Minnesota Hospital Association

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Chair Wiklund and Members of the Senate Health and Human Service Committee:

On behalf of the Minnesota Hospital Association (MHA), we respectfully submit to you the following comments on the Senate Health Care Access and Affordability budget package (SF 49 – Wiklund).

MHA supports Medical Assistance continuous eligibility for children. (Article 1, Section 5).

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 adolescent enrollees.

Further, 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. Continuous eligibility will 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 and prevent unnecessary care.

MHA opposes corrective action plans and civil penalties within the creation of a Health Care Affordability Commission. (Article 2, Sections 1-7).

This provision establishes a new and politically appointed board and advisory council to develop technical recommendations on large scale health care transformation using criteria dependent on assumed expertise of board and council membership. Notably, membership does not include or explicitly call for expertise in the delivery of acute and/or hospital level care or with input from medical professionals. In addition to unilaterally establishing health care spending growth targets, the political appointees would also be tasked with ruling on the broad concepts of payment reform, innovating delivery models, and Minnesota's response to market trends. 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.

Health care needs are often unpredictable, and 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 require establishing punitive regulatory power and severe civil penalties.

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

While MHA strongly 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

level. If eligibility is broadened without an income limit, current payment rates would not allow for a sustainable health care system given that government payers, both state and federal, pay far below the actual cost of care for their beneficiaries. This continually places stress on hospital care, especially as more patients present with higher acuity and complicated co-occurring health issues. MHA urges the Committee and the Legislature to consider a better alternative approach to expand current MinnesotaCare eligibility to 300-400% of the Federal Poverty Limit. MHA believe that the MinnesotaCare program needs to keep an upper income eligibility threshold.

In closing, Minnesota's hospitals and health systems are committed to delivering the care that their patients and communities need when and where they need it. This of course includes dedicated stewardship of shared goals through strong private and public partnership to both increase and maintain access and affordability. Hospitals and health systems occupy a truly unique space in the delivery of health care services as safety net and acute care providers 24 hours a day, 7 days week, 365 days a year. Right now, the entire country, including Minnesota, is seeing growth in health care spending due to a myriad of complex factors, including but not limited the known and unknown ongoing effects of the COVID-19 pandemic and the unprecedented workforce challenges and subsequent capacity issues.

In addition, a growing number of Minnesotans are developing chronic health care conditions that require acute care and increased spending relative to their peers. Population health care needs are unpredictable, and MHA is concerned with any efforts to establish spending growth targets that will fail to predict and account for the next crisis that hospitals will be the expected to address.

Thank you for your consideration of our comments. We welcome the opportunity to discuss these issues with you over the course of the remaining legislative session.

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