Statement on Legislative Proposal to Expand the Scope of Practice for Optometry

On behalf of tens of thousands of Minnesotans who require eye care annually, the Minnesota Optometric Association (MOA) recognizes and appreciates the progress represented by the recent legislative proposal agreed to by the Health, Children & Families Working Group. This proposal expands the scope of practice for optometrists in Minnesota and marks an important step forward in improving access to eye care and addressing the growing needs of patients across the state.

While we are encouraged by this advancement, we acknowledge that it does not go far enough to reach all of the patients we had hoped to serve. Too many Minnesotans still face barriers to timely, comprehensive eye care, particularly in underserved and rural communities.

As doctors, our commitment to patient safety and access to eye care for the people of Minnesota remains unwavering. We will continue to advocate for responsible, evidence-based scope of practice expansions that allow optometrists to provide the full range of care they are trained and qualified to deliver. Our goal is to ensure that every patient, regardless of where they live—has access to the eye care they need.

We are immensely grateful to Rep. Bierman, Sen. Maye Quade and the 45 House co-authors and 12 Senate co-authors for their time and dedication. The MOA will continue to work collaboratively with lawmakers, healthcare providers, and community leaders to build on this momentum and ensure a healthier future for all Minnesotans.

June 7, 2025

Dear Health and Human Services Working Group Members:

On behalf of the Minnesota Psychological Association's Legislative Committee, we are writing to express concern regarding the current structure of the outpatient Medicaid rate increase in the health and human services omnibus budget bill. The bill excludes doctoral-level psychologists from receiving a rate adjustment in year two of the rate increase — which would undermine the integrity and sustainability of Minnesota's behavioral health workforce.

Furthermore, we are concerned about the repeal of the current 20 percent rate differential for doctoral-level psychologists and psychiatrists (Minnesota Statutes 2024, section 256B.0625, subdivision 38). The cost of this statutory repeal, given the DHS fee schedule, will be a significant financial burden to the state, and we are uncertain if there is awareness of this among all stakeholders.

Psychologists are essential providers of evidence-based mental health care, particularly for individuals with complex and chronic conditions. Omitting psychologists from this rate increase creates a two-tier system that disincentivizes advanced clinical training and jeopardizes patient access to the highest levels of care. In a time of mounting mental health crises, particularly among youth and underserved populations, this exclusion is not just shortsighted — it is harmful.

We urge you to scrutinize this proposal carefully and advocate for a more equitable adjustment that includes psychologists. A sustainable behavioral health system must value all providers appropriately and not favor one group at the expense of another—particularly when the excluded group represents the highest level of clinical training in the field.

Thank you for your attention to this important matter.

Sincerely,

Dennis Hannon, PsyD, LP and Steve Girardeau, PsyD, LP
Co-Chairs, Legislative Committee
Minnesota Psychological Association

RE: Health care access priorities in 2025 Special Session 1 Health Omnibus

June 7, 2025

Dear Chairs and Members of the Health and Human Services Omnibus Working Group,

As consumer and worker advocates representing diverse communities across the state, we are deeply invested in improving healthcare access and affordability for Minnesotans. We appreciate your hard work to navigate a difficult target, and are grateful for some small protections and steps forward, while deeply disappointed with several choices that will reduce access to care, increase inequities, and leave us even more vulnerable to looming federal cuts and destabilization.

We support the increase included for mental health outpatient services, however we are disappointed that professional service rates will not be increased for the full range of providers of MA services. The MA professional service rates have been frozen in Minnesota for nearly 20 years, leading to a patchwork of complicated rate structures riddled with inequities. The impacts on maternity care, preventative care and more are dire, and the Senate position would have addressed these *with no impact on the state budget*. It is shortsighted and harmful to leave these rates untouched, especially given that the bill moving through Congress threatens to eliminate future opportunities to use the proposed funding mechanism. Improved professional services reimbursement rates would have expanded access to care across a wide range of clinics, provider types and care settings; reducing health disparities in access to providers; and preventing unnecessary and costly hospital emergency care. The agreement also excludes *inpatient* mental health provider rates, which is particularly concerning to SEIU mental health providers. The failure to increase MA provider rates across the board not only threatens access but *maintains the extreme complexity of our current rate structure* in a way that will make navigating upcoming federal changes all the more harmful and unworkable.

We support in concept the state directed payment (SDP) mechanism that will provide an increase just for hospitals, paid for through a hospital assessment, however the bill omits several opportunities to create accountability for how those resources should benefit patients and struggling hospitals. We are disappointed that our request to add worker organizations and consumer advocates to the table determining the "quality measures performance evaluation criteria and methodology" was not met. The bill allows MHA be the sole contributor to determining quality improvement metrics tied to the increased funding.

The few metrics specified so far would be improved by also requiring a reduction in readmissions or protections to ensure improved screening rate metrics don't create an adverse incentive to avoid serving populations with health disparities. The bill allows hospitals to be paid up to commercial rates for Medical Assistance, despite evidence that commercial rates are too high.

Furthermore there are strong indications that the Trump administration will not approve commercial rate SDPs, whereas current rules almost guarantee approval for SDP proposals up to 100% Medicare. We hope that in the application process there will be an emphasis on securing what support is possible so that the urgent opportunity to help rural, independent and critical access hospitals is not missed in pursuit of levels of funding that may not be achievable, sustainable or necessary for MA.

Thank you for including reporting on hospital facility fees charged outside hospital settings. The Minnesota Hospital Association has said that these fees amount to $1 billion dollars charged to Minnesotans seeking care each year. The included reporting will help legislators and the public to understand how those resources are distributed across our hospital systems, and to make informed policy decisions in the future.

As grassroots organizations whose members have long worked toward a MinnesotaCare public option, we are disappointed that the current federal administration is not the partner that Minnesota needs to continue the 1332 waiver application authorized in 2023. We know that the path will likely look different when we are next able to advance coverage expansion in Minnesota, but that it depends on maintaining and stewarding our existing state programs through the threatened federal cuts. **We are therefore disappointed that the bill repeals the authority of the commissioner to proceed with such an application, as we should retain as much flexibility as possible to weather the next several years.** However we understand the challenge in maintaining the funds for further implementation, and we hope that the funds removed from the public option contingent appropriation, while small, help prevent cuts that would otherwise have been proposed in this bill.

Finally, the elimination of MinnesotaCare eligibility for undocumented adults is cruel, unnecessary, and devastating. Although the language for this change will be carried in a separate bill, the funding elimination is carried in this spreadsheet. Not reflected in the spreadsheet are the increased costs to providers and all Minnesotans due to uncompensated care, and the unconscionable costs to the wellbeing of our communities.

There will be a time when the division of who is allowed access to healthcare based on birthplace will be unimaginable, and our communities and economy will be the better for it. We invite each of you to join us in working toward that recognition of human dignity and the contributions of our neighbors regardless of immigration status.

Sincerely,

ISAIAH, Minnesota Farmers Union, SEIU Healthcare MN & IA, and Unidos MN

Sources: [1] 94.25-95.4 HF2435 DE2
[2] 91.30-92.1 HF2435 DE2
[3] Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality
[4]https://nashp.org/hospital-cost-tool-and-resources/

06/08/25

RE: Inclusion of the Birth Center Reimbursement Increase in the Health and Human Services Finance and Policy Omnibus Bill

Dear Chairs and Members of the Senate and House Health and Human Services Working Groups,

The Minnesota Chapter of the American Association of Birth Centers (MN-AABC) represents all licensed freestanding birth centers in Minnesota. Our birth centers offer a high-value model of evidence-based care that is equitable, safe, and provides consistently stellar health outcomes for Minnesota families. **We are writing to express our deep delight and gratitude for the inclusion of the birth center reimbursement increase (HF1793 Clardy / SF2109 Pappas) in the final Health and Human Services Finance and Policy Omnibus Bill.**

By increasing reimbursement rates for freestanding birth centers, the legislature is supporting a model of care that has consistently exceeded benchmarks for value-based care. Patients in our care have significantly fewer cesarean sections, fewer maternal complications for them and their newborns, a lower NICU admission rate, and higher breastfeeding and patient satisfaction rates. These stellar outcomes not only help our Minnesota families but also result in health care cost savings for our state.

Thank you for recognizing that birth centers face significant challenges related to reimbursement that directly affect our ability to offer competitive wages, retain skilled staff, and pay for our supplies and overhead costs. Passing this legislation is a significant step towards building a strong maternal health system that works for everyone. **We believe freestanding birth centers can be a strong solution in Minnesota, and we are glad to be continuing this essential work with more equitable support in the form of increased reimbursement rates.** We appreciate all the work members have done, and urge strong support for our proposal and the HHS omnibus through the finish line. Thank you very much!

Amy Johnson-Grass, ND, LM, LN, CPM
President | Minnesota Chapter of the American Association of Birth Centers

MINNESOTA AFFILIATE OF AMERICAN COLLEGE of NURSE-MIDWIVES

June 8, 2025
RE: MN Certified Midwife Practice Act Inclusion in Health and Human Services Finance and Policy Final Bill

Chairs and Members of the House and Senate Health and Human Services Finance and Policy Working Groups,

The Minnesota State Affiliate of the American College of Nurse Midwives represents advanced practice midwives across the state. Our members are dedicated to providing high quality nurse-midwifery care to Minnesotans with a special emphasis on pregnancy, childbirth, gynecologic and reproductive health. **We are writing to express our heartfelt gratitude and strong support of the inclusion of the Minnesota Certified Midwife Practice Act (HF1010 Agbaje / SF832 Boldon) in this session's final Health and Human Services Finance and Policy Vehicle Bill.**

Licensure of the Certified Midwife in Minnesota has been a journey, and we are ecstatic to be taking a significant step forward in joining 13 other states already licensing certified midwives. Passage of the Certified Midwife Practice Act will help to ensure Minnesotans have access to the right care, at the right time, in the right place. In addition, it will expand patient care access, and increase the number and diversity of qualified midwifery professionals.

We are incredibly grateful that the Senate and House Health and Human Services Working Groups have included this proposal in the final bill and that Minnesota will now be able to take advantage of a critical opportunity to invest in an initiative that has proven to address disparities in maternal health. We thank the committee members for their tireless work on this bill, and for prioritizing Minnesotan families.

Thank you, deeply,

Mary-Signe Chojnacki, APRN, CNM
Board Member of the MN Affiliate of the American College of Nurse Midwives
Member of the Minnesota Advanced Practice Registered Nurse Coalition

CATHOLIC CHARITIES
Twin Cities

Catholic Charities at Elliot Park
1007 East 14th Street, Minneapolis, MN 55404
612-204-8500 | cctwincities.org

June 7, 2025

Re: Health and Human Services Finance Bill

Chairs Wiklund, Backer and Bierman and Members of the Health and Human Services Working Group:

Thank you for including $959,000 in the Health and Human Services Finance Bill to reauthorize funding for the Catholic Charities Homeless Elders program.

Catholic Charities' Homeless Elders Program is designed to help older adults exit homelessness through expert case management, connections to essential supportive programs, and placement in affordable, stable housing. With the state funding appropriated for the program in 2023, Catholic Charities cut wait times in half and doubled housing placements – helping more than 300 older adults find a place to call home. Your reinvestment will provide lifesaving services to seniors over the next biennium.

I also want to thank you for your support of additional funding provisions that will make a difference in the lives of our neighbors in need:

- Safe harbor grants
- Homeless Youth Act grants
- Family Supportive Housing Grant Program
- Medicaid Mental Health Rate Reform

Thank you for your consideration and for your work on behalf of vulnerable Minnesotans.

Sincerely,

Jamie Verbrugge, President and CEO

children's defense fund minnesota

June 7, 2025

RE: Child-Focused Investments in the Health and Human Services and Children and Families Budget Bill

Dear Chair Wicklund, Chair Bierman, and Members of the Omnibus Health and Human Services Bill Working Group:

Children's Defense Fund Minnesota (CDF-MN) is grateful for your patience, persistence and thoughtfulness creating a Health and Human Services and Children and Families budget focused on improving the health of our statewide neighbors. CDF-MN fervently believes our State is called to prioritize investments in children who are facing the greatest challenges – children who are growing, playing, learning, and praying in families with low-incomes. Black children, Indigenous children, and children from communities of color face significant opportunity gaps that begin prior to birth and continue throughout their childhoods and into their adulthoods. Our State budget has the potential to remove barriers and broaden access to life-changing opportunities for our youngest Minnesotans. CDF-MN is glad to see some funding for children and families in the Health and Human Services and Children and Families budget bill. However, we're disappointed by several missed opportunities to provide critical supports at a time when increasing numbers of Minnesota families are experiencing financial hardship, and devastating changes to federal programming loom.

CDF-MN Supports the Following Provisions in the Health and Human Services and Children and Families Budget Bill:

Child Care:

- Lowering Child Care Assistance Program (CCAP) co-payments to 7% of a family's income. *However, we wish this provision would be enacted sooner than October 2028.*
- Simplifying CCAP redetermination for families when a new eligible child is added to their family.
- Improving the safety of infants and toddlers in child care by requiring licensed child care centers that have a substantiated case of child maltreatment to have video security cameras in areas where infants and toddlers are cared for, and providing child care centers with grants of up to $4,000 for cameras and training.
- ***CDF-MN is glad the Workgroup didn't adopt the provision eliminating the 10% increase to the Great Start Compensation Support Payment Program (GSCSPP) payments in Child Care Access Equity Areas.*

Infant Maltreatment:

- Requiring pediatricians to educate parents about physical abuse of infants.

Food Access:

- Increasing funding for Regional Food Banks, Food Shelf Programs, Prepared Meals Food Relief Grants, and the American Indian Food Sovereignty Funding Program.

Out-Of-School Time:

- Studying and reporting on statewide out-of-school time programming opportunities.

Technology Modernization:

- Modernizing the Social Service Information System (SSIS).

We're disappointed the budget bill doesn't include funding for the African America-focused Homeplace grant model, the Family Assets for Independence in Minnesota (FAIM) program, and additional funding for Early Learning Scholarships for 400 more young children. We look forward to seeing additional investments in these targeted and impactful programs in the future.

Thank you for working to improve the health and well-being of children and families, especially during these challenging times! We're grateful for you and your service!

Together For Children,

/s/ Alexandra Fitzsimmons, Esq.
Senior Policy Director

85 E. 7th Place, Suite 120
St. Paul, MN 55101

651.227.6121
651.227.2553

cdfmn.org

children's defense fund minnesota

June 7, 2025

RE: Cutting Health Care for Parents and Caregivers Who Are Undocumented Immigrants Will Harm the Well-Being of Minnesota Children Living in the Shadows

Dear Chair Wiklund, Chair Bierman, and Members of the Health and Human Services Finance and Policy Working Group:

Children's Defense Fund Minnesota (CDF-MN) develops and advocates for policies and programs that improve the well-being of children, and increase the economic security of families. We focus particular attention to the healthy growth and development of Black children, Indian children, and children from communities of color. Our history, mission, and vision obligate us to speak out with and for children who are marginalized.

Today we speak out, because we are disheartened that Minnesota would target some of the most marginalized children in our State and country – children whose parents and caregivers are undocumented immigrants. Nearly 31,000 Minnesota children have at least one parent who lacks legal immigration status. CDF-MN is vehemently opposed to removing MinnesotaCare access for Minnesota adults who are undocumented immigrants – *many of whom are parents, grandparents, aunts, uncles, and caregivers*. The health and well-being of a child is inextricably connected to the health and well-being of their parents and caregivers.

Minnesota children whose parents or caregivers are undocumented immigrants are playing, living, growing, and praying in the shadows of our community playgrounds, neighborhoods, schools, and congregations. Each day, many children go to school wondering, worrying, if their parents or caregivers are safe while they are at school: rolling play-dough with their preschool friends, learning how to add and subtract in their elementary school classrooms, eating with their classmates in their lunchrooms, and reading in the quiet of their school libraries. They worry their parents will be taken away, and they fear their families will be torn apart. These children are oftentimes quiet, sharing little of themselves, and even less about their families, because they don't know who they can trust.

Eliminating MinnesotaCare access for Minnesota adults who are undocumented immigrants, many who are moms, dads, and caregivers, will have significant impacts on their children – impacts that will force children and their families deeper into the shadows. This budget proposal would:

1. *Reduce the number of Minnesota children with health care coverage*. Research over the last few decades has demonstrated a significant relationship between parental health care coverage and health care for the covered parents' children – when a parent has health care coverage, their children are more likely to have health care coverage. One study found that in states that expanded Medicaid coverage to parents, children participated in Medicaid at a rate 20 percentage points higher than children in states with no such expansion;

2. *Decrease the quality of parental health, thereby reducing the quality of child health*. When a parent reports their own health as good or excellent, their child is more than three times as likely to be in good health than a child whose parent reports having fair or poor health;

3. *Diminish a caregiver's capacity to care for, nurture, or support their child*. Untreated conditions can impede a caregiver's capacity to bond with and care for their children, thereby inhibiting the healthy growth and development of their child, and undermining child well-being;

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cdfmn.org

4. *Decrease the likelihood that children will see a pediatrician or family practice doctor for well-child appointments*. Children are more likely to receive preventative checkups when their parents have health care coverage. A study found that children are 29 percentage points more likely to have an annual well-child visit if their parents are enrolled in Medicaid; and

5. *Undermine the financial instability of families due to increased medical costs*. Medical bills are a major source of financial strain for many families. A continually growing body of research shows that health insurance improves the economic security of families by limiting out-of-pocket health care costs.

When moms, dads, and caregivers have health care coverage: their children are more likely to be insured; both parents/caregivers and children live healthier lives and experience more positive outcomes; families are more economically secure; and communities are more vibrant.

Minnesota has an opportunity to be a place where children whose moms, dads, and caregivers are undocumented immigrants can play, live, grow, and pray in the light. As a State, we have the opportunity to embrace these children, and show them we recognize the:

- human dignity of their moms, dads, and caregivers;
- importance of their caring adult's work – especially in the agriculture and manufacturing industries – to our businesses and economy; and
- value of their love, care, and nurturing as parents and caregivers.

We urge you to uphold the current law that provides Minnesota adults who are undocumented immigrants with access to MinnesotaCare. The current harmful proposal undermines the Minnesota we envision – a Minnesota where all children are welcome, and where all children thrive!

Thank you for your service to Minnesota!

Together For Children,

/s/ Alisha Porter
CDF-MN State Director

/s/ Alexandra Fitzsimmons, Esq.
Senior Policy Director

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 8, 2025

Senator Melissa Wiklund
Chair, Health and Human Services
Minnesota Senate
2107 Minnesota Senate Building
St. Paul, MN 55155

Rep. Jeff Backer
Co-Chair, Health Finance and Policy
House of Representatives
2nd Floor, Centennial Office Building
St. Paul, MN 55155

Rep. Robert Bierman
Co-Chair, Health Finance and Policy
House of Representatives
5th Floor, Centennial Office Building
St. Paul, MN 55155

Dear Chair Wiklund, Chair Backer, and Chair Bierman:

I am writing to you today to express my appreciation for your support of the Minnesota Department of Health in the Omnibus Health and Human Services budget bill, and for all of your hard work in getting us to this point. As you know, public health has historically been underfunded, and the investments of the past few years have shored up MDH's ability to protect, maintain, and improve the health of all Minnesotans. I am grateful for your efforts to produce a bill that sustains investments in public health infrastructure, at a time when federal funding has decreased and is increasingly uncertain.

Thank you for new funding for infectious disease, increasing user fees, and supporting the operating adjustment. The monies will support infectious disease prevention and control activities, including identifying outbreak sources, conducting laboratory testing, alerting the public and health care systems about health threats, and developing activities and guidelines to prevent the spread of the disease and curb outbreaks. With the increased fees, we can address backlogs in mandatory inspections, improve technical assistance to partners, and align with the statutorily required work that we do at MDH within our SGSR appropriation. The operating adjustment helps us to maintain our current service levels, support our talented and dedicated staff, maintain and update technology, and continue the oversight that we want for fiscal stewardship.

Thank you to Chair Wiklund, Chair Backer, Chair Bierman, and all of your staff for your efforts in creating this bill, and thanks to the legislature for its support of MDH and public health in Minnesota.

Sincerely,

Brooke Cunningham, MD, PhD
Commissioner

DEPARTMENT OF HUMAN SERVICES

June 7, 2025

Dear Chair Backer, Chair Bierman, Chair Wiklund, and members of the Health and Human Services working group:

On behalf of the Minnesota Department of Human Services, I am writing to extend our appreciation for your work on the Health and Human Services budget agreement. In lieu of public testimony, I want to highlight a few provisions of the bill for which DHS is particularly thankful:

- Making **investments to prevent, detect, and address fraud** to strengthen the parameters of our system and root out bad actors. Minnesota is committed to helping our neighbors and fraud against public programs harms the people we're committed to helping.
- **Extending access to audio-only telehealth**. This investment ensures ongoing to access to mental health services as well as preventative care, especially for people living greater Minnesota and younger populations.
- Recommitting to Minnesota's comprehensive long-term plan to **end new HIV infections and improve health outcomes for people living with HIV**. This investment acts as a stopgap measure to prevent further funding reductions across the state, including in Greater Minnesota and suburban regions where 56% of new diagnoses occurred in 2023.
- Funding the **operating adjustment for DHS** to ensure mounting cost pressures do not impact services delivered to Minnesotans.
- **Enhancing background study disqualifications** and federal compliance to prevent bad actors from engaging with state programs and identifying fraud schemes that are being replicated across state systems.
- **Funding to access federal data sources** that verify eligibility for Minnesota Health Care Programs (MHCP) applicants and enrollees.
- Restoring the state's ability to manage the preferred drug list by **eliminating the sunset on the Drug Formulary Committee**.
- Reforming the grantmaking process for local governments by allowing **direct payments for Adult Mental Health Initiatives and Traditional Healing programs**.

Overall, DHS appreciated the workgroup's commitment to addressing budget shortfalls in a way that was focused on people and the communities you represent. We look forward to our ongoing partnership as we work to preserve these critical services.

Sincerely,

Shireen Gandhi
Temporary Commissioner
Minnesota Department of Human Services

June 7, 2025

Dear Health and Human Services Working Group:

Thank you for your hard work addressing Minnesotans' needs while navigating negative budget targets. We appreciate that the Health and Human Services Omnibus bill includes several issues important to Gillette Children's.

Each year, Gillette Children's cares for over 26,000 patients from every Minnesota county at our 60-bed hospital in St. Paul and clinics in Alexandria, Baxter, Bemidji, Burnsville, Duluth, Maple Grove, St. Cloud, St. Paul, Mankato, and Wilmar. We rely on the support of our community and the Minnesota Legislature to continue this vital work.

We are thankful to see the inclusion of:

- **Epilepsy and Related Seizure Disorders; Data Collection and State Coordination Plan – Article 1, Section 78**
- **Implementation of the Hospital Assessment and Directed Payment Program – Article 8, Sections 4-5, 20-23, and 35**
- **Funding for the "Treat Yourself First" Campaign – Article 21, Section 3, Subdivision 16**
- **Funding for the Rare Disease Advisory Council – Article 23, Section 4**

We would also like to comment on:

- **Reporting on Facility Fees – Article 1, Section 97**

We are grateful the legislature listened to the hospital community's concerns regarding the original facility fee prohibition legislation. As a specialty healthcare provider, our clinics are an extension of the specialty care we provide at our hospital. Gillette does not provide primary care; our clinics are often utilized by patients accessing post-procedure care, and many of the same Gillette employed physicians (including surgeons) providing care in our hospital also provide care at our provider-based clinics. It is not uncommon for a Gillette patient with a lifelong condition who begins seeing us in childhood to have had several surgeries at Gillette by the time they reach adulthood with continuity of care over the years

between locations. Our facility fees are directly connected to the care and services provided by a wide range of staff, not only physicians, at our provider-based clinics.

- **Establishing Limitations on Physical and Occupational Therapy Visits for Medical Assistance Enrollees – Article 8, Section 10 and 11**

We are trying to understand the implications of these new provisions. We appreciate that prior authorization for extended visits beyond the limits is an option, while worrying that this has the potential to delay or deny needed therapies for children with disabilities, complex conditions or traumatic injuries. As an example, selective dorsal rhizotomy (SDR) surgery is a procedure provided at Gillette that treats muscle spasticity caused by abnormal communication among the brain, spinal cord, nerves and muscles. It corrects muscle spasticity by cutting the nerve rootlets in the spinal cord that are sending abnormal signals to the muscles. SDR surgery is followed by an inpatient hospital stay lasting up to six weeks, with intensive inpatient rehabilitation care, and physical therapy typically twice per day during the first few weeks. After discharge, physical therapy continues at a Gillette clinic or in the child's local community. Recommended physical therapy frequency may be up to five times per week at first, then become less frequent as progress continues in the months that follow, with physical therapy lasting approximately one-year post-surgery.

Thank you for your thoughtful work and dedication to improving access and services for children with disabilities, rare and complex conditions, and traumatic injuries.

Sincerely,

Barbara Joers

President and CEO

Marnie Falk

Director, Public Policy

Healthcare Distribution Alliance

HEALTH DELIVERED

June 7, 2025

Omnibus Health and Human Services Bill Working Group
ATTN: Sen. Melissa H. Wiklund, Rep. Robert Bierman
1200 Minnesota Senate Bldg.

Re: HHS Omnibus – rebates as gross revenue

Senator Wiklund, Representative Bierman and Members of the Working Group:

I am writing today on behalf of the Healthcare Distribution Alliance (HDA), the national trade association representing primary pharmaceutical wholesale distributors who are the essential link between 1,500 pharmaceutical manufacturers and 330,000 healthcare providers across the nation.

HDA's members work tirelessly to distribute nearly 10 million healthcare products daily, ensuring pharmacies, hospitals, and healthcare facilities are adequately supplied with the medications required for patient care. Our members have facilities located throughout the state and employ approximately 1,000 Minnesotans.

HDA has been made aware of a recent effort by the Minnesota Department of Revenue to treat rebates as part of a company's gross revenue base under the Wholesale Drug Distributor portion of the Healthcare Provider Tax. HDA contends that the rebates should not be included as taxable gross revenue for purposes of the tax calculation.

Pharmaceutical Wholesale Distributors often utilize "rebate" programs to attract and maintain pharmacy customers due to the competitive nature of the wholesale distribution market. Wholesale Distributors enter into these agreements with customers that provide "rebates" or discounts, so long as the customer meets certain purchase requirements. A "rebate" represents a purchase price adjustment necessitated by a pre-existing contract between the customer and the distributor, which the distributor is legally required to honor.

Currently, rebates provided by wholesalers, to customers, do not constitute "gross revenue" under Minn. Stat. §295.52 subd. 3. This interpretation has been affirmed by the Minnesota Supreme Court in 2024 (*Dakota Drug* v. *Commissioner Of Revenue*). Language in Sec. 32 of the Omnibus seeks to include rebates as part of "gross revenue" and would thereby increase the tax liability of wholesale distributors in Minnesota. The fiscal impact of this increased tax liability is approximately $11 million in FY 26 and ballons to upwards of $17 million by FY 29.

These costs will not only be borne by wholesalers but will ultimately pass through the supply chain to patients and impact access to medications for Minnesotans. Accordingly, **HDA urges your opposition to the language in Sec. 32, lines 279.21 – 279.27 and respectfully requests that it be removed from the bill.**

If you have any questions or concerns, please contact me at bhannon@hda.org or 765-490-9159.

Sincerely,

Bryan Hannon
Director, State Government Affairs

MINNESOTA
OFFICE OF THE FOSTER
YOUTH OMBUDSPERSON

June 7, 2025

RE: Office of the Foster Youth Ombudsperson Appropriation

Thank you, Chair Wiklund, Chair West, Chair Kotyza-Wittuhn and workgroup members. For the record, my name is Hannah Planalp. I serve as the Deputy Ombudsperson with the Office of the Foster Youth Ombudsperson, often referred to as OOFY.

Our office wants to extend our deep gratitude to the Chairs and the House and Senate workgroup members for the support you've shown our work this session. This support is more than a financial investment—it is a powerful recognition of the essential role our office plays in the lives of foster youth throughout Minnesota.

We recognize the challenges you've had to navigate in this budget process and deeply appreciate the time and care each of you has brought to these difficult decisions. Your dedication to Minnesota foster youth does not go unnoticed, and it means a great deal to our office—and to the youth we serve.

This long-term investment will support our agency's continued outreach and engagements with foster youth, including those placed in facilities out-of-state, who are amongst the most vulnerable and isolated. We look forward to continuing this work and to sharing back with you the meaningful ways this investment is helping to expand our reach and impact in the lives of youth across the system.

Thank you again for your time and continued support.

Respectfully submitted by:

Hannah Planalp

Deputy Ombudsperson for Foster Youth
651-946-2942
hannah.planalp@state.mn.us

June 7, 2025

Health and Human Services Working Goup
State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
Saint Paul, MN 55155

Dear Members of the HHS Working Group,

We write as a coalition of healthcare stakeholders, pharmacy professionals, community leaders, and patient advocates with a shared goal: to preserve access to pharmacy services and protect the health of Minnesotans.

Minnesota residents are facing increasing difficulty accessing essential medications and care due to a growing wave of pharmacy closures. The numbers are staggering—61% of independently owned pharmacies and 39% of chain pharmacies have shut their doors in Minnesota since 2013. Without meaningful legislative reform this session, we don't just fear–we know--2025 will bring even more closures, especially in rural and underserved areas.

To address this trend, we strongly support key provisions included in HHS working group language, and urge you to retain the following measures in the final bill for special session:

1. Establishment of a Single State Pharmacy Benefit Manager and the Creation of a Minnesota Actual Acquisition Cost
   A state-administered PBM model paired with a transparent acquisition cost benchmark will save the state, improve reimbursement fairness, and stabilize pharmacy access across the state.

2. Directed Pharmacy Payment Program
   We appreciate the including of the provision setting a $4.50 per-prescription payment. This targeted support is crucial to keep community pharmacies operating and ensure equitable access to care.

3. Extension of Telehealth Provisions
   Preserving Minnesotans' access to pharmacy-based telehealth services is vital, especially for rural and homebound patients who rely on remote care delivery.
4. Pharmacist Intern Licensing Reform
   Streamlining intern licensing will support workforce development, helping Minnesota attract and retain the next generation of pharmacists.
5. Clarifications to Pharmacy Drug Reporting
   Common-sense reporting updates will help maintain appropriate transparency and regulatory compliance.

We sincerely thank the working group members for your leadership and attention to this urgent issue. Without action this session, many more Minnesotans will lose access to their trusted pharmacy. The provisions in the working group language represent a lifeline for patients and the professionals who serve them.

Please don't hesitate to reach out to any of the undersigned organizations if we can provide additional information or answer any questions as you finalize the legislation.

Sincerely,

Minnesota Pharmacists Association
College of Pharmacy at the University of MN
Minnesota Independent Pharmacists
Minnesota Farmer's Union
Minnesota Society of Health System Pharmacists
Minnesota Retailers
Minnesota Grocers Association

To: Chair Wiklund
Chair Backer
Chair Bierman
Members of the Working Group

SENT VIA EMAIL

From: Waleed Sonbol
General Manager, Blue & White Taxi

Date: June 7, 2025

RE: Nonemergency Medical Transportation Modifications

I have read the new Health Bill and I have some very serious reservations about the Nonemergency Medical Transportation (NEMT) changes included in this legislation. This is now the second time in the past four years the State has put a single administrator in place without the use of actual figures on what this would accomplish. I don't believe in hypotheses - I believe in numbers.

The way this language has been written the following effects will absolutely occur:

1) NEMT income for drivers will go down.

Many MCOs pay rates higher than what is in this bill. The single administrator that has been advocating for this carveout pays the lowest amount, and puts ZERO into this.

Are you really comfortable being the one to cut working drivers' income based on zero evidence that this will have any real positive impact? Especially when we know there is a shortage of drivers. I do business in other states and can compare the rates for drivers and all of those NEMT providers in other states wish they had what we have here.

2) This will affect jobs with MCOs as well as with our own staff.

This decision will affect working class peoples' income. This bill allows a regional player to take over, where jobs can be anywhere. MCOs employ from within the State of Minnesota only.

3) This will increase rural shortages of NEMT.

We serve the 7-county metro area and we are often asked to do rides outside of that because there are no other providers. MCOs cover the deadhead miles we charge for that. The single administrator advocating for this legislation does not cover deadhead miles, meaning service providers and drivers won't want to do the rides - so there will be MORE people without transportation when this is implemented.

The bottom line is that this language will reduce driver income, reduce local jobs and and reduce accessibility in areas that don't have enough NEMT providers - which you all know is an issue. In the year you give for implementation, you can easily form a committee, conduct a study, and have actual documentation of why a change is necessary with input from businesses like mine and drivers providing NEMT services, who actually know how this system works and what could be done to improve it.

One option that is not even considered is that there are newly developed platforms allowing all the rides to go through one single database for providers. Just one location that all the data is located that can produce the reports needed. No loss of driver income. No loss of jobs. No ridership loss. Just a platform that all the MCOs and NEMT providers have to go through. It exists, it is far cheaper than inserting another layer of "management" into this process, and there is no downside to testing it for a period of time.

As always, thank you.

Waleed Sonbol

General Manager, Blue & White Taxi

MINNESOTA ASSOCIATION OF
County Health Plans
1753 Cottonwood Circle • Saint Cloud, MN 56303 • www.machp.org

June 7, 2025

TO: Health and Human Services Work Group Co-chairs

Key issues in the HHS Omnibus Bill impacting county-based MA

Dear Co-chairs Sen. Melissa Wiklund, Rep. Jeff Backer, and Rep. Robert Bierman,

We appreciate the opportunity to offer comments and concerns about the proposed HHS Omnibus Bill as you prepare for Monday's Special Session:

- **County-Administered Rural Medical Assistance (CARMA) – Article 8, Sect. 25, 37, 38**
  We strongly support this provision, and appreciate your support. This budget-neutral, bi-partisan innovation builds on more than 40 years of County-Based Purchasing success, and represents a sea change in how the state works with counties to deliver Minnesota Health Care Programs (MHCP) in rural communities. As you know, this proposal represents two-and-a-half years of careful collaboration among the Association of Minnesota Counties (AMC), the Department of Human Services (DHS), and our rural county owned-and-operated plans. It moves past years of conflict over county authority in public programs procurement as we have developed "something better together." CARMA clarifies county choice and patient choice in collaboration with DHS as we work to better address the needs of enrollees across Greater Minnesota. The program leverages closer integration of county services, including public health and social services, and the CARMA model looks upstream to address Health Related Social Needs (HRSN). Last year, the legislature, with strong bi-partisan support, directed us to bring forward this model in the 2025 session, and we look forward to enactment.

- **Single Dental Administrator, 2-year Delay – Article 8, Sect. 6, 36 and 39**
  We support this provision and appreciate the wisdom of taking the extra time necessary to consider more impactful approaches to strengthening MA dental access and utilization, and appointing a Dental Access Working Group to help inform those considerations.

- **State Pharmacy Benefit Manager – Article 4, Sect. 9**
  We oppose this provision, and again urge you to reconsider. Single PBM is a costly and disruptive effort at greater efficiency and cost savings. We share your goal of greater efficiency as we strengthen patient care. However, further fragmenting care coordination is not the answer to what ails our Medical Assistance program. As the fiscal note indicates, the vast majority of savings comes from application of Minnesota actual acquisition cost (MN AAC) to prescription drugs. Minnesota can join nine other states that have mandated AAC prescription drug pricing by statute, saving money while still paying pharmacies better and addressing DHS staffing needs. It also avoids the SPBM care and data fragmentation that would negatively impact MA enrollees. Furthermore, the SPBM fiscal note does not account for the pharmacy benefit portion of the capitation withholds and payment delays currently applied to MCOs and CBP plans. The capitation payment shift from health plans to the SPBM will cost the State approximately $250 million in the first year. The SPBM proposal also calls for $40 million per year in new state spending on a SPBM contract. Milliman's analysis of the Ohio SPBM

model showed no net savings. For these reasons, mandating AAC alone would potentially save more General Fund dollars than the SPBM proposal and avoid negative, unintended patient care consequences.

- **Uniform NEMT – Article 8, Sect. 3, 7-8, 13-14, 43**
  We oppose this provision. We share your goal of greater efficiency as we strengthen patient care. However, further fragmenting care coordination is not the answer to what ails our Medical Assistance program. We are deeply concerned about disconnects in centrally administering NEMT, leading to negative patient care impacts, costly complications and greater potential for fraud and abuse. County-based plans have done outstanding work administering NEMT across rural Minnesota, and centralization takers away that important, local responsiveness and oversight.

- **MA Coverage of Chiropractic Services Changes – Art 8, Sec. 30**
  We are deeply concerned about taking away adult chiropractic benefits. Such a benefit cut will result in negative and more complex health impacts leading to costlier health complications.

On behalf of the 32 CBP counties we represent, we appreciate your thoughtful consideration of these positions as you complete the HHS Omnibus Bill. Please contact us with any questions or concerns. Thank you.

Sincerely yours,

cc: MACHP Board of Directors

Steve Gottwalt
Executive Director
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June 8, 2025

Health and Human Services Workgroup
95 University Avenue W.
St. Paul, MN 55155

Chair Wiklund, Chair Backer, Chair Bierman and members of the work group:

The Minnesota Council of Health Plans, the trade association for Minnesota's nonprofit health plans —Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Sanford Health Plan of Minnesota, and UCare— works every day to support access to high-quality affordable health care. We appreciate that creating a bill of this size take a lot of effort and are pleased to see the inclusion the hospital financed directed payment program, the spoken language health care interpreter working group, a delay to the Medical Assistance single dental administrator, and a repeal of the Public Option waiver authority. We are otherwise disappointed to see several provisions in the proposal that will fragment care and increase costs for Minnesotans.

Premiums are expensive because health care is expensive. The recent annual Milliman Medical Index[1] found that health care costs have increased about 6% per year on average over the past two decades, which is multiples above the general inflation rate. Last biennium, the legislature enacted more than a dozen new coverage mandates, increasing costs and thereby premiums another 5%. For a family of four, new mandate costs alone added $1,200 a year to their premiums to maintain coverage. In addition, new restrictions were enacted on health plan oversight of cost-effective care that will significantly increase premiums paid by Minnesotans starting next year. A looming fiscal spike was already facing Minnesotans and several provisions in this omnibus are poised to add to their financial burden.

Managed Care Organization (MCO) Assessment – Public Programs and Commercial

We share the concern over low Medical Assistance (MA) payment rates and the impact this has on patient access to care and cost shifting into commercial markets. However, we remain concerned about financing an increase for providers by requiring MCOs to pay a new assessment on public program and commercial enrollment. Health plans already pay significant taxes into the Health Care Access Fund and the General Fund, totaling more than $800 million annually. 95% of the lives

[1] https://www.milliman.com/en/insight/2025-milliman-medical-index.

covered in the state regulated markets are through nonprofit health plan products, and their historically slim 1-3% operating margins. Increased costs must therefore be passed along in the form of increased premiums for Minnesotans. We also have many outstanding logistical questions regarding the proposal, including payment timelines, and the lack of a completed fiscal note has created additional uncertainties. Health plans are already subject to a state fiscal year payment delay that exceeds $1 billion. Finally, if public program rates are increased, then lower commercial rates should also be supported. It is disappointing that the proposal increases pay for providers without any corresponding policy to support lower commercial prices.

Health Plan Formulary Requirements

Drug manufacturers strategically increase prices after formularies are set by health plans for the enrollment year. Health plans only have a few mechanisms to shield Minnesotans from the innumerable attempts that are made for them to pay even higher costs, and this provision would further inhibit our efforts. Rather than restrict our management of growing costs, we had urged inclusion of language to prohibit drug manufacturers from increasing their prices. This price freeze was included in previous versions of this policy, so it was especially disappointing that the work group chose to not include a cap on the prices set and increased by the drug manufacturers.

Health Plan Fee Increases

Language is included that triples the licensing fees paid by Health Maintenance Organizations (HMOs). The Minnesota Department of Health advocated that the increase is needed to pay for the increased level of regulation as expanded by the legislature. We instead urge streamlining of regulations to lower costs to provide services.

County-Administered Rural Medical Assistance (CARMA) Program

Competition within the managed care program improves care for MA enrollees, while managing costs. We therefore do not oppose counties operating a health plan on the same terms and conditions as all other health plans. This proposal, however, eliminates healthy competition, and the choice Minnesotans would otherwise have for their services. The federal government has long recognized the value of ensuring public program enrollees have more than one choice with regulation that requires offering more than one plan whenever possible. The CARMA program does not meet that standard.

NEMT Carve Out

The managed care model provides several significant benefits to the state, but most importantly, it improves health outcomes because of care coordination performed by MCOs. MCOs do not just help enrollees set up needed appointments but also help to arrange transportation to and from that appointment. Carving out the NEMT benefit will mean that enrollees will no longer be able to have an appointment managed by their MCO care coordinator and will instead have to reach out to a separate entity. Minnesotans are best served when there are fewer hurdles to accessing the care that they need – maintaining the NEMT benefit under the MCOs provides for the most streamlined experience for this population. If adopted, the Council urges scrutiny of the impact that fragmented care has on enrollees and whether cost savings as suggested are actually realized.

State Pharmacy Benefit Manager

Prescription drugs are another major component of care coordination services and separating this benefit from the MCOs will have a number of detrimental downstream impacts for enrollees:

- *Member Experience*: In other states moving to a single PBM has created preventable challenges for enrollees. Enrollees have been faced with excessive call center wait times and often hang up and call their MCO instead. The MCO under a single PBM, however, would have a limited ability to answer questions related to their prescriptions or to help facilitate solutions.
- *Data*: In other state it has proven difficult for MCOs to get accurate data from the state's selected PBM. This makes it challenging for MCOs to understand which enrollees may have a new diagnosis as evidenced by new prescriptions, to do medication therapy management, to stratify for clinical program enrollment, to identify enrollees that may have medication adherence issues, and to manage the pharmacy lock-in program to assist enrollees with high potential for medication misuse. The lack of clean data has also caused concern for Medicaid risk adjustment purposes.
- *Administrative Burden*: Under a single state PBM, MCOs have no flexibility nor ability to negotiate a beneficial contract with the state-selected PBM. This has resulted in contracts requiring convoluted processes for MCOs to pay the PBM for services and validate invoices.

Minnesota implemented managed care almost 40 years ago to provide better access to care for Minnesotans served by public programs and financial certainty for the state. Through care coordination, enrollees receive optimal care and there is less wasteful spending on unnecessary or duplicative services. Because we know that managed care is most effective when care management extends across all health care services, we encourage the committee to continue working to preserve the benefits of managed care for the state and for enrollees by reconsidering these three provisions.

We encourage the legislature in the future to work on proposals with the Minnesota Council of Health Plans and our members that will support lower costs and broad access to needed care for Minnesotans.

Sincerely,

Lucas Nesse
President and CEO

MINNESOTA DENTAL ASSOCIATION

June 7, 2025

Representative Robert Bierman, Co-Chair
Representative Jeff Backer, Co-Chair
Representative Carlie Kotyza-Witthuhn
Representative Nolan West
Representative Danny Nadeau
Representative Joe Schomacker
Representative Mohamad Noor
Representative Liz Reyer

Senator Melissa Wiklund, Co-Chair
Senator Alice Mann
Senator Paul Utke

Dear Co-Chairs Wiklund, Bierman, Backer, and Members of the Committee,

On behalf of the Minnesota Dental Association (MDA), thank you for the opportunity to provide testimony on the 2025 Health and Human Services Omnibus Budget Bill. The MDA appreciates the inclusion of several important provisions in the bill and is especially grateful to the committee for not advancing the proposed increase to the provider tax.

Single Dental Administrator Two Year Delay

The MDA appreciates the inclusion of the House language regarding the transition to a single dental administrator for Minnesota Health Care Programs (MHCP). The MDA continues to support this approach to increase transparency and reduce administrative burdens for dental providers. However, important implementation details, particularly related to reimbursement, remain unresolved. To ensure a smooth and successful transition, the MDA supports a two-year delay, allowing time for thorough planning and stakeholder input. We also support the proposed current exemption for county-based purchasing, which has proven to be an effective model in rural areas.

Treat Yourself First Campaign Appropriation

The MDA thanks the committee for including the requested appropriation for the Treat Yourself First Campaign. A 2021 survey by the American Dental Association revealed that the percentage of dentists diagnosed with anxiety tripled compared to 2003. Many reported feeling less in control of their work environment, experiencing heightened stress, and scoring high on a depression scale. Burnout and stress-related conditions are increasingly affecting dental professionals. Dentists often work in small or solo practices with limited access to peer support and mental health resources. The profession's physical demands—long hours in static positions, precision-driven work, and the emotional toll of treating anxious patients—exacerbate stress and fatigue. Without proper mental health support, these challenges can lead to burnout, early retirement, reduced patient access to care, and diminished quality of service. Mentally and physically healthy dentists can provide compassionate, high-quality care for their patients.

Finally, the MDA recognizes the challenging decisions the committee faced in balancing the need to raise revenue with the imperative to control costs. We sincerely appreciate the committee's decision not to increase the provider tax, which would have further burdened dental practices already grappling with rising costs for supplies, staffing, and day-to-day operations.

Should you have any questions on the above-mentioned items, please do not hesitate to reach out.

Sincerely,

Dan Murphy, MPP
Director of Government Affairs
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612-767-4255

About the Minnesota Dental Association

The Minnesota Dental Association is the voice of dentistry in Minnesota, representing practicing dentists. It is committed to the highest standards of oral health and access to care for all Minnesotans. Learn more at: www.mndental.org.

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

June 4, 2025

Chair Melissa Wiklund, Senate Health and Human Services Committee
Co-Chair Carlie Kotyza-Witthuhn, House Children and Families Committee
Co-Chair Representative Nolan West, House Children and Families Committee

Sent via email only

Thank you for the hard work that went into completing the Children and Families budget and policy provisions included in the Omnibus Health and Human Services bill. By maximizing federal appropriations, while still protecting the long-term stability of our federal grants, the final agreement provides resources to address critical needs that will help improve the lives of children and their families across Minnesota.

As you know, the Social Services Information System (SSIS), the information technology system used to administer the child protection system, is currently ineffective, prone to system unavailability, and lacking modern capabilities. SSIS is failing to support our child welfare workforce, who often spend far more time entering data into the outdated system than they do with the vulnerable children and families that enter the child welfare system. By investing $35 million to create a new child welfare information technology system, Minnesota's children and families involved in the child welfare system, along with County and Tribal caseworkers, will be positively impacted for many years to come. I am grateful for the commitment and collaboration among counties, Tribes, policy staff and leadership at DCYF and MNIT, you as chairs, and many other legislators, who together made modernizing this system a top session priority. Thank you for your partnership.

Providing $12 million for food security will help ensure Minnesota families can meet nutritional needs despite rising food costs and reduced food deliveries to food banks, shelves, and meals programs. Having access to adequate nutrition better ensures adults can work and support their families, and children can focus and learn in school.

Other investment will address federal compliance for the Child Care Assistance Program and bolster DCYF's program integrity efforts through additional compliance staff and an electronic enrollment and attendance system for CCAP providers. The reduction of co-pays for families receiving CCAP will have a positive impact on families with the lowest incomes who need child care when working or attending school, even with a three-year delay in implementation.

Throughout session and recent discussions, it has been exciting to see the many areas of alignment across the legislative and executive branches, and I appreciate inclusion of all DCYF policy provisions in the final agreement.

Thank you, again, for working together to create a budget that supports children, their families, and our child welfare workforce.

Best,

Tikki Brown, Commissioner
Department of Children, Youth, and Families