Minnesota Hospital Association

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May 5, 2021 *Sent Electronically*

Sen. Michelle Benson
Sen. Jim Abeler
Sen. Paul Utke
Sen. Mark Koran
Sen. John Hoffman

Rep. Tina Liebling
Rep. Jennifer Schultz
Rep. Aisha Gomez
Rep. Dave Pinto
Rep. Joe Schomacker

Dear Chair Benson, Chair Liebling, and Conference Committee members:

On behalf of hospitals and health systems that we represent statewide, we respectfully submit to you the following comments on both the Omnibus Senate and House Health & Human Services budget bills (SF 2360/HF 2128). We recognize your and your staffs' hard work to put together these comprehensive appropriation bills under very difficult circumstances. 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 and reflect the issues where we have significant concerns. We are hopeful these sections will not be included in the final Omnibus Bill this year. We stand ready to work with each of you in this process.

Comments on HF 2128:

1. **MHA is opposed to the provision to carve-out the prescription drug benefit from PMAP and county-based purchasing. (Article 1, Section 43)**

   This proposal triggers a federal rule that would result in Minnesota hospitals (all Critical Access Hospitals, all children's hospitals and hospitals with a large share of low income patients) and other 340B entities losing a considerable amount in payments that are used to help provide health and community services that have either no reimbursement or low reimbursements.

   The federal government created the 340B program to help offset Medicaid underpayments and exorbitant prices from pharmaceutical companies. 340B covered entities are provided access to lower costs of drugs to recognize the high levels of Medicare, Medicaid, and indigent populations they serve. This provision causes a shift in funding away from 340B entities to DHS. We need to keep this funding in the health care system in service of our patients and communities.

   This is not an insignificant proposal. Both California and New York, the two largest Medicaid programs in the country, have recently put their previously proposed drug carve-out initiatives on hold because of the program complexities, state administrative costs and the negative impact to 340B entities.

2. **MHA is opposed to the provision to mandate reporting of drug purchase expenses and drug reimbursements. (Article 1, Section 24)**

   The proposed reporting requirements on 340B Covered Entities in this provision represent unnecessary state overreach on a federal program and do not deliver any benefits to patients. 340B Covered Entities are already frequently audited by the participating drug manufacturers and the Health Resources and Services Administration (HRSA). Additional oversight and administrative burden are not needed to ensure that the 340B program is

working as intended by Congress and the federal government: to increase patient access to significantly discounted drugs and assist providers in the delivery of more comprehensive patient care in underserved communities.

The mandated discounts on drugs administered through 340B are independent of reimbursement, public or private. 340B discounts are set by HRSA, updated quarterly, and are not available to the public. Given that the State does not share any information on Medicaid drug rebates it receives or the aggregate amount of rebate dollars and its uses, the reporting requirements on private sector entities seem uniquely unfair and burdensome.

Lastly, 340B offers benefits to all patients regardless of insurance status or coverage and supports services for all patients cared for by a 340B covered entity. Therefore, the removal of Medical Assistance coverage for 340B drugs if the provider fails to comply with the proposed reporting requirements is punitive and does not solve any problems with patient access to discounted drugs and other critical services.

3. **MHA is opposed to the provision to implement a uniform administration of non-emergency medical transportation (NEMT). (Article 1, Section 31)**

The provider and patient community have opposed this proposal on several different occasions in the past. While involving a new third-party entity in the process would add administrative simplification for the Department of Human Services, it would most likely come at the expense of moving payments from providers to this new vendor who would be awarded a DHS contract. MHA believes this will result in reduced services for vulnerable Minnesotans who rely on this form of transportation to get their medical care -- especially considering that transportation is an important social influencer of health. Previously, when third-party contracts were in place, hospitals, and health systems experienced delays in transportation for individuals waiting to be discharged. A delayed hospital discharge process adds costs in other areas of the health care system. In addition, MHA believes that greater use of telehealth, particularly for individuals who do not have their own transportation or who cannot readily access public transportation, may reduce the overall use of NEMT.

4. **MHA is opposed to efforts that increase MDH oversight into hospital operations; regulating service line change notification, right of first refusal for hospital closure, and certain requirements added to exceptions in the bed moratorium process.**

These sections **(Article 3, Sections 48 and 50)** significantly increase the amount of oversight given to MDH on individual hospital bed licenses and puts an additional burden on hospitals to report annually on the individual bed level. MDH already has significant regulatory authority across various state and federal regulations, including the overall hospital license. As has been highlighted throughout the pandemic, hospitals need the ability to maintain flexibility in staffed and operational beds available to best meet the needs of individual communities and these reporting and enforcement proposals would further strain highly regulated health care environments. MHA is especially concerned with the language for MDH to have the authority to prohibit bed license renewals - for existing moratorium exceptions.

This section **(Article 3, Section 51)** requires a minimum nine-month notice before closing a hospital or dropping certain service lines. This timeframe is too long, and a hospital may not be able to comply if there are not the health care personnel available to provide the service. In recent years, we have had a few hospitals that have made the difficult decision to drop labor and delivery services. There is currently a nationwide discussion about best practices for when a hospital should discontinue OB services for planned deliveries because of low volume. A hospital may not know about staff changes or unplanned retirements nine months in advance. Many hospitals and health systems in Minnesota continuously adjust their service lines depending on the needs in the community, which services are better provided at a larger nearby hospital, and the skills and experience of their health care professional workforce.

This section **(Article 3, Section 52)** requires a hospital with a planned closure to offer for sale the hospital facility to the local unit of government. Selling a hospital property to the city or county for them to try and run a hospital seems very unlikely to be successful. Also, the community may best be served by an alternative care model, such as providing clinic services instead of hospital services at that location.

This section **(Article 3, Section 49)** provides a permanent exception to the hospital moratorium law if it is for adding mental health beds. Unfortunately, the bill adds language that the hospital must have an emergency room and it must not be a facility that only provides mental health services or substance abuse services in order to get the moratorium exception. These two additional requirements add costs associated with emergency rooms and potentially thwarts innovation of alternative models of mental health care.

5. **MHA has concerns with requiring changes to new price disclosure information and provider identification in future APCD studies.**

   On January 1, 2021, a new CMS rule required hospitals and health systems to show five charge levels in a machine-readable format for all inpatient and outpatient procedures. The five data points include the following: the full charge amount, the discounted price for cash payment, the negotiated price for each payer contract, and the minimum and maximum price levels accepted for each detailed service and bundled service sets. The second part of the regulation requires the provision of price estimates for 300 shoppable services either as individual services, such as a diagnostic imaging procedure, or for bundled services such as the delivery of a baby.

   This provision **(Article 3, Section 12)** requires hospitals to re-format the data in a specified displayed manner. This seems redundant. In addition, MHA does not know the IT costs of this re-work effort and the capabilities of hospitals to do this work varies across the state. In addition, MHA does not know if the identified new format actually provides any additional value to health care consumers.

   Expanding uses of the All-Payer Claims Database **(Article 3, Section 15)** may have some value. However, MHA is concerned with the language which will allow for the identification of individual hospitals and clinics in future studies to be completed with data from the APCD. This level of specificity in identification within a complex system of data may lead to undue and/or misplaced judgements or punitive actions.

6. **MHA supports the provision allowing for pharmacy and provider choice related to prescribing and dispensing of biological products. (Article 5, Sections 9, 11, 12 and 21)**

   Biological medications are the most significant driver of prescription drug spending in the United States, accounting for nearly 40% of total drug spending. Promoting greater use of lower priced versions of these biosimilars makes sense. Policies should encourage health care providers, when appropriate, to order the least costly product, if it is as effective for the patient. Insurance coverage parity will promote greater use of biosimilars.

7. **MHA strongly supports the telehealth provisions found in both the House and Senate bills. We are very appreciative this is a priority for both bodies. (House Article 8 and Senate Article 8)**

   - The Senate bill has an effective date of July 1, 2021, while the House has an effective date of January 1, 2022. MHA supports the Senate effective date for the extended telehealth coverage to ensure that there are no gaps in coverage. If the public health emergency ends before November 1, 2021, the House effective date could result in a gap for public program enrollees.
   - Sunset provisions: The Senate bill sunsets coverage of audio-only services for Medical Assistance and MinnesotaCare on July 1, 2023. The House sunsets new coverage expansions for public and private coverage on July 1, 2023, with an exception of the home as an allowable originating site remaining in place. Both bills

call for a comprehensive study of telehealth services. MHA recommends that sunsets of telehealth expansions be delayed until the results of the study are analyzed.

Comments on SF 2360:

1. **MHA has concerns with the provision calling for deletion of hospital records for minors. (Article 2, Section 26)**

The proposed ability for minors to delete their hospital records after seven years or upon reaching the age of majority presents multiple administrative, legal, and clinical issues. No other state has an option to delete records in this fashion and in doing so it would create administrative complexity for managing and deleting health records, especially for patients that have received care in neighboring states. Some commercial insurers extend their right to audit health records well over seven years after a date of service. If access is no longer available to deleted records, insurers can use the lack of patient records as grounds to remove a hospital from their provider network.

Allowing patients to request the destruction of their records puts hospitals at risk both in audit and litigation circumstances. For example, if a hospital or health system no longer has records of previous injuries in a domestic violence situation to provide to law enforcement, an abusive spouse or parent could not be held accountable. For clinical purposes, the information destroyed could have continuous clinical significance into the future, such as device implantation information (pacemakers, e.g.), birth information, major procedures, vaccinations, and allergies that are relevant for a lifetime, and will need to be known if the patient is incapacitated and cannot provide it.

2. **MHA strongly supports a Senate only provision streamlining the background check and fingerprinting process for licensed health care professionals. (Article 6, Section 59)**

This provision eliminates the burden on providers and employers of a duplicative fingerprinting and background studies process, by exempting licensed health care professionals from the DHS NetStudy 2.0 process, **IF** the individual is duly licensed in good standing with their health licensing boards, like the Board of Medical Practices or the Board of Nursing – which have already conducted a background check with a fingerprint as part of licensure. This creates efficiencies for both employers and prospective employees and could potentially reduce some of the massive backlog of individuals needing to have a background check completed who were temporarily waived of this requirement during the health care emergency.

Thank you for your consideration of our comments. Please do not hesitate to call if we can provide information on these issues or other provisions of the Health & Human Services Bills.

Sincerely,

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