April 20, 2023

Re: Support for the MinnesotaCare Immigrant Inclusion Act (HF2930)

Dear Chair Olson and Members of the Committee

In Minnesota, we believe everyone deserves access to healthcare regardless of race, age, income or zip code. Across the state, we're united by the aspirations we share for ourselves and our families.

People immigrate to the United States for many reasons, and struggle to obtain legal status for many reasons as well. Immigrants without documents are neighbors, families, coworkers, caretakers, and Minnesotans who need health care like everyone else. However, many are excluded from health care coverage that other low-income families and essential workers are eligible for. After the COVID-19 pandemic, we are long overdue to change this.

Three proposals introduced this year would allow undocumented immigrants who meet the other eligibility requirements to enroll in MinnesotaCare and contribute to their coverage at the same affordable premiums paid by other Minnesotans at their income level.

- HF 1095 Agbaje/SF 896 Mann, the MinnesotaCare Inclusion Act, removes the ban on MinnesotaCare eligibility for undocumented immigrants.
- HF 96 Long/SF 49 Wiklund, the MinnesotaCare Public Option, section 4 contains the same MinnesotaCare Inclusion provision.
- Governor Walz' budget proposal extends MinnesotaCare coverage to undocumented children.

We ask you to please support proposals to include undocumented immigrants in MinnesotaCare.

According to 2019 estimates, 81,000 undocumented immigrants live in Minnesota, representing 16 percent of Minnesota's immigrant population and 1.4 percent of the total state population. An estimated 30,700 U.S. citizen children in Minnesota have undocumented parents, 2.4% of all children under 18 in the state.

Undocumented immigrants are not eligible for Medicaid, except through Emergency Medical Assistance (EMA) which only covers care provided in an Emergency Department (ED), an inpatient hospital setting resulting from an ED visit, or limited additional services when specifically approved to prevent an emergency condition within 48 hours.

EMA does not cover chronic or non-emergency conditions *even when the long-term effect would be hospitalization or death*. EMA does not cover the primary and preventative services people need to support their wellbeing and ongoing health needs.

Although uninsured undocumented immigrants may receive sliding-scale primary care at Federally Qualified Health Centers (FQHCs), there are only 17 FQHCs in Minnesota, 12 of which are in Minneapolis or St. Paul, and there is much essential specialty care they do not provide.

Access to healthcare is a fundamental human right recognized by the United Nations and the World Health Organization. Denying certain immigrants access to healthcare contributes to Minnesota's health inequities. One in three Latina women in Minnesota reported that they could not see a doctor because of costs in 2021. Immigrants receive optimal care and screening at significantly lower rates than U.S. born Minnesotans for a range of conditions including asthma, diabetes, and mental health needs. Latinx Minnesotans' have died of COVID-19 at twice the age-adjusted rate of white Minnesotans and their age-adjusted ICU-admittance rate for COVID-19 is nearly four times higher.

Undocumented Minnesotans contribute heavily to Minnesota's economy. In 2018, undocumented immigrants in Minnesota paid an estimated $191 million in federal taxes and $108 million in state and local taxes. Immigrant workers make up more than 1 in 10 Minnesota workers. According to Census Bureau Data, 69% of undocumented immigrants work in front-line jobs considered "essential" during COVID-19, including agriculture, meat packing, grocery, manufacturing, janitorial and cleaning services, security, and construction.

For all of these reasons, many states either include or are considering including low-income undocumented immigrants through state-funded healthcare programs. Eleven states (CA, CT, IL, MA, ME, NJ, NY, OR, RI, VT, WA) and D.C. already cover undocumented youth with state-only funds. Five states and the District of Columbia cover some or all age groups of undocumented adults using state-only funds.

We ask you to support the inclusion of undocumented community members in MinnesotaCare this session.

Signed,

Black Immigrant Collective
City of Minneapolis
City of St. Paul
Council for Minnesotans of African Heritage
Council on Asian Pacific Minnesotans
Epilepsy Foundation of Minnesota
Forprogress.org
Hennepin County
Hennepin Healthcare
Immigrant Law Center of Minnesota
Immigrant Welcoming Working Group, Plymouth Congregational Church, Minneapolis

Interfaith Coalition on Immigration (ICOM)
ISAIAH
Jewish Community Action
LatinoLEAD
Legal Services Advocacy Project
Minnesota Budget Project
Minnesota Council on Latino Affairs
Minnesota Doctors for Health Equity (MDHEQ)
Mitchell Hamline School of Law - Health Law Clinic
MN Immigrant Movement (MI)
MUUSJA, MN Unitarian Universalist Social Justice Alliance
Portico Healthnet
Rural Organizing Project of ISAIAH
Spirit of St Stephen's Catholic Community Sanctuary & Resistance Task Force Committee
TakeAction Minnesota
The Advocates for Human Rights
Unidos MN
Voices For Racial Justice

Linda Dick-Olson, LICSW
Director of Behavioral Health
Minnesota Community Care
March 27, 2023

Written testimony in support of the school-based health provisions in the House Health Finance and Policy omnibus bill

Chairpersons Liebling and Bierman,

Thank you for your history of supporting our children's safety net programs and in particular, school-based health centers. My name is Linda Dick-Olson and I am therapist within our Health Start program at Minnesota Community Care, a community health center, as well as the Director of Behavioral Health for our organization.

I have worked for over 20 years in my role as school-based therapist. I started on 9/11/2001, addressing a crisis with students. I know that this model of care works from experience. We can address the whole child's needs, keep kids in school and improve their learning by offering mental health care that is equitable and accessible. We do this hand in hand with school support staff.

In recent years, we have as a community, nation and as a world, experienced multiple stressors, and traumas. We as adults have been impacted, but those who have been the most impacted are those who are the most vulnerable.

In the first half of 2020, we worked hand in hand with school support staff, which is essential in school-based care, to provide students and their families a needed connection during one of the most challenging times in our recent history. We were able to provide mental health services by quickly pivoting to provide telehealth care, so that students and families were able to stay safe and continue to be supported. Once returning to schools, we responded to the elevated needs of the students walking through our doors and provided them with a place to heal and to learn healthy coping skills.

Last time I spoke before you, I spoke of a client who I worked with both during and after the pandemic. When I first met with her, she struggled with anxiety and struggled with attendance, self-esteem, school performance and peer interactions. During our work together, she improved her attendance, has become an almost straight A student, has made several new friends and has started trying new activities outside of school.

Other students were not as connected over the pandemic and had a very different experience. They had been left alone during that 12+ months when our world went on pause. Many of the clients who I have been since the pandemic started have much higher rates of depression, anxiety and general dysregulation. Their families were those who already struggled before the pandemic and they and their families were isolated during that time. Those students struggle to stay in class, to feel hopeful about their futures and are disconnected from their peers. I think of a young person who I am currently working with who's family struggled due to mom feeling stuck in an emotionally and financially abusive relationship. The student came in wary, worried, and sad. They had been referred to me due to seeming shut down since returning to school earlier that year. Mom had shared that they while they used to be close, they now sat in their room all day. During our time together, they learned to talk about the hard things in their lives to find ways to both ask for help from those around them that cared and ways to

take care of themselves during a difficult situation. Their relationship with their mom improved during our time together, they were able to speak to mom about their worries for mom. This was not a treatment goal, but mom was inspired by the growth they saw their child make and they ended up going to counseling as well and eventually left the abusive relationship.

These students are just two examples of clients who would not otherwise have been able to access therapy and are both better off because of it. The support we provide students in school helps them, their families, and their learning.

Please consider the school-based health initiative on page 169 of the Governor's budget as you see which will provide funding to current and new school-based health initiatives, support quality care and equitable access for students, and formalize the relationship between MN School Based Health Alliance and the MN Department of Health.

Thank you,

Linda Dick-Olson

April 20th, 2023

Re: Census income exclusion in HF2930

Dear Chair Olson and members of the committee,

The Minnesota Council on Foundations is a statewide association of grantmakers focused on ensuring Minnesota has a strong charitable sector and an inclusive democracy where everyone can be seen, counted, and heard. We are committed to strengthening democratic systems and civic participation. As part of this, we support state decisions and investments that will prepare Minnesota for a full 2030 Census count.

In the Health Finance Omnibus bill (HF 2930), the Minnesota Council on Foundations is grateful for the language that would ensure that income earned as Census enumerators does not exclude workers from certain benefits. Hiring enumerators was a significant challenge in the 2020 Census. Recruiting enumerators from historically undercounted communities was an even greater obstacle. This proposed change would make it easier for Minnesota to hire enumerators for the 2030 Census and especially those from historically undercounted communities. The recruitment of enumerators from historically undercounted communities is critical to ensure an accurate count in Minnesota. Excluding Census enumerator income from state benefit eligibility has been implemented in many other states and it is time to see this change in Minnesota.

We are heartened to see proposals included that promote a full and inclusive 2030 Census count. Thank you for your leadership and the opportunity to submit testimony.

Sincerely,
May Yang
Minnesota Council on Foundations
myang@mcf.org

Minnesota Hospital Association

161 Saint Anthony Ave., Ste. 915
Saint Paul, MN 55103-2382
www.mnhospitals.org

April 21, 2023 *Submitted Electronically*

Chair Olson and Members of the House Ways and Means 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 86-94, 188, 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 77)

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 1-7, Article 3 Section 5-6, 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 21- 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 strongly supports the provisions to invest in the health care workforce. (Article 3, Sections 47-55)

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, 31)

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 201)

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 57)

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 23)

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.

Mary Krinkie
Vice President of Government Relations
mkrinkie@mnhospitals.org
Cell: (612) 963-6335

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org
Cell: (616) 901-7500

April 20, 2023

Re: Support for a MinnesotaCare Public Option (HF2930)

Dear Chair Liebling and Members of the Committee:

We write to express our strong support for establishing a MinnesotaCare Public Option (HF2930). Across race, income, and zip code every person deserves access to healthcare. We know that our families, economy, and local communities are stronger when we all have access to truly affordable, high-quality healthcare that supports our health and wellbeing.

That's why we support a MinnesotaCare Public Option, to allow more Minnesotans to access the affordable, comprehensive healthcare they need.

Established in 1992 through bipartisan leadership, MinnesotaCare is affordable and high-quality healthcare that we fund together through state, federal, and enrollee contributions.

This bill would:

- **Expand access to affordable healthcare** by allowing middle-income Minnesotans struggling to afford high deductible plans on the individual market and small group market to buy-in to MinnesotaCare through a public option.
- **Expand eligibility** to include undocumented Minnesotans currently excluded from Minnesota Health Care Programs.
- **Offer temporary assistance** to help individuals and small businesses afford healthcare while the public option is being implemented.
- **Create a path toward alternative care delivery systems** that will work with providers to improve health outcomes, health equity, and access while maintaining affordability for the state and enrollees.

We believe that healthcare should be people-centered, include everyone, and not be dependent on employment. A vast majority of Minnesotans agree, with 91 percent saying that they believe the government should expand insurance options so that everyone can afford quality care (Healthcare Value Hub Survey, Nov. 2020).

We urge you to support truly affordable, high-quality healthcare for every Minnesotan. Please vote to support the expansion of MinnesotaCare through HF2930.

Signed,

AARP
AFSCME Council 5
AFSCME Council 65
Black Immigrant Collective
Children's Defense Fund Minnesota
CURE
Committee to Protect Healthcare
East Central Area Labor Center
Education Minnesota
Episcopal Church in Minnesota
Faith in Minnesota
Health Access Minnesota
Immigrant Welcoming Working Group, Plymouth Congregational Church
Interfaith Coalition on Immigration (ICOM)
ISAIAH
Land Stewardship Project
Main Street Alliance
Minneapolis Regional Labor Federation
Minnesota Budget Project
Minnesota Council on Latino Affairs (MCLA)
Minnesota Council of Nonprofits
Minnesota Farmers Union
Minnesota Public Health Association
Northeast Labor Area Council
OutFront Minnesota
Planned Parenthood MN, ND, SD Action Fund
Rural Organizing Project of ISAIAH
SEIU Healthcare Minnesota & Iowa
SEIU Minnesota State Council
Southeast Minnesota Area Labor Council, AFL-CIO
Springboard for the Arts
TakeAction Minnesota
Unidos MN
Voices for Racial Justice
West Area Labor Council

April 20, 2023

Dear Chair Olson and committee members,

As the MN School-Based Health Alliance, we are writing to offer education and support on the impact of school- based health centers on the health and education equity of Minnesota students. Thank you for thoughtfully uplifting this safety net for children and teens. We support the language in the Health Finance Omnibus Bill, HF 2930, that extends support to emerging and existing School-Based Health Centers in Minnesota as well as MN Department of Health's work in this area, and our role as a capacity-building organization in community.

School-based health centers (SBHCs) have been strongholds of accessible, equitable and comprehensive preventive care for students in Minnesota for 50 years. If passed, this legislation would be the first state policy and dedicated funding to support school-based health centers in that time. An investment in SBHCs at this pivotal time for the health of children and communities would be historic.

The gold-standard model for school-based clinics had its genesis here in St Paul, Minnesota, and is now codified in federal statute. Today, over 2,200 school-based health centers operate across the U.S. Until 2022, our local School Based Health Alliance was a voluntarily coalition of the leaders who operate school-based clinics. In MN, there are now 29 providing care to nearly 15,000 students, and at least 11 in development. The Alliance represents and supports each of the health care providers and districts.

The Alliance is a long-term community partner of the Minnesota Department of Health (MDH). MDH has provided a convener to support this work since 2015 when the Alliance became an official affiliate of the national School- Based Health Alliance. In January, MDH extended a CDC COVID Workforce grant to the Alliance, now a nonprofit, to assist schools with pandemic recovery. During distance learning, the mental health therapy, medical care, nutrition services, health education, and parent support delivered in Minnesota's school-based clinics proved SBHCs are a durable part of the health care safety net. As pediatric clinics, family physicians, dental clinics, mental health care centers and more providers struggle to meet the needs among kids, school-based access to care creates ease for families, supports a fractured health care system, and strengthens school-health initiatives. As the concern has been raised this session, please know that school-based health centers are subject to the same state and federal laws, including parent consent for care, that regulate all clinical care.

Evidence shows partnership between a local Alliance and a state program office like MDH, and dedicated state funding for new and existing school-based health initiatives, correlates with expansion of care for kids, decreases Medicaid costs and increases school success. Growth has been slow in Minnesota compared to most other states. This is a critical time to change that, particularly in rural areas where one school-based health center can offset care shortages for an entire community. This bill allows school-based health providers to be here for kids as they recover from the pandemic, a time when their needs are critically underserved and increasingly acute.

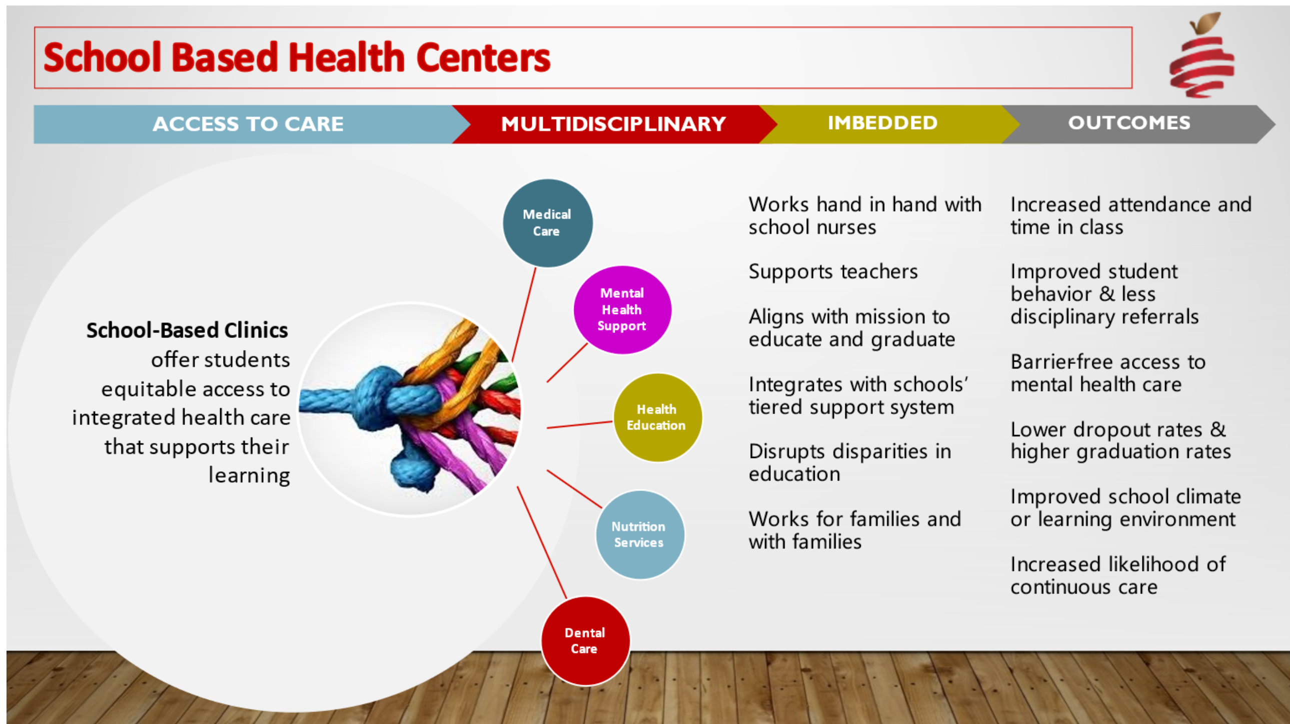
Care within SBHCs is not a replacement for the allied health professionals in schools such as Licensed School Nurses, School Counselors, and Social Workers. Simply said, their co-existence creates ease for families and optimizes learning. Expanding this to more children is a key lever for reducing disparities in education and health outcomes for children in Minnesota.

In health,
Shawna Hedlund
MN School-Based Health Alliance

The school-based health alliance supports the expansion of school-based clinics in school districts across Minnesota to address health and education disparities and ensure that every child has an equitable opportunity to meet their full potential.

WHAT ARE SCHOOL-BASED CLINICS or HEALTH CENTERS?

School-Based Clinics or SBHCs are a transformational and time-tested healthcare model that delivers care to children and adolescents where they spend most of their time – in school. They efficiently and cost effectively address health inequities like access to medical care, mental health support, dental and eye care. School-based healthcare means that students K-12 can get a flu shot, have an annual physical, have their teeth examined and their eyes checked, or speak to a mental health counselor in a safe, nurturing place without the barriers that families too often face - barriers like cost, transportation, lost work time, lost class time. SBHCs represent one of the best models for assuring ALL children and adolescents can enjoy school and learn.



MINNESOTA SCHOOL-BASED HEALTH ALLIANCE

The Alliance is the capacity-building and technical assistance alliance for school-based health centers in Minnesota. We support school districts and health care organizations operating and initiating school-based health centers by providing community advocacy, science-based expertise, shared resources, and a Community of Practice.

CLINIC LOCATIONS [Map: 29 established sites under 9 operators and 11 emerging initiatives]

Twenty-nine school-based health centers exist in Minnesota today and more are emerging. Over **30%** of SBHCs in MN are operated by federally-qualified Community Health Centers. **The CDC Social Vulnerability Index** uses 16 variables to identify communities that need support. All SBHCs in Minnesota are located within the highest quartile of the **social vulnerability index** across our communities.

Minnesota Community Care
10 "Health Start Clinics" in St. Paul Schools

NorthPoint Health and Wellness
2 clinics in Minneapolis Public Schools

Minneapolis Health Department
8 clinics in Minneapolis Public Schools

Park Nicollet Foundation
4 clinics in Richfield, Burnsville, Brooklyn Center, and St. Louis Park Schools

Ortonville Area Health Services
1 clinic in Ortonville K-12 School

Mayo Clinics
1 clinic in Rochester ALC

MyHealth
1 clinic in Hopkins School District

Minnesota State University, Mankato
1 clinic in Bloomington Schools

Rise Up Health Clinics
1 "Bear Care Clinic" in White Bear Lake

Most SBHCs in Minnesota are in Metro locations, leaving a gap for rural students. The Alliance is working hard to support communities invested in health care access for their families and students. This model of care has a profound impact on individual students, families, school systems and communities. SBHC providers do not replace school nurses and school counselors but work hand in hand with both, as well as local pediatricians and family clinics, working collaboratively to help students learn and thrive.

ENDORSEMENTS

1. NorthPoint Health and Wellness, Stella Whitney West, CEO
2. NorthPoint Health and Wellness, Dr. Paul Erickson, Medical Director
3. Rise Up Clinics/ St. Catherine's University, Dr. Jessica Miehe, Clinic Director and Assistant Professor
4. Park Nicollet Foundation, Beth Warner, ED
5. MN Chapter, American Academy of Pediatrics, Dr. Sheldon Berkowitz, FAAP
6. Twin Cities Medical Society Kate Feuling Porter, Senior Program Manager
7. St. Catherine University, Dr. Kara S. Koschmann, APRN, CPN
8. Minneapolis Health Department, Patty Bowler, Director of Policy
9. Minnesota Association of Community Health Centers, Rochelle Westlund, Policy Director
10. Northwest Family Resource Collaborative, Rachel Harris, Director
11. St. Paul City Schools, Dr. Meg Cavalier, Executive Director
12. Ortonville Area Health Services, Kelsey Henningson-Kaye, PA
13. Fairmont Area Schools, Emily Fett, Family NP and School Nurse
14. Minnesota Community Care, Reuben Moore, President and Executive Officer
    Renee Leinbach, Manager of Community Programs
    Katelyn Meaux, Registered Dietician Nutritionist
    DessaRae Smith, Manager of Nutrition Services

April 21, 2023

Re: HF2930

Chair Olson and Members of the House Ways and Means Committee,

Thank you for the opportunity to share our comments on HF2930. The Minnesota Social Service Association (MSSA) is made up of over 4,000 health and human service professionals statewide. Our members cover the health and human service spectrum—mental health providers, social workers, case managers, etc.—and are employed by for-profit and nonprofit entities, as well as state and local government agencies. We are grateful for vast provisions included in HF2930 to transform health and health care. Below are inclusions we are particularly grateful for:

Human Services Provider Safety

We are thankful for the provision to include HF1494 in HF2930. This provision would provide grants to human services organizations to invest in workplace safety measures. Grants would be used, at an agency's discretion, to pay for safety equipment; systems to track, monitor, and prevent violence; training; support; and follow-up services. The grant will also help collect data to determine meaningful future policy changes. This provision will help address a critical component of HHS provider burnout and the workforce shortage by providing human services agencies with the resources they need to ensure the safety of their employees.

In human services, this grant money will go a long way and have a lasting impact. A grant of $5,000 can pay for a “train-the-trainer” safety program which provides a human services provider with safety training they can bring back to their agency and use to train other staff in techniques such as crisis prevention and de-escalation. Additionally, higher grant amounts as would be allowed by this investment also make a big difference for human services providers. A grant of $50,000 can pay for an entire security system for one shelter site which helps ensure staff and residents remain safe by preventing safety incidents and being able to address them when they do. We are incredibly grateful for the inclusion of this funding and hope to see it in the final joint agreement between the House and Senate.

Continuous Medical Assistance (MA) Eligibility

We are thankful for the included provision to provide continuous MA eligibility for children. This will help ensure young children who are enrolled in Medicaid have uninterrupted continuous coverage from the time they are first determined eligible until age six. Consistent access to medical care and check-ups improves children’s health outcomes, supports school readiness, supports health equity, and lowers administrative burdens on families. Continuous coverage will help children be prepared for all future physical, mental, and emotional learning. It will also reduce churn –the temporary loss of Medicaid coverage in which enrollees disenroll and then

re-enroll within a short period of time –and allow for more predictable access to care, facilitating early screenings and early interventions that improve health outcomes.

Thank you again for the opportunity to share our support on behalf of our members and the clients they serve. Please reach out to us with questions, comments, or concerns at msancartier@mnssa.org.

Sincerely,

Michelle SanCartier
MSSA Director of Public Policy & Advocacy
Minnesota Social Service Association

Beth Ringer
MSSA Executive Director
Minnesota Social Service Association

MINNESOTA CHAPTER

Representative Liz Olson, Chair
Health Finance and Policy
April 20, 2023

Chair Olson and Ways and Means Committee Members,

On behalf of the National Association of Social Workers, MN Chapter (NASW - MN) and the MN Coalition of Licensed Social Workers (Coalition of Social Workers), we are writing in support of several components in House File 2930.

NASW - MN is the largest membership organization of professional social workers in our state, representing over 2000 social workers. The Coalition of Social Workers unifies membership organizations for licensed social workers. Collectively, we work as mental health professionals, in child welfare systems, nursing homes, health care, home care settings, schools, and residential care. We advocate for people who are positively impacted by components of this bill, and want to ensure that social work professionals are supported in their work.

We appreciate a number of provisions in this bill. Specifically:

Extending Telehealth: Extending the eligibility of audio-only communication and parity for telehealth while the study is completed eliminates barriers vulnerable populations face while attempting to access mental health services.

988 Suicide and Crisis Lifeline: Our community is best served by a whole-person approach to health that includes emergency mental health support for those in crisis, and stable funding will maintain this service.

Bridge Rate Increase: Implementing a temporary bridging rate increase for outpatient MA and MinnesotaCare services will allow clinicians to serve the mental health needs of the most vulnerable Minnesotans with fair payment while we wait for a more permanent solution.

Supporting the Mental Health Workforce: People seeking mental health support deserve the highest quality of care, and that includes the option to choose among professionals who share their identity and lived experiences. This bill supports workforce development activities that recruit and train mental health practitioners and professionals from diverse racial, cultural, and ethnic communities.

Thank you for your work on this bill, and we appreciate your consideration.

Sincerely,

Karen E. Goodenough, PhD, LGSW
Executive Director
NASW-MN

Karen A. Frees, MSSW, LICSW

Karen Frees, MSSW, LICSW
Chair
Coalition of Social Workers

Jennifer Arneson

Jenny Arneson, MSW, LGSW
Legislative Consultant
NASW-MN
Coalition of Social Workers

MARCH 2023

HEALTHCARE FOR ALL

UNIDOS MN
COMMUNITY • LEADERSHIP • POWER

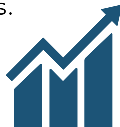
MinnesotaCare Immigrant Inclusion Act

It's time for essential workers to access healthcare

The MinnesotaCare Immigrant Inclusion Act allows mixed-status families access to MinnesotaCare. Currently, the District of Columbia, Illinois, New York, Oregon, and California provide health coverage to individuals regardless of immigration status. The MinnesotaCare Immigrant Inclusion Act will ensure Minnesota has a healthcare system that does not leave anyone behind.

Access to healthcare is good for all Minnesotans

The COVID-19 pandemic made it clear that the relationship between community health and economic health is tied together. Frontline, mixed-status families kept Minnesota running - at a disproportionately greater risk to their health and safety, while we sheltered at home. Essential sectors such as agriculture, food service, manufacturing, and construction are thus critical to Minnesota, and health coverage for these essential workers ensures our economic success.



Individuals without status make Minnesota stronger

People who move here to make a better life for their families make Minnesota a more prosperous state. Minnesotans without status largely work jobs in essential sectors that an aging and more educated U.S workforce is unable to fill and show high labor force participation rates. This is especially important for Greater Minnesota, which has an older population than the Twin Cities, with 18.2 percent of the population aged 65 years and over, compared to 14.0 percent in the metro area. Mixed-status families keep the state's economy going.

Preventive healthcare for all closes economic gaps

Investing in preventive care saves costs in the long run. Expanding healthcare coverage for all means improving the management of chronic conditions, catching issues early, and lowering the use of emergency departments. Across the state, healthcare providers support this policy because they have seen firsthand how health issues become much worse and more complicated when care is delayed.

Workers without status already pay their fair share

Undocumented members of mixed-status families pay federal, state, and local taxes and are ineligible for several state tax credits. According to the Minnesota Department of Revenue, in 2018, ITIN-filing taxpayers contributed 31M to the state. Because immigrants, especially undocumented immigrants, have lower health care use despite contributing billions of dollars in insurance premiums and taxes, these essential workers help subsidize the U.S. healthcare system and offset the costs of care incurred by US-born citizens. Immigrants pay their proportionate share of taxes and in some cases contribute even more to state revenue than US-born Minnesotans.

1. Mixed status working families might have one parent with documentation, one parent without documentation and U.S citizen children.
2. Kaiser Family Foundation, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/
3. International Monetary Fund, https://www.imf.org/en/Blogs/Articles/2021/12/02/the-economics-of-health-and-well-being
4. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/MN
5. Institute of Taxation and Economic Policy, https://itep.org/undocumented-immigrants-state-local-tax-contributions-2017/
6. Minnesota PY's 2022-2023, https://mn.gov/deed/assets/wioa-state-plan-2022-modification_tcm1045-538654.pdf
7. 81,000 undocumented immigrants are estimated to live in Minnesota, about 1.4% of the total state population.
8. https://crsreports.congress.gov/product/pdf/R/R47351
9. JAMA Network, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798221

For more information contact Sara Lopez, Policy Director sara@unidos-mn.org
or Sarah Greenfield sgreen@oconnellconsulting.net

Why We Left

2023 Nursing Workforce Report

EXECUTIVE SUMMARY

There is a staffing and retention crisis in Minnesota hospitals which leaves nurses stretched thin trying to do more with less. Executives have created unsafe and unsustainable conditions for nurses and patients in our hospitals. By focusing on the bottom line, hospital executives are driving nurses away from the bedside, putting patient care at risk.

Studies conducted by the Minnesota Nurses Association of its current members, former members, and of the general public make this point clear:

- Minnesotans understand the nature of the staffing and retention crisis, as **85 percent believe it will not be solved without direct action,** and **two-thirds understand that hospital executives created the problem before the pandemic.**
- There is **no shortage of registered nurses in Minnesota**, with **more than 122,000 nurses** here, the **highest ever** in state history
- Over **50 percent** of nurses nationally are **considering leaving the bedside**, citing **under staffing by hospital executives** as their top concern
- In **nearly 90 percent of cases** where MNA nurses filed a concern over the impact of short staffing on patient care, the nurses reported **no response** or **inadequate action** from **hospital management**.
- In this new survey of 2,403 MNA nurses who left their bedside nursing positions, the **top-cited reasons for their departure** by respondents were **stress and "burnout" (75 percent), chronic under-staffing (71 percent), working conditions (63 percent) and management issues (49 percent).**
- **Improved staffing** was the number one condition needed f**or nurses to return to the bedside**, cited by **63 percent** of nurse respondents.
- **Nearly 40 percent of nurses who left** the bedside in 2022 had only been in their **nursing careers for less than five years.**
- **Over 75 percent of MNA members have indicated their desire to stay at the bedside** for the near future.

These findings are supported and reinforced by independent studies and research. One recent survey, conducted in November 2022 by OnePoll and connectRN, found that:

- **50 percent of nurses** are considering **leaving the profession** altogether.
- **61 percent cited insufficient staffing** as the biggest contributing factor
- **58 percent** of nurses feel hospital executives are **not doing enough** to solve the staffing crisis

Additionally, recent scholarly research from the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing found that:

- High levels of nurse burnout, job dissatisfaction, and intent to leave their employer predated the pandemic
- Prior to the pandemic, 57 percent of hospital staff nurses said there were too few nurses to care for patients
- Over 69 percent of hospital staff nurses in the pre-pandemic period reported a lack of confidence in hospital management to resolve clinical care problems reported by nurses

BACKGROUND

Minnesota nurses are overworked and overwhelmed, hospitals are understaffed, and patients are overcharged by hospital executives trying to boost their bottom lines. Years of short-staffing and cost-cutting by hospital CEOs leave nurses trying to do more with less.

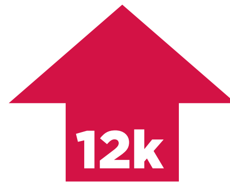
These conditions that hospital CEOs created are driving nurses away from the profession and putting patient care at risk. There is no shortage of nurses who want to care for patients, there is a shortage of nurses willing to work under these unsafe and unsustainable conditions.

- In 2014, the **Minnesota Hospital Association** (MHA) issued a study which found "**the state-level supply of RNs will more than meet the demand"** through 2024, assuming that RN graduate numbers continue to climb; this conclusion is echoed by the U.S. Department of Health and Human Services which projects a **surplus of registered nurses in Minnesota** through 2030

- A 2022 report from the MN Board of Nursing shows that **new RN graduates continue to climb** in Minnesota **every year**

- The n**umber of registered nurses in Minnesota has increased by over 12,000 in the past four years** to a total of **122,247** last year, the **highest ever** recorded in the state

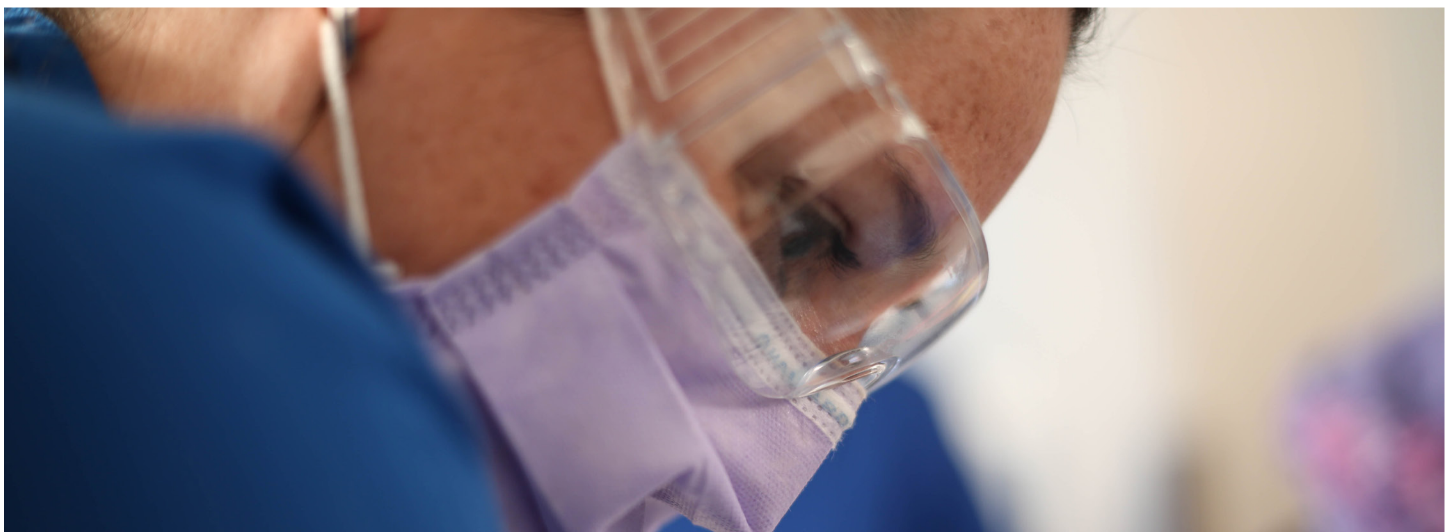
IN THE LAST FOUR YEARS



Over 122,000 total RNs in MN
highest-ever total nurses

Now, Minnesota nurses are advocating for changes that will retain nurses and prioritize quality patient care by ensuring adequate nurse staffing levels and fair compensation and benefits, putting nurses and patients at the bedside ahead of hospital CEOs and corporate profits in the boardroom.

Our healthcare workforce is in critical condition. The future of our healthcare system in Minnesota depends on the choices we make now.



EXISTING SURVEYS

In the last three years, the Minnesota Nurses Association conducted extensive studies of both its membership and of the Minnesota public to better understand the scope and severity of the staffing and retention crisis in our hospitals.

Before exploring the details of the Workforce Report below, several highlights from these previous MNA surveys are worth revisiting.

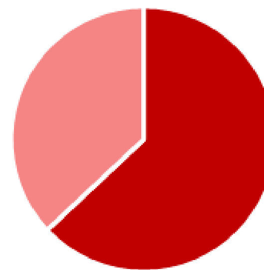
2021 MNA Member Survey

In 2021, MNA conducted a survey of members, asking a variety of questions about their experiences in the nursing profession.

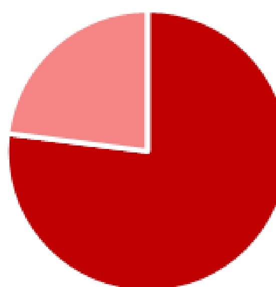
Among the highlights of this survey:

- **55 percent** of nurses reported that they had experienced a situation where they were **not able to provide the care the patient required due to short staffing**
- **44 percent** reported **patient safety had gotten worse** in their hospital over the **last five years, while only 6 percent felt it had improved**
- **63 percent** reported that they had **considered leaving their job** or the profession altogether, or that they **knew someone who had,** due to being **overworked and understaffed**
- Over **75 percent** of nurses reported that they **wanted to stay on the job and in the profession** for at least four more years

Considering leaving the bedside, or know someone who has



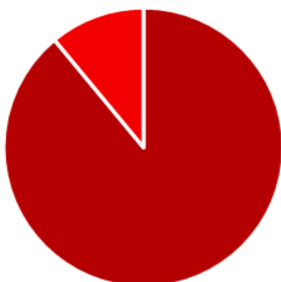
Want to stay at the bedside for the near future



Concern for Safe Staffing Forms

In Minnesota, nurses voluntarily file Concern for Safe Staffing (CFSS) Forms when they encounter situations where short staffing is negatively impacting patient care.

No response or insufficient action from hospital management



A survey of CFSS forms from 2022 reveals:

- Minnesota nurses filed **8,437 CFSS forms** in 2022, more than a 7 percent increase from 2021.
- In **over 89 percent of those cases**, nurses reported **no response or inadequate action** from **hospital management** when they brought up concerns for patient safety, which is an increase of almost 8% since last year.
- Nearly 8**0 percent of cases reported delays in patient care**, a 9.2 percent increase compared to 2021.

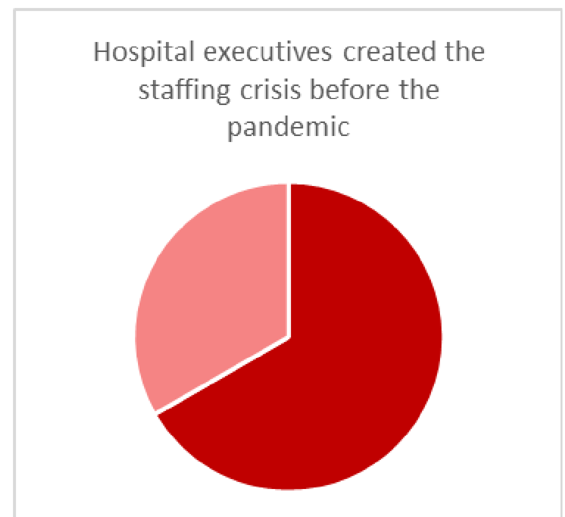
2022 MNA Workplace Violence Survey

In 2022, MNA conducted a survey of 950 nurse members about the challenges of violence against nurses and patients in Minnesota hospitals. Nurses in the survey reported that:

- **97 percent** of nurses **observed workplace violence** in the last two years, including verbal abuse, intimidation, harassment, and physical violence.
- **Only 47 percent reported** these incidents to their employer, citing a l**ack of time, inadequate staffing, and lack of management action** as the top barriers to reporting.
- **75 percent of nurses cited chronic under-staffing** as a top risk factor for an unsafe work environment, second only to the risks that specific patients might present.
- **62 percent of nurses** believe **patient safety is at risk** due to violence in Minnesota hospitals.
- **65 percent of nurses** believe **hospital executives** have **not adequately prepared** them to prevent or respond to violence.
- **Over half** of all nurse respondents – 53 percent – **have considered leaving** their job or nursing entirely due to violence

2022 MNA Public Polling

In 2022, MNA conducted public polling of registered voters in Minnesota. In this poll, Minnesotans shared the following:



- As patients and family members who see the effects of under staffing, long wait times, and other corporate healthcare policies firsthand, Minnesotans understand the nature of the staffing and retention crisis, and **85 percent understand it will not be solved without corrective action.**
- **Two-thirds of Minnesotans understand that hospital executives** created the problem and that it p**re-dates the pandemic.**
- Minnesotans believe **hospital CEOs can afford to make the changes necessary** to fix the problems they created.
- Minnesotans are especially concerned with the **high salaries and compensation of hospital executives** in Minnesota, who take home **multi-million-dollar salaries while nurses are understaffed and patients are overcharged.**

"'Nominally nonprofit community-spirited institutions have actually come to operate as profit-maximizing monopolies,' with the excess going to executive compensation instead of dividends"

Phil Longman, Policy Director, Open Markets Institute
The Intercept, December 20, 2020

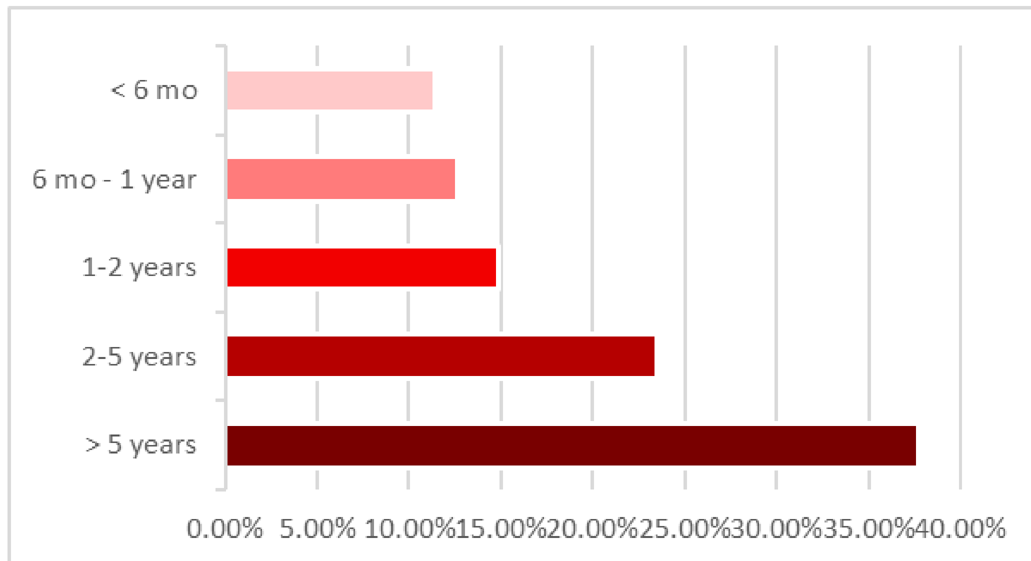
WHY WE LEFT: 2023 MNA WORKFORCE REPORT

Between December 20, 2022 and February 8, 2023, MNA surveyed 2,403 nurse members who left a bedside nursing position within the past year and did not take a new position in an MNA-represented hospital. MNA received responses from 499 nurses who fit this criteria.

The survey focused on determining why nurses left these bedside positions, and asked questions including:

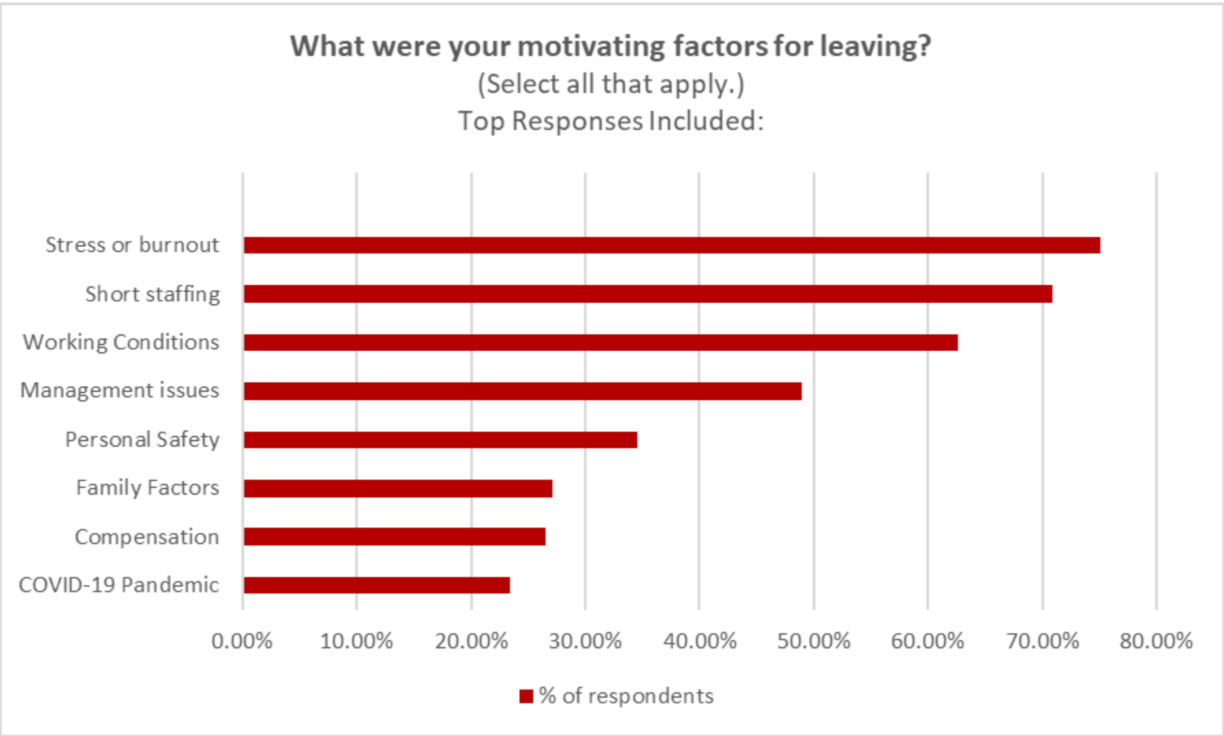
- How long the nurse had been at the bedside
- When the nurse left the bedside
- Whether they had another job when they left
- If they are currently working elsewhere as an RN
- Why they left bedside nursing
- What they would need to return to the bedside

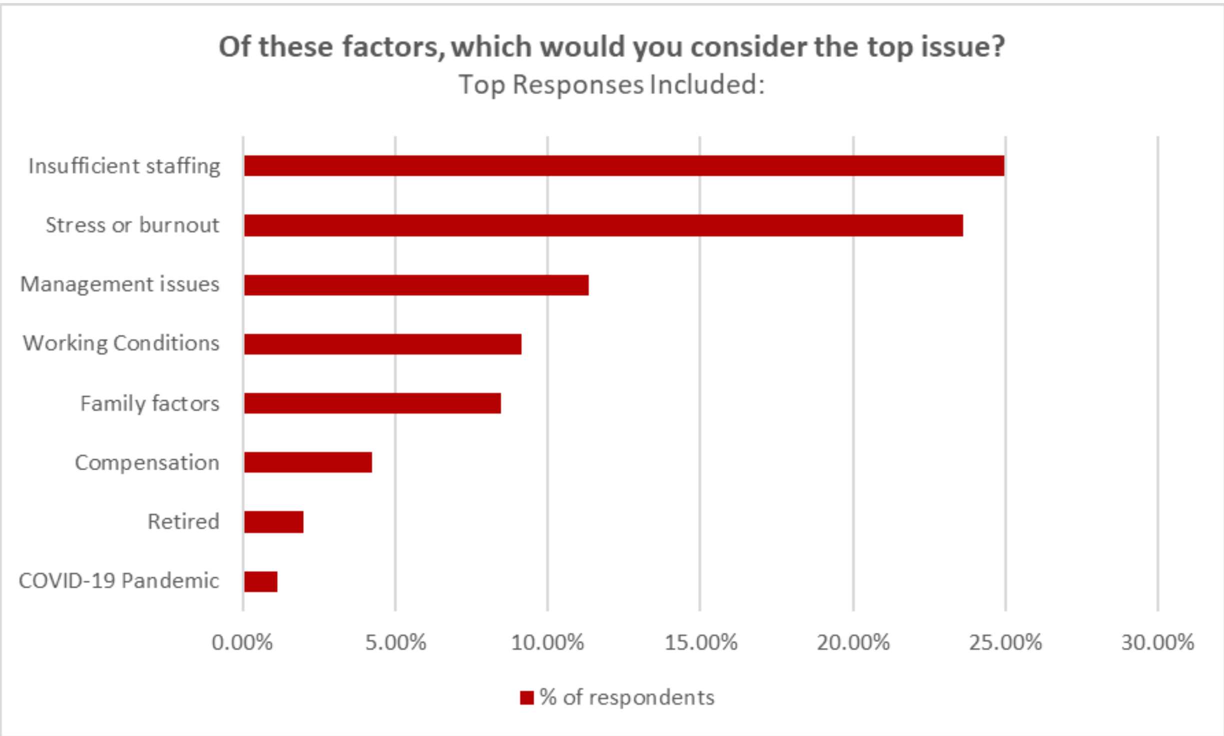
How long had you been in this position before you left?



"Everybody wants the nurse with 10 years of ICU experience when they come in the door… successful organizations develop their own work forces and invest in young people and help them to become experts over time and then create policies to retain them."

Linda Aiken, PhD, RN
Founding Director, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing
MedPage Today, December 30, 2022


What were your motivating factors for leaving?
(Select all that apply.)
Top Responses Included:
Stress or burnout
Short staffing
Working Conditions
Management issues
Personal Safety
Family Factors
Compensation
COVID-19 Pandemic
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
% of respondents

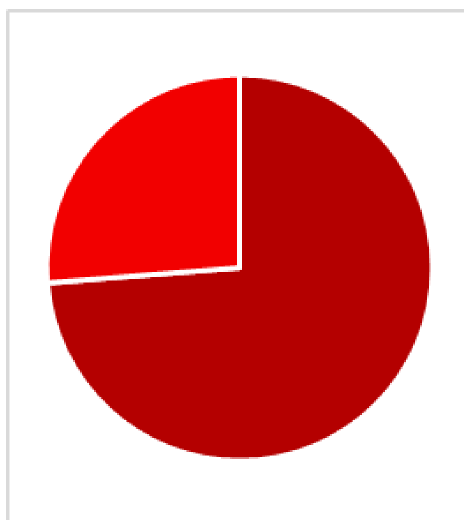

Of these factors, which would you consider the top issue?
Top Responses Included:
Insufficient staffing
Stress or burnout
Management issues
Working Conditions
Family factors
Compensation
Retired
COVID-19 Pandemic
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
% of respondents

Highlights of this data show:

- **Stress and "burnout" (75 percent), chronic under-staffing (71 percent), working conditions (63 percent) and management issues (49 percent) were the top drivers of nurse departures.**
- In particular, **insufficient staffing was the singular top issue cited** by nurses as the reason they left their bedside care position.
- Of those who identified **stress or so-called "burnout"** as a driving factor in their departure, nearly **82 percent also cited short staffing** concerns, **71 percent cited working conditions,** and **52 percent cited management concerns.**
- **Compensation and the COVID-19 pandemic** were among the lowest-cited reasons to leave the bedside; of those who cited the pandemic, over **90 percent also cited stress or "burnout"** and over **84 percent cited short staffing** as contributing to their decision to leave bedside nursing.
- Of the **31 nurses who reported retiring, 100 percent cited stress or "burnout," 77 percent cited short staffing,** and **64 percent cited working conditions** as contributing factors.

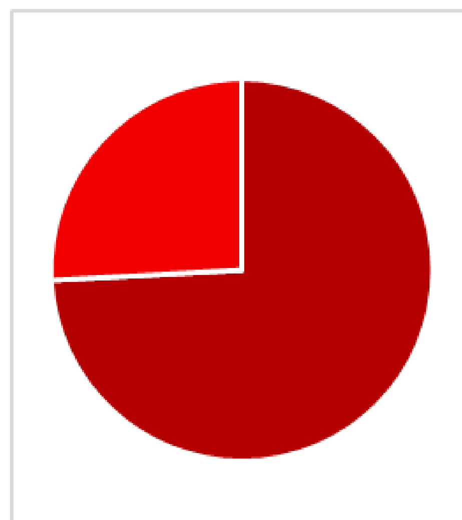
"Burnout" and Moral Injury
As described in the 2020 "Deadly Shame" report from National Nurses United, the term "burnout" refers to the issues of moral distress and moral injury which nurses experience from working under the conditions CEOs have created in our hospitals including insufficient nurse staffing, rationing and crisis standards of care, and limited resources including support staff, beds, medications, or supplies.

Did you secure new employment before leaving?



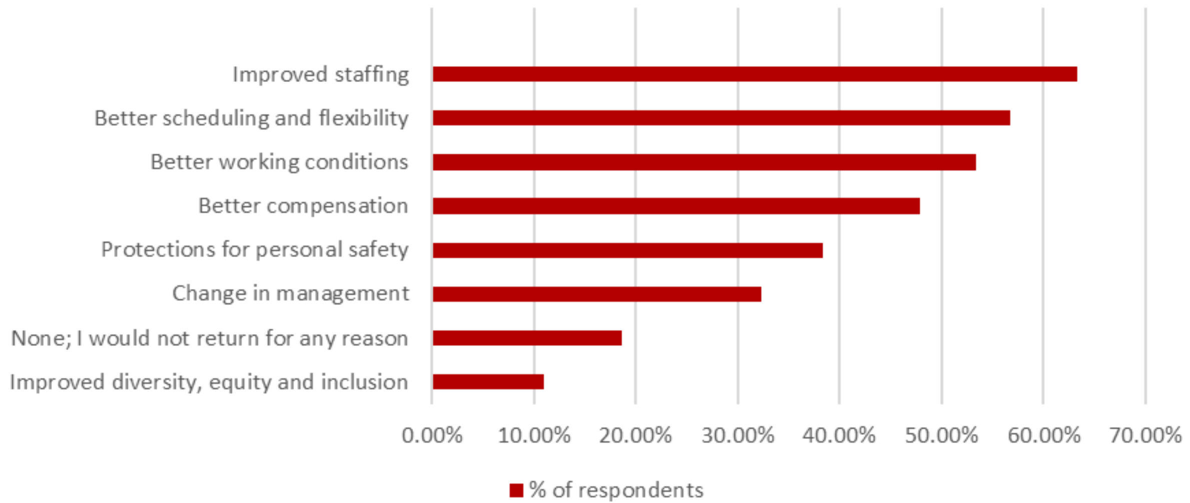
Yes 74% | No 26%

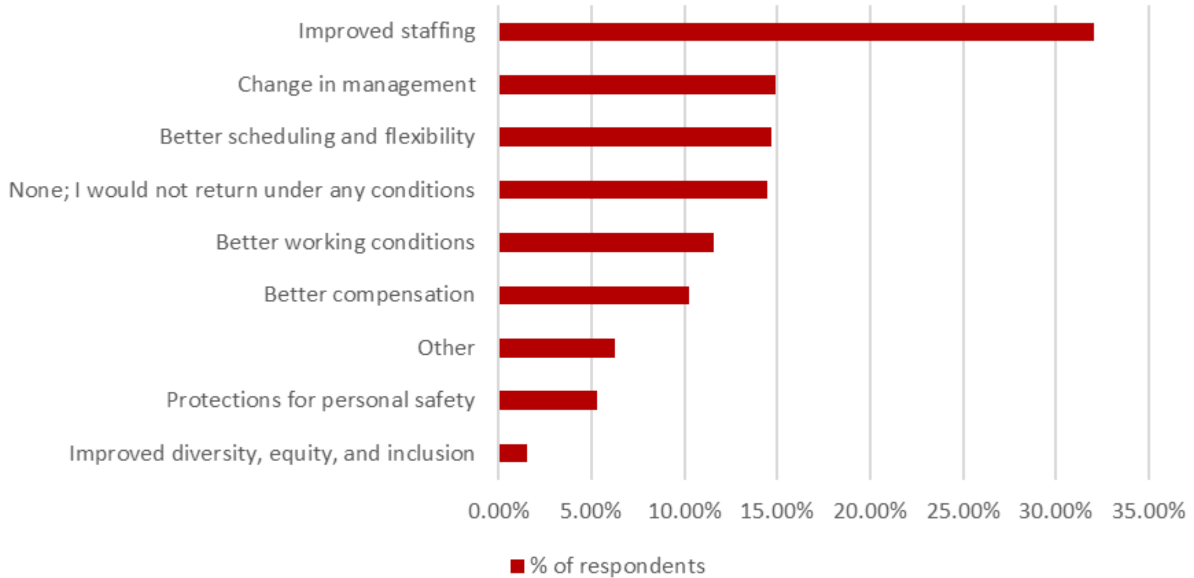
Are you currently working as an RN?



Yes 75% | No 25%

"All this business of people throwing up their arms and saying 'There are not nurses to hire because they've all left' [is] not really true... leaving your employer is not the same as leaving the field of patient care or even leaving hospitals."
Linda Aiken, PhD, RN
Founding Director, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing
MedPage Today, December 30, 2022


What changes would you need to see to get you to return to hospital bedside nursing?
(Select all that apply.)
Top Responses Included:
Improved staffing
Better scheduling and flexibility
Better working conditions
Better compensation
Protections for personal safety
Change in management
None; I would not return for any reason
Improved diversity, equity and inclusion
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
% of respondents


Of these factors, which would you consider the most important?
Top Responses Included:
Improved staffing
Change in management
Better scheduling and flexibility
None; I would not return under any conditions
Better working conditions
Better compensation
Other
Protections for personal safety
Improved diversity, equity, and inclusion
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
35.00%
% of respondents

SAMPLE RESPONSES

Below is a sampling of responses from the survey to the question: Please elaborate on why you left your previous position. These responses are being presented anonymously, and with minimal editing for content and clarity, to protect the confidentiality of survey respondents.

"Burn out, unmanageable nurse to patient ratios. Constant understaffing, not enough CNA's resulting in impossible conditions for RNs."

"There's not enough time and resources to care for patients the way they deserve to be cared for. Not enough time for walks, safe med administration, even toileting. A patient asked me, 'If you don't come to help me to the bathroom when I push my call button, should I just pee in the bed?' That's the kind of care we're forced to give. This causes severe moral injury. I'm not burnt out, I'm morally injured. I loved caring for patients. I would come back to the bedside if the conditions and compensation were safe for all."

"No support. Greedy management kept adding patients when they knew there was not enough staff to safely take care of patients."

"My previous hospital that I loved was closed due to corporate greed... I tried out [another hospital] – this was the most miserable nursing position I've ever held. Always short staffed, managers tried to make us feel guilty like we weren't team players when we wouldn't pick up double shifts to fix the lack of staff problem. There was a severe & poor low staffing ratios as far as support staff... I never felt so unsupported and short staffed... while taking care of struggling COVID patients on bipap. I just couldn't do it anymore. It wasn't safe. I witnessed turnover like I've never seen in my whole career as a nurse. In one year's time I was at the halfway point on the seniority list. I gave [the hospital] one year, a year I will never get back."

"Multiple events of taking care of patients who needed ICU management on a med-surg floor with 5-6 other patients. Multiple violent experiences with patients resulting in 'paid leave' without support from physicians or management."

"Staffing was horrible and getting worse. It was not realistic in a level 4 NICU and I was afraid that I would miss something big on a patient and they would come to harm because I had to focus on more patients than was safe. I saw this happen to other nurses and patients and it was 100% because of staffing. Management was not supportive of nurses from the top down."

"I left bedside nursing because I was sick and tired of being understaffed all the time and management/CEOs did not care. We are keeping sick people alive a lot longer now and the acuity is much higher than ever before. We constantly were out of supplies or equipment did not work. I was constantly told to do more with less resources. I don't mind hard work, actually love it but when you don't have the support and are forced to do more than you can handle it wears on you. We continuously had to take patients unsafely but because our 'grid' said we can, we couldn't say no. I was also sick of working on Holidays, weekends and night shift. No matter what management/CEOs say, they don't really care about the actual person in that bed. They care about the money. And what they won't earn if the numbers don't align with their narrative."

CONCLUSION

Minnesota nurses want to be at the bedside doing what they love, providing exceptional care to their patients. But the corporate healthcare policies of hospital CEOs are driving nurses away from the bedside.

There are more than enough nurses in Minnesota to meet the needs in our hospitals. These nurses want to stay at the bedside for the near future, despite the often unsafe and unsupportive work environments they have faced.

However, without changes that will solve the crisis of under-staffing and retention which hospital CEOs created, nurses will continue to be pushed away from the bedside and from the careers and patients they love.

Minnesota nurses are ready to fight and win legislation and contract language to put patients before profits, retain nurses at the bedside, and prioritize quality patient care throughout Minnesota.

APPENDIX: Methodology

MNA Public Poll

On behalf of the Minnesota Nurses Association, Change Research surveyed 1,025 registered voters in Minnesota between January 8-10, 2022. Respondents were recruited into an online survey instrument via Dynamic Online Sampling which continuously rebalances online advertisements to obtain a representative sample. Post-stratification was done on gender, region, age, ethnicity, education, and 2020 vote.

MNA Workforce Survey

Between December 20, 2022 and February 8, 2023, MNA surveyed 2,403 nurse members who left a bedside nursing position within the past year and did not take a new position in an MNA-represented hospital. MNA received responses from 499 nurses who fit these criteria.

MNA
Minnesota Nurses Association
An Affiliate of
National
Nurses
United

April 21st, 2023

Professional Distinction

Personal Dignity

Patient Advocacy

Chair Liz Olson
Members of the Ways and Means Committee
Minnesota State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Chair Olson and members of the Ways and Means Committee:

With 22,000 members, the Minnesota Nurses Association (MNA) represents 80 percent of all active bedside hospital nurses in Minnesota and is the largest voice for professional nursing in the state. We are a leader in nursing, labor, health care and social justice communities and a voice for nurses and patients on issues relating to the professional, economic, and general well-being of nurses and in promoting the health and well-being of the public.

The following are some provisions included in the HF2930, the Health Finance and Policy Omnibus bill, which we support:

Provisions from HF 1700 Keeping Nurses at the Bedside Act

Our hospitals are in crisis with patients waiting for hours and even days in our emergency departments; being boarded and not receiving appropriate care; or receiving that care in unsuitable and undignified spaces such as hallways and the waiting room of emergency departments. This inappropriate type of care is perpetuating thousands more registered nurses leaving the bedside due to incredible stress, physical assaults, and the moral injury they sustain when they do not have the resources and time to provide the care their patients deserve. These provisions included in the omnibus bill provide nurses and other healthcare workers a voice in staffing in their hospitals through a comprehensive, local, and flexible approach to ensure patients are receiving the best care from their nurses. The omnibus bill also includes multiple other recruitment and retention solutions such as workplace violence prevention and loan forgiveness programs. We applaud Chair Liebling and the Health committee's inclusion of these important steps to bring nurses back to the bedside and help solve the crisis in our hospitals.

Hospital Merger Regulation and HMO Conversion Moratorium

MNA is proud to support the provisions from House File 402 included in the omnibus bill because it provides the Attorney General and Department of Health with the authorities and tools desperately needed to protect patients,

345 Randolph Avenue
Suite 200
St. Paul, MN 55102
Tel: 651.414.2800
800.536.4662
Fax: 651.695.7000
Email: mnnurses@mnnurses.org
Web: www.mnnurses.org

AFL-CIO

communities, healthcare workers, and our state healthcare delivery system from the harms caused by consolidation and corporatization. We know that nationally, regionally, and right here in Minnesota, corporatization leads to vital services being stripped from rural and lower-income communities and shuttled to larger facilities further and further away. Consolidation raises prices, lowers accessibility, and has negative longstanding impacts on patients and communities. This provision establishes new safeguards at the state level for preventing harmful mergers and transactions and outlines a comprehensive and data-informed approach for ensuring that only transactions that would provide for the public good can move forward, while also preventing charitable assets from being transferred to a for-profit entity. The bill also extends the moratorium on health maintenance organization (HMO) conversions and authorizes a study on regulating nonprofit and for-profit HMO transactions to ensure Minnesotans have quality products available for their health insurance that best match the needs of our state.

MN Health Plan Study

MNA strongly supports the provisions for a study that examines the costs and benefits of a universal healthcare system, in comparison with the current public and private healthcare financing system. In other countries with some form of public healthcare financing, costs to patients and taxpayers are far lower, and health outcomes are better. We support this study to show how a public healthcare system in Minnesota would compare to our current patchwork of public and private insurance. In our current complicated, expensive, and inefficient system, too many Minnesotans are underinsured; rationing medications; delaying or skipping care due to cost; and going into debt or even bankruptcy due to healthcare bills. Minnesotans deserve to know what our healthcare could look like if the profit motive of insurance, hospital corporations and pharmaceutical companies was removed, and resources were invested into actual care.

Opting Out of Managed Care Plans

We are excited to see meaningful reform to our public health options to ensure that enrollees have choices in the care they receive through being able to opt out of managed care plans. MNA’s strong support of public programs is, in part, rooted in deep concerns about the impact of privatization which forces individuals to enroll into HMO plans that are not demonstrated to improve the quality-of-care people receive. Instead, data shows that HMO plans profit by reducing access to providers, increasing denials for medically necessary services, and removing individuals' ability to make their own healthcare decisions. This system further removes transparency from the process and requires publicly funded programs to pay private insurance companies to manage these important benefits without ensuring they are improving the quality of patient care and healthcare access.

Eligibility for Undocumented Individuals and Continuous Enrollment

We also express our support for continuous eligibility for Medicaid coverage and including undocumented individuals in coverage for MN Care. All Minnesotans deserve access to affordable and accessible healthcare regardless of income and immigration status. Our state saves money and lives when we provide healthcare to everyone. Continuous eligibility ensures that individuals and families who are already enrolled in Medicaid do not lose coverage due to administrative hurdles or minor fluctuations in income, and that the youngest Minnesotans in the state have consistent access to healthcare coverage. Thank you for your work to support a better healthcare system.

Repealing Productive Injustice Act

We know that most Minnesotans support access to full reproductive healthcare options and for individuals to have autonomy over medical decisions affecting them. MNA's own stance reflects support of this position as well. Unfortunately, there are many laws in place that prevent full access to healthcare. Nurses see the results of these policies regularly in their own profession. The barriers listed above often result in more serious healthcare issues which burden our already understaffed emergency departments and hospitals. As Minnesota begins to see an increase in patients coming from bordering states to receive reproductive care, it will even further exacerbate this issue. Now is the time for Minnesota to remove these harmful policies and ensure that we continue to be a leader in providing equitable healthcare, access and support for those in need. For the health, safety, and economic well-being of patients and nurses across the state, we strongly support this provision.

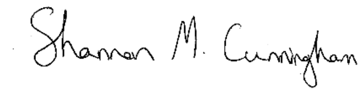
Telehealth

The pandemic revealed more clearly both the inequities in the health care system and the possibility of new technology to help more people access care. As MNA works through this language more closely, we want to ensure that telehealth does not replace individualized care at the bedside and that lack of local broadband infrastructure and economic barriers to accessing necessary equipment and internet service do not exacerbate health care issues that already exist in Minnesota.

Just as patients depend on nurses to care for them at the bedside, Minnesotans across the state are counting on legislators to ensure they have access to quality, affordable care. The overall focus on ensuring better access to healthcare is incredible and we strongly support this work to ensure our healthcare system functions better for all Minnesotans.

We appreciate and are grateful for the work and passion put into this omnibus bill and look forward to working with you all over the next weeks to continue building on this critical piece of legislation.

Thank you,



Shannon M. Cunningham
Direction of Community and Government Relations
Minnesota Nurses Association

April 20, 2023

The Honorable Liz Olson
Chair, House Ways and Means Committee
479 State Office Building
St. Paul, MN 55155

Re: Support for provisions in House File 2930

Dear Chair Olson and members of the committee:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to comment on HF 2930, the House HHS omnibus bill for the session.

LLS encourages your committee to support the following patient-friendly provisions in the bill:

1. Drug Formulary Committee composition reform (Article 1, Section 13)
   Bringing more patient voices to the table and improving public transparency in the Drug Formulary Committee's work will help the Committee make decisions that better meet the needs of the patients it serves.

2. Continuous eligibility for Medical Assistance (MA) child enrollees (Article 2, Section 12)
   Coverage gaps are potentially disastrous at any age. These changes will promote coverage stability for children, financial stability for families, and greater health equity for underserved communities.

3. Elimination of MA cost-sharing and deductibles (Article 2, Section 13)
   Especially for lower-income families, cost-sharing measures lead to diminished coverage, increased financial burdens, and poorer access to care. This proposed change in state law will help prevent these harmful outcomes that impact blood cancer patients and other Minnesotans.

4. MinnesotaCare coverage expansion (Article 2, Sections 21, 22, and 24 to 28)
   Cancer patients must have meaningful health insurance coverage to access the care they need. Their lives literally depend on it. Given the intent of this section of the amendment to establish new, competitive coverage options for Minnesota patients that offer comprehensive benefits with reasonable cost-sharing limits, adequate provider networks, and vital consumer protections, LLS supports these sections of the bill.

Office of Public Policy
10 G St NE
Suite 400
Washington, DC 20002
www.LLS.org

5. All-payer claims data provisions (Article 3, Sections 32 to 34)
   These provisions will deliver important transparency and more comprehensive data to inform the analysis of healthcare cost trends in Minnesota.

6. Health equity programs (Article 3, Sections 39 to 44, and Section 126)
   Some groups—including but not limited to people of color, those with low incomes, people who identify as LGBTQIA and those who live in rural areas—face systemic social, economic and environmental disadvantages that can impact their care. The programs created in these bill sections will help Minnesota take overdue steps forward to address these disadvantages.

7. Coverage screening and billing protections for uninsured patients (Article 3, Sections 74 and 76)
   Screening for presumptive eligibility for charity care or health insurance will provide essential protections to patients who may be uninsured yet eligible for coverage or cost-sharing supports. Similarly, billing protections will ensure that most uninsured Minnesotans are charged favorable prices for care. Both measures will reduce the risks and burdens of uninsurance.

8. Nonidentifying cancer data collection (Article 3, Section 85)
   This provision will help Minnesota participate more fully in federal and state cancer data registries without compromising patient privacy, improving the quality of policy decision-making and public health analysis impacted by these registries. Minnesota is one of few states that are not fully compliant with these data coordination standards.

9. Palliative Care Advisory Council (Article 3, Sections 194 and 204, plus markup spreadsheet)
   Palliative care help patients, caregivers, and families on multiple levels. Minnesota's Palliative Care Advisory Council strives to improve access and quality in this field and will benefit from restored staff funding and the elimination of its sunset date. LLS supports these measures and encourages the House to join the Senate in funding a study of the value of a comprehensive palliative care benefit for Medical Assistance and MinnesotaCare enrollees.

LLS hopes your committee will support the policies outlined in our letter and welcomes the opportunity to answer any questions you might have. Thank you for considering our views.

Sincerely,

Dana Bacon
Senior Director, State Government Affairs
The Leukemia & Lymphoma Society
dana.bacon@lls.org | 612.308.0479

663 UNIVERSITY AVENUE WEST
SUITE 200
SAINT PAUL, MN 55104

PHONE 651.789.2090

Rep. Tina Liebling
477 State Office Building
St. Paul, MN 55155

March 28th, 2023

Chair Liebling and Members of the Committee:

Gender Justice is the organizational home of UnRestrict Minnesota, an expansive, diverse, and inclusive coalition for reproductive rights, health, and justice. UnRestrict Minnesota is a multi-racial coalition of more than 30 health care clinics, abortion funds, practical support groups, LGBTQ advocacy groups, faith communities, organizers, lawyers, doulas, and many more.

Our coalition represents the majority of Minnesotans. Across the state, Minnesotans have made their support for abortion rights abundantly clear — including by sending to the legislature our state's first pro-reproductive-freedom majority ever.

We are writing in support of the Health Finance and Policy Omnibus Bill (HF2930). In particular we are grateful for the inclusion of provisions from the Reproductive Freedom Codification Act (HF91), to remove unconstitutional, outdated, unjust, and harmful statutes and the increase in reimbursement rates for abortion and family planning services.

Some of these provisions repeal statutes that were found unconstitutional this past summer. Lifting these restrictions had an immediate positive impact on patients, both Minnesotans, and people from the upper midwest and across the country who have lost meaningful access to reproductive health care in their home states. It was a proud moment for our state — an important step toward bringing our laws into line with the values that the majority of Minnesotans hold. Leaving these unconstitutional laws in statute creates confusion and uncertainty for providers and patients.

A majority of Minnesotans support repealing these and other restrictions on abortion, and expanding access to abortion, and they are very much looking to you to lead. In our recent statewide survey, an overwhelming 89 percent of Minnesota voters said they want to know what their elected officials are doing on the issue of abortion and want you to take decisive action.

Reproductive rights are meaningless without access. Abortion services are reimbursed at extremely low rates. Thus, we are grateful for including an increase to reimbursement rates for abortion and family planning services. However, we urge you to consider a 50%, rather than 10% increase. Many independent clinics see a disproportionate share of Medicaid patients and are only able to make ends meet through grants and fundraising. This is all the more

unsustainable and urgent due to the 40% increase in second trimester abortions due to restrictive laws that are increasing patient load overall in Minnesota, and the threat of nationwide changes to medication abortion due to a pending Texas court case.

When we talk about access to full spectrum reproductive health, that also includes support for pregnant people. We support increased funding for programs that benefit pregnant folks: Healthy Beginnings, Healthy Families; Perinatal Quality Collaborative; MN Partnership to Prevent Infant Mortality; Sustaining and expanding the jail program; and Maternal and Infant health programs. We also support the increase of funding for the Family Planning Special Projects program.

These proposals would help bring our laws back into line with the values and wishes of the vast majority of Minnesotans, restore reproductive rights, and increase reproductive health care access and equity throughout our state. We thank you for their inclusion, along with the myriad investments this bill makes in health, well-being, and equity for all Minnesotans. Thank you for your leadership.

Sincerely,

Megan Peterson
Executive Director, Gender Justice

Dear Chair Olson and members of the House Ways and Means Committee,

We are writing to express our concern with the MinnesotaCare public option (H.F. 2930) and the negative impact it could have on our state's healthcare system.

We cannot support a plan to rush the implementation of a state government-controlled health care system given the potential consequences for Minnesota patients and families. Experts have found in other states that government-controlled systems would likely lead to increased costs and higher taxes. Additionally, many government-controlled systems rely on cutting reimbursement to health care providers, forcing them to pass increased costs onto consumers or cut certain services. Lower reimbursement rates could force some hospitals to close, especially vulnerable hospitals in our rural communities.

That is why the expansion of MinnesotaCare to all residents should first be thoroughly studied before being implemented.

Making significant changes to our health care system without first studying the effects could undermine the existing coverage Minnesotans currently rely on. A state government-controlled system could threaten the employer-provided coverage that millions of Minnesotans depend on.

Taking hasty action that could undermine current health care coverage options in Minnesota would be especially irresponsible given how well our current system is working to improve access and coverage. Nearly 130,000 Minnesotans enrolled in coverage during this year's open enrollment period, which MNsure CEO Nate Clark called "one of the most successful" he has seen. In fact, Minnesota's uninsured rate was just four percent in 2021 – the lowest it's ever been.

We are calling for Minnesota lawmakers to take the time to ask the necessary questions and study the potential effects of this proposal before implementing the significant transformational changes in H.F. 2930. In the meantime, let's continue to work together to build on and improve our current system that is delivering access to affordable, high-quality care across Minnesota.

Sincerely,

April 21, 2023

Representative Tina Liebling
House of Representatives
477 State Office Building
St. Paul, MN 55155

RE: HF 2930 Health Omnibus bill

Dear Chair Liebling,

On behalf of Hennepin Healthcare, I write in support of several legislative proposals that will help protect, maintain, and improve the health of the many Minnesotans we serve, including various provisions in the Department of Human Services' (DHS) budget proposal, and with significant concern regarding changes to the 340B drug discount program. Increasing access to health care for Minnesotans will improve the health of our communities. We support the following proposals included in your Omnibus bill:

Increasing Access to Healthcare through Capacity and Workforce Investment
We must invest in proposals to increase both capacity and workforce to support individuals to discharge from the hospital into appropriate community settings that can better meet their needs.

- **Recuperative Care for people who are unhoused** (SF1951/HF 2081) should be paid for by Medicaid so health systems and housing providers can establish the infrastructure needed to care for people who are unhoused after an acute or post-acute health care incident, preventing hospitalization and pivoting to longer term housing.
- Restoration of matching funds for the **Medical Education and Research Costs (MERC) is not a new appropriation,** please include study group language to allow stakeholders to work with DHS and MDH to seek new options to maximize federal funding for health care education and ensure consistent funding for clinical training sites into the future. Additionally, new investments are appreciated in **expanded primary care rural training** and **mental health grants for health care professionals**.
- Support the **education and training of professionals providing mental health or substance use disorder treatment services, and provide loan forgiveness and professional scholarship grant**s (SF 1679/HF 1436).
- Prevention of violence in health care is one of the best ways we can recruit and retain staff. **Health care worker safety grant** funding for providers will protect our health care workers.
- Our safety-net health system serves patients statewide - Our **Medical Resource Control Centers (MRCC)** are major state assets used as "flight control centers" for local, regional, and state EMS agencies. The **Minnesota Poison Center**, which is housed in our hospital, assists families and Minnesotans across the state with managing and preventing poisoning or overdose incidents.

Improving Health Care Disparities
The patient population Hennepin Healthcare serves largely includes people on public programs and those disproportionately impacted by healthcare disparities. Minnesota faces some of the biggest health disparities in the nation.

- Expanding coverage options by making **MinnesotaCare available to undocumented noncitizens and continuous eligibility for children.**

- Removing the requirement of supervision by a licensed provider for doula services in MHCP, increasing access to services that help reduce maternal and infant health disparities.
- **Investing in oral health** for individuals enrolled in MHCP, including **reinstating the adult dental benefit** and establishing a **dental home pilot project**.
- Extended authority for the use of **audio-only telehealth** in MHCP.
- We support investments to address gaps in health care screening and management in communities disproportionally impacted by COVID -19 through data collection and analysis by the **Minnesota Electronic Health Record Consortium.**
- The Governor's recommendation for investments to expand the **community health worker (CHW) workforce** will significantly improve health outcomes by addressing the social conditions that impact health status, called social determinants of health (SDOH).
- Increasing health care access for Minnesotans by **reducing language, accessibility, and technological barriers in public health care programs.**
- Grants to s**upport capacity building to advance health equity and in organizations serving diverse communities** will support our patient population and the **Emmet Louis Till victims recovery program** will support persons who have experienced trauma and their families, all key to decreasing health disparities.
- Maternal health investments are critical to reducing disparities. **Health Beginnings, Healthy Families** focus on perinatal quality and infant mortality. **Medical Assistance (MA) coverage for long-acting reversible contraceptives** (LARC), a **rate increase for reproductive health services** in MA and MNCare, and clarification about changes related to reproductive health statute following court rulings, all support improving maternal health. The **Taskforce on Pregnancy Health and Substance Use Disorders** is necessary to ensure we are doing all we can to keep mothers and babies healthy, and establish uniform responses that are supportive and not punitive.

Substance Use Disorder and Mental Health Supports

- **The Comprehensive Drug Overdose and Morbidity Prevention Act** will help provide access to critical SUD treatment and address the drug epidemic our health care providers see every day, especially the harm reduction services for people experiencing homelessness and homeless overdose prevention hubs and advancing access to **evidence-based nonnarcotic pain management services.** We recommend including funding at the same level as the Governor's proposal.
- **Adolescent Mental Health Promotion funding** for community and evidence-based, culturally informed mental health supports and programming for young people will better serve the young people that often end up in our ED due to mental health crises.
- Providing **investments and specialization in new Psychiatric Residential Treatment Facilities (PRTFs).**
- Improving access to behavioral health services by **increasing the payment rate for Adult Day Treatment by 50%**, expanding access to **first episode psychosis teams**, and increasing investments in the **Transition to Community initiative.**
- We support the **exclusion of hypodermic syringes or needles from the definition of drug paraphernalia.**

As the Omnibus process continues, we hope you will reconsider the following proposals for inclusion:

- Investing in **statewide provider capacity to transition serving people with complex high-acuity support needs** from acute care settings to community-based settings through **acute premium pay and hospital avoidable days reimbursement** (SF 2885/HF 2848) to address the growing problem of more people living in the hospital when there is not a place to go due to a lack of capacity in the community.
- **We appreciate the 4% rate bridge for mental health, however, far more significant investment is needed in children's mental health services** including residential services as more children are boarding in emergency departments and remaining in hospitals when they do not need to be there (SF 1174/HF 1198).
- **Rebasing dental rates** as included in the Governor's budget will more accurately reflect the cost of providing dental care.
- The Improving Program Integrity in Minnesota Health Care Programs proposal that **expands Minnesota's Project ECHO** program with a focus on interventions that reduce health disparities.
- We also request funding be included for **the follow-up homeless mortality study**, **the library telehealth pilot.**
- Increasing the **medical reimbursement rates for doula services** in Minnesota (SF 2923/HF 2846).

Concerns included in the bill

We continue to have significant concerns about the MCO opt-out (~12M loss of annual revenue) and the **pharmacy carve out (~24M loss of annual revenue)** as these would result in insurmountable losses for HCMC. We appreciate your efforts to mitigate 340B losses for our health system and others, however, these will still result in millions of losses for HCMC. We sincerely request a pause until the financial implications and solutions are fully understood and clearly defined, and there are assurances we will not lose this level of reimbursement. We are glad to participate in any transparency reporting, and encourage studying how other states manage their drug discount programs, but these are truly losses we cannot sustain. We encourage legislators to address the challenges for independent pharmacies by providing a dispensing fee equal to fee for service, and to leave the existing pharmacy program as is in managed care.

Finally, all health systems are challenged by the inability to discharge patients, which exacerbates overcrowded emergency departments and places further pressure on our teams. We sincerely request legislators focus on what we know works to improve our health systems – **increasing capacity to move people to the right setting, violence prevention efforts, mental health support for our health care workers, and recruitment and retention strategies like loan forgiveness, scholarships and pipeline programs.**

We sincerely appreciate the support you've provided in your proposal to many priority areas. We understand the difficult decisions you must make due to the many competing priorities to improve Minnesota for all of our residents.

Sincerely,

Jennifer DeCubellis
Chief Executive Officer
Hennepin Healthcare System

Contact: Susie Emmert 651-278-5422 susie.emmert@hcmed.org

HEALTHCARE AT A CROSSROADS:

An Examination of the Proposed Fairview-Sanford Merger

Executive Summary

Minnesotans are increasingly at the whims of large health conglomerates pushing corporate healthcare policies throughout the state. Executives' profit-first approach has slashed staffing levels, closed hospitals and clinics, and put growth above all else. These policies are not driven by a concern for patient care, but with a focus on the bottom line, corporate growth, and lining the pockets of CEOs and other healthcare executives.

This past November, executives at Sanford Health and Fairview Health Services proposed a $11.7 billion merger, which would create a health system that would span ten states and nine countries. While CEOs Bill Gassen and James Hereford have treated their negotiations as a private business matter, the proposed merger has dire implications for the public. Fairview's wealth was created in large part by taxpayers, charitable giving, and the close partnership with the University of Minnesota. But executives have hammered out the details behind closed doors, presenting the deal to regulators, employees, and community members as a fait accompli, instead of giving this merger the public and deliberate consideration it requires.

Our report details the potential consequences of this merger, and why Minnesotans deserve better. While concerns regarding this proposed merger are extensive and explored in detail below, the most pressing regarding the further concentration of healthcare pertains to the fate of workers, patients, and the public interest in Minnesota.

In our review of the impact consolidation has on the workforce, we find that top-down healthcare mergers may exacerbate healthcare workers' exodus from the bedside. Presently, over half of registered nurses are considering leaving the profession – research and surveys show that the restructuring of health systems is associated with decreased job satisfaction and increased burnout, especially emotional exhaustion.

We examine the current academic literature on mergers, and their impact on healthcare costs and quality. We find that research shows "cross-market" mergers – increasingly relevant and difficult to regulate – lead to higher prices for healthcare by as much as 17 percent. Meanwhile, claims that mergers can and will improve the quality of healthcare are not substantiated.

Our analysis of Sanford's previous attempts to grow reveal that their allegiance is not to any one geographic market or community. At least one of Sanford's recent attempts at acquisition earned the attention of the Federal Trade Commission (FTC) over antitrust and anti-competitive concerns.

We evaluate the impact previous mergers and acquisitions had at Fairview and Sanford, finding that closures often followed. Fairview CEO James Hereford instituted major cuts at legacy HealthEast facilities almost immediately after acquiring them, ultimately closing Bethesda and St. Joseph's hospitals during a global pandemic. Surveyed nurses at facilities acquired by Sanford reported drastic reductions in services and specialties, and the elimination of entire service lines. Especially concerning for both systems is the pattern of reducing and outright eliminating areas of mental health within systems when they are most needed in our communities.

Closures to desperately needed service lines came at the same time executive compensation skyrocketed. Since arriving at Fairview in 2017, CEO James Hereford has received more than a 100 percent increase in his total compensation. Over in Sioux Falls, Sanford paid out a $49.5 million golden

parachute to their former CEO after he spread medical misinformation to employees of the massive health system. Meanwhile both Sanford and Fairview rank poorly on the Lown Institute's data-driven evaluation of charity care and community benefit spending. These values are not shared by patients and Minnesotans.

We share concerns expressed by leaders and physicians at the University of Minnesota, who have questioned the impact a merger with Sanford would have on the land grant mission as well as taxpayer-funded research coming under the influence of an out-of-state entity. While Minnesota hospital executives are already driving a profit-focused approach to healthcare, Sanford Health's namesake, T. Denny Sanford, stands apart. Having amassed billions through subprime lending, most notably in the form of high-interest credit cards, Minnesotans need to carefully consider the role Denny Sanford would have in determining the future of our healthcare system.

Given these two systems' track records, we examine the implications a merger could have, especially where it may involve further cuts and closures to facilities and service lines. A merger between these two systems would create one of the largest healthcare providers in the Upper Midwest and could dramatically change the lives of patients, healthcare workers, and their communities.

As of this report, Fairview and Sanford executives have done little to explain the rationale for this merger, to describe how exactly it would benefit patients and communities, or to address concerns raised across the state. Minnesota workers and patients are uniting to fight against the growing influence of corporate healthcare chains, including a merger that would give authority over Minnesota hospitals to executives in Sioux Falls, who are less accountable to our communities. We urge the Attorney General and elected officials to continue to act in the interest of patients, workers, and their communities and to prevent the further entrenchment of corporate healthcare in our state.

Table of Contents

Executive Summary 1

Introduction 4

A Merger Will Push More Healthcare Workers from the Bedside 4

Healthcare Mergers Result in Higher Prices, Not Better Care 5

Fairview and Sanford's Record Should Concern, Not Inspire Minnesotans 8

- Sanford's Volatility and Fixation on Growth 8
- Fairview and Sanford Prioritize Executive Compensation over Community 10
- Sanford's Ties to T. Denny Sanford 12
- Previous Cuts to Services 13
- Do Overlaps in Service Foreshadow Future Cuts? 16
- Long-Term Care 19

Corporate Healthcare and Taxpayer-Funded Medical Center Don't Mix 20

- University Partnerships 20
- T. Denny Sanford's Interest in Research 22

Conclusion 23

Introduction

For decades, executives have been pushing corporate policies in hospitals across the nation, including here in Minnesota. These policies include understaffing nurses to cut costs, closing "underperforming" hospitals and clinics, and pursuing massive mergers and acquisitions. These policies are not driven by a concern for patient care at the bedside, but with a focus on corporate growth, excess revenues, and millions of dollars in the pockets of hospital CEOs.

Now, during an era of rising healthcare costs, a global pandemic, and a mass exodus of healthcare workers from the bedside, Fairview and Sanford CEOs James Hereford and Bill Gassen are trying to ram through another corporate mega-merger in our healthcare system. Nurses and patients recognize the tragic consequences of these disastrous policies, which is why they rejected the same proposed merger less than ten years ago.

Just as it would have in 2013, a merger between Fairview Health Services and Sanford Health will put corporate profits and CEO compensation ahead of community care by increasing the market power and coffers of Sanford Health. Despite having fewer choices of providers, Minnesotans may end up paying more for services as a result of the merger. Rural patients may hurt the most, forced to travel farther if services are reduced, cut, or hospitals are entirely shuttered, which has happened all too often in the aftermath of corporate mergers.[1] Healthcare workers will be put at a disadvantage too. Thousands will suddenly be employed by Sanford Health, an employer whose priorities became apparent when it paid out its disgraced former CEO a golden parachute of $49.5 million.[2]

At a time of increased scrutiny of corporate mergers in healthcare and other industries, Minnesotans have a second opportunity to protect their healthcare from executives who do little more than pay lip service to community healthcare. Our hospitals need to be controlled locally by patients, workers, and their communities, not by a handful of wealthy healthcare executives out of state.

A Merger Will Push More Healthcare Workers from the Bedside

At a time when over half of nurses are considering leaving the profession,[3] health systems desperately need to improve staffing levels, guarantee workers a voice on the job, and address the moral distress from successive waves of COVID-19, influenzas, and other illnesses such as RSV. Rather than focus resources on attracting and retaining experienced healthcare professionals, a corporate merger may exacerbate these exits. Researchers have found that restructuring is associated with decreased job satisfaction and increased burnout, especially emotional exhaustion.[4] This is not limited to nurses – a survey of 799 physicians by athenahealth revealed that those who went through mergers and

---

[1] Carmen Comsti, "Request for Information on Merger Enforcement (Docket No. FTC-2022- 0003)," April 21, 2022, https://www.regulations.gov/comment/FTC-2022-0003-1831.

[2] Jeremy Fugleberg, "Ex-Sanford Health CEO Got $49.5M Payout after Departure Following Unscientific Remarks about COVID-19," *Pioneer Press*, November 16, 2021, https://www.twincities.com/2021/11/16/ex-sanford-health-ceo-got-49-5m-payout-after-departure-following-unscientific-remarks-about-covid-19/.

[3] Grace Dunn et al., "Registered Nursing in Crisis" (Illinois Economic Policy Institute and Project for Middle Class Renewal (PMCR) at the University of Illinois at Urbana-Champaign, June 23, 2022), https://illinoisepi.files.wordpress.com/2022/06/pmcr-ilepi-registered-nurses-in-crisis-final.pdf.

[4] Bonnie M. Jennings, "Restructuring and Mergers," in *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, ed. Ronda G. Hughes, Advances in Patient Safety (Rockville (MD): Agency for Healthcare Research and Quality (US), 2008), http://www.ncbi.nlm.nih.gov/books/NBK2675/.

acquisitions were more likely to experience burnout and less likely to recommend their organization to friends or family members.[5]

A top-down merger may create uncertainty in the minds of many nurses, especially at Fairview, which is largely seen as the junior partner in the deal. Nurses at Fairview and HealthEast facilities have had to contend with considerable upheaval in the past two decades. More senior nurses may remember when they or their counterparts at the University of Minnesota Medical Center – East Bank lost their union after the teaching hospital was sold to Fairview, who refused to recognize existing union contracts.[6] Nurses at HealthEast were thrust into a period of uncertainty following Fairview's 2017 acquisition.[7] Three years in – and during a global pandemic – Fairview CEO Hereford shut down Bethesda[8] and St. Joseph's[9] hospitals. Sanford nurses in Minnesota have also seen major changes at their facilities, many of which were previously publicly owned.[10]

Healthcare Mergers Result in Higher Prices, Not Better Care

While healthcare executives often tout the efficiencies they plan to achieve, they refuse to address the evidence that corporate mergers lead to higher prices for patients.

While there is a long body of research on the price increases from hospital mergers in general, recent scholarship has focused on a subset of "cross-market" mergers. Unlike traditional mergers, cross-market mergers involve entities that either 1) do not directly compete in the same local market, but sell the same, similar, or complementary services to a common customer or customers or 2) offer different

---

[5] Jill McKeon, "Healthcare Mergers and Acquisitions Linked to Physician Burnout," *RevCycleIntelligence*, July 8, 2021, https://revcycleintelligence.com/news/healthcare-mergers-and-acquisitions-linked-to-physician-burnout.

[6] Lisa Scott, "Can Marriage of Academic, Community Hospitals Work?," *Modern Healthcare*, March 17, 1997, https://www.modernhealthcare.com/article/19970317/NEWS/703170305/can-marriage-of-academic-community-hospitals-work.

[7] Mark Zdechlik, "Fairview Rescues Struggling HealthEast in Merger," *MPR News*, March 8, 2017, https://www.mprnews.org/story/2017/03/08/fairview-healtheast-merger.

[8] Jeremy Olson, "Fairview Cuts Include Bethesda, St. Joseph's Hospitals; 900 Jobs to Be Lost," *Star Tribune*, October 6, 2020, https://www.startribune.com/fairview-cuts-will-include-two-hospitals-affect-900-jobs/572641022/.

[9] Frederick Melo, "St. Joseph's Hospital Signage Comes Down, Fairview's Center for Community Health Equity Launches," *Pioneer Press*, June 23, 2022, https://www.twincities.com/2022/06/23/st-josephs-hospital-signage-comes-down-fairview-center-for-community-health-and-equity/.

[10] Beth Rickers, "A Pair of Thumbs Up," *Worthington Globe*, November 30, 2007, sec. News, https://www.dglobe.com/news/a-pair-of-thumbs-up; Sanford Health, "Worthington Regional Hospital Enters Ownership Agreement," Sanford Health, January 8, 2008, https://news.sanfordhealth.org/news/worthington-regional-hospital-enters-into-ownership-agreement-with-sanford-health/; Kari Lucin, "Sanford's Jackson Purchase Unopposed," *Daily Globe*, August 18, 2009, https://www.dglobe.com/news/sanfords-jackson-purchase-unopposed; Maura Lerner and Warren Wolfe, "Feud Reveals Troubles of a Country Hospital," *Star Tribune*, January 10, 2010, https://www.startribune.com/feud-reveals-troubles-of-a-country-hospital/81074432/; Anne Williams, "A New Prescription; Clearwater Health Services to Partner with Sanford Health," *Bemidji Pioneer*, March 30, 2011, sec. News, https://www.bemidjipioneer.com/news/a-new-prescription-clearwater-health-services-to-partner-with-sanford-health; Associated Press, "Sanford Buys Medical Center from Minnesota City of Tracy," *The Washington Times*, March 31, 2016, sec. News, https://www.washingtontimes.com/news/2016/mar/31/sanford-buys-medical-center-from-minnesota-city-of/.

services, either in the same or different markets (e.g., a merger of cardiologists and pathologists in a single physician practice).[11]

These types of mergers have become increasingly relevant in recent years. By one measure, over half of hospital mergers and acquisitions in the U.S. between 2009 and 2019 crossed geographic market boundaries, and by 2019, nearly 60 percent of hospital systems were cross-market systems.[12] We have several cross-market systems operating in our state, including Fairview and HealthPartners. Some, such as Catholic Health Initiative (CHI), Essentia, and Mayo Clinic operate across state borders.

Three main studies provide strong empirical evidence that cross-market mergers result in higher prices and that hospitals belonging to cross-market systems have higher prices:[13]

- Using data from 2000-2010, economists Matthew Lewis and Kevin Pflum found that **hospitals acquired by out-of-market systems increased prices by about 17 percent more than unacquired, stand-alone hospitals.** Additionally, they found that out-of-market mergers resulted in a relaxing of competition, where prices at nearby rival hospitals increased around 8 percent in response to price increases by acquired hospitals.[14]
- Using data on hospital mergers from 1996–2012, economists Leemore Dafny, Kate Ho and Robin S. Lee found that **hospitals involved in cross-market mergers had relative price increases of 7 to 10 percent** if the acquisition was in-state. This is notable in that the authors removed "crown jewel" hospitals from their sample and focused on what they referred to as "bystander" hospitals. In doing so, they also found that acquirers raised their own prices, suggesting that such price increases were not the result of significant quality improvements.[15]
- A third study by economist Matt Schmitt found that the increase in multimarket contact (when health systems compete in multiple markets) among hospitals between 2000-2010 was associated with higher prices.[16]

The reason mergers result in higher prices, academics explain, is that they often alter the bargaining relationship between the hospital and the insurer.[17] Economists have identified five main ways in which cross-market mergers can lead to price increases:

1. **Common Customers** – Households may, for example, value hospitals that specialize in cardiac services as well as hospitals that specialize in pediatric services, creating linkages between product markets. This could result in a situation where having access to both services provides

[11] Jaime S. King et al., "Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power," *Hastings Law Journal*, Forthcoming May 2023, https://doi.org/10.2139/ssrn.4037747.
[12] Brent D. Fulton et al., "The Rise of Cross-Market Hospital Systems and Their Market Power in the US," *Health Affairs* 41, no. 11 (November 2022): 1652–60, https://doi.org/10.1377/hlthaff.2022.00337.
[13] King et al., "Antitrust's Healthcare Conundrum."
[14] Matthew S. Lewis and Kevin E. Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *The RAND Journal of Economics* 48, no. 3 (2017): 579–610, https://doi.org/10.1111/1756-2171.12186.
[15] Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50, no. 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270.
[16] Matt Schmitt, "Multimarket Contact in the Hospital Industry," *American Economic Journal: Economic Policy* 10, no. 3 (August 1, 2018): 361–87, https://doi.org/10.1257/pol.20170001.
[17] King et al., "Antitrust's Healthcare Conundrum."

greater value than the sum of the individual values of both services. Similarly, employers needing to provide health insurance to their employees across Minnesota could give a hospital system operating in multiple markets leverage when negotiating with an insurer.

2. **Tying** – Hospitals that can link coverage of one facility to coverage of another have tremendous bargaining power with insurers. In a particularly egregious case, Sutter Health in California was sued by the California Attorney General for using its market power to insist on all-or-nothing coverage of its providers and engaging in punitive measures for insurers that did not want to play ball, practices that allegedly led to higher prices for consumers.[18]
3. **Change in Control** – This is the theory that the acquisition of a hospital by a larger system may improve a hospital's bargaining power with insurers by improving negotiations skills, increasing access to information, and changing the relationship between the hospital and the community it serves (though this may be more acute when a nonprofit is acquired by a for-profit).
4. **Hospital Quality Improvements** – By excluding the target hospital from their analysis, Dafny, Ho, and Lee ruled out this mechanism as a reason for their findings. However, an acquiring hospital could theoretically bring improvements to the quality of a hospital they acquire. King et al. theorize that this effect is likely stronger when an individual hospital is acquired, rather than an entire system.
5. **Multimarket Contact** – Given that hospital systems increasingly compete across multiple markets, this is the theory that hospital executives may decide to collude with one another and not compete as much on price as if they were just competing in a single market.

Increased concern about anticompetitive behavior and increasing prices have led California's Attorney General to intervene in multiple high-profile mergers. Following an economic expert's finding that an affiliation between Cedars-Sinai Health System and Huntington Memorial Hospital would result in price increases at one or more hospitals despite their limited patient overlap, Attorney General Xavier Becerra conditionally approved the merger, but imposed conditions including a ten-year prohibition on tying and all-or-nothing contracts, punitive pricing practices, and a five-year price cap.[19]

Moreover, mergers may not bring the quality improvements promised by executives. One 2020 research study published in the *New England Journal of Medicine* found that acquisition was associated with modest declines in patient experiences and no significant changes in 30-day readmission or mortality rates.[20] The study's findings provided no evidence of quality improvement attributable to changes in ownership, and supported previous studies' findings that "increased concentration of the hospital market has been associated with worsening patient experiences."[21] Further, these declines in patient-experience performance were not a continuation of preexisting trends within hospitals and healthcare systems, but rather the outcome of decreased market competition following mergers and consolidation.

Another 2020 study in the journal *Risk Management and Healthcare Policy* found that market competition has direct effects on hospital staffing levels, with increased competition being associated

---

[18] People of California ex rel Xavier Becerra v. Sutter Health, CGC 18-565398 (Cal. Super. Ct. 2019), https://oag.ca.gov/system/files/attachments/press_releases/Sutter%20Complaint.pdf.
[19] King et al., "Antitrust's Healthcare Conundrum."
[20] Nancy D. Beaulieu et al., "Changes in Quality of Care after Hospital Mergers and Acquisitions," *New England Journal of Medicine* 382, no. 1 (January 2, 2020): 51–59, https://doi.org/10.1056/NEJMsa1901383.
[21] Ibid.

with increased staffing levels of RNs and LPNs.[22] Physician services are also negatively impacted by market concentration and merger activity, as found in a 2018 study published in *Health Services Research*.[23] The study found that an increase in consolidation leads to a statistically and economically significant increase in negative health outcomes.

Fairview and Sanford's Record Should Concern, Not Inspire Minnesotans

Sanford's Volatility and Fixation on Growth

In recent years, Sanford has pursued a growth-at-all-cost strategy that ultimately failed to see the system extend beyond its historic service area centered in the Dakotas and Minnesota. This merger-mania may be driven in part by investment banker Jim Cain, a Sanford trustee since 2015[24] whose day job includes underwriting the health system's bonds[25] and advising hospitals involved in mergers and acquisitions.[26] Cain's vision for a more expansive health system was highlighted by former CEO Krabbenhoft who said the board member helped him think through Sanford's 25-year vision.[27]

In 2016, Sanford executives announced their intention to acquire Bismarck-based Mid Dakota Clinic, which had traditionally partnered with rival CHI.[28] Shortly after, the Federal Trade Commission (FTC) intervened, alleging that the merger would significantly reduce competition and violate antitrust regulation. After two years in court, in which the FTC argued that the proposed deal would grant Sanford at least a 75 to 85 percent share of the market for adult primary care physician services, pediatric services, and obstetrics and gynecology services, Sanford abandoned the deal.[29]

At around the same time the Mid Dakota Clinic acquisition was officially declared dead in 2019, Sanford announced merger discussions with Des Moines-based UnityPoint Health, which operated in Iowa,

---

[22] Dong Yeong Shin, Robert Weech-Maldonado, and Jongwha Chang, "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective," *Risk Management and Healthcare Policy* 13 (October 13, 2020): 2103–14, https://doi.org/10.2147/RMHP.S274529.

[23] Thomas Koch, Brett Wendling, and Nathan E. Wilson, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries," *Health Services Research* 53, no. 5 (2018): 3549–68, https://doi.org/10.1111/1475-6773.12825.

[24] Sanford Health, "Investment Banker Helps Steward Sanford Health's Resources," Sanford Health, July 22, 2022, https://news.sanfordhealth.org/health-care-leadership/investment-banker-helps-steward-sanford-healths-resources/.

[25] South Dakota Health and Educational Facilities Authority, "Official Statement," November 18, 2021, https://emma.msrb.org/P21518739-P21174498-P21590720.pdf.

[26] KeyCorp, "Healthcare Investment Banking Expertise: Jim Cain," Key.com, n.d., https://www.key.com/businesses-institutions/find-an-expert/jim-cain.html.

[27] Kelby Krabbenhoft, Q&A: Sanford Health CEO Krabbenhoft discusses growth, acquisition of Good Samaritan, interview by Matthew Weinstock, *Modern Healthcare*, January 19, 2019, https://www.modernhealthcare.com/article/20190119/NEWS/190119935/q-a-sanford-health-ceo-krabbenhoft-discusses-growth-acquisition-of-good-samaritan.

[28] Patrick Springer, "Sanford, Mid Dakota Clinic Step Closer to Merger in Bismarck," *Dickinson Press*, June 21, 2017, sec. News, https://www.thedickinsonpress.com/news/sanford-mid-dakota-clinic-step-closer-to-merger-in-bismarck.

[29] Federal Trade Commission, "After Healthcare System Sanford Health Abandons Acquisition of North Dakota Healthcare Provider Mid Dakota Clinic, FTC Dismisses Case from Administrative Trial Process," *Federal Trade Commission*, July 9, 2019, https://www.ftc.gov/news-events/news/press-releases/2019/07/after-healthcare-system-sanford-health-abandons-acquisition-north-dakota-healthcare-provider-mid.

Illinois, and Wisconsin.[30] Plans were quickly squashed by the UnityPoint board,[31] leading some to question whether a difference in culture was to blame.[32] Talks may have also been influenced by Sanford's $20.25 million settlement with the federal government to resolve allegations that a Sanford neurosurgeon received kickbacks for using implantable devices distributed by his company in medically unnecessary procedures.[33]

In 2020, Sanford announced its intention to merge with Intermountain, to leave its long-established headquarters in Sioux Falls, and cede decision making authority to a CEO in Salt Lake City, Utah.[34] While the organizations cited their similarities,[35] they were dissimilar in terms of geographies and culture; Intermountain was founded by The Church of Jesus Christ of Latter-day Saints while Sanford traces its origins back to Lutherans.[36] Talks were ultimately abandoned in the aftermath of long-time Sanford CEO Kelby Krabbenhoft stepping down after spreading medical misinformation about COVID-19.[37]

Sanford's goal in seeking mergers and acquisitions appears to be to grow its geographic footprint. When Sanford was in talks with senior-care operator Evangelical Lutheran Good Samaritan Society in 2018 (the only merger that came to fruition in the past few years), Sanford executives framed the merger in opportunistic terms, with a spokesperson boasting, "[a]s a function of the momentum created with our new relationship with the Evangelical Lutheran Good Samaritan Society, we are in discussions with

---

[30] Christopher Snowbeck, "Sanford Health Seeks Iowa Merger to Create $11 Billion Health System," *Star Tribune*, July 9, 2019, https://www.startribune.com/sanford-health-seeks-iowa-merger-to-create-11-billion-health-system/512439812/.
[31] Michael Geheren and Angela Kennecke, "Email Shows What Led to Sanford Health, UnityPoint Merger Talks Breaking Down," *KELOLAND.com*, November 12, 2019, https://www.keloland.com/news/your-money-matters/sanford-health-unitypoint-end-plans-for-merger/.
[32] Michaela Ramm, "Culture Clash Could Be to Blame for UnityPoint, Sanford Health Merger Halt," *The Gazette*, November 25, 2019, https://www.thegazette.com/health-care-medicine/culture-clash-could-be-to-blame-for-unitypoint-sanford-health-merger-halt/.
[33] Alex Kacik, "Sanford Health to Pay $20M to Settle False Claims Act Allegations," *Modern Healthcare*, October 28, 2019, https://www.modernhealthcare.com/legal/sanford-health-pay-20m-settle-false-claims-act-allegations.
[34] Joe Carlson, "Rural Minnesota Provider Sanford Health Merging with System Based in Salt Lake City," *Star Tribune*, October 26, 2020, https://www.startribune.com/rural-minnesota-provider-sanford-health-merging-with-system-based-in-salt-lake-city/572878081/; Tina Reed, "One of the Big Reasons for Intermountain Healthcare, Sanford Health Merger: Their Insurance Plans," *Fierce Healthcare*, October 26, 2020, sec. Finance, https://www.fiercehealthcare.com/hospitals/sanford-health-plans-to-merge-intermountain-healthcare.
[35] Ibid.
[36] Tina Reed, "One of the Big Reasons for Intermountain Healthcare, Sanford Health Merger: Their Insurance Plans," *Fierce Healthcare*, October 26, 2020, sec. Finance, https://www.fiercehealthcare.com/hospitals/sanford-health-plans-to-merge-intermountain-healthcare.
[37] Tina Reed, "Sanford Health, Intermountain Healthcare Merger Discussions Halted," *Fierce Healthcare*, December 7, 2020, https://www.fiercehealthcare.com/hospitals/sanford-health-intermountain-healthcare-merger-discussions-halted; Fugleberg, "Ex-Sanford Health CEO Got $49.5M Payout after Departure Following Unscientific Remarks about COVID-19."

various entities in the Greater Chicago area."[38] Sanford's "aggressive" growth strategy[39] reveals that its presumed focus on rural health and legacy in the Dakotas is always subject to change.

Fairview and Sanford Prioritize Executive Compensation over Community

Recent investigative reporting from journalists at *The New York Times* has exposed how many of the nation's top nonprofits have become "virtually indistinguishable" from for-profit companies.[40] In exchange for receiving enormous tax exemptions, hospitals are required to provide benefits, including free care for the poor, to the communities they serve. Yet, executives at hospital systems have adopted a profits-first approach, including profiting from a staffing crisis[41] that puts patients and healthcare workers at risk and aggressively pursuing bills from indigent patients entitled to free care.[42]

These articles have exposed to the public what many healthcare workers and academics have known for years: that the term "nonprofit" is a misnomer – hospital systems often earn windfall profits, which they spend on executive compensation and shiny infrastructure, investing little in the communities they purport to serve.

Fairview and Sanford are no different. Their executives pick from the same playbook as their counterparts across the country. Last year, the independent, nonprofit Lown Institute listed Fairview as having one of the largest "fair share deficits" of any hospital system in the country, receiving $253 million more in tax breaks than it spent on charity care and community investment.[43] Their findings demonstrate the misplaced priorities of company executives when it comes to their own employees and the communities they claim to serve.

Sanford did not perform much better. Despite making over $367.6 million in operating income in 2021, Sanford executives invested less than 2 percent of their expenses in charity care, a key component of community benefit spending which reflects the dollar value of services provided for which payment was never expected and for which the patient is not pursued. This means that Sanford spends less than for-profits, on average, who do not have the same obligations to provide charity care or other community benefits.[44]

---

[38] Christopher Snowbeck, "Sanford Health Continues to Expand Its Reach beyond South Dakota," *Star Tribune*, July 5, 2018, https://www.startribune.com/sanford-health-growing-beyond-the-dakotas/487445181/.

[39] Patrick Anderson, "Growing Pains: Sanford's Aggressive Growth beyond Sioux Falls Not Always an Easy Path," *Argus Leader*, June 28, 2018, https://www.argusleader.com/story/news/business-journal/2018/06/28/sanford-health-aggressive-growth-strategy-beyond-sioux-falls/738536002/.

[40] Jessica Silver-Greenberg and Katie Thomas, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay," *The New York Times*, September 24, 2022, sec. Business, https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html.

[41] Rebecca Robbins, Katie Thomas, and Jessica Silver-Greenberg, "How a Sprawling Hospital Chain Ignited Its Own Staffing Crisis," *The New York Times*, December 15, 2022, sec. Business, https://www.nytimes.com/2022/12/15/business/hospital-staffing-ascension.html.

[42] Silver-Greenberg and Thomas, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay."

[43] Lown Institute, "Are Hospitals Earning Their Tax Breaks?," Lown Institute Hospital Index, n.d., https://lownhospitalsindex.org/2022-fair-share-spending/.

[44] Ge Bai et al., "Analysis Suggests Government and Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment," *Health Affairs* 40, no. 4 (April 1, 2021): 629–36, https://doi.org/10.1377/hlthaff.2020.01627.

Lown Institute Rankings		
Category	**Fairview**	**Sanford**
Community Benefit *Measures the extent of hospital investment in community health*	B	C
Charity care spending *Measures spending on charity care as a share of total expenses*	★☆☆☆☆	★★☆☆☆
Other community benefit spending *Measures other community benefit spending as share of total expenses*	★☆☆☆☆	★★☆☆☆

While Sanford and Fairview executives have touted their "lean" approach,[45] there's nothing lean about the executive compensation at these two hospital systems. Since arriving at Fairview in 2017, CEO James Hereford has received more than a 100 percent increase in his total compensation.[46] Earning close to $2.8 million,[47] he earns more than 32 times the salary of the average nurse in the Twin Cities.[48] During the global pandemic, and a time where healthcare has become more expensive, Hereford chose to reward board members and executives rather than reinvest into patient care. While most nonprofits do not compensate their board members,[49] M Health Fairview does. Board members were compensated in 2020[50] and 2021,[51] even after Hereford told frontline workers that they had "given up their board

[45] James Hereford, From Basketball Coach to CEO of a $5.5B Health System: Where James Hereford is Taking Fairview Next, interview by Eric Larsen, *Advisory Board*, October 4, 2017, https://www.advisory.com/Blog/2017/10/Hereford-interview; Jodi Schwan, "Health Systems Learn to Be Lean," *Argus Leader*, May 6, 2014, https://www.argusleader.com/story/news/business-journal/2014/05/07/health-systems-learn-lean/8781179/.
[46] Fairview Health Services, Return of Organization Exempt from Income Tax for the 2017 Calendar Year (filed November 6, 2018), https://projects.propublica.org/nonprofits/organizations/410991680/201833109349300023/full; Fairview Health Services, Return of Organization Exempt from Income Tax for the 2021 Calendar Year (filed October 26, 2022).
[47] Fairview Health Services, Return of Organization Exempt from Income Tax for the 2021 Calendar Year (filed October 26, 2022).
[48] U.S. Bureau of Labor Statistics, May 2021 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates, https://www.bls.gov/oes/2021/may/oes_33460.htm.
[49] Economic Research Institute, "Nonprofit Board Members – To Pay or Not to Pay in 2018?" Economic Research Institute (blog), May 8, 2018, https://www.erieri.com/blog/post/nonprofit-board-members-to-pay-or-not-to-pay-in-2018.
[50] Fairview Health Services, Return of Organization Exempt from Income Tax for the 2020 Calendar Year (filed November 1, 2021).
[51] Fairview Health Services, Return of Organization Exempt from Income Tax for the 2021 Calendar Year (filed October 26, 2022).

compensation for the year."[52] This reversal is especially disturbing as it came the same year that Hereford and other executives eliminated 900 jobs.[53]

Over in Sioux Falls, Sanford recently paid out a $49.5 million golden parachute to their former CEO after he spread medical disinformation to employees of the massive health system.[54]

Sanford's Ties to T. Denny Sanford

The origins of what is now Sanford Health reach back to 1893, when residents of Sioux Falls, South Dakota initiated the establishment of a new hospital. This new hospital opened in 1894 as The Seney House, the beginning of what would grow and expand throughout the 20th century into the Sioux Valley Hospitals and Health System.[55] The Sioux Valley Health System was relabeled in 2007, following a $400 million donation to the health system by its namesake Thomas Denny Sanford.[56] T. Denny Sanford was already a known and significant benefactor to the health system, having donated $16 million three years prior to the gift that attached his name to the health system.[57]

Denny Sanford was capable of such largesse due to the billions he amassed as founder and owner of First Premier Bank, an institution that specializes in subprime credit cards.[58] The Federal Deposit Insurance Corporation defines subprime lending as "programs that target borrowers with weakened credit histories typically characterized by payment delinquencies, previous charge-offs, judgments, or bankruptcies."[59] Individuals with low credit ratings are targeted for "last ditch" credit lines such as those offered by Sanford's First Premier Bank as they often face extremely limited options. These types of loans typically involve substantially higher interest rates and significantly less favorable agreement terms for borrowers compared to other lending practices. Consumer advocate groups liken subprime credit cards to predatory payday loans, with a lawyer from the National Consumer Law Center characterizing Denny Sanford's practice as "gouging" vulnerable, low-income consumers.[60]

T. Denny Sanford's First Premier Bank didn't simply dabble in subprime lending practices – they are seen as one of the pioneers of subprime credit cards, with Denny Sanford himself boasting "[w]e were the

---

[52] James Hereford to Fairview Employees, "COVID-19 Update: Tackling Unprecedented Challenges," April 27, 2020.
[53] Olson, "Fairview Cuts Include Bethesda, St. Joseph's Hospitals; 900 Jobs to Be Lost."
[54] Fugleberg, "Ex-Sanford Health CEO Got $49.5M Payout after Departure Following Unscientific Remarks about COVID-19."
[55] Sanford Health, "Sanford Health Timeline: Rented House to Regional Network," *Sanford Health*, July 22, 2019, https://news.sanfordhealth.org/company/sanford-health-history-timeline/.
[56] Lindsay Hamilton, "Man Gives Away $400 Million to Hospitals," *ABC News*, February 3, 2007, https://abcnews.go.com/Business/story?id=2847653/.
[57] Sanford Health, "Sanford Health Unifies Health System with New Name Mission Vision Values and Wordmark," *Sanford Health*, July 20, 2010, https://news.sanfordhealth.org/news/sanford-health-unifies-health-system-with-new-name-mission-vision-values-and-wordmark/#:~:text=The%20South%20Dakota%20businessman%20and,transformational%20nature%20of%20his%20gift.
[58] Stu Whitney, "Denny Sanford Lifted Hospital to New Heights, but Distancing Has Now Begun," *Argus Leader*, September 6, 2020, https://www.argusleader.com/story/opinion/2020/09/02/t-denny-sanford-health-system-child-pornography-investigation/5691700002/.
[59] Federal Deposit Insurance Corporation, "FDIC Joint Release – Banking Agencies Issue Guidance on Supervision of Subprime Lending," *FDIC Archive*, January 31, 2001, https://archive.fdic.gov/view/fdic/1952.
[60] Jennifer Bjorhus, "Subprime Credit Business Fueled Sanford's Wealth," *Star Tribune*, April 5, 2013, https://www.startribune.com/subprime-credit-business-fueled-sanford-s-wealth/201714261/?refresh=true.

first, in the unsecured [credit cards].[61] Sanford founded First Premier Bank (parent United National Corporation) in the state of South Dakota, six years after the state repealed its usury laws, eliminating the cap on interest rates and fees and thus paving the way for lenders like Denny Sanford to borrow money with a much higher return for the bank.[62] At one point in First Premier's lending history, they charged some customers a 79.9 percent interest rate.[63]

These practices have garnered attention from more than consumer advocates, including then Attorney General of New York Andrew Cuomo. In 2007, the same year Sioux Valley Health System rebranded after receiving a donation from Denny Sanford, First Premier Bank reached a $4.5 million settlement over accusations the bank was using deceptive and illegal marketing tactics for their credit cards.[64] The Attorney General's investigation found that consumers were offered cards with $2,000 limits, a 9.9 percent fixed interest rate, and no processing fees; First Premier would then instead provide these consumers with a $250-$300 credit line, interest rates that could double without notice, upfront processing fees of nearly $200, and subsequent hidden costs.[65]

Previous Cuts to Services

Fairview has significant experience making cuts to care. In 2017, Fairview acquired HealthEast,[66] a system whose hospitals have long served low-income communities and communities of color in the East Metro.[67] Since buying out these hospitals, Hereford has slowly chipped away at the community service model under the guise of a "bold new vision."[68] Hereford has closed Bethesda[69] and St. Joseph's[70] hospitals less than a year after writing an op-ed in the *Pioneer Press* about an "affordability crisis" in healthcare.[71] Under his leadership, Hereford has also helped bring out-of-state for-profit healthcare

---

[61] Ibid.
[62] *Chapter 54-3 Interest and Usury*, South Dakota Legislature, https://sdlegislature.gov/Statutes/Codified_Laws/2072181.
[63] Bjorhus, "Subprime Credit Business Fueled Sanford's Wealth."
[64] Associated Press, "First Premier Bank to Pay Penalty," *The New York Times*, August 16, 2007, https://www.nytimes.com/2007/08/16/business/16bank.html.
[65] Ibid.
[66] Zdechlik, "Fairview Rescues Struggling HealthEast in Merger."
[67] Fairview Health Services, "2021 Community Health Needs Assessment Report: Bethesda Hospital," n.d., https://stcr-prd-cd.fairview.org/-/media/Files/Local-Health-Needs/Read-full-reports/2021-CHNA-Report-Bethesda-Hospital2125.pdf?_ga=2.266109903.1124601112.1663949233-1817923240.1650646946; Fairview Health Services, "2021 Community Health Needs Assessment Report: St. John's Hospital," n.d., https://stcr-prd-cd.fairview.org/-/media/Files/Local-Health-Needs/Read-full-reports/2021-CHNA-Report-St-Johns-Hospital2125.pdf?_ga=2.199544430.1124601112.1663949233-1817923240.1650646946; Fairview Health Services, "2021 Community Health Needs Assessment Report: St. Joseph's Hospital," n.d., https://stcr-prd-cd.fairview.org/-/media/Files/Local-Health-Needs/Read-full-reports/2021-CHNA-Report-St-Josephs-Hospital2125.pdf?_ga=2.199544430.1124601112.1663949233-1817923240.1650646946.
[68] Fairview Health Services, "Creating a Healthier, More Equitable Future in St. Paul and the East Metro," Fairview Health Services, n.d., https://www.fairview.org/east-metro.
[69] Olson, "Fairview Cuts Include Bethesda, St. Joseph's Hospitals; 900 Jobs to Be Lost."
[70] Melo, "St. Joseph's Hospital Signage Comes down, Fairview's Center for Community Health Equity Launches."
[71] James Hereford, "James Hereford: We're Reckoning with the Affordability Crisis in Healthcare," *Pioneer Press*, December 22, 2019, sec. Opinion, https://www.twincities.com/2019/12/22/james-hereford-were-reckoning-with-the-affordability-crisis-in-healthcare/.

companies to Minnesota through joint ventures with AccentCare[72] and Acadia Healthcare,[73] a company with a spotted track record.[74] Acadia Healthcare will have 85 percent ownership in their new venture with M Health Fairview,[75] a clear move towards a profit-first approach to healthcare.

While Sanford touts its investments in Minnesota, nurses tell a different story. An overwhelming majority of nurses at Sanford owned and operated facilities surveyed by MNA reported that healthcare services and specialties offered became worse during their time there. At the same time, they revealed that their staffing levels worsened and access to decisionmakers, who could make a difference for patients, decreased.

Surveyed nurses elaborated on reductions and eliminations to services and specialties they have seen at their facilities once Sanford became involved. These include:

- Elimination of mental health services
- Elimination of home health services
- Elimination of Cardiac Critical Care Unit
- Elimination of cardiac rehabilitation services
- Elimination of in-home physical and occupational therapy
- Elimination of Intensive Care Unit (ICU)
- Elimination of wound care services
- Elimination of ostomy services
- Elimination of Respiratory Therapy services
- Elimination of outpatient services (including MRIs, mammograms, surgeries, and ultrasound)
- Drastic reduction in surgery cases

As a consequence of Sanford purchasing their hospital, one nurse stated that they lost many providers from the local clinic who admitted most of the patients and cared for patients in the ICU. Now, they report, “We no longer have a true ICU.” Another nurse reported that losing nurses, providers, and specialists has impacted the hospital’s offerings, using the example of losing wound care/ostomy services and with it, many patients. Decisions being made a hundred miles away was also brought up as an issue – one nurse expressed that the larger the system got, the less autonomy their hospital had. They stated that decisionmakers in Fargo decide whether they get certain surgery supplies, even if they are considered chargeable items.

---

[72] Carrigan Miller, “Fairview Plans Sale of Home Health and Hospice Business with Nearly 1,000 Employees,” *Minneapolis / St. Paul Business Journal*, September 3, 2020, https://www.bizjournals.com/twincities/news/2020/09/03/fairview-plans-sale-accentcare-home-hospice.html.

[73] Mark Reilly, “Minnesota Health Department OKs Fairview Plan for Psychiatric Hospital at St. Paul’s Bethesda,” *Minneapolis / St. Paul Business Journal*, September 13, 2022, https://www.bizjournals.com/twincities/news/2022/09/13/minnesota-health-department-oks-plan-bethesda.html.

[74] Chelsea Schafter and Ami Tillemans to Office of Commissioner Jan Malcolm, “Public Interest Review,” June 27, 2022, https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/mnaletter.pdf.

[75] Trudi Trysla, “Fairview Health Services and Acadia Healthcare Provide the Enclosed Responses to Your Additional Requests for Information on the Proposed Inpatient Mental Health Hospital,” Minnesota Department of Health, February 16, 2022, https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/fwacadiareponses.pdf.

These dual trends in consolidation of Sanford decisionmakers and healthcare services offered by the system in population centers raise critical questions and concerns about care access in non-metropolitan areas. From Sanford's public-facing remarks on the matter, their remedy to healthcare access disparities appears to be the increased use of telemedicine. On August 22, 2022, Sanford Health hosted a national Summit on the Future of Rural Health Care at its event center in Sioux Falls. In a press release ahead of the event, members of the industry panel arranged for the event issued statements highlighting expanded virtual care offerings as their proposed means of addressing issues of rural access.[76] This summit took place on the heels of Denny Sanford donating $350 million for a virtual care initiative.[77] Speaking about the creation of a new telemedicine facility Sanford broke ground on following this donation, president of virtual care, Brad Schipper, said "[t]his will be the way we deliver healthcare in the future. It won't replace all the traditional avenues that we're used to, but it will sure become much more mainstream."[78] Sanford Health's rhetoric and capital allotments both point towards a future for rural healthcare involving much less brick and mortar, meaning an increased reliance on virtual care and potentially long drives to population centers with increasingly consolidated care and services.

One area where both the Fairview and Sanford systems have made cuts is in the area of mental health. Between 2016 and 2020, M Health Fairview decreased mental health beds system-wide by nearly 15 percent, opposed a proposal at a non-Fairview site to increase mental health beds in the Metro,[79] and proposed a mental health hospital to replace Bethesda that the Minnesota Department of Health noted had an "unusually lean staffing plan."[80]

In response to MNA's survey, nurses identified cuts to mental health services offered by Sanford, including one who described it as "the largest negative impact I've seen with Sanford as a whole." Back in 2010, Sanford's hospital in Worthington closed its behavioral health unit and transitioned behavioral health services to Avera Marshall Regional Health Center. While outpatient services were set to continue to be offered in Worthington, outpatient services would be housed at the Marshall hospital.[81] The decision had rippling effects, as months later, a listening session held by then Minnesota Senator Yvonne Prettner Solon revealed that area patients were not being properly served.[82] Local residents working in the mental healthcare and disabilities fields stated that the closest facilities were in Marshall or Sioux Falls, both over an hour away. A school psychologist expressed concern that children "end up

---

[76] Sanford Health, "Sanford to Convene Summit on the Future of Rural Health Care," *Sanford Health*, August 22, 2022, https://news.sanfordhealth.org/news-release/sanford-to-convene-summit-on-the-future-of-rural-health-care/.

[77] Ibid.

[78] Dominik Dausch, "Sanford Virtual Care Center Groundbreaking Underscores Need for Rural Health Investment," *Argus Leader*, August 24, 2022, https://www.argusleader.com/story/news/2022/08/23/sanford-health-takes-next-steps-telemedicine-virtual-care/7876270001/.

[79] Chelsea Schafter and Ami Tillemans to Office of Commissioner Jan Malcolm, "Public Interest Review," June 27, 2022, https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/mnaletter.pdf.

[80] Minnesota Department of Health, "Public Interest Review: Evaluation of a Proposed Inpatient Mental Health Hospital in Saint Paul, Minnesota," November 30, 2022, https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/fvwacadappendixc.pdf.

[81] Beth Rickers, "SRHW to Close Mental Health Unit," *Worthington Globe*, March 30, 2010, sec. News, https://www.dglobe.com/news/srhw-to-close-mental-health-unit.

[82] Justine Wettschreck, "Prettner Discusses Mental Health Issues with Area Experts," *The Daily Globe*, October 13, 2010, sec. State and Regional News, https://www.dglobe.com/news/prettner-discusses-mental-health-issues-with-area-experts.

being released to their parents instead of receiving the care they need," with another telling Prettner Solon that the Marshall facility does not take juvenile patients.[83] Access is also constrained by long waiting lists to see a psychologist for the first time, attendees asserted, meaning that an appointment could be months away.[84]

In Minnesota, Sanford is not a major provider of inpatient mental health beds. According to 2020 data from the Minnesota Department of Health, Sanford facilities offer only 28 inpatient mental health (psychiatric) beds throughout the State and do not offer any inpatient chemical dependency beds.[85] That Fairview, "the largest provider of mental health and addiction care in the Upper Midwest,"[86] may lose autonomy, as expressed by many nurses, with decisions being made in Fargo or Sioux Falls, is extremely concerning given Sanford's limited existing mental health footprint in Minnesota.

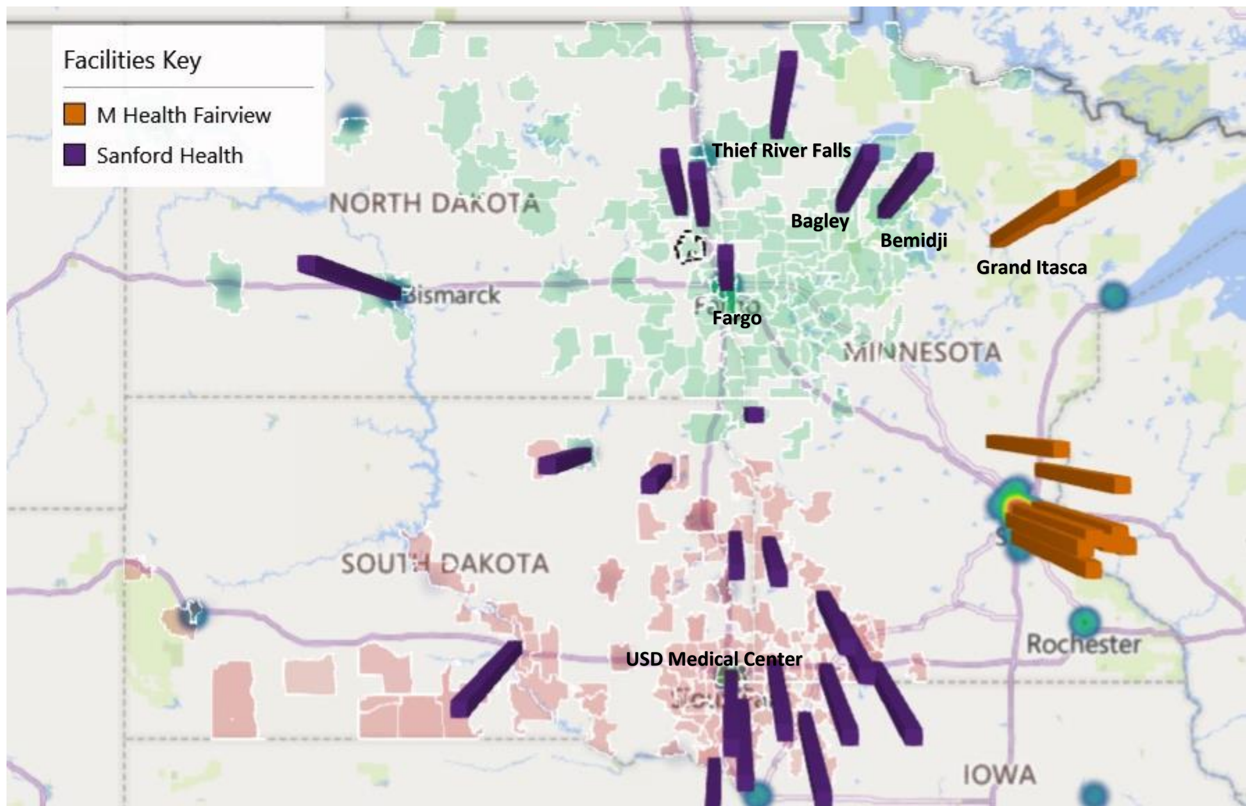
Do Overlaps in Service Foreshadow Future Cuts?

Data from the Centers for Medicare & Medicaid Services on patient origin by hospital illustrate the pull Sanford's largest facilities have across across state lines.[87] As seen in Fig. 1, patients from Northern Minnesota travel more than an hour to the Sanford Medical Center in Fargo, while patients from Southern Minnesota make the trip to receive care in Sioux Falls. That patients are traveling to Fargo and USD from areas where Sanford has other hospitals (e.g., Bagley, Bemidji) is evidence of a "feeder" model. Instead of fully resourcing local hospitals, this corporate approach strips community hospitals of all but the most basic services; patients requiring more specialized treatment are referred to the larger (and often more expensive) metropolitan hospitals.

---

[83] Ibid.
[84] Ibid.
[85] Statistics gathered from Minnesota Department of Health's data set, "Mental Health and Chemical Dependency," available at https://www.health.state.mn.us/data/economics/hccis/data/stndrdrpts.html.
[86] Laura Reed to Stefan Gildemeister, "MDH Public Hearing Follow Up Letter," June 20, 2022, https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/fvwappletter.pdf#page=2.
[87] See Centers for Medicare & Medicaid Services' data set, "Hospital Service Area," available at https://data.cms.gov/provider-summary-by-type-of-service/medicare-inpatient-hospitals/hospital-service-area.

Fig. 1



MNA is concerned that hospital executives running a combined system will seek additional service closures or even plan to shutter entire hospitals given Sanford's pull on residents to its flagship Fargo and Sioux Falls facilities, and the overlap in services and patient populations in both systems' local hospitals.

Fig. 2 shows the service areas of Sanford Health Bemidji (in purple) and Fairview – Grand Itasca (in blue) while Fig. 3 shows maps Sanford Health Bemidji (in purple) and Fairview – Range (in orange). For reference, Sanford Health Bemidji and Fairview – Grand Itasca are 75 miles away, which is approximately 1 hour and 20 minutes by car, while Sanford Health Bemidji and Fairview – Range are 107 miles away, which is an approximately 2-hour drive.

As shown on Fig. 2 and Fig. 3, these Fairview and Sanford facilities pull from patients who reside within the same or neighboring zip codes. Whether patients *currently* choose to seek care at one health system's hospital versus another may be a function of their insurance network, preferences, services offered, and/or geography. Under a merged system, several of these factors would be dramatically different and could push a patient towards one facility or another: 1) Sanford could use its leverage to tie facilities together when negotiating with insurers to ensure multiple (or all of its) facilities are included in network; 2) Sanford could seek to remove or consolidate services in existing facilities; 3) Sanford could force doctors to move locations. In the end, the result may end up burdening rural patients, who now need to spend more time in transit to receive care.

Fig. 2

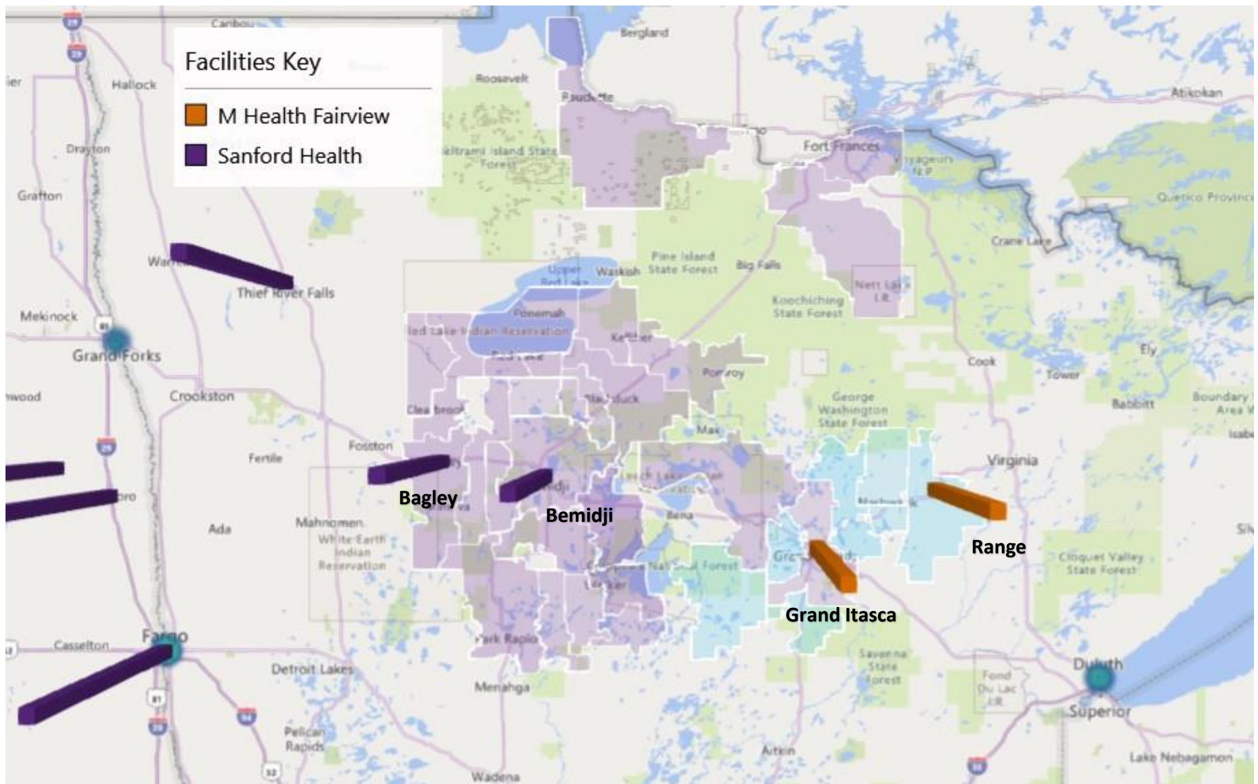
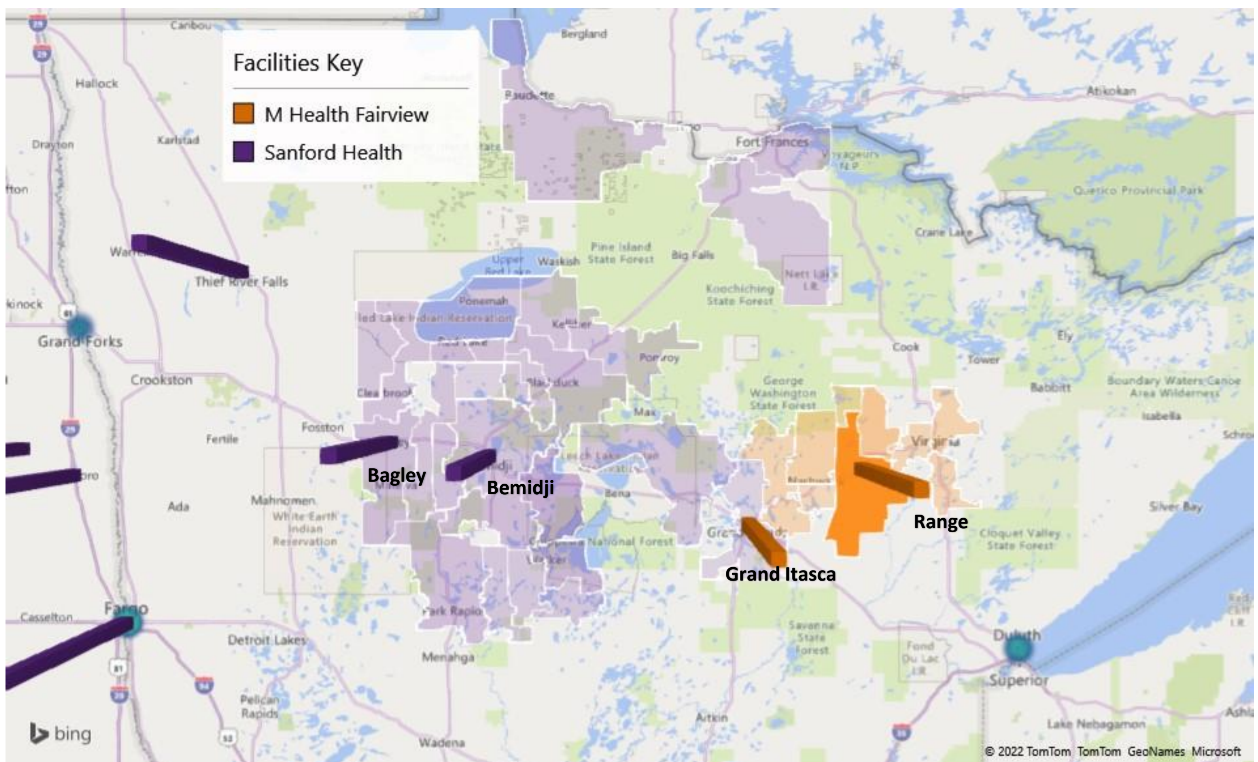


Fig. 3

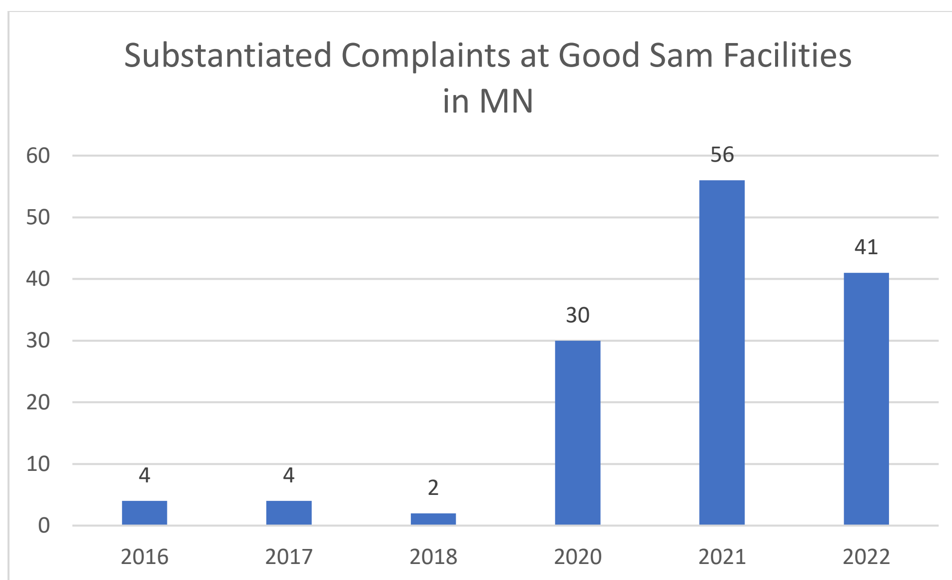


Long-Term Care

One way to examine a healthcare organization's record is to look to how it treats its most vulnerable patients. As operators of long-term care facilities, both Fairview and Sanford's practices deserve scrutiny, with consideration of how a combined system may operate.

Between 2020 and 2022, the Minnesota Department of Health identified 144 substantiated complaints at Sanford-owned and Sanford-managed facilities. 18 percent were related to quality of care; 26 percent were related to safety, including falls, elopement, and other injuries; and 11 percent were related to medication errors or issues.[88] As a result of these complaints, and others, Sanford-owned and managed facilities were fined at least $208,000 in recent years by the Centers for Medicare and Medicaid Services (CMS), with an additional $173,184 in suspended penalties.[89]

In 2019, Sanford merged with Evangelical Lutheran Good Samaritan Society ("Good Sam") which operated 200-plus post-acute, skilled-nursing, hospice, assisted-living, rehabilitation and home-health facilities across several states, including Minnesota.[90] Prior to its merger, Good Sam had relatively few substantiated complaints; following its partnership with Sanford, complaints skyrocketed.



Many nurses expressed their frustration over the merger between Good Sam and Sanford, viewing the changes – Sanford's home health division closed and was turned over to Good Sam – as a net negative to both staff and patients. Potentially related, nurses identified cuts to home health physical and occupational therapy.

Fairview's own record in their area is better compared to Sanford but is nowhere near spotless. Between 2020 and 2022, MDH identified 51 substantiated provider complaints from Fairview's hospice

---

[88] Available at https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.
[89] Compiled from ProPublica Nursing Home Inspect, available at https://projects.propublica.org/nursing-homes/.
[90] Alex Kacik, "Sanford Health and Good Samaritan Close Merger," *Modern Healthcare*, January 2, 2019, https://www.modernhealthcare.com/article/20190102/NEWS/190109991/sanford-health-and-good-samaritan-close-merger; Evangelical Lutheran Good Samaritan Society, "Locations," Good Samaritan Society, n.d., https://www.good-sam.com/locations.

and home care facilities, long-term senior care facilities and senior housing.[91] 16 percent were related to quality of care; 16 percent to abuse or rough treatment; and nearly 13 percent involved infection control.[92] As a result of these complaints, and others, Fairview-owned and managed facilities were fined at least $33,181 in recent years by CMS, with an additional $35,000 in suspended penalties.[93]

Both Fairview and Sanford's pattern of violations deserve examination by federal and state regulatory agencies. Objections from Sanford nurses who have experienced changes in home health under management at Good Sam should make clear that a merger between two companies which repeatedly put profits before patients will not be in the best interests of the elderly and other vulnerable Minnesotans.

Corporate Healthcare and Taxpayer-Funded Medical Center Don't Mix

University Partnerships

While the University of Minnesota's partnership with Fairview has been far from perfect, it could spell disaster for academic medicine under a partnership with Sanford.

Under Hereford's leadership, the health system has paid tens of millions each year under their agreement with the University of Minnesota to rebrand as M Health Fairview.[94] Despite this partnership, University officials and Fairview executives are at odds over the future.[95]

Under its land-grant mission, the University of Minnesota educates the state's clinicians, conducts research to discover new cures and treatments, and works with providers to bring doctors directly to patients.[96] Almost immediately after Fairview and Sanford made their merger announcement, the University of Minnesota expressed concern that big questions were left unanswered:[97]

- "How a combination would respect the University's land grant mission and critical role in the healthcare provided to patients at our flagship campus facilities and around the state;
- Fairview's and Sanford's commitment to respecting the independence of our faculty in the vision outlined for a combined organization, and;
- How these plans address Fairview's financial challenges."

In his public testimony on January 10, 2023, University of Minnesota Medical School Dean, Dr. Jakub Tolar, called for the Attorney General to prevent the merger "until Fairview and Sanford work with the university [to] address and resolve how we will continue to use all of our public resources in service to

---

[91] Available at https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.
[92] Ibid.
[93] Compiled from ProPublica Nursing Home Inspect, available at https://projects.propublica.org/nursing-homes/.
[94] University of Minnesota, "University of Minnesota, U of M Physicians and Fairview Enhance M Health Agreement," University of Minnesota, June 18, 2018, https://twin-cities.umn.edu/news-events/university-minnesota-u-m-physicians-and-fairview-enhance-m-health-agreement.
[95] Christopher Snowbeck, "Sanford-Fairview Delaying Merger until May 31 Following Pressure from State Officials," *Star Tribune*, February 10, 2023, https://www.startribune.com/university-of-minnesota-regents-chair-blasts-fairview-sanford-health-timeline-hospital-minneapolis/600250651/.
[96] Josh Skluzacek, "Fairview, Sanford Health Announce Plan to Merge," *KSTP.com Eyewitness News*, November 15, 2022, https://kstp.com/kstp-news/local-news/fairview-sanford-health-announce-plan-to-merge/.
[97] Ibid.

Minnesota," stating that because the flagship medical center was part of the deal, "[this] is not a private transaction but a public question for the future for public academic medicine in Minnesota."[98]

That the University has not been party to the merger talks and, as Dr. Tolar claimed, could not provide assurances regarding the University's public purpose[99] speaks to the disturbing dynamics at play. Dr. Tolar is one of three University-appointed representatives on Fairview's board, and according to reporting, spoke with Sanford board member Brent Teiken prior to the announcement. Sanford CEO Krabbenhoft wrote the Sanford board that the call between Dr. Tolar and Teikin "validated how much sway the university currently has over Fairview affairs and how necessary it will be to resolve that before we move forward with a merger."[100] While these close ties may have informed Sanford's decision to pursue a merger with Intermountain instead of Fairview back in 2020, it appears that Sanford and Fairview did little to assuage the University this time around. In fact, it prompted the University to announce its intention to purchase back the University of Minnesota Medical Center,[101] framing it as the way to safeguard research and medical education in the state.

Concerns about Sanford's commitment to research and medical education are warranted. While the University of Minnesota's Medical School is ranked #43 in terms of research and #3 in terms of primary care by U.S. News & World Report,[102] the University of South Dakota Sanford School of Medicine and the University of North Dakota Medical School are unranked in both of these critical areas.[103] One of the University of Minnesota's goals is to improve its Blue Ridge Rankings,[104] which compiles the National Institutes of Health (NIH) funding by medical school.[105] In 2022, the University of Minnesota ranked 21st in the country out of 144 schools, with $341,147,370 in funding – in contrast, the University of South Dakota is ranked 109th, receiving just $8,590,597.[106] The University of North Dakota stands in between at #98, with $18,053,063 in funding.[107]

[98] Christopher Snowbeck, "If University of Minnesota Opposes Sanford-Fairview Merger, It Could Repurchase Teaching Hospital, Execs Say," *Star Tribune*, January 10, 2023, https://www.startribune.com/minnesota-attorney-general-to-hold-first-public-meeting-tuesday-on-sanford-fairview-merger/600242221/.
[99] Ibid.
[100] Jonathan Ellis, "Sanford, Fairview's Decade of Flirtation," *The Dakota Scout*, November 17, 2022.
[101] Christopher Snowbeck, "University of Minnesota Wants Teaching Hospital Back as Part of Expansion Plan," *Star Tribune*, January 12, 2023, https://www.startribune.com/university-of-minnesota-wants-ownership-of-hospital-as-part-of-plan-for-new-medical-center/600242872/.
[102] U.S. News & World Report, "University of Minnesota," U.S. News & World Report, n.d., https://www.usnews.com/best-graduate-schools/top-medical-schools/university-of-minnesota-twin-cities-04054.
[103] U.S. News & World Report, "University of South Dakota (Sanford)," U.S. News & World Report, n.d., https://www.usnews.com/best-graduate-schools/top-medical-schools/university-of-south-dakota-04105; U.S. News & World Report, "University of North Dakota," U.S. News & World Report, n.d., https://www.usnews.com/best-graduate-schools/top-medical-schools/university-of-north-dakota-04085.
[104] Office of the Executive Vice President and Provost, "2021 University Performance and Accountability Report," Report (University of Minnesota, February 2022), http://conservancy.umn.edu/handle/11299/226291.
[105] Blue Ridge Institute for Medical Research, "BRIMR Rankings of NIH Funding in 2022," Blue Ridge Institute for Medical Research, n.d., https://brimr.org/brimr-rankings-of-nih-funding-in-2022/.
[106] Funding gathered from Blue Ridge Institute for Medical Research's data set, "Medical Schools & Their Depts," available at https://brimr.org/brimr-rankings-of-nih-funding-in-2022/.
[107] Ibid.

As the University of Minnesota trains roughly 70 percent of the state's physicians,[108] there is reason to be worried that the ranking may fall under a partnership with Sanford if executives are more concerned with profits than academic medicine.

Finally, there is the issue of finances and who controls them. Given Sanford's relationships with University of South Dakota and University of North Dakota, executives in Sioux Falls may not want to be willing to provide the same financial support to the University of Minnesota Medical Center and University of Minnesota Physicians, which was approximately $83 million in 2022.[109] Unless the University purchases back the medical center, it will have little leverage after the M Health Agreement expires in 2026 to negotiate a good deal. If that happens, important research and services that benefit Minnesotans may be at risk.

T. Denny Sanford's Interest in Research

T. Denny Sanford has certainly made his mark in healthcare, donating more than a billion to Sanford Health and other institutions that adopted his name.[110] While donations like these have been a boon to health systems and centers throughout the country, they come at a cost when organizations, governed by existing boards of directors, are suddenly beholden to donors who hold the purse strings.

In 2007, Sanford donated $400 million to Sioux Valley Hospital (now Sanford Health), which established a network of clinics around the globe and created a research center with the stated goal of curing a major disease, which became Type 1 diabetes.[111] At the time, the announcement that Sanford would search for a cure was critiqued by Gary Schwitzer, director of the University of Minnesota health journalism program, who told *MPR News*: "When a private entity enters into a research project with goals like these, I think these are vital questions for us to ask and for us to drop back and have the broader discussion … What's the national research agenda? Where are the dollars coming from? Should we care about that?"[112]

Similar questions arise with more recent philanthropy, such as with his gifts to UC San Diego for stem cell research and regenerative medicine,[113] which he said in 2008 "may be a significant part, if not the major (driver) of medicine in the future."[114] Given this type of research is banned in South Dakota,[115] T. Denny Sanford may try to use his weight to push his own research priorities if Sanford Health takes over Fairview's partnership with the University. Similarly, his $350 million donation to build a virtual care center and create "innovation, education and research initiatives to advance digital health care solutions

---

[108] Snowbeck, "University of Minnesota Wants Teaching Hospital Back as Part of Expansion Plan."
[109] Snowbeck, "Proposed Sanford-Fairview Merger Raises Financial Questions in Minnesota."
[110] Stu Whitney and Jonathan Ellis, "T. Denny Sanford's Electronic Device Center of Child Pornography Investigation," *Argus Leader*, August 28, 2020, https://www.argusleader.com/story/news/2020/08/29/t-denny-sanfords-electronic-device-center-child-pornography-investigation/4977312002/.
[111] Ibid.
[112] Cara Hetland, "Sanford Health Announces It Will Focus Research Effort on Juvenile Diabetes," *MPR News*, June 6, 2008, https://www.mprnews.org/story/2008/06/06/sanfordcure.
[113] Scott LaFee and Jade Griffin, "$150 Million Gift Takes Stem Cell Research to New Heights," University of California - San Diego, September 6, 2022, https://today.ucsd.edu/story/150-million-gift-takes-stem-cell-research-to-new-heights.
[114] Associated Press, "S.D. Banker Supports Stem Cell Research," *CBS News*, September 17, 2008, https://www.cbsnews.com/news/sd-banker-supports-stem-cell-research/.
[115] Ibid.

for the future"[116] may indicate an interest in programs that shift the burden of care to patients and their family members.[117]

There is reason to believe that T. Denny Sanford may use his influence to push his priorities. When Sanford executives were in talks to merge with Utah-based Intermountain, Denny Sanford sent an aggressive email blasting the deal: "It was my intent to donate several billion dollars to Sanford Health but mergers can be very costly to the acquired entity, the communities, and the people therein!"[118] Ultimately, the deal fell apart and Sanford has continued to heavily subsidize the Sioux Falls-based health system. While any nonprofit health system would be hard pressed to turn their back on outside funding, a careful review of this proposed merger must consider the role T. Denny Sanford could play in determining major healthcare research in the State.

Conclusion

A decade ago, Minnesotans united against healthcare executives to reject a corporate merger that would benefit a select few. What Minnesotans knew then, and know now, is that mergers make our hospitals less accountable and less connected to communities, resulting in higher costs for patients, reductions in services, and increased burnout for healthcare workers. While this merger is driven by private greed, public money and public services are at risk. This deal would see nearly $5 billion in assets,[119] created by Minnesotans through tax breaks, property and monetary donations,[120] transferred to unaccountable executives in Sioux Falls. We urge the Attorney General and elected officials to continue to act in the interest of patients, workers, and their communities and prevent the further entrenchment of corporate healthcare in Minnesota.

---

[116] Sonya Swink, "Sanford Health Receives $350 Million to Support Virtual Health in Rural Areas," *Argus Leader*, September 8, 2021, https://www.argusleader.com/story/news/business-journal/2021/09/08/sanford-health-t-denny-sanford-donation/5770066001/.

[117] National Nurses United, "Medicare's Hospital At Home Program Is Dangerous for Patients," September 2022, https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0922_Medicare_HospitalAtHome_Report.pdf.

[118] Ellis, "Sanford, Fairview's Decade of Flirtation."

[119] Fairview Health Services, "Continuing Disclosure Statement for the Nine Months Ended September 30, 2022," 2022, https://emma.msrb.org/P21644472-P21265699-P21692197.pdf.

[120] Elizabeth Stawicki, "Attorney General Questions Proposed Fairview-Sanford Merger," *MPR News*, April 8, 2013, https://www.mprnews.org/story/2013/04/08/attorney-general-questions-proposed-fairview-sanford-merger.