partners (*in*)fertility

INFERTILITY • PREGNANCY LOSS • ASSISTED REPRODUCTION

March 31, 2023

Senator Melissa Wiklund
Chair, Health and Human Services Committee
2105 Minnesota Senate Bldg.
St. Paul, MN 55155

RE: IVF Budget Provision - SUPPORT

Dear Chair Wiklund:

My partner, Debbie Fischer, and I work closely with the 1 in 8 Minnesotans who are suffering from infertility or are having trouble sustaining a pregnant, as well as straight and LGBTQ Minnesotans who need medical intervention to build their families. Thank you for supporting adding the provisions of SF 1704 for in vitro fertilization (IVF) and fertility preservation insurance coverage in your HHS omnibus finance bill for large fully insured groups. This is an important and significant first step to assuring that all Minnesotans have access to infertility care.

This pro-family provision will significantly improve access to the standard of care for patients with infertility and those diagnosed with cancer or other conditions that may cause infertility. Infertility cuts across socioeconomic levels, and all racial, ethnic and religious lines. Medical conditions such as endometriosis, ovulation disorders, premature ovarian failure, and male factor are some causes of infertility. The American Medical Association, the American Congress of Obstetricians and Gynecologists, and the World Health Organization all recognize infertility as a disease. Health insurance should cover infertility like other diseases.

The average cost of an IVF cycle in the U.S. is approximately $15,000. Many of our patients go into significant debt just to have a family. Medical and financial stress is very difficult for our patients.

Minnesota should join the growing list of states that require fertility coverage. As proven in these states, insurance covering IVF decreases the chance of multiple births, and lowering multiple births decreases overall health care costs and results in healthier babies and healthier moms.

On behalf of all of our patients who are struggling to build their families, we thank you for your support and leadership in supporting this important pro-family-building provision.

Sincerely,

Deborah S. Simmons, PhD, LMFT *Deborah M. Fischer, MA, LMFT*

Deborah S. Simmons, PhD, LMFT Deborah M. Fischer, MA, LMFT

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March 31, 2023

Public written testimony for SF2995 DE amendment

Name: Ann Ehlert, PharmD
Title: Testifying on my own behalf, pharmacist practicing in Minnesota
Director of Pharmacy at a health plan

Comment: Chair Wiklund, Vice Chair Mann, and Members of the Committee:
Thank you for the opportunity to testify on SF2995.

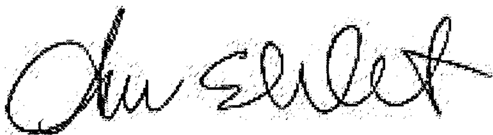
Subd. 6d.(a) Prescription Drugs: I would like to testify against the changes in Subd. 6d of SF2995. This language is confusing. It shall exclude and may include, exclude or modify. I would suggest removing the changes to Subd 6d.(a) until further review can be done to refine changes to be consistent in the statute.

Subd. 36. I would like to testify against opt-out of managed care. Providing consistent services to members helps outcomes and helps establish relationships and trust. If members opt-out, and in, etc they do not get streamlined care.

I would like to testify in favor of Subd. 6d.(b) and the doula provisions. These are positive changes to benefit providers and members.

Subd. 13c.Formulary Committee:
I would like to testify against the changes to Subd. 13c. While the changes to the Formulary Committee are appropriate, getting physician participants is very, very difficult. It would present a hardship if the physician participants were of specific areas of medicine. It is difficult to get committee participants in general but placing restrictions on the types of participants will make it even more so. Physicians have many demands on their time, and finding the specialties listed, to participate four times a year, at the current honorarium will be near impossible. It will make it difficult to get enough physicians to meet the quorum requirements and may result in lack of action. I have set up a committee like this and it took 6 months to find only 2 physicians to participate.

Thank you



Ann Ehlert, PharmD

Section for comment :
SCS2995a

43.27 Sec. 28. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

43.28 Subd. 6d. **Prescription drugs.** (a) The commissioner ~~may~~ shall exclude or modify
43.29 coverage for outpatient prescription drugs dispensed by a pharmacy to a medical assistance
43.30 or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this
44.3 contingent on federal approval of the managed care contract changes and the collection of
44.4 ~~additional prescription drug rebates~~ chapter and chapter 256L. The commissioner may
44.5 include, exclude, or modify coverage for prescription drugs administered to a medical
44.6 assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into
44.7 under this chapter and chapter 256L.

Subd.13c. Formulary Committee

14.25 Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to
14.26 read:

14.27 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
14.28 from professional medical associations and professional pharmacy associations, and consumer
14.29 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
14.30 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed
14.31 physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must~~
14.32 ~~be actively engaged in the treatment of persons with mental illness~~ is an actively practicing
14.33 psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one

15.1 of whom specializes in pediatrics, and one of whom actively treats persons with disabilities;
15.2 at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota,
15.3 one of whom practices outside the metropolitan counties listed in section 473.121, subdivision
15.4 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision
15.5 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer
15.6 ~~representative~~ representatives, all of whom must have a personal or professional connection
15.7 to medical assistance; and one representative designated by the Minnesota Rare Disease
15.8 Advisory Council established under section 256.4835; the remainder to be made up of health
15.9 care professionals who are licensed in their field and have recognized knowledge in the
15.10 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.
15.11 Members of the Formulary Committee shall not be employed by the Department of Human

Minnesota Hospital Association

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March 31, 2023

Submitted Electronically

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

On behalf of the Minnesota Hospital Association (MHA), we respectfully submit to you the following comments on the Senate Health and Human Services Omnibus bill (SF 2995 - Wiklund). 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 supports provisions that provide timely updates to the Medical Assistance (MA) payment rate rebasing process (Article 1, Section 3)

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.

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 9-17, 19, 20, 23)

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 4, Section 35)

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 1, Sections 28)

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 strongly supports multiple included provisions to invest in the health care workforce.

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 omnibus. 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 Section 41; Article 2, Section 7)

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 4, Section 80)

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 9, Section 6)

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 coverage for recuperative care services for persons experiencing homelessness. (Article 1, Section 22, 24)

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 5)

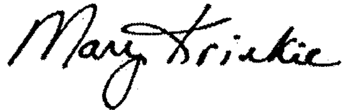
MHA is appreciative of this provision to comply with an updated federal rule from the Centers for Medicare and Medicaid Services regarding the MERC payment mechanism. This is not new funding for the program but is a necessary policy change to ensure ongoing support for training new medical professionals in Minnesota.

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

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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The Kid Experts™

March 31, 2023
Senate Health and Human Services Committee

Dear Chair Wiklund and Committee Members,

On behalf of Children's Minnesota, I am writing to offer comments on several provisions in SF2995, the Senate Health and Human Services Omnibus bill. Children's Minnesota is the state's largest pediatric health care provider, seeing over 165,000 patients last year alone. We serve children and teens from all 87 counties and 60 percent of the counties in surrounding states. Nearly half of our patients are insured through Medicaid. Because of the diversity of patients we see, we understand the unique and varied challenges Minnesota children face.

SF2995 includes several important provisions that would benefit the patients and families we serve:

- Improving transparency and processes of the Drug Formulary Committee.
- Removing prior authorizations requirements for liquid methadone. This medication is used to provide comfort to kids receiving hospice and palliative care, and to treat babies born dependent on opioids, avoiding hospital stays for serious withdrawal symptoms.
- Ensuring inpatient hospital fee-for-service Medicaid rates are rebased using current costs and inflationary trends.
- Continuous Medicaid eligibility for children through age 6- and 12-month continuous eligibility for children ages 19 and under.
- Ensuring Medical Education and Research Costs (MERC) funding continues under a new mechanism. Because this is new, we encourage the committee to include hold harmless language to avoid unintended funding reductions.
- Children in our state are in the midst of a mental health crisis which has led many families to seek care for their child in a hospital emergency department. Often, these kids do not need hospital level care but there are not spaces available in community, residential or home settings. Kids therefore end up boarding in hospitals, waiting sometimes weeks or even months for space to open in the right care setting. We support the included investments in kids' mental health:
    - A 35 percent increase in outpatient mental health rates while DHS continues to study long term increases to these rates.
    - Workforce investments including mental health professional scholarships and the pediatric primary care mental health training grant program.
    - Capacity building funds to support PRTFs who treat and accept individuals with complex support needs, including support for evidenced-based, culturally appropriate curriculums and training programs for staff and clients.

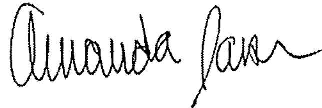
We also hope the committee will consider concerns we have with the following:

- While Children's Minnesota supports the nursing loan forgiveness program, mental health supports and workplace violence prevention components of the Keeping Nurses at the Bedside Act, we remain very concerned about the current staffing provisions in the bill. Children's Minnesota and the Minnesota Nurses Association recently agreed to a new contract that included new and improved staffing committee structures and processes that give bedside nurses more of a voice on staffing. The contract also included a commitment to collaborative problem solving in the areas of patient boarding, workplace violence and diversity, equity and inclusion.

- Additional investments in respite care are urgently needed for children and families who have utilized crisis services, emergency room services or experienced a loss of in-home staffing support.
- Increased funding is needed for culturally responsive school-linked mental health services and early childhood mental health services and consultation.

At Children's Minnesota, our vision is to be every family's essential partner in raising healthier children. As the kid experts in our community, we appreciate the opportunity to partner with you to collectively improve the health and wellbeing of kids in our state.

Sincerely,



Amanda Jansen, MPP
Director of Public Policy
Children's Minnesota

Chair Wiklund and Members of the Senate Health and Human Services Committee,

Thank you for the opportunity to provide written testimony. My name is Anne St Martin and I live in Inver Grove Heights with my husband and two sons. I am asking you, **PLEASE INCLUDE SF 1029, INCREASED ACCESS FOR RARE DISEASE PATIENTS,** in your Omnibus bill. **My family has personally dealt with insurance barriers and had limited access to the proper services my son has needed over the years.**

My son Leo is 6 years old and has a rare genetic disease called Pompe Disease. Pompe Disease affects 1 in 40,000 people. Leo was born on May 17, 2016. In all senses it was a normal pregnancy and delivery. As Leo turned 3 months, he developed feeding issues. Those issues progressed and we knew Leo needed help. We knew we needed to see a specialist.

Our pediatrician recommended that we go see a pediatric neurologist. First we needed to wait for prior authorization from our insurance. **As I sat there and watched my beautiful baby get weaker and weaker I knew I could not wait the 3 to 6 weeks they said it could take for insurance to approve the appointment. On top of that there are limited numbers of specialist appointments available to you. So, even after you get the prior authorization, you then can wait 8 more weeks to even get into see a doctor.**

I called the specialist office and told them we would pay out of pocket for the visit. They told me it could cost up to $5000 or more for the visit. They then told me the next available appointment was in 4 weeks. I told them I would not stand for that. Luckily a pediatric neurologist appointment had opened up the next day. We took that appointment and prayed. The next morning we checked in at our neurology appointment. I gave my credit card to the receptionist and we waited. I remember thinking this was it. We were going to get the answers we needed. It would be worth the cost and Leo would be ok. Instead the PA came into the room, looked him over, listened to his heart, and then told us she was calling an ambulance and checking us into the hospital. When we got to the hospital they did an EKG and saw that Leo was in heart failure. At 4 months old Leo's heart was so large it was crushing his left lung and he was in the beginnings stages of respiratory failure.

Leo was rushed into emergency surgery the first night in the hospital where they stabilized his heart, put in a G-tube for feeding, and later a trach for him to breathe...then we just waited. Two weeks later still in the hospital the results of the expensive genetic labs (that we paid out of pocket for) finally came back and we were given the official diagnosis of Pompe disease. **It took 6 weeks for insurance to approve the recommended dose of medicine while in the hospital.** We were in the hospital for a total of 4 months until Leo was strong enough to come home.

I know today that WE are one of the lucky rare disease families out there. We had good private insurance when we entered that hospital. We had the ability to afford thousands of dollars of out of pocket expenses to be seen quickly which literally saved Leo's life. We were told by the doctors that if we would have waited for a prior auth to get that initial neurologist appointment Leo would have died of heart failure at home. Can you imagine waking up to your dead child in his crib because you were waiting on a stranger to review a piece of paper recommending they see a specialty doctor...? **But you know who was not lucky ....Leo. Those 4 to 6 months we waited for appointments, diagnosis, medicine, and insurance approvals for treatments the glycogen continued to build up in his outer skeletal muscles taking away his ability to walk.**

As a parent and a citizen I am asking you to **PLEASE INCLUDE SF 1029** in your Omnibus bill. I want all the rare disease children who come after Leo to have access to a provider that is knowledgeable about their disease. **I don't want the financial standing of a family to determine how long they have to wait to save their sick child. I want the medical community to understand that time is essential to treating these rare diseases and not feel the pressure to wait for insurance approval before they do. And most importantly I want insurance companies to not stand in the way of a child's life or future because it needs a prior authorization.**

Thank you for your time and your support of children like Leo.