Minnesota Hospital Association

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Chair Liebling and Members of the House Health Finance and Policy Committee:

On behalf of the Minnesota Hospital Association (MHA), we respectfully submit to you the following comments on the House Health Finance and Policy Omnibus bill (HF 2930 - Liebling). While many provisions impact hospitals and health systems and the patients and communities we serve, our comments are focused on the issues of highest priority of support or opposition.

MHA strongly opposes certain provisions of the Keeping Nurses at the Bedside Act that require hospitals to establish nurse staffing committees and other staffing and reporting mandates. (Article 3, Sections 74, 82, 87-95, 188-189, 192)

These provisions would have a drastic, negative impact on access to patient care.

Minnesota, like the rest of the nation, is facing a health care workforce shortage. Many hospitals and health systems have thousands of vacancies that they are trying to fill. Hospitals are paying signing bonuses, retention bonuses, and higher salaries to find the workforce to meet patient care needs, but there are still over 5,000 open nursing positions in the state. Creating new committees will not attract more individuals into the nursing profession, nor help retain the nurses we have.

If a hospital needed to admit a patient that was not accounted for in the mandated staffing plan, or a registered nurse (RN) calls in sick and could not provide care for their designated patients, the consequences for a community or patient needing care could be dire. Patients would likely be turned away for admissions if the hospital could not take them while adhering to their staffing plan.

Scheduling staff, both the number and the category of health care professionals that will produce the best patient outcomes, is constantly evaluated by nurse leadership. This is the primary role of the chief medical officer and chief nursing officer. The current day-to-day decision making by nurse leaders is better for patient outcomes than staffing by a committee that meets quarterly. Staffing decisions should not go to arbitration involving lawyers, additional costs, and time delays.

The unnecessary mandates in these provisions will inevitably lead to unit closures, rising costs, longer wait times for patients, and the loss of vital services that communities rely on.

MHA opposes the requirements for notice and review of health care entity transactions. (Article 3, Section 78)

MHA believes that the current robust review and oversight processes and procedures in place for health care entity transactions have been working effectively for many years. These include federal and state antitrust laws, authorities provided to the Minnesota Attorney General, the robust licensing laws, and the transparent public interest review processes enforced by the Minnesota Department of Health (MDH). These significant regulatory procedures have ensured appropriate oversight of health care entity transactions and allowed health care entities in Minnesota to meet the needs of our patients, families, and communities while making necessary organizational changes to fulfill their mission. We question the need for this extensive additional oversight given the robust processes already in place and working well.

MHA is concerned about many of the new, wide-ranging administrative oversight procedures in this provision, including the volume of sensitive information required to be provided, the expansive discretion granted to the Attorney General, and the lack of timeline or sunset on the authority of the Attorney General to unwind a completed transaction. The scope of the authority is so broad it could potentially inundate MDH and the Attorney General's office with frequent organizational changes that would now

need to have a lengthy process to be approved. This provision will limit the ability of our state's hospitals and health systems to make the timely and nimble organizational adjustments needed to stay viable to serve patients and communities.

MHA has been working with the bill authors in an effort to scale back the scope and breadth of the current language. We are hopeful that significant changes will still be made.

MHA opposes carving out the prescription drug benefit from managed care contracts. (Article 2, Sections 11, 13, 17, 21)

These provisions trigger a federal rule that would negatively impact disproportionate share and children's hospitals, critical access hospitals, federally qualified health centers, Ryan White HIV clinics and other critical safety-net providers across Minnesota. These providers would lose millions of dollars in annual savings from the 340B Drug Pricing Program (340B) that are used now to help provide health and community services.

The federal government created 340B to help offset Medicaid underpayments and exorbitant prices from pharmaceutical companies. The program requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at significantly discounted prices to specific health care providers that serve many uninsured and low-income patients. The exclusion of outpatient prescription drugs from PMAP and moving into the FFS program will mean a significant loss of funding for hospitals and other 340B covered providers. While this increases the state's ability to get pharmacy rebate dollars, it is at the expense of safety net providers. The elimination of 340B savings affects patient care and community benefit services.

While MHA appreciates the additional proposed new funding, it is not nearly enough to offset the full loss of 340B savings.

MHA opposes corrective action plans and civil penalties within the creation of a Health Care Affordability Commission. (Article 2, Sections 1-8)

This provision establishes a new commission and advisory council to develop technical recommendations on large scale health care transformation. In addition to unilaterally establishing health care spending growth targets, the commission would also be tasked with ruling on the broad concepts of payment reform, innovating delivery models, and Minnesota's response to market trends. Rather than creating an entire new entity, existing efforts at MDH could be leveraged to accomplish similar goals within existing and transparent partnerships between the state and provider organizations.

Health care needs are often unpredictable, and MHA is concerned with any effort to establish arbitrary health care spending growth targets that will likely fall short of accounting for the entirety of market pressures and demands. MHA is particularly opposed to corrective action plans for exceeding a spending target and the ability of a non-governmental entity to impose civil penalties.

MHA opposes the provisions to create a MinnesotaCare public option. (Article 2, Sections 9, 22-29)

While MHA supports the MinnesotaCare program for low-income individuals, MHA is opposed to allowing anyone the ability to buy into MinnesotaCare coverage regardless of the individual's income. If enrollment is allowed to be broader without an income ceiling, current payment rates would not allow for a sustainable health care system. MHA thinks a better alternative approach would be to expand current MinnesotaCare eligibility to 300-400% of the Federal Poverty Limit.

MHA supports the provisions to invest in the health care workforce. (Article 3, Sections 53-56, 183, 184)

The Minnesota Department of Employment and Economic Development (DEED) estimates that 1 in 4 job vacancies in Minnesota are in health care, amounting to 52,000 health care job vacancies. The health care workforce shortage – both nationally and in Minnesota - is nothing short of alarming. While hospitals and health systems will continue to do what we can, this problem cannot be solved exclusively by providers. MHA strongly supports any additional investment in health care workforce recruitment and retention, including the grant and loan forgiveness programs included in the provision. Specifically, creating an Employee Recruitment Education Loan Forgiveness Program and providing rural primary care residency training program grants will help attract and retain health care professionals in rural communities.

MHA supports extending the use of audio-only telehealth through July 1, 2025. (Article 1, Sections 2, 28)

Audio-only telehealth services are important for patients who lack access to reliable broadband, may be economically disadvantaged, or who are not comfortable using video technology. With the final state agency telehealth reports not yet completed, it is prudent to extend the sunset of coverage for audio-only telehealth services until July 1, 2025.

MHA supports establishing a workplace safety grant program for health care entities and human services providers. (Article 3, Section 200)

In order to address the increased incidence of violence against health care professionals, this grant funding will help health care provider organizations offset costs to enact increased safety measures. Safety improvements may include infrastructure updates, implementation of new software to track safety incidences, and increased education and training opportunities such as those typically associated with health care-based violence intervention programs. The grant program will better enable organizations to invest in safety measures and protocols that take steps to increase safety for both employees and the patients they serve.

MHA supports start-up and capacity-building grants for psychiatric residential treatment facility sites. (Article 7, Section 22)

Hospitals and health systems across the state are continuing to experience a significant increase in the number of children and teenagers seeking mental health care in hospitals. While often they need an inpatient bed, frequently they do not meet inpatient admission standards and therefore many of these children end up boarding in the emergency departments. By expanding access to psychiatric residential treatment facilities (PRTFs), mental health services for children and adolescents can be better provided in the most appropriate care setting that is best for the patient and their family.

MHA supports Medical Assistance continuous eligibility for children. (Article 2, Section 12)

Due to the COVID-19 pandemic, state Medicaid agencies across the country suspended eligibility redeterminations to allow individuals to maintain health care coverage. Given the impending expiration of the federal public health emergency, DHS is restarting the renewal processes for Medical Assistance. To better support patients seeking care at hospitals and health systems, we support the provisions to ease this transition and help ensure continuous coverage for eligible child enrollees.

MHA supports Medical Assistance coverage for recuperative care services for persons experiencing homelessness. (Article 1, Section 21)

This provision establishes a bundled payment for a set of defined services and settings

to care for people who are unhoused after an acute or post-acute health care incident or to prevent hospitalization. Recuperative care saves taxpayer dollars, costs significantly less than hospital boarding, and leads to fewer hospital readmissions.

MHA supports the modifications to the Medical Education and Research Costs (MERC) program. (Article 4)

MHA is appreciative of this provision to comply with an updated federal rule from the Centers for Medicare and Medicaid Services regarding the MERC payment mechanism. This is not new funding for the program but is a necessary policy change to ensure ongoing support for training new medical professionals in Minnesota.

In addition to the comments above, MHA is very disappointed that the following provisions were not included in the DE1 amendment. MHA encourages the Committee to consider the inclusion of the following provisions:

Hospital payment rates rebased (HF 2924)

MHA urges the legislature to increase Medicaid reimbursement rates to more accurately reflect the current cost of care. HF 2924 would provide an inflationary increase in the inpatient fee-for-service rates. The larger hospitals in Minnesota would receive an inflationary increase using more current cost data. Critical access hospitals would all be raised to 100% of their actual patient care costs. Over half of the hospitals in Minnesota report having negative operating margins, and state government needs to pay for more of the cost of care in our public health care programs.

Summer Health Care Internship Program (HF 2090)

Funding for MDH's Summer Health Care Internship Program (SHCIP) needs to be increased. SHCIP gives students the opportunity to explore a career in a high demand field through a paid internship. Interns gain direct work and patient care experience with hospitals, clinics, nursing facilities, and home care providers. Employers benefit from more team support for the summer and the strengthening of their long-term workforce recruitment and development. Since 2014, 1,275 interns have participated in SHCIP with many continuing to pursue an education and career in health care. However, due to flat funding since 2014, the program has had to turn down nearly 1,000 individuals requesting participation.

Children's mental health provisions (HF 1198)

MHA supports strengthening the continuum of care and funding the development of placement options for children boarding in hospitals. We also support provisions related to providing Medical Assistance coverage for care coordination, enhancing transition support services, and investing in culturally responsive school-linked and early childhood mental health services.

Thank you for your consideration of our comments. We know there is a lot of information here and we would welcome the opportunity to discuss these issues with you over the course of the remaining legislative session.

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