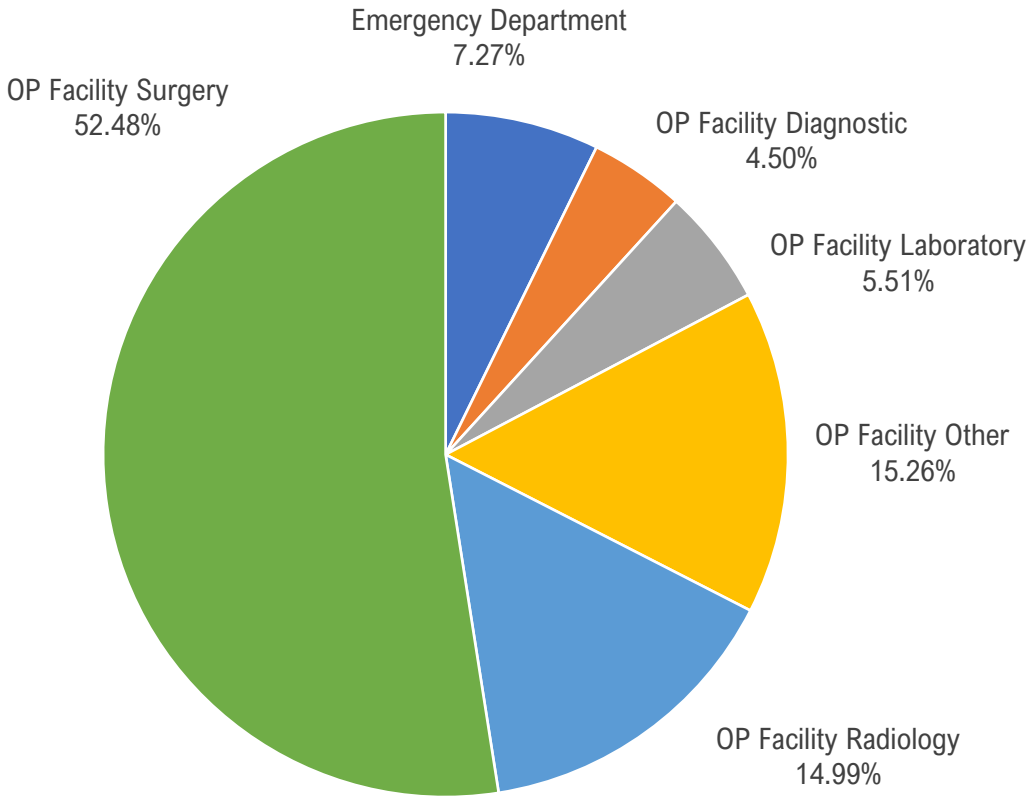
* Average days per prescription is 45.



Spending on and Utilization of Outpatient Facility Services

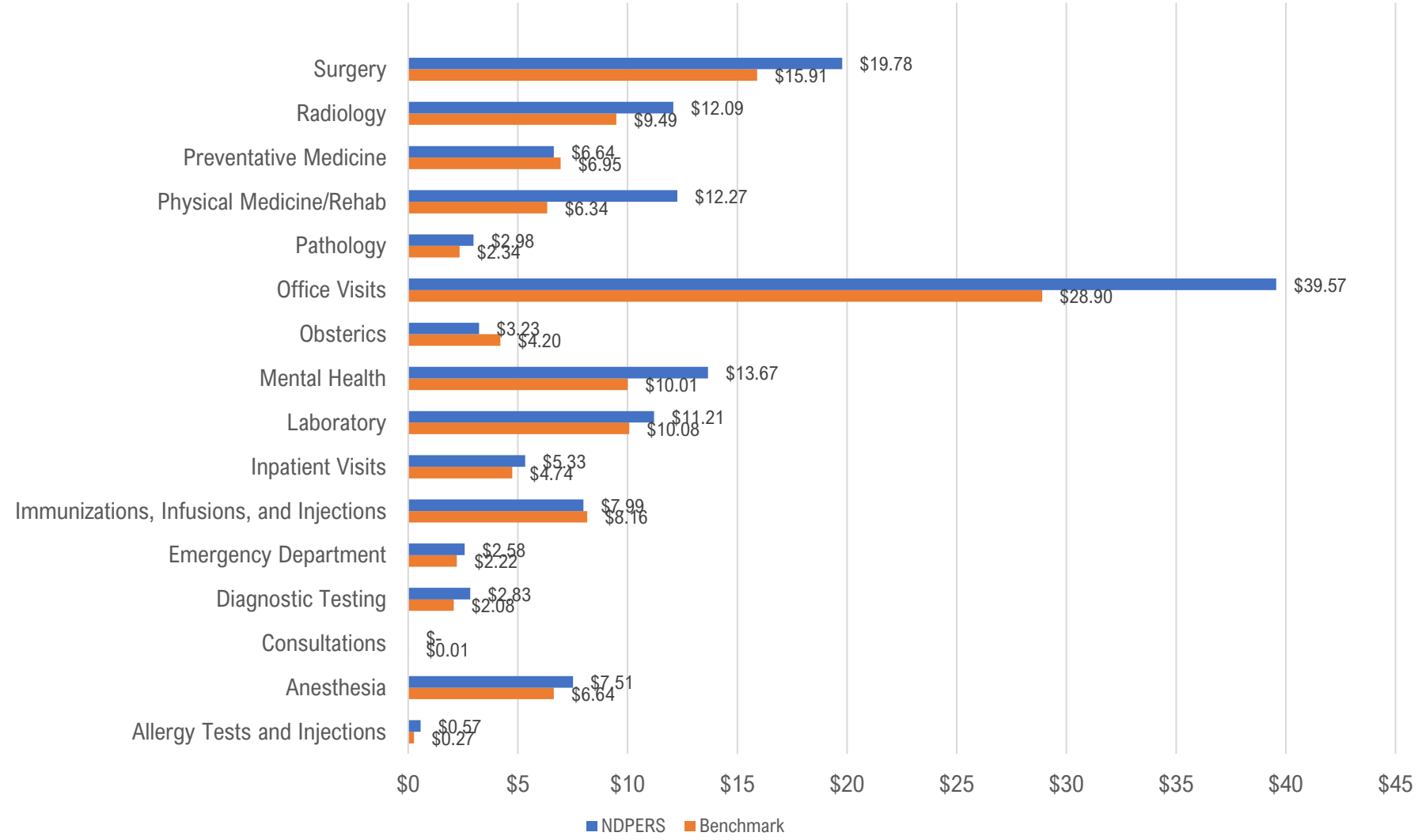
More than half of outpatient facility spending is on surgeries, which are among the highest priced outpatient services.

Service Category (Level 2)	Amount Paid	Paid/Visit (Current)	Encounters/1000 (Current)
Emergency Department	$4,780,645	$1,143	177
OP Facility Diagnostic	$2,957,612	$164	364
OP Facility Laboratory	$3,623,070	$156	469
OP Facility Other	$10,035,801	$173	1,170
OP Facility Radiology	$9,863,390	$847	235
OP Facility Surgery	$34,519,909	$3,607	193
Total	**$65,780,428**	**$528**	**2,607**



Per Member Per Month Spending on Professional Services

NDPERS per member per month spending is significantly different from benchmark* spending in the areas of physical medicine/rehab, obstetrics, mental health, office visits, and surgery.

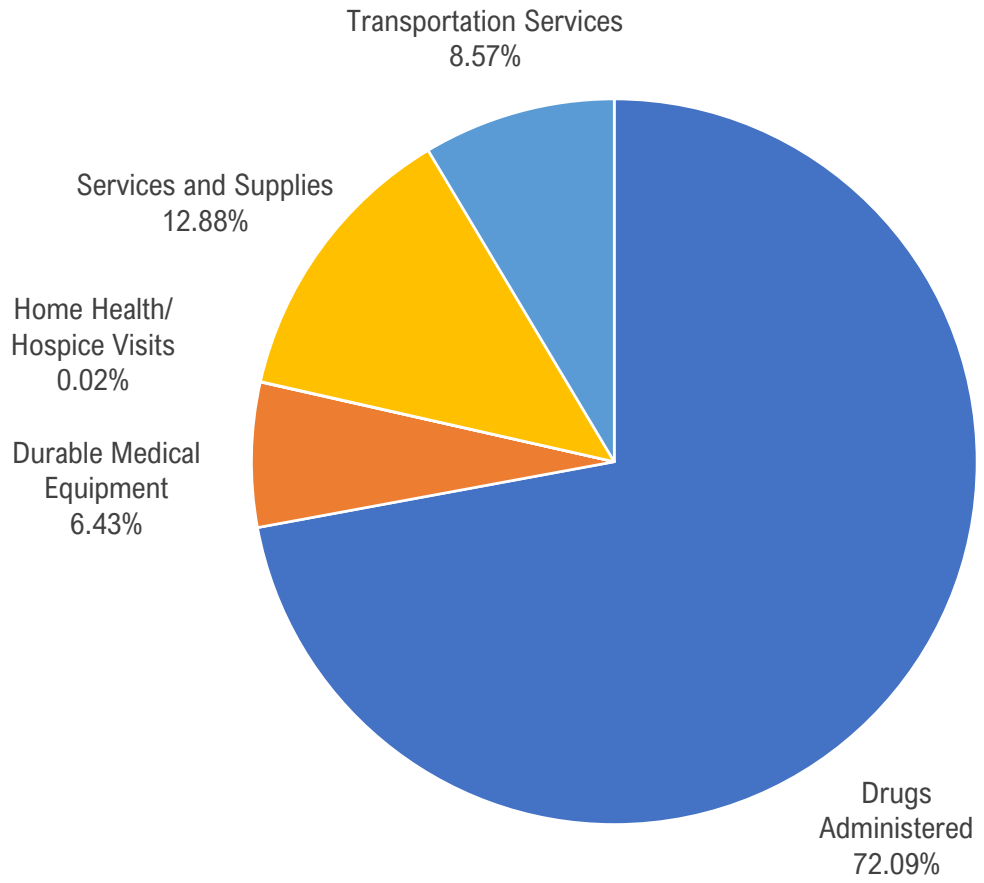


* Benchmark values are based on a national population, sourced from a multi-payer research database of over 40 million commercial members, and adjusted for NDPERS' age and gender distribution.

Spending on and Utilization of Ancillary Services

Prescriptions drugs made up approximately 3/4th of spending on ancillary services.

Service Category (Level 2)	Amount Paid	Paid/Visit (Current)	Encounters/1000 (Current)
Drugs Administered	$22,074,553	$368	1,211
Durable Medical Equipment	$1,969,728	$451	88
Home Health / Hospice Visits	$5,664	$67	2
Services and Supplies	$3,943,934	$205	388
Transportation Services	$2,625,163	$3,018	18
Total	**$30,619,041**	**$362**	**$1,706**



Spending on and Utilization of Retail Pharmacy Services

On average, 9 scripts per member are dispensed in a year, with each script averaging 45 days.

Most retail prescription drugs prescribed are for generic drugs and on the plan's formulary.

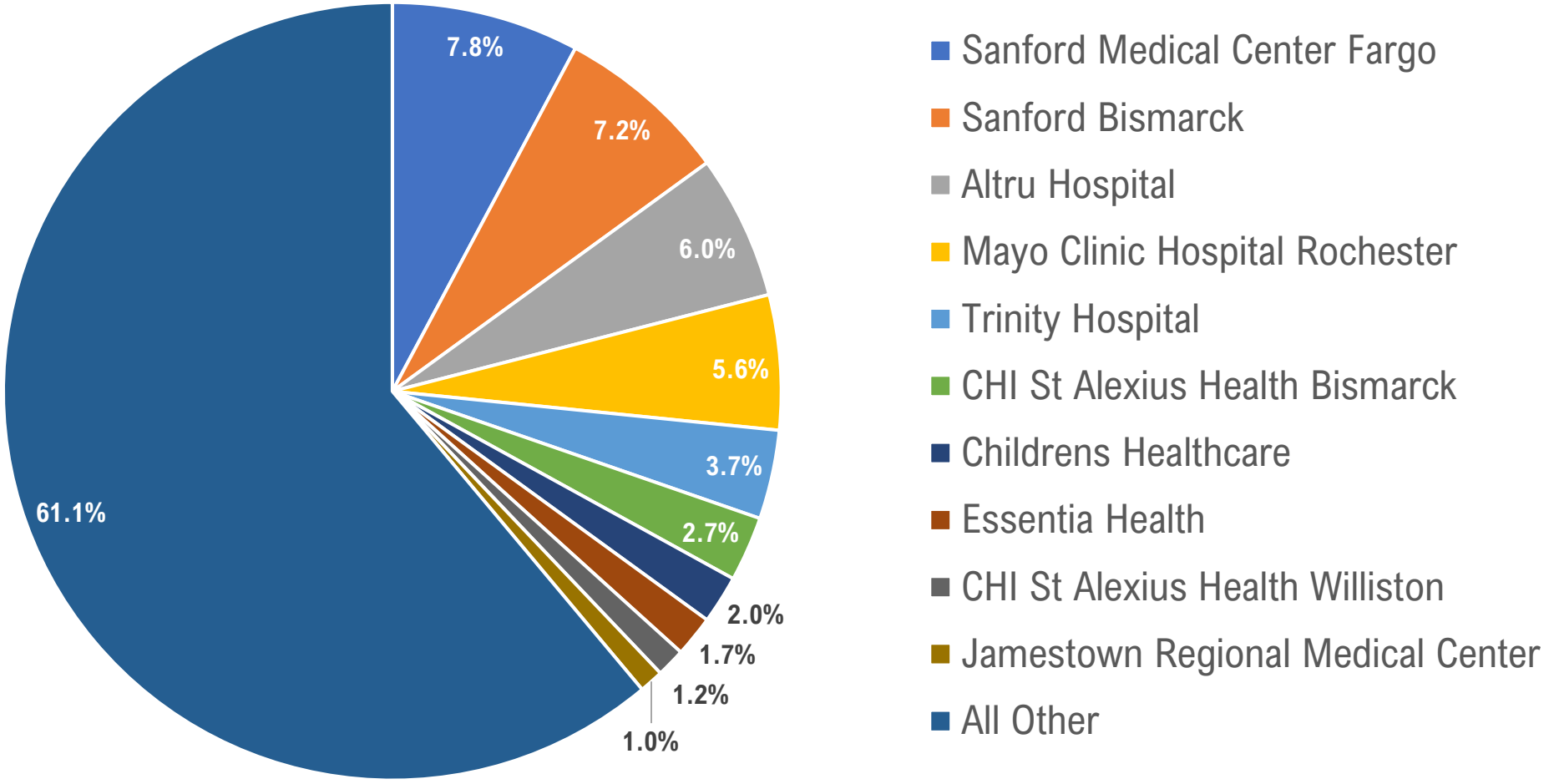
Measure	Prior Period	Current Period	Change
Utilization (Scripts PMPY)	8.8	9	2.1%
Unit Cost	133.47	152.08	13.9%
Average Days per Script	45	45	0.6%
% Generic Dispensing	85.8%	86.0%	0.3%
% Mail Order	0.0%	0.0%	-0.0%
% Formulary	99.2%	99.1%	-0.0%

Top Drugs by Paid Amount

Brand Name	Therapeutic Class	Common Uses	Scripts	Amount Paid	Days Per Script	PMPM by Drug
HUMIRA(CF) PEN	Biologic & immunologic agents	Arthritis, skin disorders	1,167	$10,400,634	33	$17.49
STELARA	Skin & mucus membrane condition agents	Crohn's disease and ulcerative colitis	272	$6,681,517	45	$11.24
OZEMPIC	Hormones, synthetic substitutes, & metabolic agents	Type 2 diabetes mellitus	3,911	$3,563,026	35	$5.99
HUMIRA PEN	Biologic & immunologic agents	Arthritis, skin disorders	271	$2,368,801	33	$3.98
TRIKAFTA	Hormones, synthetic substitutes, & metabolic agents	Cystic fibrosis	61	$1,774,440	32	$2.98
JARDIANCE	Hormones, synthetic substitutes, & metabolic agents	Type 2 diabetes mellitus	2,412	$1,739,426	48	$2.93
TREMFYA	Skin & mucus membrane condition agents	Plaque psoriasis, active psoriatic arthritis	139	$1,715,027	54	$2.88
HAEGARDA	Blood formation & coagulation agents	Hereditary Angioedema	24	$1,420,655	27	$2.39
COSENTYX PEN (2 PENS)	Skin & mucus membrane condition agents	Plaque psoriasis, active psoriatic arthritis, active ankylosing spondylitis	178	$1,346,765	31	$2.26
SKYRIZI PEN	Skin & mucus membrane condition agents	Plaque psoriasis	69	$1,334,083	73	$2.24

Spending Attributed to the Top 10 Providers

Approximately 40% of spending can be attributed to 10 providers.

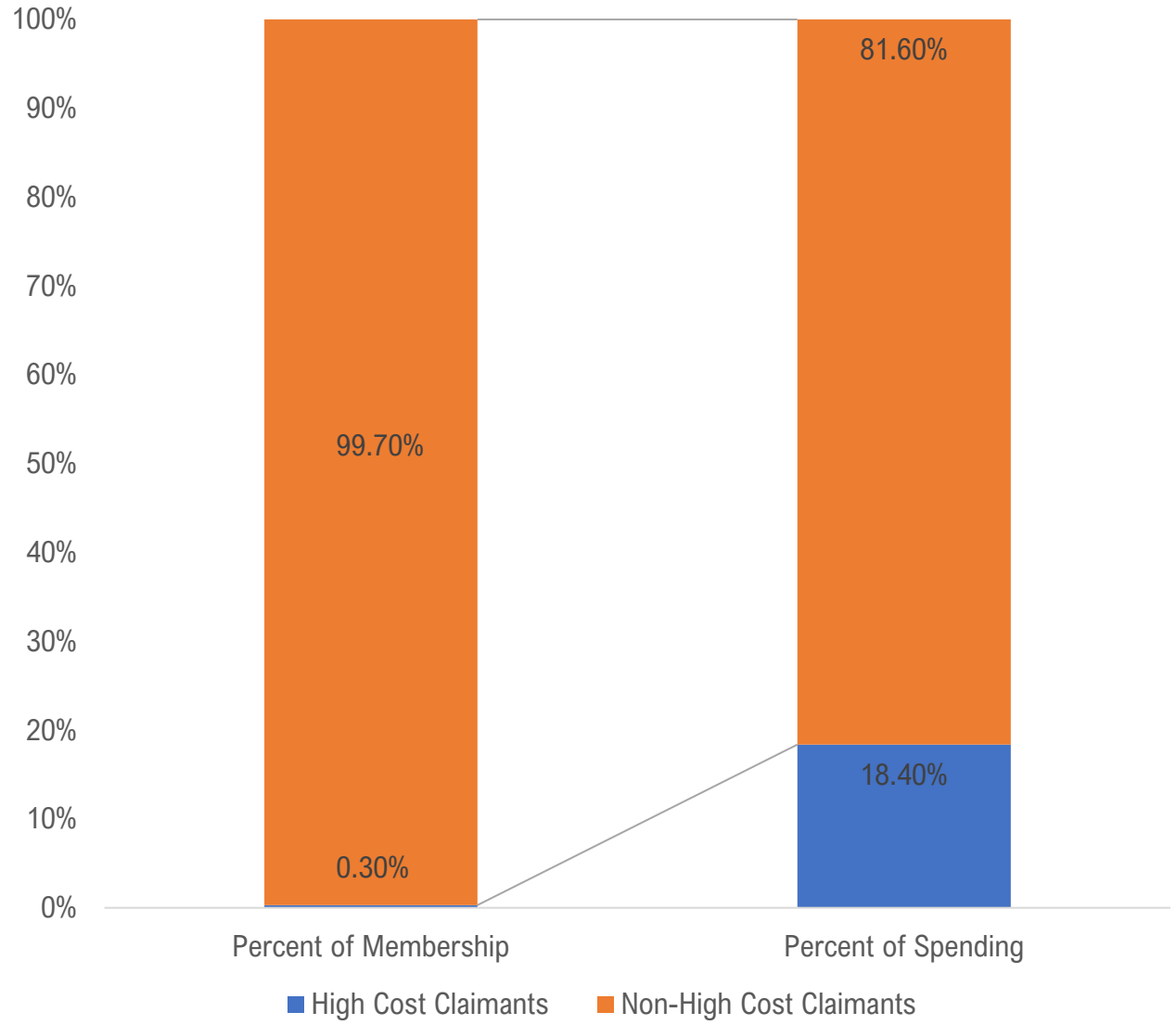


Spending on High Cost Claimants, June 2023

In 2023, high cost claimants* represent less than half a percent of members but account for 18% of total spending.

The top 5 diagnostic categories for high cost claimants, for which total spending ranged from $5m to $7m, were:

- Gastroenterology;
- Hematology;
- Neurology;
- Cardiology; and
- Endocrinology.



* High cost claimants are members with claims exceeding $200k.

Top Episode Treatment Group Episodes

Chronic

- Diabetes, w/o surgery ($15.8m)
- Inflammatory bowel disease, w/o surgery ($13.6m)
- Psoriasis ($11.7m)
- Mood disorder, depressed ($8.2m)
- Adult rheumatoid arthritis ($6.9m)
- Joint degeneration, localized – knee & lower leg, w/surgery ($5.2m)

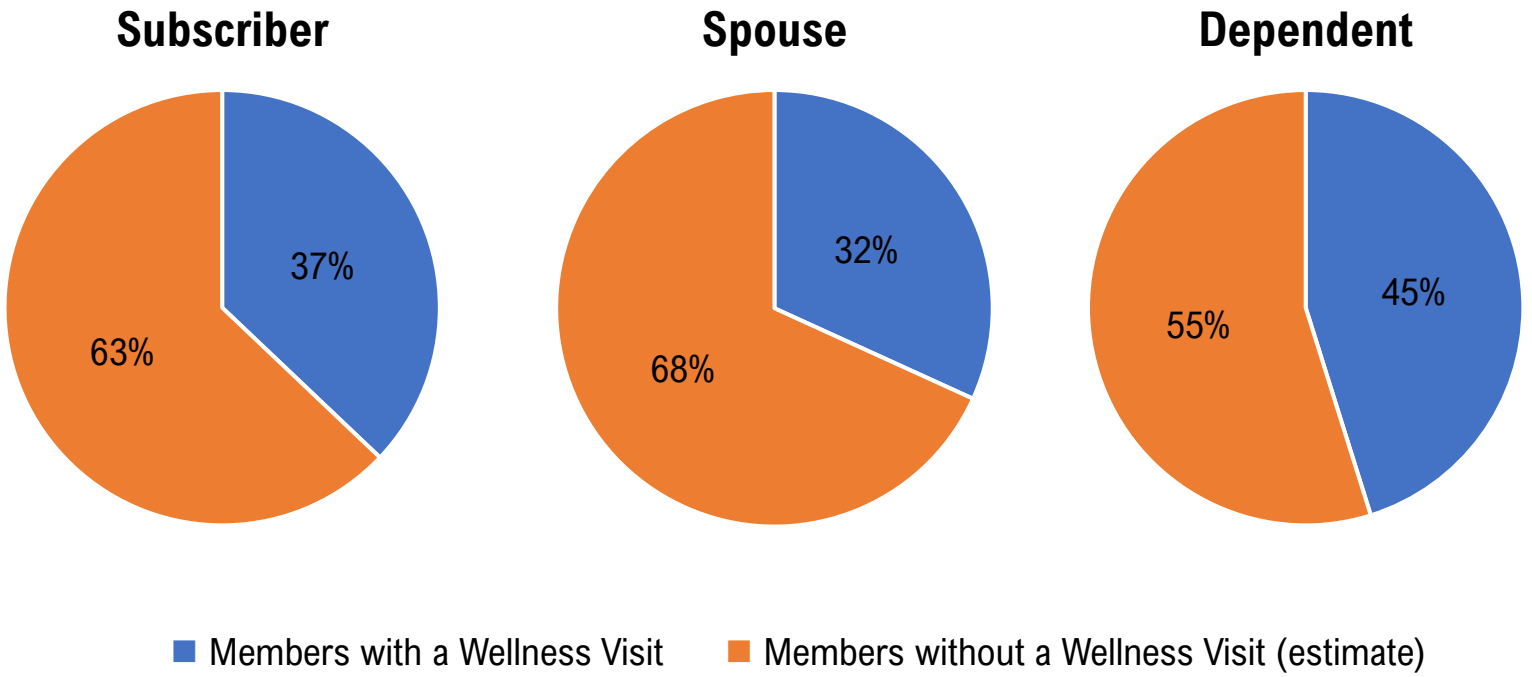
Non-Chronic

- Routine exam ($5.8m)
- Pregnancy, with delivery, w/o c-section ($5.1m)
- Other neonatal disorders, perinatal origin ($4.3m)
- Pregnancy, with delivery, with c-section ($2.7m)
- Viral pneumonia ($2.7m)
- Other inflammation of skin ($2.7m)

Wellness Visits

Overall, only 39% of plan members had a wellness visit, with higher wellness visit rates among dependents.

Coverage Status	Members	Members with a Wellness Visit
Subscriber	18,562	6,884
Spouse	11,241	3,575
Dependent	19,753	8,921
Total	**49,556**	**19,283**



Key Takeaways from NDPERS Data

- Spending on prescription drugs grew most rapidly. This was due to a slight increase in utilization, and a significant increase in price.
- Overall spending on inpatient and outpatient hospital facility services also grew significantly, while utilization decreased, pointing to price increases as the main drivers of spending growth.
- Future efforts to lower spending by improving care delivery could explore care for chronic conditions such as diabetes and arthritis, and maternity care.
- There are opportunities to increase the rate of preventive care and wellness visits, which could lead to reduced spending over the long-term.

Next Steps

- Request some customized analyses from Sanford on NDPERS data, including deeper dives into:
  - Maternal health
  - Mental health
  - Preventive care
- Discussions with Medicaid to produce analyses to closely mirror the NDPERS analyses.

Discussion

- How do the data presented resonate with you?
- How do the data align with what you are seeing in practice?
- For which areas of care/which services would you like to see deeper dives?

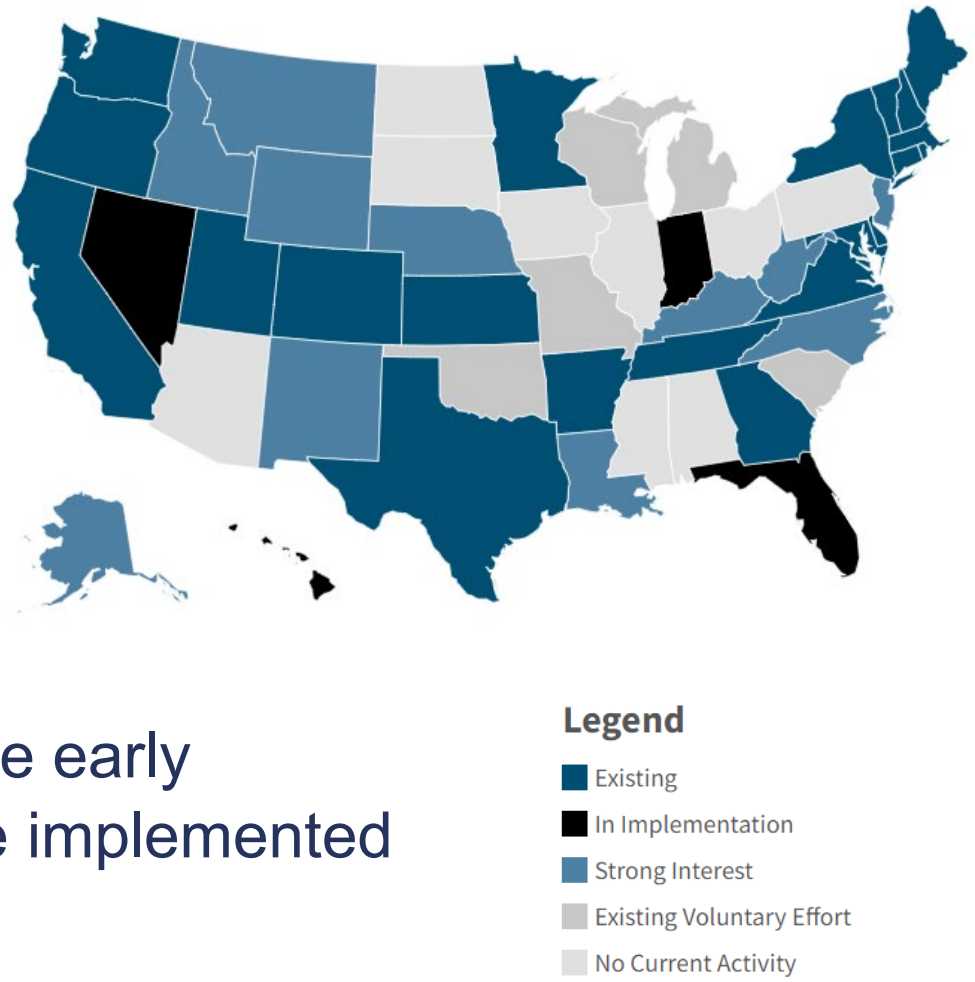
ALL-PAYER CLAIMS DATABASE DISCUSSION

What Are All-Payer Claims Databases?

- All-payer claims databases (APCDs) are large state databases used for monitoring health care spending and utilization
- APCD data are typically collected from insurers as part of a state mandate.
  - The data collection process usually includes commercial, Medicaid, and Medicare plans.
  - Additionally, some states collect data from dental plans and other public sources, such as state employee benefit plans.
  - However, per the Gobeille decision, self-insured plans cannot be compelled to share their data with states
- APCDs hold several advantages over single-payer or population-based databases:
  - Capture longitudinal care information on individuals
  - Patient data that spans care settings
  - Data from most or all insurance companies in the state
  - Demographic, diagnostic, procedural and reimbursement information

States That Have Implemented APCDs

- Twenty states have implemented (APCDs):
  - Arkansas
  - California
  - Colorado
  - Connecticut
  - Delaware
  - Kansas
  - Maryland
  - Massachusetts
  - Maine
  - Minnesota
  - New Hampshire
  - New York
  - Oregon
  - Rhode Island
  - Tennessee
  - Texas
  - Utah
  - Vermont
  - Virginia
  - Washington



- Several other states are engaged in voluntary efforts related to APCDs
- The first APCD was operationalized in Maine in the early 2000s. However, the vast majority of APCDs were implemented after 2008

SOURCE: APCD Council, State Efforts, accessed Jan 4, 2024.

Key Functions of APCDs

Uses of APCDs

- Reporting on health care spending, utilization, and performance
- Enhancing state policy and regulatory analysis
- Informing the public about health care prices and policy
- Enabling value-based purchasing and health care improvement
- Supporting public health monitoring and improvement
- Providing reliable data for health care research and evaluation

How Different Stakeholders Can Use and Benefit from APCD Data

Consumers
- Compare cost information for specific procedures across providers

Policymakers
- Monitor health spending in the state
- Understand health status and disease burden of the state population
- Evaluate state efforts to improve value

Providers
- Compare performance against other providers on spending, quality, and outcome measures
- Use data to develop pricing bundles for an episode of care alternative payment methodology
- Understand performance of potential referral providers

Payers
- Understand provider practice patterns
- Identify high- and low-value providers' successful cost containment strategies

Employers
- Track progress on cost, quality and preventive service measures across employee populations
- Understand health status and disease prevalence to create wellness programs or targeted interventions

Researchers
- Study the outcomes of state or federal health reform initiatives on spending and quality
- Understand provider pricing variations

Examples of Data Submitted to APCDs

Data Elements Typically Included

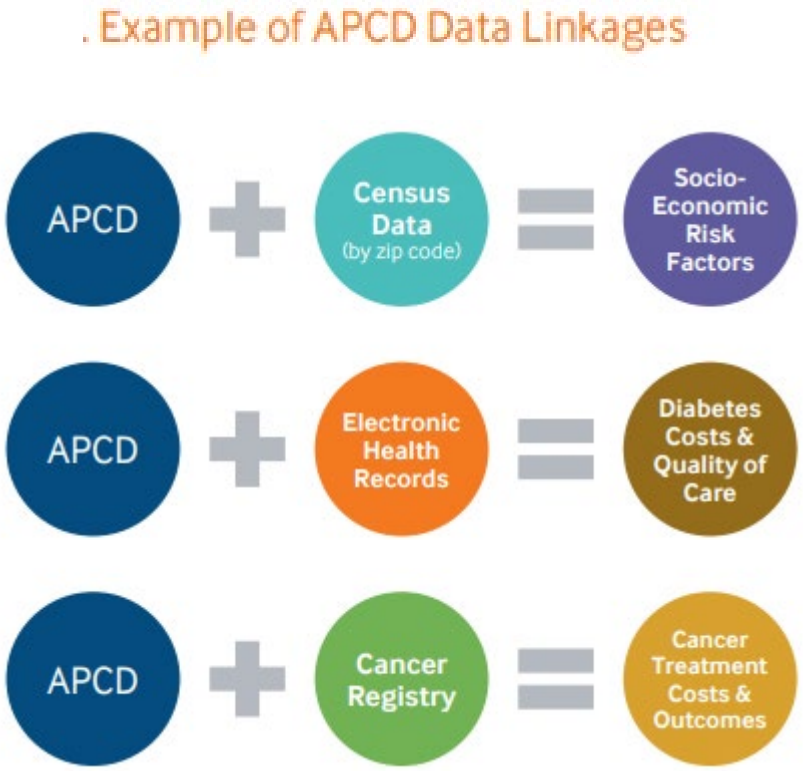
- Hospital prices (charged and billed)
- Diagnosis codes
- Procedure codes
- Revenue codes
- Provider information (name, tax identification, payer identification, specialty code, city, state)
- Patient costs
- Health plan payments
- Health plan discounts
- Type of product (HMO, POS, etc.)
- Type of contract (individual, family)

Data Elements Typically Not Included

- Services provided to the uninsured
- Denied claims
- Workers' compensation claims
- Premium information
- Capitation fees
- Administrative fees
- Back-end settlement amounts
- Referrals
- Test results from lab work or imaging
- Provider affiliation with group practice

Potential Linkages Between the APCD and Other Data

- Data from the APCD can be linked to other data, including information on:
  - Alternative Payment Models
  - Prescription Drug Rebates
  - Provider/Plan Quality Data
  - Hospital Encounters
  - Vital Records
  - Cancer Registries



SOURCE: Douglas McCarthy, State All-Payer Claims Databases: Tools for Improving Health Care Value, Part 1 — How States Establish an APCD and Make It Functional, Commonwealth Fund, Dec. 2020.

Types of Questions that Can Be Answered by APCD Data

- Who received care and why?
- What types of services do people use most?
- Does health care cost more in rural areas or urban areas?
- Are patients using health care services for preventive tests and annual exams?
- Is the emergency department being used as a source of care for non-urgent situations?
- How and why are health care costs increasing?
- What types of services have the highest variation in payments?
- How do payments for the same service differ by setting and location?

Types of Questions that Can Not Be Answered by APCD Data

- What types of care did uninsured people get and how much did they pay for that care?
- Were there claims or procedures that were denied by insurance?
- What are the outcomes of a test or procedure?
- What prescriptions were written but not filled?
- Did the doctor or clinic refer a patient to social or non-medical support services?
- Who – at the specific individual level – received care.

Example of APCD Usage: Minnesota

Minnesota has made its APCD accessible to non-technical users by creating dashboards that allow the public to look at various dimensions of health care.

Member
How much do Minnesotans spend on health care each year?

Diagnoses
What are the most commonly diagnosed conditions in Minnesota?

Utilization
In what types of settings do Minnesotans receive health care?

Services
What are the most frequent health care services in Minnesota?

Provider Specialty
Who provides Minnesotans with health care?

Prescription Drugs
How much do Minnesotans spend on prescription drugs?

SOURCE: Minnesota Department of Health, Minnesota All Payer Claims Database Public Use File Dashboards, accessed Jan 4 2024.

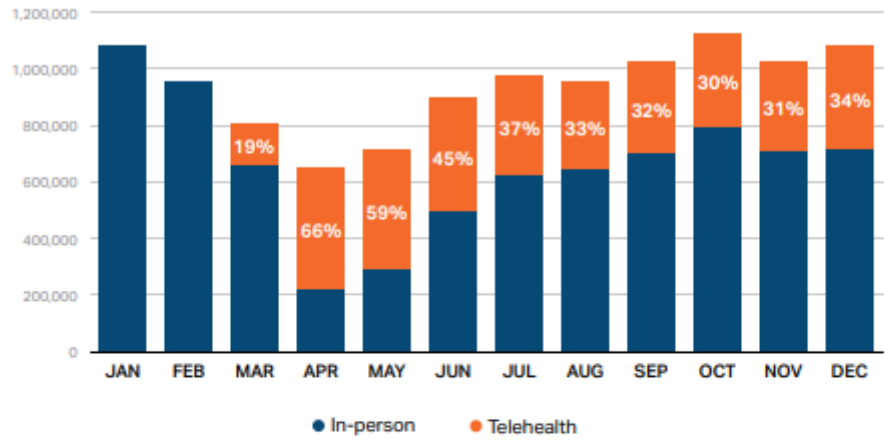
Example of APCD Usage: Massachusetts

The Massachusetts Health Policy Commission (HPC) regularly analyzes APCD data to monitor trends in spending, utilization and quality, as well as changes in the state's health care landscape. The HPC regularly makes recommendations on initiatives and regulatory action the state should undertake based on these analyses.

Most recently, the HPC reported to the legislature on trends in telehealth usage.

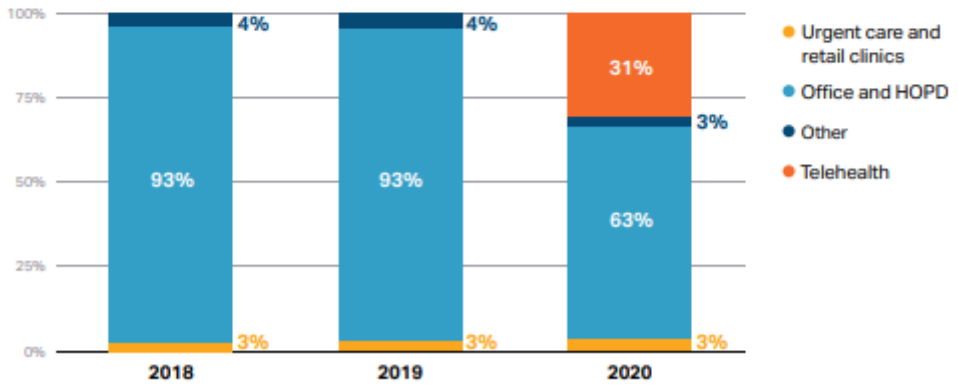
SOURCE: Massachusetts Health Policy Commission, Telehealth Use in the Commonweatlh and Policy Recommendations: Report to the Massachusetts Legislature, Jan 2023.

Exhibit 1: Number of in-person and telehealth ambulatory visits by month, 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Exhibit 2: Share of ambulatory visits by site, 2018-2020

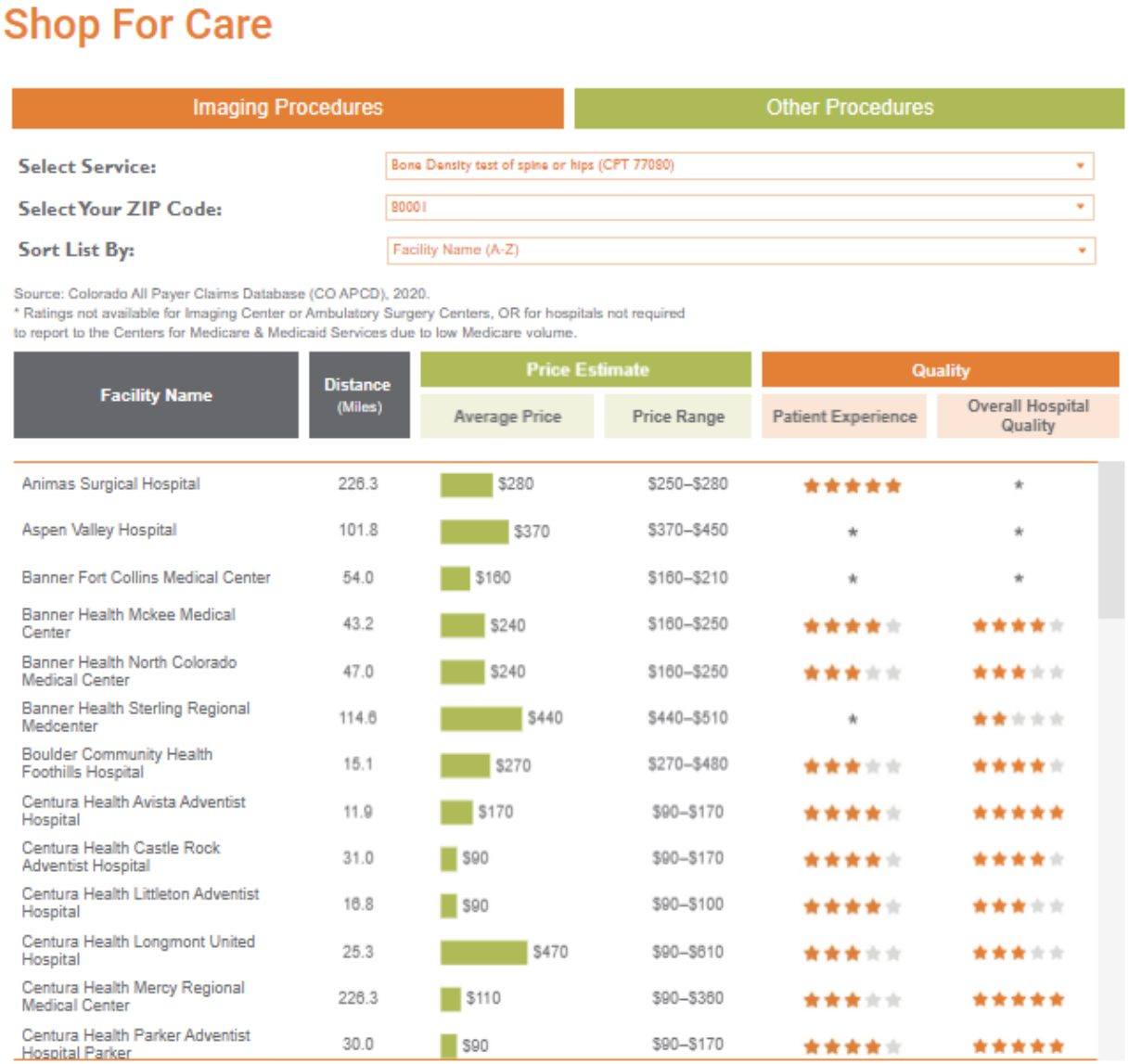


Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Example of APCD Usage: Colorado

Colorado built a tool to help consumers shop for care using data from their APCD.

The tool allows consumers to look up health care facilities' prices and quality ratings for specific procedures, as well as geographic distance from consumers based on zip codes.



Shop For Care

Imaging Procedures | Other Procedures

Select Service: Bone Density test of spine or hips (CPT 77080)

Select Your ZIP Code: 80001

Sort List By: Facility Name (A-Z)

Source: Colorado All Payer Claims Database (CO APCD), 2020.
* Ratings not available for Imaging Center or Ambulatory Surgery Centers, OR for hospitals not required to report to the Centers for Medicare & Medicaid Services due to low Medicare volume.

Facility Name	Distance (Miles)	Price Estimate		Quality	
		Average Price	Price Range	Patient Experience	Overall Hospital Quality
Animas Surgical Hospital	226.3	$280	$250–$280	★★★★★	★
Aspen Valley Hospital	101.8	$370	$370–$450	★	★
Banner Fort Collins Medical Center	54.0	$160	$160–$210	★	★
Banner Health Mckee Medical Center	43.2	$240	$160–$250	★★★★☆	★★★★☆
Banner Health North Colorado Medical Center	47.0	$240	$160–$250	★★★☆☆	★★★☆☆
Banner Health Sterling Regional Medcenter	114.6	$440	$440–$510	★	★★☆☆☆
Boulder Community Health Foothills Hospital	15.1	$270	$270–$480	★★★☆☆	★★★★☆
Centura Health Avista Adventist Hospital	11.9	$170	$90–$170	★★★★☆	★★★★★
Centura Health Castle Rock Adventist Hospital	31.0	$90	$90–$170	★★★★☆	★★★★☆
Centura Health Littleton Adventist Hospital	16.8	$90	$90–$100	★★★★☆	★★★☆☆
Centura Health Longmont United Hospital	25.3	$470	$90–$610	★★★☆☆	★★★☆☆
Centura Health Mercy Regional Medical Center	226.3	$110	$90–$360	★★★☆☆	★★★★★
Centura Health Parker Adventist Hospital Parker	30.0	$90	$90–$170	★★★★☆	★★★★★

SOURCE: Center for Improving Value in Health Care, Shop for Care, 2020.

Example of APCD Usage: Utah

Utah has run APCD data through Milliman's Health Waste calculator to report on how much of the care provided in the state is considered wasteful.

Wasteful Spend Findings

Top 4 measures account for more than 40% of total wasteful dollars

~0.8% of total allowed or $3.41 PMPM wasted*

Wasteful spend from claims totals **$88,492,829,** with a potential range of $75M to $247M (or 0.7% – 2.3% total spending)

Measure	Waste Services	Total Waste Dollars Case	Total Waste Dollars Line	% of Total $
APA01: Two or more antipsychotic medications Don't routinely prescribe two or more antipsychotic medications concurrently	33,241	$17,544,753	**$16,943,458**	0.15%
AAPMR05: Opiates in acute disabling low back pain Don't prescribe opiates in acute disabling low back pain before evaluation and a trial of other alternatives is considered	120,190	$9,640,043	**$9,639,841**	0.09%
SCP01: 25-OH-Vitamin D Deficiency Don't perform population based screening for 25-OH-Vitamin D deficiency	19,187	**$4,897,419**	$928,222	0.04%
AFP05: Annual Resting EKGs Don't order annual EKGs or any other cardiac screening for low-risk patients without symptoms	105,732	$45,443,334	**$4,499,796**	0.04%
Total	637,059	$247,421,629	$75,327,173	0.81%

SOURCE: Utah Department of Health, "A Discussion About Utah's Health Waste Calculator Results," July 2021.

Models of APCD Governance

State Health Data / Policy Agency Management (e.g., Kansas, Maine, Minnesota)

Legislation authorizes the state agency or health data authority to collect and manage data either internally or through contracts with external vendors.

Legislation grants legal authority to enforce penalties for noncompliance and other violations, with separate regulations to define reporting requirements

Insurance Department Management (e.g., Vermont)

The APCD reporting program is managed by an agency responsible for the oversight, regulation, and licensing of insurance carriers.

Advisory committees of major stakeholders guide decisions. Reporting is mandated under the authority of the Insurance Code, with penalties for noncompliance

Shared Agency Management (e.g., New Hampshire)

Two state agencies with separate authorities share in the governance and management of data collection, reporting, and release.

The shared responsibilities are defined in statute and expanded on in a Memorandum of Understanding that further defines the scope of authority and decision-making process

Private APCD Initiative (e.g., Wisconsin Health Information Organization, Washington Health Alliance)

Data are collected voluntarily from participating carriers with no authority to leverage penalties for nonreporting.

A board of directors composed of all major stakeholders guides the decision-making process

APCD Development and Maintenance

- Development typically takes 1-2 years.
- Annual operating costs vary by state, but generally run between $1-4 million.
- Funding sources include appropriations, industry fee assessments, grants, and data product sales.
- Factors influencing operating costs include the database's scope, the number of plans reporting, the complexity of analyses, and reporting requirements

	APCD Core Staff (FTEs)	Agency/Org Staff (FTEs)	APCD Budget	Agency Budget
Arkansas	2.2	10.0	$1.8M	$7.0M
Colorado	12.0	26.6	$4.2M	$5.3M
Maine	NA	7.0	NA	$2.0M
Minnesota	10.5	12.0	NA	NA
New Hampshire	1.5	NA	$1.2M	NA
Utah	3.5	6.0	$0.8M	$1.7M
Virginia	2.6	12.0	$1.4M	$9.0M
Wisconsin	7.0	7.0	NA	NA

NA: Not available.
SOURCE: Douglas McCarthy, State All-Payer Claims Databases: Tools for Improving Health Care Value, Part 1 — How States Establish an APCD and Make It Functional, Commonwealth Fund, Dec. 2020.

APCD Implementation Challenges

- Patient privacy and HIPAA
  - States need to take steps to safeguard PHI and adhere to privacy regulations issued by SAMHSA, including de-identifying data.
- Data completeness
  - Some payers such as TRICARE or FEHBP do not submit data.
  - ERISA plans cannot be compelled to submit data, although many states submit data from their state employee health plan.
- Data collection burden
  - There is currently no standard approach for collecting and reporting data to APCDs. Each state has its own unique reporting and submission requirements, which pose challenges for carriers.
- Costs of establishment and maintenance
  - It take a few years to establish, so states need an interim strategy until APCDs are fully functional.
  - APCDs typically rely on appropriations that can fluctuate, making it difficult for long-term planning.

Discussion

- Does the Health Care Task Force want to consider an APCD for North Dakota?
- If yes:
  - What factors that are important to consider in establishing a state APCD?
  - What governance and oversight structure should North Dakota consider?
  - What types of data linkages should the state consider?
  - What information should be produced and made available using the APCD?

NEXT STEPS