Minnesota Hospital Association

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Sen. Melissa Wiklund
Sen. Kelly Morrison
Sen. Liz Boldon
Sen. Rob Kupec
Sen. Jim Abeler

Rep. Tina Liebling
Rep. Robert Bierman
Rep. Dave Pinto
Rep. Heather Keeler
Rep. Joe Schomacker

Dear Chair Wiklund, Chair Liebling, and members of the Health Finance and Policy Conference Committee,

On behalf of the hospitals and health systems that we represent statewide, we respectfully submit to you the following comments on the Omnibus Senate and House Health & Human Services budget bills (HF 2930/SF 2995). While many provisions of the respective bills would 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.

Below you will find comments on six key provisions that would be of the greatest impact to Minnesota's hospitals and health systems and our ability to sustainably serve patients:

1. **MHA strongly opposes certain provisions of the Keeping Nurses at the Bedside Act.** *(House 2nd Unofficial Engrossment Article 3 Sections 72, 80, 85-93, 184-185, 189) (Senate 3rd Engrossment Article 3 Sections 6, 8-25)*

These provisions establishing a limit on how many patients a nurse can care for 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 hundreds 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 lead to unit closures, rising costs, longer wait times for patients, and the loss of vital services that communities rely on.

We urge conferees to be openminded to accept needed changes. MHA is supporting compromise language that would likely include violence prevention measures, nurse staffing committees, staffing complaint forms, posting of staffing plans and hospital report cards. Hospitals are advocating to delete the language that would set patient admission caps, mandatory arbitration to settle disputes, and nurses deciding hospital elective surgery schedules.

2. **MHA opposes carving out the prescription drug benefit from managed care contracts.** *(House 2nd Unofficial Engrossment Article 2 Sections 11,16,20) (Senate 3rd Engrossment Article 1 Sections 5, 27, 33)*

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 is supporting alternative language that keeps the current 340B payments in place. DHS would also be tasked with conducting a study of what other states are doing with their 340B programs as well as some new reporting requirements for 340B entities.

3. **MHA strongly <u>supports</u> provisions and funding included in the Senate bill (and regrettably not included in the House bill) that provides timely updates to the Medical Assistance (MA) payment rate rebasing process.** *(Senate 3rd Engrossment Article 1 Section 4)*

This provision provides timely updates to the Medical Assistance (MA) hospital inpatient fee-for-service reimbursement rate setting process at the Department of Human Services (DHS). This provision ensures that the inflationary adjustments to hospital inpatient MA fee-for-services rates better account for current costs and inflationary trends, and it ensures that Minnesota's 78 critical access hospitals are reimbursed for 100% of inpatient fee-for-service MA patient care costs.

Using language developed in consultation with the Department of Human Services (DHS), this provision improves hospital inpatient reimbursement rates for care delivered to fee-for-service enrollees at a time when Minnesota's hospitals of all sizes continue to struggle with the long-term financial repercussions of the COVID-19 pandemic, an unprecedented rise in labor and supply costs, and increasing patient acuity and complexity. All this combined has begun to erode the sustainability and accessibility of the inpatient hospital care that Minnesotans rely on at their time of greatest need for acute care.

4. **MHA opposes the requirements for notice and review of health care entity transactions.** *(House 2nd Unofficial Engrossment Article 3 Sections 76,177,194) (Senate 3rd Engrossment Article 4 Sections 37, 80)*

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 (AG), and the lack of timeline or sunset on the authority of the AG to unwind a completed transaction. The scope of the authority is so broad it could potentially inundate the Minnesota Department of Health (MDH) and the AG'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 to scale back the scope and breadth of the current language. MHA is supportive of an alternative that would create a two-tiered approach to transaction oversight. The initial review for mergers and acquisitions with revenue over $40 million would consist of general transaction information submitted to the MDH. If MDH believes that the transaction would result in a dominant market provider with higher costs, then the transaction would be referred to the AG. The AG could then request more in-depth and detailed information on the transaction and determine if it is in the public interest to proceed. Key issues such as data privacy, provider burden to produce information, transaction uncertainty, AG look back authority, and an appeal process should all be considered as part of this oversight.

5. **MHA opposes the provisions to create a MinnesotaCare public option.** *(House 2nd Unofficial Engrossment Article 2, Sections 9, 21-22, 24-28) (Senate 3rd Engrossment Article 16 Section 18-28)*

Public health care programs, which comprise on average 62 percent of patients that Minnesota hospitals and health systems care for, reimburse at about half the rate that commercial health plans pay. While Minnesota hospitals serve all patients with a high level of care regardless of their payer source or payment amount, our current delivery model is not sustainable with government payment rates that do not cover the costs of providing care. MHA urges legislators to investigate the impact broad changes in MinnesotaCare eligibility would have on the ability of providers to deliver care. MinnesotaCare coverage could be expanded while still preserving an upper income threshold.

6. **MHA opposes corrective action plans and civil penalties within the creation of a Health Care Affordability Commission.** *(House 2nd Unofficial Engrossment Article 2, Sections 1-8) (Senate 3rd Engrossment Article 16 Sections 1-9)*

This provision creates a new and politically appointed board and advisory council to develop recommendations on large scale health care transformation and the establishment of health care spending growth targets. These broad responsibilities and any directive from the Board would be subject to limited oversight and approval and offers few opportunities for partnership with the significant work already being done by state agencies and private health care organizations.

MHA is concerned that any effort to establish arbitrary health care spending growth targets will likely fall short of accounting for the entirety of market pressures and demands, specifically on hospitals and the increase in patient acuity. Issues such as patient boarding and inability to discharge, RSV surges, and other unforeseen emergencies inject new and unforeseen costs that are shifted to hospitals. 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.

Creating a new body to analyze health care spending in Minnesota may be necessary to better understand the shared goal of sustaining access to care, but it does not need to include punitive regulatory power and severe civil penalties.

MHA supports the following provisions contained in both bills:

- Medical Assistance continuous eligibility for children.
- MHA strongly supports multiple provisions to invest in the health care workforce.
- Extending the use of audio-only telehealth through July 1, 2025.
- Establishing a workplace safety grant program for health care entities and human services providers.
- Start-up and capacity-building grants for psychiatric residential treatment facility sites.
- Medical Assistance coverage for recuperative care services for persons experiencing homelessness.
- Modifications to the Medical Education and Research Costs (MERC) program.

In addition to the comments above, MHA encourages the Conference Committee to consider the inclusion of the following provision:

Summer Health Care Internship Program (SF 2387/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.

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

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