April 17, 2024

Representative Tina Liebling
477 State Office Building
St. Paul, MN 55155

Re: HF4571 – the Health Budget Bill

Chair Liebling and members of the committee,

On behalf of Allina Health, I would like to express our sincere gratitude for your work and collaboration this session as we address many of the systemic challenges plaguing our healthcare continuum.

Minnesota's healthcare continuum is facing a turbulent, challenging and dynamic environment. Regulatory and administrative barriers, chronically low reimbursement rates, and workforce shortages threaten our patients' ability to access care. We are pleased to see several proactive measures to reduce barriers to care and increase access in HF4571, including:

- Allowing hospitals to be designated as thrombectomy-capable stroke centers
- Requiring health plans to cover orthotic and prosthetic devices, supplies, and services
- Requiring the development of a MA benefit for children's residential mental health crisis stabilization
- Implementing restrictions on the use of Prior Authorizations

While we support these provisions and many others, there are several proposals included in HF4571 that raise significant concerns as to their impact on patients, providers, and our entire healthcare continuum. This includes extending the requirement for notification of hospital service changes from 120 to 182 days, modifying authority in the Minnesota Health Records Act, and requiring additional reporting of data in the 340B Covered Entities Report under a condensed timeline.

We also recognize the limited target given to the committee this session but would like to emphasize the importance of increasing reimbursement rates for critical services like mental health.

Thank you for the opportunity to comment and we look forward to continuing to work with the committee to address barriers to patient care in Minnesota.

Sincerely,

Kristen McHenry
Director of Public Affairs
Allina Health

Fairview

March 18, 2024

House Health Finance and Policy Committee

RE: Fairview Health Services Comment Letter – HF4571 – House Health Finance Omnibus Budget Bill

Dear Chair Liebling and Committee Members:

On behalf of Fairview Health Services ("Fairview"), we appreciate the opportunity to comment on HF4571, the House Health Finance and Policy Committee Omnibus Budget Bill. Fairview, like other non-profit hospitals and health systems across the state, continues to face systemic challenges that impact health care delivery including rising costs, supply chain challenges, persistent inflation, and lagging reimbursement rates not covering the cost of care. We are committed to continuing to push for positive change in the face of these challenges and solving for the barriers that too often get in the way of our patient's health.

We understand the difficult budget targets and competing priorities you and your colleagues had in putting this budget bill together. We are very appreciative of many of the items that have been included that will have a direct impact on the patients we serve and the care our teams provide. Specifically, we wanted to highlight our support for the following items:

Mental Health Rates:

- Increasing Medicaid rates for mental health care is a critical step to helping improve access to mental health services across Minnesota. The current reimbursement rates in Medicaid for mental health services – inpatient and outpatient – are well below the cost of providing care. While we know more is needed to significantly invest in our state's mental health system, we appreciate the funding that has been included in this bill as a key first step.

Health Care Workforce

- **Graduate Medical Education Supplemental Payments** We appreciate the inclusion of Rep. Liebling's legislation, HF5020, which creates a new supplemental payment program to support graduate medical education training at teaching hospitals across Minnesota. We currently support the training of almost 1050 medical residents and fellows across our health system, with the majority of those trained at the M Health Fairview University of Minnesota Medical Center. The supplemental payment program in this bill will help to offset the significant costs our teaching hospitals bear in training the state's future physician workforce.

Fairview

Health Coverage Changes:

- **Coverage for Scalp Prosthetics –** We appreciate the inclusion of Rep. Klevorn's legislation, HF4557, which provides insurance coverage for scalp prosthetics. This is an important way to support individuals and families throughout their healing journey by removing common barriers faced by patients after a cancer diagnosis.

- **Coverage for Rapid Whole Genome Sequencing –** We appreciate the inclusion of Rep. Hemmingsen-Jaeger's legislation, HF3330, to provide coverage for rapid whole genome sequencing.

- **Coverage for Gender-Affirming Care –** We appreciate the inclusion of Rep. Finke's legislation, HF2607, which provides equitable health plan access to medically necessary gender-affirming care.

Other Provisions:

- **Thrombectomy Capable Stroke Centers –** We appreciate the inclusion of Rep. Wolgamott's legislation, HF2421, which adds thrombectomy capable stroke centers to the current list of recognized stroke center designations with the Minnesota Department of Health.

- **Prior Authorization Legislation** – We appreciate the inclusion of Rep. Bahner's legislation, HF3578, which makes important changes to prior authorization processes. These processes often result in delays for our patients, including those navigating serious health issues like substance abuse disorder, mental health challenges and adult and pediatric cancers. They also lead to increased administrative burnout of our providers.

Thank you again for all the work that went into putting this budget together. We know that many of the provisions highlighted above, and others that we did not include, will have a direct impact on the patients, families, and communities we serve across our health system.

Sincerely,

Nate Mussell

Nate Mussell

Vice President of Public Policy, Fairview Health Services

-

HennepinHealthcare

April 17, 2024

Rep. Tina Liebling
Room 477, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
St. Paul, MN 55155

RE: HF 4571 Health Omnibus Bill

Dear Chair Liebling and Committee Members:

I am writing in support of various provisions included in your health omnibus budget bill that ensure health system sustainability, address current workforce shortage challenges, and invest in health equity. Hennepin Healthcare System is Minnesota's largest Medicaid provider system and safety-net level I trauma hospital with primary care clinics across Hennepin County.

We are also facing the same workforce shortage challenges impacting several industries. As a teaching hospital, the inclusion of HF 5020 in the omnibus bill will support our workforce by drawing down federal funds and establishing supplemental payments to eligible hospitals for **graduate medical education** costs. Additionally, we believe equity is essential for optimal health outcomes. Thank you for including health coverage of **gender-affirming care** for Minnesotans (HF 2607). Accessibility to healthcare services is critical to closing health inequities; and as you know, barriers to coverage contribute to disparate health outcomes.

As the Omnibus process continues, we hope you will also reconsider the following proposals for inclusion:

- **Mental health services payment rate increases** (HF 4981). Low reimbursement rates are creating barriers to accessing critical mental health care services. Investing in mental health to provide appropriate care, early intervention, and prevention services will help Minnesotans heal and prevent crises.
- Removing prohibitions on **specialty dentists** who hold a general dental license from practicing in another area of dentistry outside the dentist's specialty area (HF 3612).
- Establishing **programs for physician wellness and health care professional well-being** HF 4188.

I respectfully ask for your support of these legislative proposals that will make a difference for patients across the State of Minnesota. Thank you for your continued partnership to create and healthy and bright future for all.

Sincerely,

Jennifer DeCubellis
Chief Executive Officer
Hennepin Healthcare System

Contact: Susie Emmert 651-278-5422 susie.emmert@hcmed.org

An association of resources and advocacy for children, youth and families
www.aspiremn.org

April 17, 2024

Dear Chair Liebling and Members of the Health and Human Services Committee,

Thank you for your thoughtful development of HF4571, your omnibus budget proposal. As a statewide association of children and family serving providers we have shared that due to the crisis in access to mental health care, our very top priority is investing in Medicaid mental health rates.

We are so grateful that despite the very challenging spending target that the committee received that you were able to dedicate funding for mental health care. The provision to shift billing codes for Children's Therapeutic Servies and Supports (CTSS) to CPT codes we believe will increase access to care by allowing additional payors to more easily reimburse for care, and, will decrease administrative burden for providers. Thank you for including this item in your proposal.

Minnesota has been discussing the need for Children's Residential Crisis Stabilization services for many years. We are grateful for the language and funding to advance a Medicaid benefit that will allow for the development of this level of care statewide.

Your inclusion of the policy language that was crafted within the Human Services Policy committee will also contribute to the work of decreasing administrative burden, supporting providers to work at the top of their licensure and make incremental changes to enhance access to care.

We look forward to continued dialogue as this omnibus moves into conference and actively supporting shared goals for all Minnesota children and families to experience wellbeing and hope for their futures.

Gratefully,

Kirsten Anderson
Executive Director

AspireMN improves the lives of children, youth and families served by member organizations through support for quality service delivery, leadership development and policy advocacy.

1919 University Avenue W. #450, St. Paul, Minnesota 55104

clean energy economy mn

cleanenergyeconomymn.org

April 18, 2024

Minnesota House of Representatives
Committee on Health Finance and Policy
State Office Building, Room 5
Saint Paul, MN 55155

RE: House File 4571 - Health Budget Omnibus Bill

Dear Chair Liebling, Vice Chair Bierman, Representative Schomacker, and Committee Members,

On behalf of Clean Energy Economy MN (CEEM), we write today to thank you for including HF4096, Representative Acomb's bill for groundwater thermal exchange permits in the House Health Budget Omnibus bill, HF4571. This provision will help the development of Aquifer Thermal Energy Storage (ATES) technology and will continue to supply cost-effective low-carbon heating and cooling in buildings.

CEEM is an industry-led, nonpartisan, non-profit organization representing the business voice of energy efficiency and clean energy in Minnesota. We are focused on educating Minnesotans about the economic benefits of transitioning to a clean energy economy. Our business membership is comprised of over 60 clean energy companies ranging from start-up businesses to Fortune 100 and 500 corporations that employ tens of thousands of Minnesotans across the state. CEEM stands committed to delivering a 100% clean energy future where all Minnesota businesses and citizens will thrive.

Utilizing ATES technology will require a smaller footprint compared to traditional geothermal energy systems by using a series of wells and piping that move heat between buildings and the local aquifer. This allows for buildings to be heated and cooled without on-site natural gas consumption. Supporting low-carbon alternatives like ATES allows Minnesota to make important progress towards achieving its 100% Clean Energy by 2040 law.

We thank Chair Liebling and the House Health Finance and Policy Committee for their thoughtful work this session and for including the provision for groundwater thermal exchange permits. This provision is important to support Minnesota's transition to a clean energy economy. We look forward to continuing to work with the legislature to move toward a clean energy future.

Sincerely,

George Damian
Director of Government Affairs
gdamian@cleanenergyeconomymn.org

Chandra Her
Policy Associate
cher@cleanenergyeconomymn.org

GENDER JUSTICE

663 UNIVERSITY AVENUE WEST
SUITE 200
SAINT PAUL, MN 55104
PHONE 651.789.2090

RE: Support for American Indian Birth Centers, Chosen Vessels midwifery, Birth Justice Collaborative in SF4699

April 18, 2024

To Chair Melissa Wiklund and members of the Health and Human Services Committee:

Gender Justice is a legal and policy advocacy organization dedicated to advancing gender equity through the law. We believe that all people deserve affordable access to the healthcare they need, and we work to advance reproductive justice for all people, including the right to have and raise a child.

We are writing to express our thanks for funding the American Indian Birth Centers, Chosen Vessels midwifery, and the Birth Justice Collaborative in SF4699. This funding will address disparities in Minnesota's maternal health outcomes and improve access and utilization of culturally appropriate perinatal health care and services in the American Indian and African American communities, respectively.

In Minnesota, Black and American Indian pregnant and parenting people face disproportionately negative maternal health outcomes. A maternal mortality study conducted by the Minnesota Department of Health, published in 2022, showed that "Black Minnesotans represent 13% of the birthing population but made up 23% of pregnancy-associated deaths, and American Indian Minnesotans represent 2% of the birthing population, but 8% of pregnancy-associated deaths."[1]

Beyond the most tragic outcomes of discriminatory health care systems, we know that people of color, especially Black, Hispanic, and American Indian women seeking pregnancy care report higher instances of having their concerns or pain not taken seriously by health care providers, being ignored by health care providers, experiencing verbal abuse, being refused care, or being forced to accept care they do not want.[2] Both current and historical mistreatment of women of color in reproductive healthcare is unacceptable and must be addressed if we care about equitable access to safe, trusted, and culturally responsive healthcare for all.

Investment in community birth centers offers a path forward. A recent survey of more than 2000 women showed that rates of discriminatory practices were lower in community birth centers compared to hospitals.[3] Community birth centers can offer culturally congruent care, provide case management and systems navigation, and provide more holistic care overall.

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[1] https://www.health.state.mn.us/news/pressrel/2022/maternal080322.html
[2] https://blackmamasmatter.org/wp-content/uploads/2022/04/0322_BMHStatisticalBrief_Final.pdf
[3] https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2

GENDER JUSTICE

663 UNIVERSITY AVENUE WEST
SUITE 200
SAINT PAUL, MN 55104
PHONE 651.789.2090

With this funding, we have the opportunity to create the conditions where more families can have healthy pregnancies in their own communities, with the support they need. We thank you again for funding the American Indian Birth Centers, Chosen Vessels midwifery, and the Birth Justice Collaborative.

Thank you for your support,

Megan Peterson
Executive Director, Gender Justice

Professional Distinction

Personal Dignity

Patient Advocacy

April 18, 2024

Representative Tina Liebling, Chair
House Health Finance and Policy Committee
100 Rev. Dr. Martin Luther King Jr. Boulevard
St. Paul, MN 55155

Chair Liebling and Members of the Health Finance and Policy Committee,

On behalf of the Minnesota Nurses Association (MNA), I am writing to you today to express MNA's strong support for several provisions included in the amended Health Budget Bill (HF4571), specifically provisions included that would increase access and affordability of patient care, as well as language that MNA has advocated for throughout sessions that would provide for more financial transparency and accountability across tax-exempt hospitals. MNA's 22,000+ members represent 4 out of 5 nurses that work at the bedside in hospitals across the state, and as such, are extremely connected these issues and are committed to fighting for equity, accessibility, transparency, and accountability across our healthcare delivery system. Collectively, there are many pieces to this bill that align with our mission and vision for a better healthcare system, and we hope that this committee will support the following statutory changes:

Increased Transparency Around Hospital Closures, Service Reductions or Relocations, and Other Consolidations of Community Health Services – from H.F. 3700

Over recent decades, massive health systems have taken over most of Minnesota's community hospitals. These health systems – which are exempt from most local, state, and federal taxes – continue to function and operate more and more like profit-driven corporations. Often, local governments and community-based organizations accepted offers from these health systems to run their hospitals based on promises about services they would provide to the community. Sadly, these promises continue to be broken time and time again. Two of the biggest casualties of corporatized healthcare, led by executives making millions, have been mental health and OB/labor and delivery services. Despite the ongoing mental health crisis, the largest healthcare systems in our state have reduced beds, closed units, and even closed hospitals that deliver vital mental health services – always justifying their decisions based on profits

345 Randolph Avenue
Suite 200
St. Paul, MN 55102
Tel: 651.414.2800
800.536.4662
Fax: 651.695.7000
Email: mnnurses@mnnurses.org
Web: www.mnnurses.org

AFL-CIO

and their bottom lines. These same justifications are being used to justify closing birthing units across the state, forcing residents in Greater Minnesota to drive hours to give birth. Often, staffing issues are cited as an additional reason for closure, and yet in none of these cases have health systems deployed comprehensive employee retention strategies to address these issues. Instead, executives turn to more "churn and burn" recruitment strategies that do not solve the issues.

If our state is to be serious about supporting rural communities across the state and the health of all communities outside of the Metro Area, including young families that need these services in order to even consider staying in or moving to Greater Minnesota to establish roots, something needs to be done to address the opaque problems of closures and consolidations.
The table below demonstrates the most significant closures here in Minnesota – in *just the past 6 months*:

System	Facility	Location	Unit Closed and/or Services Reduced
Allina	Cambridge	Cambridge	Mental Health Services
Allina	New Ulm	New Ulm	Addiction Services
Allina	United Hospital	St. Paul	Adolescent Mental Health
Allina	Abbott NW	Minneapolis	Infusion
Allina	Unity	Fridley	ICU
Allina	Unity	Fridley	Surgeries
Allina	Mercy	Coon Rapids	Child Adolescent Beds
Essentia	Fosston	Fosston	Labor and Delivery/OB
Lake Region	Fergus Falls	Fergus Falls	Mental Health Services
Mayo	New Prague	New Prague	Labor and Delivery/OB

Last session, the Minnesota Legislature worked to pass comprehensive merger regulations – H.F. 402 – in order to curb consolidation. While this legislation will not stop closures from happening, it will bring more transparency to the process, and we believe that this is a continuation of the type of work we accomplished last session with the support of many members of the House Health Finance and Policy Committee.

Increased Accountability: Improving Reporting and Oversight of the Community Health Needs Assessment (CHNA) – *from H.F. 4870*
MNA is proud to support the provisions on Community Health Needs Assessments (CHNAs) from HF4870, which will go a long way to ensure that hospitals are living up to the promises they are making to patients, communities, workers, and even local, state, and federal governments about prioritizing and addressing the greatest health needs of the community they not only claim to serve, but also have a legal obligation to serve. Unfortunately,

existing CHNA reporting requirements and oversight in Minnesota has been severely inadequate, with little to no accountability measures built in to ensure that hospitals are engaging in community outreach, utilizing community input, and prioritizing addressing community health needs in their policies, practices, and budgets. Most existing CHNA oversight relies on the IRS, and with little to no reporting requirements or guidance from state agencies or policymakers on how to utilize the CHNA in a meaningful way to address statewide health goals, the existing CHNA process is a largely "check the boxes" compliance activity done by tax-exempt hospitals in order to appease the federal government. Federal law allow states to establish stronger financial reporting requirements than the floor that was set federally under the ACA, which many other states have done – including Texas, Massachusetts, Utah, Pennsylvania, and Oregon – and we hope that passing this change into law now will provide for the basis to establish future changes that are needed in the area of financial transparency and accountability across tax-exempt healthcare corporations.

Prohibiting Nonprofit to For-Profit HMO Conversions – *from H.F. 4853*

The language from H.F.4853 targets one of the largest contributors to rising patient costs, barriers to accessing the medically necessary services (or services at all), and blatant profiteering off the backs of patients and taxpayers. Profit-driven behaviors and motivations should not be the guiding force behind the policies and practices that guide HMOs and how they administer services, something that Legislature has recognized on a bipartisan basis in the past when the current HMO conversion moratorium became law. Until the Legislature takes the additional steps laid out in H.F. 4853 to prohibit for-profit entities from accessing public assets when converting to for-profits this problem will continue to come before this committee annually, while the risks and patient harms will remain. Notably, there is little stopping the private health insurance companies – who are currently sitting on almost $6 billion in assets, including many charitable assets they have acquired from nonprofit entities at a fraction of their actual value through mergers and acquisitions – from further consolidating and monopolizing our state healthcare delivery system. This legislation takes us forward by protecting taxpayer-funded state assets, better regulating charitable assets, and preventing harmful profit-based takeovers that current law leaves open for exploitation.

MNA Support for Increasing Access and Affordability for Patients:

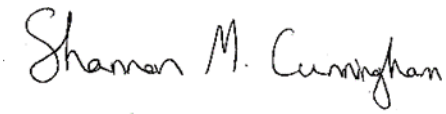
- **From HF4053 - Health plan coverage of abortion and related services:** We know that most Minnesotans support access to full reproductive healthcare options and for individuals to have autonomy over medical decisions affecting them. Unfortunately, there are many laws in place that prevent full access to healthcare and the overturning of Roe v. Wade led to a flood of cruel and harmful laws attacking not only abortion rights but also other reproductive healthcare access. Patients should not have to face financial repercussions for accessing abortion care nor should providers struggle through a mess of complicated

funding options and barriers to receiving payment. Healthcare should always be affordable and accessible.

- **From HF2607 - Health plan coverage of gender-affirming care:** MNA fully supports creating systems to ensure more access and affordability for the lifesaving and lifechanging healthcare services categorized as gender-affirming care, and supports efforts to make these services more accessible and affordable for Minnesotans, which the language from H.F. 2607 does by expanding guaranteed coverage under health plans operating in the state. MNA strongly opposes any state and federal legislative efforts that impair the human rights of transgender people, including those that limit transgender people's access to gender-affirming healthcare, school activities, employment, and public facilities or those that seek to prosecute healthcare professionals for providing the care that a patient needs.

MNA asks members of the committee to support these provisions today, and to continue to advocate for these changes as we move forward this session.

Sincerely,



Shannon Cunningham
Director of Governmental and Community Relations
Minnesota Nurses Association

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 17, 2024

The Honorable Tina Liebling
Chair, House Health Finance and Policy Committee
477 State Office Building
St. Paul, MN 55155

Dear Chair Liebling and Members of the House Health Finance and Policy Committee,

I am writing to you today to express my appreciation for the inclusion of so many of the Administration's public health priorities in the House's Health Omnibus bill (HF4571). I also appreciate the hard work that you, your committees, and your staff have put into creating this bill. I greatly appreciate your efforts and want to highlight MDH priorities included in this bill.

The Department of Health remains grateful for everything included in last year's budget, and this year the Governor's supplemental budget requests are centered around adding clarity to our work for the Minnesotans we serve. We wanted to highlight a few of the MDH proposals included in the bill.

988 Telecom Fee

Added in 2023, MDH is requesting to establish the 988 fee at 12 cents to provide certainty to consumers and providers, and to ensure MDH has adequate funding to provide essential services. As you know, the 988 Suicide and Crisis Lifeline provides free and confidential phone, text, and chat support for any person who may be experiencing a suicide, mental health, substance use crisis or other emotional distress. It provides lifesaving support to Minnesotans 24 hours a day, seven days a week, every day of the year via call, text, and online chat.

Background Studies Reduction

MDH is seeking a reduction to our SGSR appropriation, as licensees regulated by MDH are now responsible for paying fees associated with the preparation of fingerprints, criminal records check consent form, and the criminal background check to the Department of Human Services.

Loan Forgiveness Account Creation

MDH is seeking to establish a dedicated loan forgiveness SGSR account for health professionals. Currently, funds remaining after each biennium are canceled, meaning any awards that are returned may not be re-awarded. This account will allow those funds to be reinvested and more awards granted. In 2023, over 350 eligible health professionals applied for slightly more than 150 awards.

Clinician Training Expansion Grant Program

Updates to a three-year grant period allowing more flexible spending for grantees due to the different funding needs during the years of their training.

International Medical Graduate (IMG) Program Expansion

This program supports trained physicians as they prepare to get licensed to practice in Minnesota and to enter the U.S. medical system once their permanent status has been determined. It would expand the program to allow international medical graduates, who are granted temporary immigrant status, such as those from Afghanistan and Ukraine, to seek guidance and support for preparing to use their medical background to serve communities in Minnesota and build a career in Minnesota as a licensed health care provider.

Assisted Living and Home Care Licensure Updates

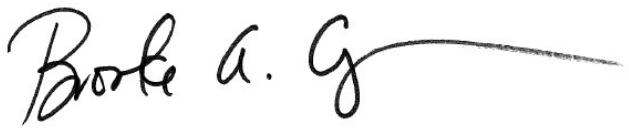
In 2019 the legislature established assisted living licensure laws to set consistent, clear expectations for providers and create more protections for people living in assisted living establishments. Since implementation on August 1, 2021, MDH has continued to engage in a robust stakeholder conversation on how to best operationalize these licensing laws. Through this process, we've identified new needs that require further clarification in statute.

Supplemental Nursing Services Updates

Clarifies qualifications, training, and requirements of Supplemental Nursing Services Agencies to ensure a high quality of care for children, families, and other vulnerable individuals requiring these services.

Thank you to Chair Liebling and the Health Finance and Policy Committee for your efforts in creating this bill and the endless support you and your committee have provided the agency over the last few years. We look forward to further discussions with you over the coming weeks.

Sincerely,



Brooke Cunningham, MD, PhD
Commissioner of Health

ABH | ADVOCATES FOR BETTER HEALTH

April 18th, 2024

House Health Finance and Policy Committee
RE: HF4517 DE

Dear Chair Liebling and Committee Members:

I am writing to you as an Infectious Disease physician and President of Advocates for Better Health (ABH), an organization dedicated to fostering a healthy, equitable, and thriving state through community-driven public health initiatives.

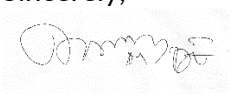
On behalf of ABH, I want to thank you for including HF4251, which aims to prohibit the sale of flavored cannabis that is burned, inhaled, or vaporized, in the HF4517 delete everything amendment. This is an important policy for the health of our state as it's the enticing flavors that lure kids into trying these products. We extend our sincere gratitude to Representative Her for carrying this crucial public health legislation.

While we are grateful for the inclusion of HF4251, we are deeply disappointed that HF2177 (Cha), legislation to end the sale of all commercial flavored tobacco products, was left out. Our community of healthcare advocates witness firsthand the inequitable and deadly health consequences that result from commercial tobacco usage. The tobacco industry purposely uses flavored tobacco products to target adolescents whose brains are particularly vulnerable to nicotine addiction, and flavors are a key reason Minnesota is facing a youth tobacco epidemic.

Flavored tobacco products are also an issue of racial health equity. For decades, tobacco companies have channeled menthol tobacco products into Black communities, causing death and disease. It is imperative that we remove flavored tobacco, including menthol cigarettes, from the marketplace, as it is these products that make smoking easier to start and harder to quit.

Thank you again for the inclusion of HF4251 (Her), however it is critical these policies are passed together and that we fully reverse the youth tobacco epidemic, shape cannabis policy with a focus on prevention and public health, address racial and health inequities, and reduce health care costs.

Sincerely,



M. Etienne Djevi, MD
Advocates for Better Health
President

Advocates for Better Health
2355 Fairview Avenue #139 Roseville, MN 55113 | 612-623-2885
www.abhmn.org

April 17, 2024

Representative Tina Liebling
Chair
Health Finance and Policy Committee
Minnesota House of Representatives
St. Paul, MN

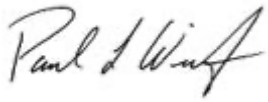
Dear Chair Liebling:

On behalf of the American Heart Association, I want to extend my appreciation to you and the committee for including the stroke thrombectomy capable designation language from House File 2421 in the committee's omnibus policy bill (HF 4571).

Hospitals designated as thrombectomy-capable stroke centers will ensure that patients can go directly to best-practice facilities that provide the highest standard of care. With the passage of this legislation, stroke patients can be transported to the appropriate facility equipped to provide advanced stroke treatment and strengthen the continuum of care across our state and help ensure patients receive the appropriate care they need when they need it.

The American Heart Association applauds Rep. Dan Wolgamott for authoring this important legislation and extends our appreciation to you and the committee for supporting this life-changing proposal in your policy bill.

Sincerely,



Paul L. Weirtz

Paul L. Weirtz, State Government Relations Director – Paul.Weirtz@heart.org

April 17, 2024

Dear Chair Liebling and Members of the House Health Finance and Policy Committee,

We are grateful for the inclusion of the alternative payment rate language included in Article 1, Section 6. This language will allow Gillette Children's - a specialty children's hospital serving children with disabilities, rare diseases, and complex medical conditions from all 87 Minnesota counties - to retain approximately $7.3 million in Medical Assistance payments we have already received for the 2021 rate year. We appreciate Rep. Bierman's leadership as the Chief Author of this legislation and the support from our bipartisan co-authors.

We also appreciate the inclusion of:

Article 1:

- Supplemental graduate medical education (GME) payments for hospitals

Article 4:

- Health plan coverage and MA coverage of rapid whole genome sequencing
- Modifications of health care prior authorization requirements
- Requirement for health plan companies to include essential community providers in all provider networks and the establishment of payment rates
- Requirement for health plans to cover orthotic and prosthetic devices, supplies, and services and required MA coverage.

Thank you for all of your hard work this session! We appreciate your support of Gillette Children's and the patients and families we serve.

Sincerely,

Barbara Joers

President and CEO

Marnie Falk

Director, Public Policy

April 17, 2024

Representative Tina Liebling, Chair
Committee on Health Finance and Policy
477 State Office Building
St. Paul, MN 55155

Dear Chair Liebling and Committee Members,

The Minnesota Association of County Health Plans (MACHP) is an alliance of County-Based Purchasing (CBP) plans serving more than 90,000 members enrolled in Minnesota Health Care Programs across 33 counties – all in Greater Minnesota.

For more than 40 years, CBP plans, owned and operated by the counties they serve, have successfully administered Medical Assistance benefits, bringing added value by integrating care with county public health, social services and other services, delivering dependable access and improving outcomes, partnering with local providers, applying local innovation and accountability, and reinvesting in rural communities.

We appreciate the inclusion of a County Administered Medical Assistance (CAMA) model in the House Health Omnibus Bill. For more than a year, our county-based plans, DHS, and the Association of Minnesota Counties (AMC) have been meeting regularly to develop the next phase in rural, county-based solutions for Minnesota Health Care Programs (MHCP) enrollees – County Administered Rural Medical Assistance (CARMA). We are concerned that adding nonrural counties where CBP does not currently exist may create a complication that upsets the outstanding progress we have made.

We are pleased to work with you, your staff, and other stakeholders to pass CARMA and discuss your ideas for strengthening county-based approaches.

Sincerely,

Steve Gottwalt
Executive Director
Minnesota Association of County Health Plans

April 18, 2024

RE: Support for HF 4571

Chair Liebling and Members of the Committee,

TakeAction Minnesota is a grassroots, multi-racial people's organization that believes in a democracy and government that works for all of us. With our members, we advocate for policies that promote justice and fairness. For over 15 years, TakeAction Minnesota has worked to promote a people-centered healthcare system.

We write today to share our strong support for the HMO conversion regulations contained within Article 4, §§ 15, 51-58.

In 2017, the legislature passed legislation to end the state's requirement that all HMOs be nonprofit. TakeAction opposed, and still opposes, allowing for-profit HMOs to operate in the state and profit off our health. Even worse, the policy change did not include any changes to account for the presence of for-profit HMOs, and no regulations for what would happen if a nonprofit converts its assets to a for-profit entity. Although the Attorney General has authority to protect charitable assets, time and again across the country, the lack of notice, lack of transparency, and lack of a process by which to assess and protect the value of those assets has resulted in billions of dollars of public assets becoming private profit. We will see this happen here if we do not act.

We have the opportunity to learn from experiences in other states, many of whom did not pass conversion regulations until many public benefit assets had already been stripped in the name of corporate greed.

In California, a $3 billion dollar transfer of assets to two foundations came about after Blue Cross initially offered to donate only $100 million to charity. Thanks to strong conversion regulations, they ensured all of those assets remained a public benefit.

Because of conversion protections in Maryland, the insurance commissioner was able to review the transaction when Wellpoint tried to buy CareFirst and hold public hearings around the state.

There, they uncovered that $75 million was set to go to corporate executives. That conversion was found to be not in the public interest and was denied.

In Ohio a controversial conversion proposal from one nonprofit inspired conversion legislation that was employed in a subsequent merger between a nonprofit and Anthem. But the review of the merger was not open to the public, only $28 million in assets were protected, and the board of the new foundation included the for-profit insurer.

A lot is at stake in getting this right. These examples point to the importance of four things, all of which this bill does well:

1. The Attorney General has the opportunity to review conversions, gather independent assessment of value, and protect public assets for the public interest;
2. The public has the opportunity to have input into those decisions;
3. The governance of the resulting conversion benefit entity is independent and responsive to community needs; and
4. The department of health is notified of a broader set of transactions so that they can analyze trends and be alert to emerging concerns or gaps in the regulations.

We urge you to support the regulations and consumer protections authorized in this bill to ensure that public assets are used for the public good and not converted to corporate profits.

Sincerely,

Robert Haider
Legislative Director
TakeAction Minnesota

April 17, 2024

Chair Tina Liebling
477 State Office Building
St. Paul, MN 55155

Re: MinnesotaCare Public Option (HF4571)

Chair Liebling and Members of the Committee:

In 2023, the Legislature took a critical step forward to advancing a MinnesotaCare Public Option by directing the Department of Commerce to conduct an actuarial analysis and report that it provided to the Legislature in February 2024 so additional legislative action could be taken this year.

We write to express our deep disappointment that the House Health omnibus bill (HF4571) does not include further action on the MinnesotaCare Public Option.

While we understand the limited nature of the global budget targets this year, policy action can continue deliberate steps forward toward a MinnesotaCare Public Option. At a minimum, we respectfully request legislative action this year that directs state agencies to submit a federal waiver application that is necessary to secure federal authorization and funding for the MinnesotaCare Public Option. By taking this action, the state can gain complete analysis work and the waiver application process that can inform future legislation, implementation, and funding. This work can begin without state funding commitments for the program.

Inaction this session means unnecessarily delaying the federal waiver process, while rendering the Commerce Department's actuarial analysis useless to Minnesotans, instead of using it as a timely reference for continued analysis and the federal waiver application.

For years, Minnesotans have made it clear that expanding access to MinnesotaCare is a priority that cannot wait. We urge lawmakers to reconsider the oversight in this bill and continue taking deliberate steps toward a meaningful healthcare reform without delay or failure to finish the half-step taken last year.

Signed,

AFSCME Council 5
AFSCME Council 65
Committee to Protect Health Care
Education Minnesota
ISAIAH
Minnesota AFL-CIO
Minnesota Farmers Union
Planned Parenthood Minnesota, North Dakota, South Dakota Action Fund
SEIU Healthcare MN & IA
Unidos MN

ISAIAH
Faith in Democracy

April 15, 2024

Dear Chair Liebling and Members of the Health Finance Committee:

ISAIAH is a multi-racial, state-wide, nonpartisan coalition of faith communities, Black barbershops, childcare centers, and other community-based constituencies working toward racial, economic, and climate justice in Minnesota. No matter what corner of the state we live in, or what we look like, all Minnesotans deserve high quality affordable health care. Yet for too long, greedy corporations and those who would defend the status quo have propped up a healthcare system rife with inefficiencies. We spend far too much for worse health outcomes than most any other nation.

For over sixty years, progress in healthcare has come via incremental improvements. We have made major gains in fixing the failures of the private market through the creation of such programs as Medicaid and Medicare. Here in Minnesota we led the nation with the creation of MinnesotaCare. The Affordable Care Act, while imperfect, saved thousands of lives and expanded health care coverage to millions. Last year we were thrilled with the further expansion of MinnesotaCare to cover our undocumented families and neighbors.

It is for these reasons that we are writing to express our utter dismay that the MinnesotaCare Public Option waiver direction is not included in the Health omnibus bill (HF4571, DE).

Too many Minnesotans remain uninsured or underinsured. We've heard the stories of so many who spend thousands of dollars on premiums for bronze plans who then have deductibles of thousands - or tens of thousands of dollars more. While at any given moment this may be a relatively small segment of the population, it is a dynamic situation: about 25% of Americans are expected to be without insurance within a given 2 year period. It is also a hindrance on the freedom of Minnesotans who feel yoked to jobs that don't unlock their true potential because of access to healthcare insurance.

Expanding access to MinnesotaCare, a highly successful 30-year old program, to more Minnesotans is an important next step in improving our health care system. Minnesotans were excited when the legislature last session passed the first important steps towards such an expansion, with the waiver authorization, actuarial analysis and some initial funding. This year, continuing the path towards the MinnesotaCare public option has the support of the Senate Majority Leader and Senate Health Chair, as well as the House Majority Leader, Speaker and 33 other co-authors. While the program was not able to be funded in this year's limited supplemental budget targets, it is crucial for the legislature to provide further direction to state agencies so that the federal waiver process can proceed without delay.

We are not giving up and will continue to work until high-quality affordable health care is available to more Minnesotans through the MinnesotaCare public option.

Sincerely,

Lars Negstad, Policy Director

2356 University Ave. W, Suite 405 Saint Paul, MN 55114
isaiahmn.org | 651-376-1001 | isaiah@isaiahmn.org

April 17, 2024

The Honorable Tina Liebling
Chair, Health Finance and Policy Committee
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

The Honorable Joe Schomacker
Republican Lead, Health Finance and Policy Committee
Minnesota House of Representatives
209 State Office Building
St. Paul, MN 55155

Re: Legal Aid letter of support for HF 4571 DE Amendment regarding medical record fees for legal services organizations

Dear Chair Liebling, Lead Schomacker, and Members of the Committee:

Legal Aid provides civil legal services statewide to low-income Minnesotans, Minnesotans with disabilities, and elder Minnesotans. Legal Aid strongly supports the changes on lines 154.21-155.3 in the DE amendment (originally found in HF 4758).

Legal Aid represents clients in Social Security appeals, moving clients from state benefits like General Assistance to federal Social Security benefits, and allowing clients with disabilities to have a higher and more stable income. Medical records for these appeals must be ordered and submitted to Social Security prior to the hearing. Most healthcare providers do not have in-house medical records copying services and use companies outside of Minnesota.

Getting medical records for these cases is a needlessly time-consuming task because of the runaround we receive from these copying services. It usually takes hours to get one set of records, and most clients have records at several hospitals and clinics. I was a benefits attorney for 22 years prior to moving within Legal Aid to do legislative work two years ago. This was the typical process I went through requesting records:

1. Submit paperwork, including a cover letter quoting the statute and specifying the date range of the records needed and a letter from the Minnesota Supreme Court which explains that Legal Aid is a legal services program to show that we qualify for free records under the statute).
2. Receive an invoice for the full cost of the records days or weeks after submitting the request. This is the price for getting records in cases other than Social Security appeals.
3. Call the copying service, wait on a lengthy hold, and speak to a representative. Sometimes there would be pushback requiring a longer conversation, sometimes not.
4. Get transferred to a supervisor involving another lengthy hold. Again, sometimes there was pushback, sometimes not.
5. My issue would be escalated to a billing specialist I was not allowed to speak to.
6. Receive an invoice for $10 (the cost for private attorneys representing clients in Social Security appeals) days or weeks later.
7. Repeat steps 3-5.

The sticking points with the copying services were usually that we did not submit the right proof (which was a moving target) or they did not understand that we were an organization entitled to free records.

These delays often mean that we do not receive the records prior to the hearing. When this happens, we cannot use those test results, diagnoses, or doctor's notes to prove disability, and it weakens the client's case. Even if the judge agrees to hold the record open so we can submit records after the hearing, the client has not had their strongest case presented at the hearing, and the medical and vocational experts have not given their opinions in consideration of the full record. We have had cases where the records never arrived or arrived after the record closed.

By clarifying the statute and specifying what proof is required to show that we are entitled to receive records without charge, we hope to put a stop to the delay in receiving medical records. We sympathize with these medical records services that have to navigate multiple billing rules, but action is needed to ensure that clients' cases are not jeopardized.

Thank you for allowing Legal Aid to share its views.

Sincerely,

Ellen Smart, Staff Attorney
Legal Services Advocacy Project

This document has been formatted for accessibility. Please call Ellen Smart at 612/746-3761 if you need this document in an alternative format.

MINNESOTA BUSINESS PARTNERSHIP

Minnesota House of Representatives
Health Policy and Finance Committee
April 18, 2024
HF 4571 – DE2 Amendment

Dear Health Policy and Finance Committee Members,

The Minnesota Business Partnership is a membership organization consisting of business leaders from Minnesota's largest employers, employing almost half a million workers across the state. Minnesota ranks near the top in the nation for health care coverage, and we are very grateful to our many world-class health care providers headquartered here in Minnesota. Health care affordability, access, and equity are vitally important to our members, and we appreciate the opportunity to provide feedback relative to the Committee's consideration of the House Health Omnibus bill and would like to address a few concerns on provisions included in the DE2 amendment:

HMO Transactions (HF 4853)

We advise exercising caution in proceeding with this proposal, as rushing its passage would be premature without the completion of the final HMO study by the Minnesota Department of Health.

Although the preliminary report provides valuable insights, Minnesota Department of Health Commissioner Dr. Brooke Cunningham emphasizes in the accompanying cover letter that the final report "will provide more in-depth analysis of how other states approach regulating HMO conversion transactions, as well as options for legislators to consider related to both the ongoing regulation of for-profit and foreign HMOs in Minnesota and the treatment of conversion transactions."

Following the 2023 legislative session and the enactment of HF 402, a state study was initiated to examine HMO conversion and regulation. The final findings of this study are slated for release on June 30, 2024, and it is crucial to consider these findings and the detailed analysis provided in the final report before proceeding with the legislation.

HMO Licensing (HF 3529)

Under current law, both for-profit and nonprofit HMOs are providing Minnesota consumers and employers the choice to select the best value for their health care coverage. All HMOs operating in Minnesota are already subject to oversight by the Minnesota Department of Health and the Minnesota Department of Commerce. Given that the preliminary HMO report released earlier this year stated that minimal data is available to shed light on if differences do exist between nonprofit and for-profit HMOs, we think it is clear that more information is needed before changing the law to ban for-profit HMOs from doing business in Minnesota.

MINNESOTA BUSINESS PARTNERSHIP

Healthcare Operations (HF 3700)

The circumstances that contribute to a hospital service line closure are predictable, but the arrival of those circumstances at a particular hospital are not. Increasing the notification period to the Department of Health from the current requirement of 120 days is an unworkable mandate to put on our hospital systems that are already facing operational challenges while continuing to deliver care to patients.

While a hospital can be forced to drop a service line due to financial challenges, it can also be a result of a shortage of specialized healthcare providers, and more broadly, the workforce crisis health care is facing.

We know the significant challenges our hospitals - and specifically rural hospitals - are facing. Demographics, economics, and geography can all work against the sustainability of rural healthcare – but pinpointing exactly when those conditions will create a crisis for a particular hospital is not possible, and this puts greater pressure and uncertainty on an already unpredictable situation.

Anti-retaliation (HF 4200)

Ensuring the safety and well-being of patients is the top priority for Minnesota hospitals. Hospitals are already short-staffed and fewer individuals are training to enter the health care workforce. Allowing a nurse to decline a patient care assignment based on professional judgement raises serious concerns on health equity and the treatment of patients with conditions such as a mental illness or substance abuse issues. This could adversely affect patients and is an improper interference with a hospital's role to determine their own patient and staff needs. This also interferes with the chain-of-command reporting process hospitals already have in place where a nurse who feels they need additional help can request it.

Our shared goal is for patients to have access to the highest quality of care possible. We look forward to working together to find solutions that help solve our health care workforce shortage without impacting the quality and availability of patient care.

Sincerely,

Abby Loesch
Health Policy Director
Minnesota Business Partnership

Minnesota Coalition
FOR FAMILY HOME VISITING

April 17, 2024

Representative Tina Liebling
Chair, Health Finance & Policy Committee
State Office Building, Room 5

Dear Chair Liebling and Members of the Committee,

The Minnesota Coalition for Family Home Visiting (MCFHV) is excited to support HF 4571, to invest in children's mental health care, and the provider workforce that supports the wellbeing of families in Minnesota. Young children and their families are facing an unprecedented mental health crisis and too often parents are forced to choose between their family's financial wellbeing and treating their mental health.

Thank you for including the following in HF 4571; we urge you to continue supporting this provision as you enter Conference Committee discussions.

- **Respite Care Services Grants,** HF 3495
- **Report to Develop MA Benefit Children's Residential Mental Health Crisis Stabilization,** HF 3495
- **Mental Health Procedure Codes Report,** HF 4779A1

When addressed and treated early in childhood, mental health interventions are shown to prevent the need for additional mediation, saving costs and mitigating the lifelong impact of mental health challenges on a child's cognitive, physical and emotional development.

Please join the Minnesota Coalition for Family Home Visiting in supporting this provision in HF 4571, to address rising mental health concerns, and to improve access to preventative and early intervention mental health services for both caregivers and their young children.

Thank you,

Laura LaCroix-Dalluhn,
Minnesota Coalition for Family Home Visiting
Coordinator

Cati Gómez,
Minnesota Coalition for Family Home Visiting
Policy Associate

MINNESOTA COUNCIL of HEALTH PLANS

CAPITOL OFFICE BUILDING

525 PARK STREET

SUITE 140

ST. PAUL, MINNESOTA 55103

651-645-0099 FAX 651-645-0098

April 18, 2024

Health Finance and Policy Committee
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Chair Liebling and Members of the Committee:

The Minnesota Council of Health Plans' nonprofit members (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Sanford Health Plan of Minnesota, and UCare) provide more than 4.6 million Minnesotans with health care coverage. Throughout this legislative session, the Council has expressed support for policies that maintain stability in the market, lower costs, and increase access to high-quality care. To achieve outcomes that meet these goals, the Council appreciates the opportunity to provide feedback on several items included in the House Health Finance and Policy Omnibus Bill.

Market Impacts

State Funded Cost Sharing Reductions (CSRs)

The Council supports efforts to make health insurance more affordable and accessible to more Minnesotans. The targeted cost sharing reductions included in the bill to increase the actuarial value for silver plans from 73% to 87% for those between 200-250% FPL is an appreciated step forward in addressing affordability concerns for these Minnesotans who make just over the threshold to qualify for MinnesotaCare. The Council has been urging policymakers to address the looming fiscal cliff for Minnesotans who purchase health insurance in the individual market that will result from the simultaneous sunset of reinsurance and federal enhanced ARPA subsidies at the end of 2025. Absent changes, premiums can be expected to increase 25% or more and thousands of Minnesotans will become uninsured. The RAND study was commissioned by the Council to provide coverage projections and cost analysis on additional viable approaches to support a stable, affordable individual market.

Premium Security Plan Account Transfer

The Council opposes transferring out the remaining funding in the Premium Security Account. Reinsurance is a proven program that has provided stability in the individual market and reduced premiums on average by 20% since 2018. Ending this successful program without identifying a viable alternative beginning 2026 will jeopardize access to affordable insurance for Minnesotans who purchase health insurance on their own, including farmers, day care providers, contractors and entrepreneurs. We strongly urge the Committee to reassess this position and to reinstate the previously transferred out funding in order to continue reinsurance and our state's high rates of coverage and access to needed care.

Health Plan Operations

Prior Authorization (PA)

PA is a real-time, double check of health care services and treatments to check if the care being delivered is safe and appropriate and that providers are promoting lower-cost options so patients are not over-paying for their care. Every session we hear about rising out-of-pocket costs and the growing problem of medical debt.

Council health plans try to be targeted in their use of PA and it is not used for all health care services - over 98% of our claims do not involve PA. It is focused on services and treatments which have the potential to cause significant patient harm, have a high-cost, have various alternatives, or for services in which plans see a track record of inappropriate or fraudulent care.

But we know providers have concerns over PA and that's why we worked with them on legislation in 2020 regulating PA and establishing timelines on when a PA review must be completed. Rather than passing legislation which will impact patient safety and the cost of insurance, we should apply these 2020 regulations equally to public programs, and providers and insurers should work collaboratively on specific problems and work towards specific solutions.

Direct Payment System Implementation Plan

The Council is concerned by the moving up of the direct payment implementation plan from 2026 to 2025. The elimination of managed care organizations (MCOs) from MA will not improve the lives of the one million Minnesotans enrolled in this program. The managed care model provides several significant benefits to the state, but most importantly, it improves health access and outcomes for Minnesotans enrolled in Medicaid because of care coordination performed by MCOs. Care coordination means serving the whole person – it is not just paying claims, but also helping to schedule doctor appointments, arranging transportation, developing mobile clinics, and arranging access to community-based services who can bridge cultural and language barriers. Building health equity and addressing social determinants of health is a theme that is woven through all aspects of care coordination and MCOs have been working together with DHS on integrating health equity requirements into the latest round of MCO contracts. Managed care and MCO procurement is a policy lever used by the state to ensure accountability and progress towards these requirements. Another advantage of the managed care model is financial predictability and accountability. Health plans take on the financial risk of insuring these Minnesotans so the state can set a reliable health care budget. The Council urges further consideration of whether the department and county-based purchasers can fully manage coverage for everyone currently enrolled in MA, what would be the impacts to providers who serve this population, or the impacts of removing enrollee choice.

Integrated Systems Payment Requirement

The Council is opposed to further attempts to remove flexibility from health plans' ability to contract with providers. The ability to negotiate payment rates is an essential tool health plans utilize to hold down costs of health care for Minnesotans.

Health Insurance Mandates

Apply Mandates Equally

The Council has a long-standing position that any coverage requirements enacted by the legislature must apply equally to all state regulated markets, which includes the fully-insured market (individual and group commercial markets), state public programs (Medical Assistance and MinnesotaCare) and the state employee health insurance program (SEGIP). We appreciate the consistency with which most of the benefit mandates are applied across markets.

Adjust Effective Dates of Benefit Mandates

Finally, the Council requests the new coverage mandates to have effective dates of January 1, 2026. All health carriers in the fully-insured market must submit their insurance products proposed for sale in these markets to the Department of Commerce for their approval. Submission of these plans for an upcoming plan year occurs in April of the year prior. Health carriers are already in the process of submitting their plans for the 2025 plan year and will have done so before this bill is enacted.

Cumulative Impact of Mandates

The Council encourages thoughtful consideration of the cumulative impacts of passing the mandates in this bill. Some of the mandates included in this bill will have significant cost implications for both premiums and the state budget. Additionally, these mandates were evaluated with the assumption that plans would continue to be able to utilize prior authorization for these benefits. However, with the inclusion of the PA language in this bill as well, the costs for these mandates are likely to come in significantly higher than currently budgeted for in this bill. The Council does not weigh-in regarding the merits of benefit mandates, but we do urge caution due to the potential to increase premiums to the point of unaffordability for some Minnesotan's.

Level Playing Field

County-Administered Medical Assistance Model (CAMA)

The Council supports competition that occurs on a level playing field. However, we hold concern that the CAMA model may limit options for those on medical assistance, by creating a system in which a county could restrict their options of coverage to a single option. We encourage the bill author and committee to examine this language further in order to ensure that the existing federal requirement of at least two plan options is preserved.

Minnesota Health Records Act (HRA)

We respectfully oppose the HRA language included in the bill, because it would lead to delayed access to care, duplication of services, patient frustration, and increased costs. Access to health records is already a highly regulated process under federal and state law. Federal regulations, including HIPAA, the HITECH Act and the Omnibus Privacy Rule strictly govern when, where, and to whom health information can be shared. This language would put Minnesota at odds with 48 other states who do not deem these extra regulations necessary to sufficiently protect private health information. We understand the author's intent may be to return to a pre-Supreme Court ruling landscape in Minnesota. However, we are concerned this language is open to even stricter interpretations, which could hinder Minnesotans' ability to access timely care.

We look forward to continuing working with you as this bill progresses to ensure its impact is to lower health care costs, maintain stability in the market, and help Minnesotans gain access to needed care.

Sincerely,

Lucas Nesse President
and CEO

MINNESOTA COUNCIL of HEALTH PLANS

CAPITOL OFFICE BUILDING

525 PARK STREET

SUITE 140

ST. PAUL, MINNESOTA 55103

651-645-0099 FAX 651-645-0098

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Sincerely,

Lucas Nesse President
and CEO

April 17, 2024

Rep. Tina Liebling
Room 477, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Chair Liebling and Committee Members:

I am writing on behalf of Minnesota Doctors for Health Equity to thank you for including **HF 2607** in the health omnibus budget bill. Minnesota Doctors for Health Equity is a statewide coalition of health professionals working toward health equity for all Minnesotans. We believe everyone deserves to live a healthy life, regardless of their race, gender, age, income, or neighborhood.

HF 2607 provides coverage of gender-affirming care for Minnesotans and ensures Minnesotans will have full access to the health care they need and deserve. Accessibility to these health services is critical to closing health inequities. As you know, barriers to coverage contribute to disparate health outcomes.

Lastly, while **HF 3600**, legislation that would establish continuous Medical Assistance (MA) eligibility for adults, and **HF 3891**, which would diversify the physician workforce, did not receive hearings this year, we believe this legislation to be fundamental to future conversations around health equity. These bills are important steps toward removing barriers to quality health care and improving health outcomes for families.

We respectfully ask for your support of these legislative proposals that will make a difference to eliminate inequities that exist to create a healthier, brighter future for Minnesotans. Thank you for your service and dedication to serving our community.

Sincerely,

Cuong Pham, MD
President, Minnesota Doctors for Health Equity
pham0079@umn.edu

MedicalAlley

04/17/24

RE: HF4571DE2 Amendment

Members of the House Health Finance and Policy Committee,

Medical Alley represents a global network of more than 800 leading health technology and care companies including representation from all corners of the state of Minnesota. Our mission is to activate and amplify healthcare transformation.

Recognized worldwide as a leader in healthcare innovation, Minnesota sets a standard for excellence – impacting local communities and influencing global health outcomes and advancements. With access, affordability, and quality as top priorities, Medical Alley and our partners are committed to developing solutions which drive meaningful change and save lives.

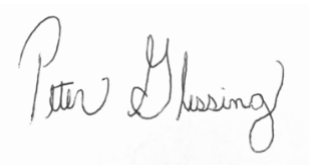
It is with this these guiding principles that we express concern about the HF4571DE2 Amendment impact on patient access to healthcare coverage.

As you are aware, the Minnesota Department of Health released a preliminary report on HMO conversions in February. Department of Health Commissioner Brooke Cunningham states on page four:

> **The issues addressed in this report are complicated and often highly technical. They are also of significant importance to Minnesotans: access to affordable, comprehensive health insurance coverage is an important factor that contributes to an individual's overall health, and one that has clear financial implications for individuals, families, and employers. Having a robust, transparent regulatory structure for entities that provide insurance coverage is necessary for accountability in meeting all state and federal requirements. The final report from MDH on these issues, due on June 30, 2024, will provide more in-depth analysis of how other states approach regulating HMO conversion transactions, as well as options for legislators to consider related to both the ongoing regulation of for-profit and foreign HMOs in Minnesota and the treatment of conversion transactions.**

Medical Alley believes that passing this language would be premature given the limited data currently available pertaining to an issue affecting the healthcare coverage for Minnesotans. We urge legislators to oppose this provision and wait for the full report in June before moving forward on legislation with such wide-ranging impact on access to healthcare in Minnesota.

Sincerely,



Peter Glessing
Senior Director of Policy and Advocacy
Medical Alley

Minnesota Farmers Union

305 Roselawn Ave E | Suite 200 | St. Paul, MN 55117
Phone: (651) 639-1223 | www.mfu.org

April 17, 2024

Chair Tina Liebling
House Health Finance and Policy Committee
477 State Office Building
St. Paul, MN 55155

Dear Chair Liebling and members of the committee:

On behalf of Minnesota Famers Union (MFU), I write to share our organization's views on the Health Omnibus Finance Bill (HF4571 DE), to thank you for provisions that will help address healthcare challenges famers and rural communities are facing, and to share our concern that the MinnesotaCare Public Option in not addressed in this proposal. We hope that will earn the committee's consideration as this bill moves forward.

MFU is a grassroots organization that has represented Minnesota's family farmers, ranchers and rural communities since 1918. Farmers, like other small business owners, disproportionately purchase insurance on the individual market and are hit hard by the high cost of healthcare—and many can't afford it. This limits rural economic vitality by creating barriers for young people who want to build a life in agriculture and leads to tragic stories from some who cannot afford insurance. Last session, lawmakers led the nation by authorizing a public option that would allow farmers and other small business owners to 'buy-in' to the comprehensive coverage provided to lower income Minnesotans as part of our state's Basic Health Plan (BHP).

This is why we write to express our deep concern that this proposal does not include further action on a MinnesotaCare Public Option. Going forward, we hope you will include provisions clarifying instructions for the administration regarding the waiver application that is necessary to secure federal authorization and funding. This will allow the state to stay on track for delivering a Public Option to Minnesotans while helping inform future legislation regarding implementation and state funding.

While we hope this committee will take steps to continue the work needed on a MinnesotaCare Public Option, we appreciate several of the provisions included in HF4571. This includes provisions from HF4853 that will create stronger regulation of health maintenance organization (HMO) conversions. Without strong regulations in place charitable assets could be used for private gain and nonprofit HMOs could become targets for acquisition, leading to further consolidation.

MFU also supports provisions from HF3902 that will update reimbursement for independent pharmacies serving Medical Assistance patients, which will provide a critical lifeline to those providers as the legislature works in future sessions on addressing the anticompetitive harm driving many pharmacies out of business.

Finally, MFU is also supportive of the provisions from HF3700 that will create greater notice for communities when hospitals are slated to close or eliminate services, which builds off the work done last year to create greater oversight of large healthcare mergers.

We urge the committee to reconsider addressing MinnesotaCare provisions in this bill and we appreciate the steps taken in this legislation to address issues of affordability and access. If you have any questions, please contact our Government Relations Director, Stu Lourey, at stu@mfu.org or (320) 232-3047 (C). Thank you for considering the needs and perspectives of Minnesota's farm families.

Sincerely,

Gary Wertish
President, Minnesota Farmers Union

Minnesota Hospital Association

161 Saint Anthony Ave., Ste. 915
Saint Paul, MN 55103-2382
www.mnhospitals.org

April 18, 2024

Chair Liebling and Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Hospital Association (MHA) and the patients that our 141 hospital and health system members across the state serve, we write to you today regarding multiple provisions in the House Health Finance and Policy Budget Omnibus, HF 4571 as amended. We are still reviewing the Omnibus and will provide additional comments as needed throughout the remaining legislative process. For your reference, upon initial review MHA supports the following provisions:

- Establishing a cost-sharing reduction program for those enrolled in silver level plans. (Article 1, Section 1).
- Providing new and additional funding for Graduate Medical Education (GME) via a teaching hospital surcharge and supplemental payments (Article 1, Sections 3-5).
- Providing an alternative payment rate for Gillette Children's Hospital related to long term patients. (Article 1, Section 6).
- Establishing needed guardrails to Minnesota's Prior Authorization process so patients can receive timely and needed health care. (Article 4, Sections 3, 10, 17-33, 61, 68-69).
- MHA supports the Chairs recommendation to create an evaluation of health care needs and care capacity. This is important baseline information to know what health care services we have and what are the projected needs. (Article 5, Section 54).
- Numerous policy changes contained in Article 9 related to mental and behavioral health. (Article 9).

Additionally, MHA has remaining concerns and will continue to work with this Committee, bill authors, and key legislative stakeholders on the following provisions:

- Medical debt changes, specifically prohibiting communications with debtors via automated dialing systems which may lead to the patient missing important appointment or health related information and eliminating the use of revenue recapture. (Article 3, Sections 1-6, 19-26).
- MHA is thankful to Rep. Smith in listening to concerns from non-profit hospitals, however we still are concerned about changes in the timeframe related to hospital closure and service line modifications notice requirements that do not reflect the reality that hospital staff seek new employment as soon as notification of service changes are made. Additionally, significant financial penalties levied on non-profit health care providers are excessive and do not allow flexibility for the commissioner to first issue a correction order. MHA is also still concerned about the language related to right of first refusal. (Article 5, Sections 8-13).
- MHA has concerns with making changes to the Minnesota Health Records Act and is fearful this could disrupt current care coordination and billing. (Article 6, Sections 16-20).

- MHA has some concerns about the granularity of the reporting that is being requested relating to Community Health Needs Assessments and hospital community benefits. We hope to work with Rep. Bierman on aligning the dates with current hospital submissions to the IRS. (Article 6, Section 25).

Furthermore, MHA would like the Chair to consider the following items that are missing from this bill:

- MHA is disappointed that language from Rep. Heather Keeler's HF 5124 did not make it into the bill. The bill would have helped Indian Health Services facilities leverage additional federal dollars. In addition, the bill would also remove restrictions related to accrediting authorities for adult day treatment programs.

- While MHA is appreciative of the mental and behavioral health policy changes contained in Article 9, we encourage the Chair and Members to continue to advocate for greater resources and an increased target to reflect the urgent mental and behavioral health needs of Minnesotans.

In closing, we are supportive of many provisions in the House Health Finance and Policy Budget Omnibus, and recognize the Chair's effort to maximize the inclusion of positive changes despite significant demand for the limited resources available.

Sincerely,

Mary Krinkie
Vice President of Government Relations
mkrinkie@mnhospitals.org

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org

MINNESOTA
FAMILY COUNCIL

April 18, 2024

HF4571 DE2
Members of the House Health Finance and Policy Committee
100 Rev Dr Martin Luther King Jr Boulevard
St Paul, MN 55155

Dear Members,
HF4571 DE2 contains provisions that come from HF2607, a bill which mandates that all insurers operating in Minnesota cover so-called "gender-affirming care" except for those eligible organizations which qualify for an exemption under religious objection.

Minnesota Family Council gave versions of the below verbal testimony (second page) on SF2209/HF2607 in multiple committees:

- House Commerce Finance and Policy Committee on March 6, 2024
- Senate Commerce and Consumer Protection Committee on March 7, 2024
- Senate Health and Human Services Committee on March 20, 2024
- House Health Finance and Policy Committee on April 4, 2024

Globally, there are concerns with prescribing medicalized "gender-affirming care" to children. While some Western nations are pulling back on medicalization in this way, the Minnesota legislature will likely mandate that all insurers offering health plans in Minnesota cover so-called "gender-affirming care," exempting health plans offered by qualified organizations. This policy approach actively ignores warning signs from other nations.

Detransitioner Camille Kiefel testified in the Senate Health and Human Services committee on March 20, 2024, sharing how "because of the stigma of detransition," members of her community have health needs that "are going unaddressed."[1] She said, "We do not feel safe going back to our medical providers who are not trained in how to care for us. There is no support for us." She explained that there are no specific ICD-10 WHO codes for detransition; she shared how billing detransitioners under a "transition" code "puts providers at risk for medical fraud…many individuals who want to detransition can't because their insurance won't cover it." She has grave concerns that members of her community are unable to get healthcare and asked members of the committee to accept an amendment that would ensure the bill will mandate coverage for detransitioners as well. The amendment was not accepted by the bill author.

Minority health needs are going unaddressed by this bill, and global concerns over so-called "gender-affirming care" are being ignored. We ask members of the Minnesota House to carefully consider these issues when including HF2607 into the Health omnibus bill, HF4571.

Sincerely,
Rebecca Delahunt
Director of Public Policy
Minnesota Family Council

[1] https://www.youtube.com/watch?v=Y5zlz9whS7s&t=1973s

MINNESOTA FAMILY COUNCIL

Chair Liebling and Members of the Committee, my name is Rebecca Delahunt, and I work as the Director of Public Policy with Minnesota Family Council.

HF2607 requires all physical and mental health plans offered by insurers who operate in Minnesota to "not exclude" what the bill authors call "gender-affirming care," which the policy states must now be designated as "medically necessary."[2]

Based on the language of this policy, one might assume that the medical community has consensus on this issue, but that's not the case. Last year, a Forbes reporter noted how "longitudinal data collected and analyzed by public health authorities in Finland, Sweden, and England have concluded that the risk-benefit ratio of…[pharmaceutical and surgical interventions for youth in this way]…ranges from unknown to unfavorable."[3] The reporter shared that Finland, Sweden, the U.K., and Norway are "shifting toward… a less medicalized approach that addresses possible psychiatric comorbidities and explores developmental etiology."

The WPATH files, released on March 4, 2024, show how WPATH has misled the medical community, all while leading insurance companies and legislatures with its protocols.[4]

It's not just red states which have concerns – NHS the health service of the UK banned puberty blockers except in the use of clinical trials on March 14, 2024.[5]

In short, there is a lack of consensus within the global medical community on how to treat minors. The USA is behind our European neighbors in this understanding.

In prior hearings, bill authors have stated that detransitioners will be covered through this bill, but I will note that so-called "gender affirming care" was not created with the intent to help folks detransition. There is no specific WHO ICD-10 code for treating detransition.

For detransitioners, the physical and mental impacts of cross-sex hormones and diverse surgeries are broad. This community should not be excluded from healthcare.

When we consider this division, forcing all insurers to pay for this is misguided, and forcing all state taxpayers to pay for so-called "gender-affirming care" is coercion.

Children cannot give informed consent on treatment that alters or potentially removes their sexual or reproductive health.

I respectfully ask for a no vote.

[2] https://www.revisor.mn.gov/bills/text.php?number=HF2607&type=bill&version=1&session=ls93&session_year=2023&session_number=0
[3] https://www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors/?sh=50a9106e7efb
[4] https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/65e6d9bea9969715fba29e6f/1709627904275/U_WPATH+Report+and+Files.pdf
[5] https://news.sky.com/story/children-to-no-longer-be-prescribed-puberty-blockers-nhs-england-confirms-13093251#:~:text=Children%20will%20no%20longer%20be,part%20of%20clinical%20research%20trials.

MINNESOTA MEDICAL ASSOCIATION

The voice of medicine in Minnesota since 1853

612-378-1875 | 800-342-5662 | mnmed.org

April 18, 2024

Dear Members of the House Health Finance and Policy Committee,

On behalf of the more than 10,000 members of the Minnesota Medical Association (MMA), I am writing to thank the author for including the contents of HF 3578, regarding prior authorization reform, in HF 4571, the committee's omnibus bill.

Too many patients experience dangerous delays in care due to unnecessary and unwarranted prior authorization requirements. The included language directly addresses these serious concerns by prohibiting prior authorization for a limited list of services where a delay in care leads to serious negative patient health outcomes. These items include medications to treat a substance use disorder, outpatient mental health treatment, treatments to fight cancer consistent with national cancer-care guidelines, and chronic conditions, among others. The legislation also requires health plans to submit data reports to the Commissioner of Health, to develop recommendations to improve the prior authorization process for both patients and providers

Most importantly, this language will greatly improve the health outcomes for Minnesotans. 94% of physicians report that prior authorization has led to care delays, 80% report that prior authorization can and has led to treatment abandonment by patients, and 33% report that prior authorization has led to a serious adverse event for their patients, including 19% reporting that it has been a life-threatening event, or one intended to prevent a permanent impairment. Additionally, while prior authorization may have a role for services for which the treatment is questionable or where services may be overutilized, the overuse of the process delays needed care, adds to administrative costs, and results in a net cost to population health.

National data also shows that physicians complete on average of 41 prior authorizations per week and that they or their staff spend more than 13 hours a week on getting prior authorization approvals. Growing prior authorization burdens the leading driver of physician burnout, and this legislation will have a positive impact on the state's physician workforce.

The MMA thanks you for the inclusion of this item in the omnibus bill.

Sincerely,

Laurel Ries, MD
President, Minnesota Medical Association

April 17, 2024

Dear Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Chamber of Commerce, representing 6,300 employers and their more than 500,000 employees across the state, I write to share our concerns with HF 4571 (Rep. Liebling), as amended by the DE2 amendment.

Health Insurance Mandates

For our members who offer health insurance to their employees, 70% do so through the fully-insured market, which is the segment of the health insurance market regulated by the state. It should come as no surprise, then, that each year our members rank making health care more affordable as a top concern for state policymakers to address. And yet the cost of health insurance continues to rise.

There are many reasons for year over year increases in health insurance costs, but as the regulator of the state's fully-insured market, decisions made by the Legislature also impact costs.

Minnesota has more than 60 coverage mandates currently in place, more than most other states. Last year alone, the Governor and Legislature added six more, adding an estimated $114 million to the cost of health insurance in the fully-insured market. As part of this bill, this Committee is considering several additional new health insurance mandates. While all of these health insurance mandates would provide a benefit to someone, they also all come with a cost. At a time when researchers at the University of Minnesota tell us that Minnesota families' all-in health care spending *ranks third highest in the country*, we have significant concerns about any proposal that would add to that cost burden.

If the Committee decides that there are policy or other public health reasons for adding additional coverage mandates to state statute – above and beyond the long list that is currently in place – we encourage those proposals to be married up with the provisions of HF 1158. This approach would ensure the goals of the new coverage mandates are met without further increasing costs on the Minnesotans and Minnesota families who rely on the coverage provided through the state-regulated fully-insured market.

Prior Authorization

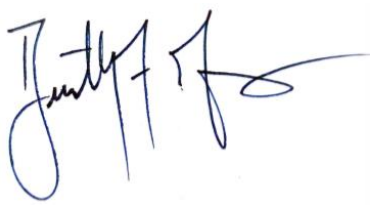
This bill would make a number of changes to the way the prior authorization process is used in health insurance. While we agree that some changes are likely necessary to bring the prior authorization process in line with today's technology and health care ecosystem, any changes that are made to the prior authorization process must maintain its usefulness in ensuring quality and safety and lowering health care costs. While there are provisions in this bill – like the requirement for an automated, real time prior authorization process - that would help to address the problems that have been identified with the prior authorization process, there are other provisions in the bill, like exempting large groups of procedures from prior authorization, that will likely increase costs and, at the very least, require more study and review.

HMO Licenses

Absent more information about the rationale for doing so, we are concerned about a move to prohibit certain types of HMOs from being licensed in the state. While there are certainly differences between how non-profit and for-profit HMOs are structured and established, there are no regulatory or demonstrated performance differences between the two and how they are required to operate in this state. And yet, this bill would prohibit for-profit HMOs from doing business here. This despite the fact that the state chose to have one such HMO manage the health care needs of tens of thousands of Minnesotans in the metro areas as part of PMAP enrollees, and despite the fact that work from the Minnesota Department of Health to research this issue is not yet complete. Nevertheless, the interim report from MDH noted, "…minimal data are available to shed light on whether differences exist between nonprofit and for-profit HMOs with regard to day-to-day operations, enrollee satisfaction, and quality of care."

Thank you for the opportunity to provide this input.

Sincerely,



Bentley Graves
Director, Health Care & Transportation Policy

April 17, 2024

The Honorable Tina Liebling, Chair, House Health Finance and Policy Committee
Minnesota House Health Finance and Policy Committee Members
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

Re: **PCMA Comments Opposing Prior Authorization Language within the Delete-Everything Amendment to HF 4571 – the Health Budget Bill**

Dear Chair Liebling, Vice Chair Bierman and Members of the House Health Finance and Policy Committee:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to provide written testimony and I apologize I am not able to be there in person. We respectfully submit the following comments for consideration in opposition to the prior authorization language in the current Delete-Everything Amendment to HF 4571 – the House Health Budget Bill, given the significant patient safety and cost impacts this bill will have on Minnesota patients.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

Prior Authorization Ensures Consistent, Guideline-Based Care While Reducing Costs for Minnesota Payers

Prior authorization is a form of utilization management where a health plan requires pre-approval of a prescription drug. The primary goals are 1) to ensure the appropriateness and suitability of the prescribed medication for the specific patient; 2) to ensure safety; and 3) to reduce costs.

The use of prior authorization in the medical benefit and drug benefit are different. Prior authorization in the medical benefit is for a service and prior authorization use in the drug benefit is for a product – a prescription drug. The difference is important because a drug is typically prescribed for use over a length of time, not just once. Ongoing use of a drug may require monitoring or testing to ensure the drug is safe and effective.

Prior authorization is a tool used for drugs with the following characteristics:

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

- Dangerous side effects
- Harmful when combined with other drugs
- Should only be used for specific health conditions
- Are often misused or abused
- Have equally, more effective, or more affordable drugs that would work for the majority of patients based on evidence-based drug therapy standards of care

According to the National Academy of Sciences, Engineering, and Medicine (NASEM), "Formularies are used to steer patients and prescribing clinicians toward generic substitutes, biosimilars, drugs with similar therapeutic efficacy for the same disease, or other therapeutic options." Without formulary controls, "insurance premiums would rise," notes NASEM. Prior authorization and step therapy are among the most effective formulary controls, thus prohibiting use of these programs would likely raise premiums. Increased premium costs are passed on directly to Minnesotans who are already feeling the strain from rising costs on their pocketbooks.

Prior Authorization Requirements are Developed by a Panel of Independent Experts.

Health plans and PBMs rely on independent Pharmacy & Therapeutics (P&T) Committees, comprised of independent experts including licensed physicians, pharmacists, and other medical professionals, to develop evidence-based guidelines used in drug management programs—including prior authorization—and to ensure that these management controls do not impair the quality of clinical care.

Every Plan has a Prior Authorization Exceptions Process to Safeguard Coverage of Non-Formulary Drugs when Appropriate.

NASEM has also stated that, "Every plan, whether Part D or an employer-sponsored pharmacy benefit, has an exception process that permits coverage of a drug not on formulary or reduces out-of-pocket cost if a prescriber provides information about side effects the patient has experienced from a lower-tiered drug or offers another medical reason for switching."[1] This process safeguards against the use of prior authorization being too restrictive.

Industry Concerns with HF 4571

In 2020, when prior authorization legislation was enacted in Minnesota, the concept was heavily negotiated, and the negotiations took place during the height of the pandemic. A mere four (4) years later, the issue is again at the forefront.

[1] Making Medicines Affordable: A National Imperative," National Academies of Sciences, Engineering, and Medicine (NASEM), Nov. 2017.

This bill, as drafted, puts all prior authorizations into the same bucket when there is a difference between medical benefits and prescription drug benefits. For example, under Article 4 – Sections 3 and 26, a prescription drug prior authorization under the prescription drug benefit is never retrospectively denied, nor would it be denied if the "service" has already been received. This is because once a prior authorization is approved for a prescription drug using the prescription drug benefit, a patient receives said prescription drug for the amount of time clinically appropriate for the patient and their condition being treated, taking FDA approved recommendations into account. Also, a prescription drug is not a service.

Minnesota was one of the first states in the nation to require electronic prior authorization for prescription drugs, which can be found in §62J.497. This became effective in 2011 and mandates all prescribers to submit, and payers to accept, electronic prior authorizations by 2016. This is still in effect and is not used 100% by providers, and the language in the Delete-Everything Amendment to HF 4571 does not address this long-standing requirement and appears to set forth a new standard and process.

It is due to these problematic provisions noted above that we must respectfully oppose the prior authorization language in the Delete-Everything Amendment to HF 4571.

Thank you for your time and consideration. Please feel free to contact me should you have any questions.

Sincerely,

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

April 17, 2024

The Honorable Tina Liebling, Chair, House Health Finance and Policy Committee
Minnesota House Health Finance and Policy Committee Members
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

Re: **PCMA Comments Opposing Prior Authorization Language within the Delete-Everything Amendment to HF 4571 – the Health Budget Bill**

Dear Chair Liebling, Vice Chair Bierman and Members of the House Health Finance and Policy Committee:

Thank you for the opportunity to comment on the delete everything amendment for H 4571. I represent Prime Therapeutics (Prime), a pharmacy benefit manager (PBM) owned by 19 not-for-profit Blue Cross and Blue Shield Insurers, subsidiaries, or affiliates of those Insurers, including Blue Cross & Blue Shield of Rhode Island. If HF 4571 is enacted, the total cost of health care and premiums for Minnesota citizens will increase. Utilization management tools, such as prior authorization, are important to managing patient safety risks for drugs that are only approved for very specific health conditions, have dangerous side effects, or pose risk for misuse and abuse. Utilization management tools are also important in addressing the ever increasing cost of prescription drugs, when used for drugs that have other more affordable but equally effective alternatives available on the market. For this reason, Prime opposes the delete-everything amendment for HF 4571.

Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers, and government programs including Medicare and Medicaid. Our company manages pharmacy claims for more than 30 million people nationally and offers clinical services for people with complex medical conditions. Our business model relies on transparency and advocating for simpler, lowest-net-cost pricing for drugs. Importantly, Prime is not focused on driving profit margins.

Prior authorization use for the health benefit and the drug benefit are very different. For example, a knee replacement surgery is performed once. A drug to treat a chronic illness is taken for life and requires ongoing monitoring. Because of these differences it's important to note that my testimony today solely discusses the impact of HF 4571 on the use of prior authorization for prescription drugs.

Prior authorization requirements are set on prescription drugs that should be used only:

- for certain – limited – health conditions
- have dangerous side effects
- are harmful when combined with other drugs
- may be misused or abused
- or if there are equally affective drugs available at a more affordable cost.

For example, many drugs to treat breast cancer require genetic testing to confirm that the prescribed therapy will benefit the patient. In that instance, a prior authorization would ensure that the genetic testing was completed, and the drug will be of benefit.

This session, we've heard testimony on the burden that prior authorization causes for providers. Yet, this has already been addressed. In 2010 Minnesota passed a law requiring the use of electronic prior authorization, often referred to as ePA. The ePA process is in real time, and when utilized, will not delay a patient from receiving a prescription that is covered for their condition. This law was a great first step in improving the prior

authorization process, but prescribers have not reached 100% adherence with the law. Adhering to current law would go a long way to addressing burden.

We've also heard a lot about S.F. 3204, the Minnesota law passed in 2020 and set reasonable requirements for use of prior authorization such as:

- annual posting of prior authorization data on a plans website
- A limit on prior authorization data request requirements
- Required health plan change notifications
- A requirement for any adverse determinations to be made by a licensed physician in the same area of practice as the prescribing physician.
- And many more.

S.F. 3204 was touted as the answer to all of the problems raised by Minnesota physicians. Unfortunately, Minnesota Medicaid and State Employee plans were excluded from this law. As we continue to hear physicians raise concerns about turnaround times or physicians in a different field of study making adverse determinations on a Prior Authorization its important to bear in mind that the law is already in place for commercial plans to follow these guidelines, but Minnesota Medicaid and State Employee plans are exempt.

S.F 3204 did not include state funded plans because of the large financial impact. That financial impact has been felt by Minnesotans insured in the Commercial market and Minnesota employers. Now, after enacting the solution to Prior authorization, we're here to discuss an amendment to HF 4571 which greatly restricts the use of prior authorization through broad categorical prior authorization bans like a ban on prior authorizations for generic drugs or multisource brand name drugs. This bill will have a significantly larger financial impact than the previous prior authorization legislation.

Due to the significant financial and safety costs with the broad, categorial prior authorization bans in this bill, Prime Therapeutics is in opposition.

I welcome the opportunity to further discuss these concerns and work towards evidence-based solutions to help people get the medicine they need to feel better and live well. Thank you for your time and consideration.

Respectfully,

Michelle Crimmins
Government Affairs, Prime Therapeutics
Phone: 612.329.3245 | Email michelle.crimmins@primetherapeutics.com

Minnesota Chapter

INCORPORATED IN MINNESOTA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Minnesota Chapter of the American Academy of Pediatrics
1609 County Road 42 W #305,
Burnsville, MN 55306

April 16, 2024

Chair Tina Liebling
Health Finance and Policy Committee
100 Rev Dr Martin Luther King Jr Boulevard.
St. Paul, MN 55155

Chair Liebling,

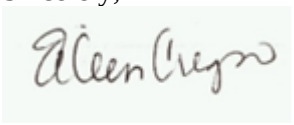
On behalf over the over 1,000 members of the Minnesota Chapter of the American Academy of Pediatrics (MNAAP), I am writing to thank you for including the following items in HF 4571.

MNAAP appreciates you including language to prohibit prior authorization for services where a delay poses an immediate danger to patient health. This includes treatments for substance-use disorder, outpatient mental health care, cancer care, and treatment for chronic conditions, among others. This also includes pediatric hospice care and treatments neonatal abstinence MNAAP also supports requiring health plans to submit data on prior authorization to the Department of Health, who in turn will submit recommendations to improve the prior authorization process.

MNAAP supports a variety of mandated coverage items in the bill. These include extending required coverage for services in prenatal, delivery, and postpartum periods for a mother and infant and extends the duration of postpartum care to a year and prohibits cost sharing for all required services associated with this care. Additionally, MNAAP supports mandating insurance plans to provide coverage of abortion services and gender-affirming care.

Thank you for including these items in HF 4571.

Sincerely,



Eileen Crespo, MD, FAAP
President, Minnesota Chapter of the American Academy of Pediatrics

MINNESOTA
ORTHOPAEDIC
SOCIETY

April 18, 2024

Chair Liebling,

On behalf of the Minnesota Orthopaedic Society (MOS), I am writing to express our gratitude for including HF 3578 in your omnibus bill.

MOS strongly supports prohibiting prior authorization for those services, when delayed, often lead to negative patient outcomes. Additionally, MOS strongly supports language requiring health plans to submit prior authorization data so a recommendation to improve the prior authorization process, including a recommendation for a prior authorization exemption process for providers, can be developed.

According to data from the American Medical Association, 94% of physicians report that prior authorization has led to delays in care for their patients. In that survey, 1 in 3 physicians reported that prior authorization has led to serious adverse events for patients. Additionally, while 100% of health plans report using peer-reviewed evidence-based studies when designing prior authorization programs, 31% of physicians polled report that prior authorization criteria are rarely or never evidence-based.

This reflects what we are hearing from our own members. According to data gathered among MOS members, well over 90% of prior authorization requests were ultimately approved. These numbers suggest that services which are not overutilized still undergo frequent prior authorization reviews. This does not benefit the patient. This does not benefit the provider. This does not benefit anyone except health plans that save money when patients give up on pursuing treatment due to prior authorization.

On behalf of MOS, I greatly appreciate your work to reform prior authorization for Minnesota's patients and providers.

Sincerely,

Paul Lafferty, MD
President, Minnesota Orthopaedic Society

April 18, 2024

House Health Finance and Policy Committee
RE: HF4517 DE

Dear Chair Liebling and committee members:

Minnesotans for a Smoke-Free Generation is a coalition of more than 50 organizations that share a common goal of advancing justice by striving toward a future where every person is free from commercial tobacco's harms and can reach their full health potential.

We are writing to share our support for the inclusion of HF4251 (Her), legislation to prohibit the sale of flavored cannabis products that are burned, inhaled, or vaped, in the HF4517 delete everything amendment. However, we are deeply disappointed that HF2177 (Cha), legislation to end the sale of all commercial flavored tobacco products, was left out.

As commercial tobacco prevention advocates working diligently to prohibit the sale of menthol and flavored commercial tobacco, it is imperative to have consistency in the market between commercial tobacco and cannabis. Tobacco companies are investing heavily in the cannabis industry. This is concerning given what we know about the tobacco industry's predatory marketing practices that target youth, low-income communities, Black Minnesotans, American Indians, and the LGBTQIA2S+ communities. The cannabis industry is borrowing from Big Tobacco's playbook, creating flavored and highly appealing products aimed at attracting young people and masking the harshness of a product.

Our state should not wait another year to end the sale of commercial flavored tobacco products. Every year we do nothing, 10,000 kids try tobacco for the first time, lured in by fruity flavors; thousands of people die preventable, premature deaths, and the Minnesotans most likely to be impacted by this are those from our Black, American Indian and LBGTQIA2S+ communities, because that's who the tobacco industry is targeting.

Removing flavored tobacco products – including menthol cigarettes, flavored cigars, e-cigarettes, hookah, and smokeless tobacco – from the marketplace will prevent youth addiction and improve health for all Minnesotans. The policy will especially benefit communities targeted by the tobacco industry – including young people, Black Americans, LGBTQIA2S+ people, and American Indians.

Passing these policies together will ensure the legislature can fully reverse the youth tobacco epidemic, shape cannabis policy with a focus on prevention and public health, address racial and health inequities, and reduce health care costs.

Sincerely,

Emily Myatt
Tri-Chair, Minnesotans for a Smoke-Free Generation
Regional Government Relations Director, American Cancer Society Cancer Action Network

LaTrisha Vetaw
Tri-Chair, Minnesotans for a Smoke-Free Generation

Janelle Waldock
Tri-Chair, Minnesotans for a Smoke-Free Generation
Senior Director of Policy, Blue Cross and Blue Shield of Minnesota

About Minnesotans for a Smoke-Free Generation

Minnesotans for a Smoke-Free Generation is a coalition of more than 50 organizations that share a common goal of advancing justice by striving toward a future where every person is free from commercial tobacco's harms and can reach their full health potential.

A Breath of Hope Lung Foundation, Advocates for Better Health, Allina Health, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association in Minnesota, Asian Media Access, Association for Nonsmokers – Minnesota, Blue Cross and Blue Shield of Minnesota, Cancer Legal Care, CentraCare, Children's Minnesota, Comunidades Latinas Unidas En Servicio – CLUES, Dodge County Public Health, Essentia Health, Eugene Nichols, Faribault Martin & Watonwan Co SHIP, Gillette Children's Specialty Healthcare, Greater Friendship Missionary Baptist Church, HealthPartners, Health Plan Partnership of Minnesota, Hennepin County Public Health, Hennepin Healthcare, Horizon Public Health, Indigenous Peoples Task Force, Lao Center of Minnesota, Lincoln Park Children and Families Collaborative, Local Public Health Association of Minnesota, March of Dimes, Masonic Cancer Center, University of Minnesota, Mayo Clinic, Medica, Meeker McLeod Sibley Community Health Services, MHA – Minnesota Hospital Association, Minnesota Academy of Family Physicians, Minnesota Alliance With Youth, Minnesota Association of Community Health Centers, Minnesota Cancer Alliance, Minnesota Council of Health Plans, Minnesota Dental Association, Minnesota Medical Association, Minnesota Prevention Alliance (MPA), Minnesota Public Health Association, Minnesota Society for Public Health Education, MNAAP – Minnesota Chapter of the American Academy of Pediatrics, Mowery Communications, LLC, NAMI Minnesota, Native Sun Community Power Development, NorthPoint Health & Wellness, Olmsted Medical Center, Parents Against Vaping e-cigarettes, PartnerSHIP 4 Health, Perham Health, Preventing Tobacco Addiction Foundation/Tobacco 21, Public Health Law Center, Rainbow Health, SEIU Healthcare Minnesota, Steele County Public Health, Team EPIC (Encouraging Positive Impact Through Change), Tobacco-Free Alliance, Twin Cities Recovery Project, UCare, Vision in Living Life "Change is Possible", WellShare International, Winona County Alliance for Substance Abuse Prevention

Find out more at: smokefreegenmn.org.

Representative Tina Liebling, Chair
Health Finance and Policy Committee
April 18, 2024

Chair Liebling and Health Finance and PolicyCommittee Members,

On behalf of the National Association of Social Workers, MN Chapter (NASW-MN) and the MN Coalition of Licensed Social Workers (Coalition), we are writing to comment on several components in HF4571, the Health and Human Services omnibus bill.

NASW-MN is the largest membership organization of professional social workers in our state and the Coalition includes the MN Association of Black Social Workers, the MN Hmong Social Workers' Coalition, the MN Nursing Home Social Workers Association, the MN School Social Workers Association, and the MN Society for Clinical Social Work. Collectively, we represent over 3,000 social workers.

We support expanding the child and family psychoeducation MA services to mental health practitioners. This is a practical way to address funding gaps in mental health settings. These are services that are often already being provided, but with no payment to the providers. Furthermore, this change has the added benefit of extending to school settings. With payment, social workers can better utilize this preventative strategy.

Additionally, your attention to simplifying mental health billing codes will allow social workers and other mental health professionals to better utilize reimbursement options that are currently available.

As you enter into conference committee discussion, we urge you to discuss mental health rates. There is a significant gap between the cost of delivering services and reimbursement rates. Addressing this gap will improve access to services, increase capacity in mental health settings, and reduce staffing shortages. The Senate included increasing mental health provider rates in their budget proposal, and we believe this will be an important conversation as the bill progresses.

Social work is based on a mission to enhance the well-being of humans. We advocate for our clients, and want to ensure that social workers and other professionals are supported in their work.

We recognize that there are other components in this bill designed to support individuals and professionals. For example, expanding mental health supervision grants to rural MN and investment in respite services will support individuals who need support and the professionals addressing their needs. We appreciate that resources are limited and the needs are great. Thank you for your work in balancing competing needs.

We look forward to continue collaboration.

Sincerely,

Coalition of Licensed Social Workers Representatives,

Karen Goodenough, PhD, LGSW, National Association of Social Workers, MN Chapter
Renita Wilson, MSW, LICSW, MN Association of Black Social Workers
Kao Nou Moua, PhD, MSW, LGSW, MN Hmong Social Workers' Coalition,
Joanna Genovese-Cairns, MSW, LISW, MN Nursing Home Social Workers Association
Julie Campanelli, LICSW, Ed.S, MN School Social Workers Association
James Stoltz, LICSW, LADC, MN Society for Clinical Social Work
Jenny Arneson, MSW, LGSW, Legislative Consultant

April 17, 2024

Representative Tina Liebling
Health Finance & Policy Committee
State Office Building | Room 5

Dear Chair Liebling and Committee Members:

Minnesota's Prenatal to Three Coalition (PN-3) urges you to support HF 4571, to invest in the services and programs that support babies, young children, and families in Minnesota. Minnesota's Prenatal to Three Coalition (PN-3) represents a diverse group of stakeholders supporting policies and programs aimed at ensuring infants, toddlers and families have the best start in life regardless of income, geography, or race.

Thank you for including the following provisions in SF 4699; we ask you to continue to support them as you enter Conference Committee discussions:

- **Respite Care Services Grants,** HF 3495
- **Report to Develop MA Benefit Children's Residential Mental Health Crisis Stabilization,** HF 3495
- **Mental Health Procedure Codes Report,** HF 4779A1

Minnesota cannot afford to have more people leave the mental health field or have more agencies close because they cannot afford to pay staff and provide services for families. Investing in the mental health field will improve the ability of community-based organizations and public agencies to pay providers to perform critical care for services to children and families.

Thank you,

Deb Fitzpatrick, Children's Defense Funds-MN, Co-Chair	Nancy Jost, West Central Initiative, Co-Chair	Laura LaCroix-Dalluhn MN Prenatal to Three (PN-3) Coalition, Coalition Coordinator

Planned Parenthood®
Minnesota, North Dakota, South Dakota Action Fund

April 17, 2024

Chair Liebling and Members of the House Health Finance and Policy Committee
Via Electronic Delivery

Re: Letter in Support of Inclusion of Coverage for Abortion and Gender Affirming Care

Chair Liebling and Members of the Health Finance and Policy Committee:

Planned Parenthood North Central States (PPNCS) provides a full range of sexual and reproductive health care to Iowa, Minnesota, Nebraska, North Dakota, and South Dakota at 25 health centers, serving nearly 100,000 patients in the fiscal year 2023. As experts in reproductive health care, Planned Parenthood's mission is to ensure that Minnesotans have access to the care and resources they need to control their bodies, their lives, and their futures.

Founded in 1992, the Planned Parenthood Minnesota, North Dakota, South Dakota Action Fund is an independent, non-partisan, non-profit organization that advocates for the policy and support needed to make PPNCS's care possible. We work with supporters of all parties to defend and increase access to family planning services, fact based, medically accurate sexuality education, and healthcare abortion access. To that end, we're writing today to thank you for including House File 4053 and House File 2607 – insurance coverage for both abortion and gender affirming care – in the health omnibus bill.

Minnesota has already led the way to protect the right to abortion and gender affirming care, and we can play a critical leading role in further safeguarding people's health by covering this essential health care in both public and private insurance plans. Expenses are a real barrier for patients accessing health care, and they disproportionately impact patients who already face increased barriers to care.

Minnesotans need to be able to make decisions knowing that they are not going to be stuck with out-of-pocket payments they cannot afford. Insurance coverage is essential for real access and health equity.

Health care is a human right. Now is the time to expand access and reduce barriers to health care. Thank you again for including House File 4053 and House File 2607 in the health omnibus bill.

Sincerely,

Tim Stanley
Executive Director

671 Vandalia Street • Saint Paul, MN 55114

TESITMONY OF MARK PETERSON, CEO, NYSTROM & ASSOCIATES
BEFORE THE HOUSE HEALTH FINANCE AND POLICY COMMITTEE
April 18, 2024

Madame Chair and Members of the Committee, my name is Mark Peterson, CEO of Nystrom & Associates, one of the largest providers of outpatient therapy, psychiatry and substance use treatment in Minnesota.

Unless the Legislature acts this session, critical access mental health providers rates will be cut by 9.6% starting 1/1/25.

To make it concrete… providers serving Medicaid patients will go from $161 to $145. This 9.6% cut takes into consideration the 3% rate increase passed last session.

We've heard several concerns about delaying this phase-out of critical access funding and I want to take a moment to address them. We've heard:

- It's not a budget session and that surplus is less than anticipated.
  That is why we are only asking that you postpone the phase-out by one year.

- The Department of Human Services told lawmakers that phase-out of critical access funds was necessary to avoid problems with Federal Upper Rate Limits.
  This issue only applies if or when the Legislature passes broader mental health rate increases, which it has not done. There is no upper rate limit concern by delaying the cut to critical funding until rate reform occurs.

- There are many other priorities.
  While we understand the many demands, at the very least, the State should not be cutting mental health rates at a time when needs are so high.

  As DHS said in its rate study, current rates don't even cover the cost of providing care. Several providers have already had to stop serving Medicaid patients and cutting rates will force more to do so. Medicaid patients with mental health issues will have less access, forcing them to go without care or end up in more costly settings -- emergency rooms, hospitals or jails.

For these reasons, I urge you to delay the phase-out of critical access mental health funding for one year. Mental health providers and the patients they serve are counting on you.

Thank you!

NAMI
National Alliance on Mental Illness
MINNESOTA

1919 University Ave. W, Ste. 400, St. Paul, MN 55104 | 651-645-2948 | namimn.org

April 17, 2024

Members of the House Health Finance and Policy Committee:

On behalf of NAMI Minnesota, we are submitting our comments on HF4571, the supplemental budget health omnibus bill. We are grateful for the inclusion of many provisions brought by the Mental Health Legislative Network this year and we support:

- Clarifying that clubhouses are a community support services program;
- Expanding provider supervision programs to rural areas;
- Expanding access to respite care for families whose children have experienced crises, been in the ER, or lost in home staffing, GREATLY increasing funding, and developing proposals to increase access to licensed respite foster homes;
- Ensuring access to ACT team services for young adults in first episode of psychosis programs;
- Moving away from grants and working to provide sustainable formula funding for services such as school linked programs, respite care, and mobile crisis teams;
- Expanding the definition of "clinical trainee" to people who are waiting to take the licensure test or are waiting for results which will increase our workforce;
- Clarifying that CTSS providers can bill for treating the child and the family;
- Raising Medical Assistance payment rates for Masters-level mental health professionals;
- Developing a Medical Assistance benefit for children's crisis residential stabilization.

Additionally, we support:

- Reforming prior authorization to increase access to care;
- Requiring health plans have to accept all essential community providers in their network;
- Requiring coverage of gender affirming care; and
- Requiring hospitals to share their community needs assessments to share more broadly with the public and the Department of Health.

We are happy to discuss any of these issues further and continue to work with you this session to build our mental health system.

Sincerely,

Sue Abderholden, MPH
Executive Director

Elliot Butay
Senior Policy Coordinator

Sarah Knispel, MSW
Public Policy Coordinator

Date: April 18th, 2024

To:
Chair Tina Liebling
Members of the House Health, Finance and Policy Committee

From:
The Minnesota Pharmacy Alliance, the MNIndy's, the College of Pharmacy at the University or MN and the Minnesota Retailers Association

Re: Minnesota Senate HHS Omnibus Finance legislation – HF4571-DE

Representatives and members of the House, Finance & Policy Committee,

The Minnesota Pharmacy Alliance (MPA), which represents over 1500 retail and health system pharmacists, pharmacy technicians, and student pharmacists across the state of Minnesota; the MNIndy's, who represent over 120 independently owned pharmacies in Minnesota as well as the Minnesota Retailers Association write you to share our thoughts and suggestions about the provisions contained in the Senate HHS Omnibus Finance legislation.

Pharmacists and pharmacy staff care for patients in all healthcare settings throughout Minnesota. Pharmacies are where an overwhelming number of Minnesotans get their health care needs met every day in Minnesota. We are the health care provider a patient will see the most throughout the year and are the closest point of access for health care services for Minnesota patients. Pharmacies and pharmacists are also represented by the Minnesota Retailers Association. We are writing to you today to outline and detail the provisions important to Minnesota pharmacist and pharmacies you are considering as you put your HHS Omnibus Finance legislation, HF4571.

Thank you all for devoting your time and energy to so many important aspects of overall health budget, policy and priorities in Minnesota. Minnesotans are acutely aware of the importance of their local community, hospital, and clinic pharmacists. During the COVID-19 pandemic Minnesota pharmacists and pharmacy technicians have provided over 4.5 million COVID-19 vaccinations and boosters to patients in addition to the millions of flu vaccines and other vaccines administered by pharmacists, pharmacy technician and pharmacy interns across the state. Pharmacists have also provided millions of COVID-19, diabetes, cholesterol panel, blood pressure and other patient tests, results and guidance.

We greatly appreciate the legislation including the language and provisions that will authorize pharmacists and supervised pharmacy technicians and pharmacy interns to continue to be able to provide patients of age 6 and older all ACIP recommend and FDA approved vaccinations and pharmacists will continue to provide CLIA waived – non-lab testing services in pharmacies across Minnesota.

This year again saw many pharmacies close in Minnesota. In the first quarter of 2024 Minnesota has seen at least 6 pharmacies close on main street and in our grocery stores. Since 2018 Minnesota has lost 34% of non-chain independently owned pharmacies and 20% of all chain community pharmacies. This trend will not stop if adequate reimbursement is not realized and the business model for community pharmacy changes to a to reimbursement that is at least at the cost of the ingredient of a medication and the dispensing reimbursement covers overhead costs.

Pharmacy deserts from rural Minnesota towns to Twin Cities locations such as NE Minneapolis are real and the closure of many culturally based community pharmacies across Minnesota are leaving fewer communities with pharmacies that are close and can meet the growing number of patient needs. Many rural Minnesota communities have lost their health care asset on main street. Pharmacies that close are most likely never coming back to those communities. We appreciate the Senate prioritizing pharmacy economic sustainability and ensuring patient access to pharmacies across Minnesota. We also appreciate the Committee listening to Minnesota pharmacy owners and pharmacist's patients across Minnesota.

We greatly appreciate the House adopting language to update the Medical Assistance Fee for Service dispensing reimbursement rate. This will help.

Below we have outlined the provisions important and supported by Minnesota pharmacies and pharmacists as well as provisions that need changes we suggest. Thanks for your consideration.

Provisions included in HF4571, the Health, Finance & Policy Omnibus Finance bill, important to Minnesota pharmacy and their patients:

Please include - We strongly support the following provisions:

Lines 218.17-222.10 (SF1197): Continuation of immunizations by pharmacists, pharmacy technicians & pharmacist interns in a pharmacy setting (fed PREP Act declarations codification).

Since 2020, the federal PREP Act declarations have enabled pharmacists, pharmacy technicians, and pharmacy interns to administer indicated immunizations to patients 3 years of age and older. It has also ensured that patients are able to receive COVID-19 and other CLIA waived tests in a timely fashion. This bill would make these changes permanent in MN state law, with one exception, MN patients 6 years and older and 3 years and older for Flu & COVID-19 vaccinations would be permitted. In addition, pharmacists would be able to order, administer, and interpret any CLIA-waived test.

Lines 10.23-13.34 (HF3902): MA-FFS pharmacist dispensing fee update/increase to $11.55
If professional dispensing fees are not updated over time as intended, pharmacies may not be available to serve Medical Assistance patients. Underwater and unjustifiable reimbursement rates (set by PBMs) across Medicaid managed care (MC), and employer-based payers are leading to closures of pharmacies, understaffed pharmacy locations, and pharmacy “deserts." The FFS pharmacy reimbursement model used by Medical Assistance, including the professional dispensing fee, is the only reimbursement model affecting Minnesota pharmacies that is under direct control of the state government. DHS completed an updated Cost of Dispensing survey and made such recommendations in August 2023. Based on the results of the 2023 Minnesota Cost of Dispensing Survey, DHS recommends revising the current professional dispensing fee ($10.77) to the median weighted by Medicaid prescription volume ($11.55) for all community retail pharmacies.

Lines 222.13-223.15, 223.18-225.19 (HF2466): Pharmacists authorized to prescribe, counsel & administer HIV Prep & PEP medications.

HIV pre-exposure and post-exposure prophylaxis (PrEP and PEP) have remarkable rates of transmission prevention if patients are able to start them in a timely fashion and maintain high adherence rates. PrEP and PEP are well-tolerated medications that may be taken orally or through intramuscular injections. The proposed bill will expand prescriptive authority to allow pharmacists to prescribe PrEP and PEP following adequate training. In addition, pharmacists will be able to order, administer, and interpret laboratory tests to ensure proper and safe use of PrEP and PEP.

Lines 34.1-41.15 (HF4605): Medication Repository modifications - Roundtable Rx

We have always supported affordable and accessible medications for all patients in Minnesota. We also are supportive of all efforts to reduce prescription medication waste. Roundtable Rx has been nothing short of a heralded success. We support expanding the recycling program and we hope that all unused and unopened or adulterated prescription medications can be acquired and provided to patients who need them at little or no cost.

One provision we hope would be included in the final Health Conference report that is included in the Senate HHS Omnibus Finance legislation, SF2459, but not included in the House is Representative Bahner's HF2503: Coverage for health services performed under scope by a pharmacist.

Pharmacists are trained to perform many of the same clinical assessments and actions as other health care providers. However, many insurance companies do not cover pharmacist services. This bill would ensure that pharmacists and pharmacies are being reimbursed for the services being provided. Payment for services would increase sources of revenue for businesses that employ pharmacists and improve the outlook for struggling independent pharmacies.

This legislation is essential for Minnesota pharmacies to be able to offer authorized patient health services in a Minnesota pharmacy. If Minnesota pharmacies cannot get reimbursed for health services delivered, they cannot provide or offer the service to patients who want these services from their local community pharmacist. We are dedicated to making certain all patients are covered by their health insurer payers for health services authorized to be provided to patients in a Minnesota pharmacy setting.

We also appreciate Chair Liebling, Representative Bahner as well as the Department of Human Services working with Minnesota pharmacy to devise and come up with a Directed Dispensing Payment program that would reimburse certain pharmacies for MA managed care/PBM medications dispensed an additional dispensing fee reimbursement that would help sustain Minnesota pharmacies and Medicaid and MNSure eligible patient access to care.

Thank you for working with the members or the Minnesota Pharmacy Alliance (MPA), MNIndy's and the MRA this year on issues important to Minnesota patients and pharmacy in Minnesota. We appreciate your support! We hope you will consider our feedback and recommendations as you put together your final Health omnibus legislation for 2024. If we or our representative, Buck Humphrey, can be of any assistance, please reach us through Buck at: hubert4@gmail.com; C 612-889-6515

Sincerely,

Tamara Bezdicek , PharmD, BCPS, FMSHP -Medication Policy Manager, MSHP-Co-Chair of MN Pharmacy Alliance (MPA)
Deborah Keaveny, MNIndy's, Pharmacist & owner of Keaveny Drug
Bruce Nustad, President of the MRA

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Department of Neurology
Medical School

Phillips Wangensteen Building
420 Delaware Street S.E., MMC 295
Minneapolis, MN 55455
Office: 612-625-9900
Fax: 612-625-7950
www.neurology.umn.edu

April 17, 2024

Representative Tina Liebling
Chair
Health Finance and Policy Committee
Minnesota House of Representatives
St. Paul, MN

Dear Chair Liebling:

I am the Stroke Director at the University of Minnesota and Cerebrovascular Director at M Health Fairview. I am writing to express my appreciation to you and the committee for including the stroke thrombectomy capable designation language from House File 2421 in the committee's omnibus policy bill (HF 4571).

Recognition of this designation is critical to providing the best stroke care within the state of Minnesota. Stroke patients with large vessel occlusions, the worst type of stroke, require endovascular thrombectomy (minimally invasive clot removal within the blood vessels) as quickly as possible. Hospitals designated as thrombectomy-capable stroke centers are equipped to provide this emergency intervention. This legislation ensures that stroke patients can be transported to the appropriate facility equipped to provide the necessary advanced stroke treatment.

Thank you again to you and your committee for supporting this very important proposal in your policy bill.

Christopher Streib
Vascular Neurology Fellowship Director
Associate Professor, University of Minnesota
Cerebrovascular Director, M Health Fairview Hospital System