Preserve meaningful health care coverage for low-income Minnesotans
MHA urges legislators to preserve coverage for Minnesotans with incomes below 200 percent of the Federal Poverty Guidelines who are currently eligible for our state’s Medical Assistance and MinnesotaCare programs.

Support mental health initiatives
MHA urges passage of a new Mental Health Innovation Grant Fund program (HF 737/SF 564) that would provide seed money to community collaborations to improve mental health access and redirect money that is currently going into the general fund rather than invested in mental health. In addition, MHA urges legislators to provide funding for community-based mental health services, particularly services aimed at improving hospital patient discharge options. Patients who do not need a hospital level of care should be able to receive the services they do need in a community setting.

Update Minnesota’s Medical Assistance payment methodology
MHA supports a recommendation in the governor’s budget that reauthorizes the Department of Human Services (DHS) to use policy adjusters within the inpatient fee-for-service Medical Assistance program. This legislation (HF 1559/SF 1335) will allow DHS to move a portion of the hospital payments from all service lines to better fund mental health and obstetric services for Medical Assistance enrollees.

Modernize Minnesota’s Health Records Act to allow for better coordination of patient care
Minnesota’s Health Records Act should not be more restrictive than federal privacy laws. This creates an impediment to more streamlined exchange of clinical information, and its requirements go far beyond those of the federal Health Insurance Portability and Accountability Act (HIPAA). By changing state law, we could give our caregivers access to the potentially life-saving information they need to deliver the best care possible. State policy should encourage greater care coordination across the continuum and more innovative care delivery models. Minnesota should adopt the HIPAA standard that 48 other states have in place.

MHA places a priority on preserving the Health Care Access Fund for health care coverage for low-income Minnesotans
- While there is currently a surplus in the Health Care Access Fund, MHA urges legislators to preserve those funds for future coverage of low-income Minnesotans. This was the intent of the fund.
- Minnesota should be proud that we were an early Medicaid expansion state and one of just two states in the country that implemented a Basic Health Plan, which leveraged significant federal funding. We have had a bipartisan, shared goal of reducing the number of uninsured Minnesotans.
- Under the Affordable Care Act (ACA), Minnesota receives about $1.6 billion a year in federal funding to support the Medicaid expansion. In addition, Minnesota receives about $500 million a year in federal funding by implementing the ACA’s Basic Health Plan for our MinnesotaCare program.
- MinnesotaCare has provided lower premiums, lower copayments and a good benefit set for low-income Minnesotans between 138 and 200 percent of the Federal Poverty Guidelines. MHA continues to support the MinnesotaCare program for this population.
• With potential repeal and replacement of the ACA, there is enormous uncertainty regarding how much federal money Minnesota could lose. The Health Care Access Fund will likely be needed to help pay for coverage. This money should not be diverted for other purposes.

**MinnesotaCare should be reserved for low-income Minnesotans**  
• MHA opposes a public option for MinnesotaCare. Under this proposal, MinnesotaCare eligibility would not have an upper income threshold, and any individual would be allowed to buy a MinnesotaCare insurance policy. State public health care programs currently pay providers about half of what a commercial plan pays. In addition, this proposal could entice people out of the small group market because of the lower-priced MinnesotaCare insurance product further constricting the individual market.
  
• MHA supports efforts to maintain commercial insurance markets. Minnesota's hospitals have a payer mix comprised of 63 percent government payer and only 37 percent commercial payer. With public program payments below costs, maintaining a private insurance market is important for all hospitals and health systems.

**Creation of a new Mental Health Innovation Grant Fund**  
Nearly one in five days that mental health patients spend admitted to inpatient community hospital psychiatric units is potentially avoidable. These mental health patients could have been more appropriately cared for in a different care setting. Throughout the state, hospitals and health systems are partnering with other regional and community organizations to find local solutions to the mental health crisis. MHA is proposing a new grant fund to be administered by the Department of Human Services that would redirect money from the general fund into mental health, providing seed money to collaborative mental health efforts. The proposal includes:
  
• A first-year request of $10 million for 2018 grants – $5 million for the seven-county metropolitan area and $5 million for Greater Minnesota.

• Entities eligible to apply for the grant include: counties, community hospitals (other than those operated by the state) and community mental health centers.

• Beginning July 1, 2017, payments received from the counties currently being deposited into the general fund for stays at Anoka Metro Regional Treatment Center and Community Behavioral Health Hospitals will be redirected into the newly created Mental Health Innovation Grant Fund.

**Other legislation of interest to Minnesota’s hospitals and health systems**  
• MHA supports HF 582/SF 386, preventing the Minnesota Department of Health from expanding regulations currently applied to nurse staffing agencies to other health care providers like physicians and physician assistants.

• MHA supports HF 559/SF 341, allowing Minnesota’s 26 public, government-owned hospitals to make investments.

• MHA supports legislation that builds our health care workforce. These efforts include: Medical Education and Research Costs (MERC), family residency grant programs, loan forgiveness initiatives and preceptor tax credit legislation (HF 1167/SF 139).

• MHA opposes HF 2115/SF 1784, mandating a new proprietary-based quality improvement reporting system, which would be in addition to numerous state and federal quality reporting laws. This could also jeopardize the work of Minnesota’s nation-leading Integrated Healthcare Partnerships (IHPs) in our Medical Assistance program.

• MHA opposes HF 2026/SF 2164, allowing for the sale of health insurance policies without any requirements of Minnesota’s currently mandated benefit set. MHA believes that any changes to our benefit set should only be done after thoughtful consideration with input from consumers and health care stakeholders. Minnesota’s hospitals and health systems want Minnesotans to have meaningful insurance coverage for all essential health care services, including preventive care, mental health care, routine screenings and other health care throughout a person’s lifetime.