Hospitals have been coming together through the New Hampshire Hospital Association to advocate and support public policy that ensures citizens of the Granite State have access to high quality, affordable care for more than 80 years. New Hampshire hospitals are eager to continue the partnership with the Governor, legislative leaders and key policy makers on both sides of the State House in Concord to support and extend many of the accomplishments over the past two years and achieve progress on other important issues.

**MET SETTLEMENT AGREEMENT IMPLEMENTATION**

The MET Settlement Agreement that was reached in June, 2014 was a significant step forward in providing stability to the state’s hospitals and health care systems, patients and the state budget. Absent the agreement, the state was facing lawsuits that threatened to disrupt the state budget, lower New Hampshire’s bond rating, and make it more difficult for patients to get the care they need. Implementation consistent with the Settlement Agreement with the hospitals and SB 369 is essential. There are three conditions to final settlement of the MET/DSH deal:

- Enactment of statutory provisions necessary to implement the agreement (SB 369, which was adopted and signed into law);
- CMS approval of waivers and State Plan Amendments necessary (submitted, awaiting CMS approval); and
- Hospitals will make timely SFY 2015 MET payments.

Failure to make good on these conditions would be a significant step backwards and would put the entire agreement at risk. **Settling the lawsuits is predicated on the successful, complete and timely implementation of the MET agreement, and any attempt to undo that agreement would mean those legal cases would continue, creating increased and even greater budgetary issues for policymakers as it would place the state’s short and long term financial health at risk.**

**EXTEND THE NEW HAMPSHIRE HEALTH PROTECTION PLAN**

Enactment of the New Hampshire Health Protection Plan (NHHPP) this past year was a significant, bipartisan achievement that brought together business, providers and other advocates to extend private insurance coverage to more low-income, uninsured New Hampshire residents. Currently, more than 20,000 low-income residents in New Hampshire have signed up for coverage under the NHHPP. There are several key components to the implementation of the NHHPP:
• Submission and approval of the **Section 1115 Research and Demonstration Premium Assistance Waiver** is critical to the continuation of the New Hampshire Health Protection Plan (NHHPP);

• Submission and approval of the **Section 1115 Transformation Waiver** is an essential component of helping to improve the care delivery system for patients with mental health and substance use issues, and hospitals are actively engaged with the Department of Health and Human Services to achieve federal approval of the state’s waiver application; and

• Hospitals are actively working with DHHS, the managed care organizations (MCO’s) and others to ensure Medicaid beneficiaries are receiving the right care, at the right time, and in the right place to manage their health and chronic conditions, and to **discourage inappropriate use of the hospital emergency department** when their condition can be more effectively managed in a more appropriate setting.

_Hospitals believe it is essential to extend the NHHPP beyond its original end date of 12/31/16 to ensure that low-income patients and families receiving coverage under the law continue to have access to the care and security it offers, and we look forward to working with policymakers in Concord to do so._

**OPPOSE EXTENDING the BET to NOT-FOR-PROFIT INSTITUTIONS**

New Hampshire’s not-for-profit hospitals and health systems provide significant benefit to the state and their communities. Proposals that were defeated in the last Session of the Legislature to apply the Business Enterprise Tax (BET) to large not-for-profit organizations, including colleges, universities and hospitals, will be reintroduced in the coming year. New Hampshire’s hospitals are community assets that provide hundreds of millions of dollars of charity care and community benefits that far exceed the amount they would pay in taxes if they were no longer not-for-profit organizations.

_Efforts to increase taxes on not-for-profit organizations would only serve to increase the cost of care at a time we are all working to reduce them, as well as reduce the services and support they could offer to their patients and communities._

**REAUTHORIZE CERTIFICATE OF NEED**

In 2013, the Legislature adopted significant changes to the Health Planning Services and Review Board, otherwise known as the certificate of need or CON Board, to modify its membership, structure and approach. Hospitals supported those changes. But the Legislature also directed the CON Board to develop a state health plan so that its work could be done within the context of the overall approach to health care services in New Hampshire. That state health plan has not yet
been developed, and the 2013 legislation requiring the development of a state health plan also called for the CON law to sunset in 2016.

*The law overseeing the CON Board should not be repealed or allowed to sunset until all of the provisions of the prior legislation have been fulfilled, at which time the Legislature and stakeholders can assess and decide what regulatory framework is appropriate in New Hampshire going forward.*

**MEDICAID DSH**

The *federal Medicaid DSH audits of the SFY 2011 DSH payments* represents a significant challenge for hospitals and the health care system in New Hampshire. Audits conducted by the state’s auditors, Meyers and Stauffer, pursuant to the federal DSH audit rule have shown large discrepancies between the initial DSH payment amounts and uncompensated care calculations (UCC) for many hospitals across the state. We believe that there are several issues with the audits that must be reconciled before any decisions are made that could negatively impact hospitals.

- These audits were conducted on the first year the DSH program in New Hampshire was actually based on the amount of uncompensated care provided by a hospital…the 19 years prior it was simply a paper exercise where hospitals received a DSH payment in the exact amount of their MET payment; CMS described it as a “transitional” year in approving the state plan amendment authorizing these payments.
- There are several issues with respect to how UCC and DSH payments were calculated and paid in SFY 2011 and in how they are being audited today. We need to ensure the audits are conducted appropriately and consistently, but should not be considered final until further analysis has been completed.

*Hospitals are working collaboratively with DHHS and the Governor’s Office in responding to these audits.*

**WORKERS COMPENSATION**

Workers’ Compensation (WC) in New Hampshire needs reform and modernizing. But the way to that is through market-based reforms that will level the playing field, bring transparency to provider pricing, and begin to treat WC like other forms of private insurance. The one thing New Hampshire should not be doing is putting in place government price controls, which inevitably lead to higher costs and less access to care. It’s time to come together around a New Hampshire solution that brings WC into the 21st century, lowers costs for NH businesses, and ensures continuing access to high quality care for injured workers.
Overview

WC is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment, in exchange for employees relinquishing the right to sue their employer for their injuries. While the WC system needs improvement and modernization, it is largely working as intended, ensuring high quality care for injured workers and getting them back to work quickly. Here are some key facts about New Hampshire’s WC program:

- Injured workers in New Hampshire have full access to high quality health care, and return to work more quickly than in any other state.
- The faster turnaround results in lower wage replacement costs.
- Since 2010, New Hampshire WC premiums are down 9%, and overall costs are down about 6%.
- New Hampshire WC costs are the lowest in Northern New England, lower than Maine and Vermont. Notably, both Maine and Vermont have government price controls for their WC programs.
- While some employers raise concerns about WC insurance premiums, it is important to note that WC is the most profitable line of insurance in New Hampshire. Any reforms should be structured to benefit workers and employees, not insurance companies.

The Case for Modernization

Health care is changing at a dramatic pace. Electronic medical records and billing are transforming the health care business model. But WC is still working under an old business model. For example:

- WC claims are still processed on paper, with extensive care management, detailed medical records, forms, phone calls, all requiring significant time and personnel costs. Often times, it takes 2-3 more FTEs to process WC claims than it does for commercial and government payors.
- By contrast, other private insurance, Medicaid and Medicare are all processed electronically.
- Health care providers face delays of months and years in getting paid for services in the WC program. For example, if an employer or the employer’s insurance carrier denies a WC claim, that claim is adjudicated in the NH Department of Labor and is subject to several levels of appeal, including an appeal to the NH Supreme Court. During adjudication and appeal, health care providers do not get paid. If the claim is ultimately denied, they face the potential of receiving no payment whatsoever.

It’s time we modernize WC and bring the program into the 21st Century.
Government Price Controls Not the Answer

Some voices are loudly calling for government price controls as the only solution to bring down WC costs. They cite wild examples of WC provider charges being much more expensive than the commercial market. Here are the facts:

- The outrageous cost examples are most likely outliers. The truth is, no one knows how the WC provider cost structure compares to the market average, because WC provider cost data isn’t collected and reported. We think it should be.

- Both Vermont and Maine have government price controls, and both states have WC programs that are more expensive than New Hampshire.

- Other states with price controls have seen access to care substantially cut back, with fewer providers willing to take on WC cases.

- Here in New Hampshire, some providers have already said they will no longer take WC cases if the state imposes price controls. This would have a particularly dramatic impact on quality and access, especially in underserved areas such as the North Country.

- We cannot create a situation that makes it more difficult for injured workers to get the care they need and to get them back to work as quickly as possible.

Moving Toward a New Hampshire Solution

As we look to modernize our WC system, we should follow the medical oath: first do no harm. It’s time to come together around a New Hampshire solution that brings WC into the 21st century, lowers costs, and ensures continuing access to high quality care for injured workers. Here’s how we get there:

- Good data. We need better cost data, which was the key recommendation of the Governor’s recent WC Commission. We need to understand just what’s driving WC costs. Data collection will have the added benefit of shining a light on pricing practices and create pressure on outliers to bring prices in line. Reform should be driven by facts and data, not anecdotes.

- Private market solutions. We should move to treat WC just like every other form of insurance, with the private market determining costs. One step would be to change the WC statute, allowing providers and carriers/employers to negotiate reasonable rates.

- Modernization. Reform efforts must include modernization of record keeping and billing, antiquated features of our WC system that drive up costs.

- No price controls. Price controls are not the New Hampshire way, and will lead to higher costs and less access to care.