Legislative History for Connecticut Act

PA 19-48

HB7165

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Human Services	338, 344-350, 365, 381-388, 390-393, 518-531, 533-564, 566-573, 612-634	98
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have voted, the machine will be locked and the Clerk will take a tally.

The Clerk will announce the tally.

CLERK:

House Bill No. 5181 as Amended by House "A"

Total Number Voting	141
Necessary for Passage	71
Those voting Yea	141
Those voting Nay	0
Absent not voting	10

SPEAKER ARESIMOWICZ (30TH):

The Bill as Amended passes. [Gavel] Will the Clerk please call House Calendar 275.

CLERK:

On Page 21, House Calendar 275, Substitute House Bill No. 7165, AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. Favorable Report of the Joint Standing Committee on Human Services.

SPEAKER ARESIMOWICZ (30TH):

Representative Abercrombie of the 83rd District, madam you have the floor.

REP. ABERCROMBIE (83RD):

Good evening, Mr. Speaker. Mr. Speaker I move for Acceptance of the Joint Committee's Favorable Report and Passage of the Bill.

SPEAKER ARESIMOWICZ (30TH):

The Question before the Chamber is on Acceptance of the Joint Committee's Favorable Report and Passage of the Bill. Will you remark? Representative Abercrombie, you have the floor.

REP. ABERCROMBIE (83RD):

Mr. Speaker the Clerk has an Amendment LCO 8769. I ask that they call the Amendment and that I be grated leave of the Chamber to summarize.

SPEAKER ARESIMOWICZ (30TH):

Will the Clerk please call LCO No. 8769 which will be designated House Amendment Schedule "A".

CLERK:

House "A" LCO No. 8769 offered by Representative Abercrombie, Senator Moore and Representative Case.

SPEAKER ARESIMOWICZ (30TH):

Representative seeks leave of the Chamber to summarize the Amendment. Is there objection to summarization? Is there objection to summarization? Seeing none, Representative Abercrombie.

REP. ABERCROMBIE (83RD):

Thank you, Mr. Speaker. Mr. Speaker where permissible under Federal Laws breast mild donor would be now covered. I move adoption.

SPEAKER ARESIMOWICZ (30TH):

Question before the Chamber is on Adoption of the Amendment. I will try your minds. All those in favor signify by saying, aye.

REPRESENTATIVES:

Aye.

SPEAKER ARESIMOWICZ (30TH):

Those opposed, nay. The ayes have it. The Amendment is adopted. Will you remark further on the Bill as Amended? Representative Case of the 63rd you have the floor.

REP. CASE (63RD):

Thank you, Mr. Speaker. This is a great topic,

great Bill. I've learned a lot about this topic over the last year and learning about what we can do further. Good Bill, ought to pass and I thank the good Chairwoman for her hard work in getting this Amendment going through. Thank you, Mr. Speaker.

SPEAKER ARESIMOWICZ (30TH):

Thank you very much, sir. Representative Mastrofrancesco of the 80th District. Ma'am, you have the floor.

REP. MASTROFRANCESCO (80TH):

Sorry. Thank you, Mr. Speaker. Mr. Speaker I have questions for the proponent of the Bill.

SPEAKER ARESIMOWICZ (30TH):

Representative Abercrombie, please prepare yourself. Representative please proceed.

REP. MASTROFRANCESCO (80TH):

Thank you. I am happy to hear, I listened to this Bill in Human Services and I had some concerns about it. I think it's great that infants when they are born premature obviously breastmilk is the best thing we can do for them. But I did have some

concerns about this Bill in Human Services and I'm glad to hear that this Amendment, that Medicaid will cover the breastmilk under this Amendment. Is that correct?

Through you, Mr. Speaker.

SPEAKER ARESIMOWICZ (30TH):

Representative Abercrombie.

REP. ABERCROMBIE (83RD):

Through you, Mr. Speaker.

DSS has to do a SPA which is a State Plan Amendment to get it covered through Medicaid.

Through you, Madam, ah, Mr. Speaker, sorry.

[Laughter]

SPEAKER ARESIMOWICZ (30TH):

It's getting late. Representative it's totally okay. Representative Mastrofrancesco. You have the floor, ma'am.

REP. MASTROFRANCESCO (80TH):

Thank you, Mr. Speaker.

And through you. Is that because I know Medicaid right now will not cover breastmilk because

it is considered a food. Is it because it would have to be medically necessary and they will then cover that under that? Do we have confirmation that it will be covered through Medicaid if it was done through prescription?

Through you, Mr. Speaker.

SPEAKER ARESIMOWICZ (30TH):

Representative Abercrombie.

REP. ABERCROMBIE (83RD):

Through you, Mr. Speaker.

There is no confirmation on this. You never get confirmation from CMS unless you do a State Plan Amendment.

Through you.

SPEAKER ARESIMOWICZ (30TH):

Representative Mastrofrancesco.

REP. MASTROFRANCESCO (80TH):

Thank you.

Through you, Mr. Speaker.

The other concern, there’s two more concerns I have on this Bill. The cost. We don’t really know

what the cost is, right. I remember hearing in the Public Hearing it is very expensive, right. There was a fortifier that came with it, it was a very expensive and so we don't know the exact fiscal note on it, number one. The other question I have and the concern is, is this covered through, if people are not on Medicaid, and they have regular insurance, would you know if they are covered through regular insurance?

Through you, Mr. Speaker.

SPEAKER ARESIMOWICZ (30TH):

Through you, Mr. Speaker.

That is not addressed in this Bill, we are only pertaining to Medicaid.

Through you.

SPEAKER ARESIMOWICZ (30TH):

Representative Mastrofrancesco.

REP. MASTROFRANCESCO (80TH):

Thank you.

And through you, Mr. Speaker.

That was a concern of mine. I mean I think

this is great and it should really be covered for everyone and that's where I am having concerns with it. And what happens to a baby when their mother or the family is just over the line and they are not on Medicaid and they cannot afford it, what happens to their baby. I would love to see this for everyone. And those were my concerns. I will listen if there is any more questions and make a decision but I appreciate it and I think it is a wonderful thing that we can do for our infants. Thank you.

SPEAKER ARESIMOWICZ (30TH):

Will you remark further on the Bill as Amended? If not, Staff and guests the Well of the House. Members take your seats, the machine will be open.

[Ringing]

CLERK:

The House of Representatives is voting by roll, Members to the Chamber. The House of Representatives is voting by roll, Members to the Chamber.

SPEAKER ARESIMOWICZ (30TH):

Have all members voted? I know many members are off in various areas negotiating Bills but I'd ask you to stay close to the Chamber. If all the members have voted please check the board to make sure your vote has been properly cast. If all members have voted, the machine will be locked and the Clerk will take a tally.

The Clerk will announce the tally.

CLERK:

House Bill No. 7165 as Amended by House "A"

Total Number Voting	141
Necessary for Passage	71
Those voting Yea	141
Those voting Nay	0
Absent not voting	10

SPEAKER ARESIMOWICZ (30TH):

Bill as Amended passes. [Gavel] Will the Clerk please call House Calendar 69.

CLERK:

On Page 4, House Calendar 69, Substitute House Bill No. 5124, AN ACT INCREASING THE PROPERTY TAX

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Those voting Yea	33
Those voting Nay	3
Absent and not voting	0

THE CHAIR:

[Gavel] The measure is adopted. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Could we stand at ease for a moment?

THE CHAIR:

Senate will stand at ease. Senator Duff, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, I would like to call a number of items for our Consent Calendar, please? Place a number of items on our Consent Calendar I should say.

THE CHAIR:

Yes, please proceed, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. On Calendar page 21, Calendar 374, House Bill 6403, I'd to place that item on the Consent Calendar. On Calendar page 25, Calendar 412, House Bill 7168, I'd to place that item on the Consent Calendar. On Calendar page 27, Calendar 425, House Bill 7229, I'd to place that item on the Consent Calendar. On Calendar page 32, Calendar 479, House Bill 7378, I'd to place that

item on the Consent Calendar. On Calendar page 36, Calendar 506, House Bill 7130, I'd to place that item on the Consent Calendar. On Calendar page 37, Calendar 511, House Bill 5455, I'd to place that item on the Consent Calendar. On Calendar page 38, Calendar 521, House Bill 7093, I'd to place that item on the Consent Calendar. On Calendar page 40, Calendar 537, House Bill 6927, I'd to place that item on the Consent Calendar. On Calendar page 50, Calendar 602, House Bill 7165, I'd to place that item on the Consent Calendar. On Calendar page 50, Calendar 605, House Bill 6916, I'd to place that item on the Consent Calendar. On Calendar page 51, Calendar 606, House Bill 5125, I'd to place that item on the Consent Calendar. On Calendar page 52, Calendar 611, House Bill 5779, I'd to place that item on the Consent Calendar. On Calendar page 52, Calendar 612, House Bill 7291, I'd to place that item on the Consent Calendar. On Calendar page 61, Calendar 66, I'm sorry, Calendar page 660, I'm sorry, Calendar page 61, Calendar 660, House Bill 7212, I'd to place that item on the Consent Calendar.

THE CHAIR:

Thank you, sir. So ordered.

SENATOR DUFF (25TH):

Thank you, Madam President. Senate stand at ease please.

THE CHAIR:

Senate will stand at ease. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. One more for the consent calendar please?

THE CHAIR:

Please proceed, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. Calendar page 61, Calendar 659, House Bill 7063, I'd to place that item on the Consent Calendar.

THE CHAIR:

So ordered.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, if the Clerk can now read back the items on the Consent Calendar followed by a vote on the Consent Calendar, please.

THE CHAIR:

Mr. Clerk.

CLERK:

Consent Calendar No. 1. Senate Bill 1069, page 21, Calendar 374, House Bill 6403, page 25, Calendar 412, House Bill 7168, page 27, Calendar 425, House Bill 7229, page 27, Calendar 421, House Bill 6522, page 32, Calendar 479, House Bill 7378, page 36, Calendar 506, House Bill 7130, page 37, Calendar 511, House Bill 5455, page 38, Calendar 521, House

Bill 7093, page 40, Calendar 537, House Bill 6927, page 50, Calendar 602, House Bill 7165, page 50, Calendar 605, House Bill 6916, page 51, Calendar 606, House Bill 5125, page 52, Calendar 611, House Bill 5779, page 52, Calendar 612, House Bill 7291, page 61, Calendar 660, House Bill 7212, page 61, Calendar 659, House Bill 7063, and page 66, Calendar 226, Senate Bill 424.

THE CHAIR:

Mr. Clerk, if you would kindly call the vote, the machine will be opened, sir.
CLERK:

Consent Calendar No. 1. An immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1. An immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1. An immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1. Immediate roll call vote in the Senate.

THE CHAIR:

Have all the Senators voted? Have all the Senators voted? The machine will be locked. Mr. Clerk, please announce the tally.

CLERK:

Consent Calendar No. 1.

Total number voting	36
Those voting Yea	36
Those voting Nay	0
Absent and not voting	0

THE CHAIR:

[Gavel] The Consent Calendar is adopted. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, I move immediate transmittal of all items needing further action to the House of Representatives, please.

THE CHAIR:

So ordered, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, does the Clerk have Senate Agenda No. 4 on his desk, please?

THE CHAIR:

Mr. Clerk.

CLERK:

The Clerk is in possession of Senate Agenda No. 4 dated Tuesday, June 4, 2019.

THE CHAIR:

Senator Duff.

SENATOR DUFF (25TH):

Madam President, I move immediate all items on Senate Agenda No. 4 dated Tuesday, June 4, 2019 be

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love to be able to continue our conversation here, but we cannot support the bill in its present form.

H.B. 7165, AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. We wish to offer our strongest endorsement of breastfeeding for all newborns. After loving parents, breastfeeding is one of the best ways to start a newborn on his life's journey, but breast milk is neither a nutritional supplement nor an artificial nutritional product to treat a medical condition. Breast milk is food. Federal law does not allow us to cover breast milk or any other type of food because food does not fall within the federal definition of medical assistance that may be covered by Medicaid. The Department of Social Services strongly supports breastfeeding, but must oppose this legislation. H.B. 7166, AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID BENEFICIARIES. I'm just gonna skip to the chase. All of the provisions that are identified in the bill are contained within the contract provisions that currently exist between Veyo, the broker, for any MT services and the agency. We continue to publish the information before MAPOC every month. On average, we complete about 350,000 to 400,000 trips for Medicaid members. We get detailed information. We have call center performance. The pickup and return wait times are within contract standards for approximately 70 percent of A leg trips and 92 percent of B leg trips. To-date, the department has imposed sanctions most commonly related to late pickup times totaling some $22,000. To the best of our information, Veyo has typically passed these sanctions along to the involved transportation providers.

necessary to improve that service, but I wanna go back to one point that I made earlier, that is a 1 percent error rate across let's say four million people is still a lot of problems. And, so we're gonna continue to try to drive that towards perfection, but if you contrast this vendor with the previous experience, it is better. Our rides – I mean our utilization is even up, so yes, there are issues. We hear about them. We wanna address them and we're being very aggressive about that.

REP. WILSON (66TH): Okay. Have another question – another bill question on another bill. The other question I had related to 7165 on donor breast milk. I was – my understanding of the use of donor breast milk was more along the lines of premature babies and in instances where the mother cannot provide her own breast milk and so while it is not – while it certainly is a food when you're talking about a preemie, it really does skate the lines of a medical necessity I'm thinking if that's what the child can tolerate and they don't have their own mother's milk and they are needing that supplement.

COMMISSIONER RODERICK BREMBY: Yeah, we fully support the use of breast milk. It is the best food that there is, but Medicaid statutes will not allow us to use Medicaid dollars for food.

REP. WILSON (66TH): I mean, I understand what you're saying. There's no – no one can – there's no way around it. There's no way to redefine this is a medical necessity.

COMMISSIONER RODERICK BREMBY: There's no way around it that we're aware of.

REP. WILSON (66TH): Okay. All right.

REP. ABERCROMBIE (83RD): Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. Good morning, Mr. Bremby. Nice to see you. Just to go back real quickly and not to belabor it because we've been talking about this for a while in this building, but I don't know if the Representative is aware, but when we worked with your office and sat in your office, we did set up an email line that would go directly to you into Veyo with any complaints. Do you have the numbers of how many have gone to that through Representatives?

COMMISSIONER RODERICK BREMBY: I don't have that, but I will – we can get that information. We did have a – we tried to streamline to make sure that complaints come in that we could escalate those and resolve those. I know that Rod Winstead and Kate are monitoring those complaints on a routine basis and in fact I know Rod turns those around very quickly.

REP. CASE (63RD): Right. And, I do appreciate that because I've seen multiple, because we thought that in the meeting we could – as you mentioned, the previous contract we had much more issues than we do right now, but they're about 219 of those emails that went to both Veyo and yourself and out of those, 51 percent of those, were not to be the fault of Veyo through your office and through the contractor, but it is also correct that yes, this is a multimillion dollar contract, but there is a clause in there that it's only a 3 percent profit that's allowed through this contract?

COMMISSIONER RODERICK BREMBY: That is correct.

REPRESENTATIVE CASE (63RD): So, it's not that this company is making millions of dollars off of the – you guys put a stipulation on how much the contractor can actually make, right?

COMMISSIONER RODERICK BREMBY: Yes.

REP. CASE (63RD): Right. So, it's not to their ability to – they wanna work the best to get the best solution. I know I had a – Charlotte Hungerford Hospital called me probably about two weeks ago at 10 o'clock at night because you know sometimes people have to come from the health center in Winsted and get transported to Charlotte Hungerford which is a 24-hour care facility. The Winsted Place is only a 12-hour. Come to find out it's not within Veyo's contract to transport somebody with medical and that particular nurse manager didn't know that, but I field those calls around 10 o'clock at night and they were answered, but Veyo went above and beyond and actually found them a ride which they didn't have to do, but there are some good cases. There are some negative stuff, but I think we're trying to work through the negative.

Anybody who wants to bring stuff forward that – that will help the situation. I tell my phone rang off more with the previous contractor than it has with this contractor and that's that – that's just coming from me, but that's why we set up and maybe the good Representative, if she can work with her office, that email is still viable and is answered within less than a day and her aide in her office can also get the answer that came through on how it was rectified, but I thank you, Commissioner, for coming forward.

COMMISSIONER RODERICK BREMBY: Thank you.

REP. ABERCROMBIE (83RD): Representative Dathan followed by Representative Hughes.

REP. DATHAN (142ND): Thank you, Madam Chair, and thank you, Commissioner, for your testimony today. It was great. I know you discussed with the other Representative H.B. – sorry 7165, the breast milk one. I'm a mom with three kids. I breastfed all three of them for as long as I could not just for the benefits of providing nutrition, but from what – and I actually delivered two of my kids with midwives which is another home problem with what you were talking about, but in terms of my healthcare provider – said that breast milk actually provides not just the nutrients, but also immunities and helps your kids provide immunities and I'm kind of failing to see how we can just say for a premature baby who's immune system may be more compromised than a traditional full-term baby, how we can say why that baby should be more subject to different diseases out there, particularly when we have many health crises going on in our state.

I know during the course of my kids' first year, they were very rarely sick and it was – I really relate it to breastfeeding them. And so, understand what the federal guidelines about this, that it's a food, but is there a way that we can maybe talk about breast milk, especially for premature children, that they can receive this to help with their immune systems to help build up immunity? Thank you.

COMMISSIONER RODERICK BREMBY: Good morning. I really appreciate your argument. I really do. We – and I don't discount what you just said because

breast milk also provides for the transfer of immunities between – immune protection between the parent and the child, but a lot of our federal regulations may not hold up to the rationality that we would like them to or be as forward learning as we would want them to. We know, for example, that housing is a tremendous aid to people who are suffering from a lot of medical conditions, but Medicaid won't allow us to those resources for housing either.

So, I'm gonna and ask to defer to our medical doctor for Medicaid to speak specifically to the point you raised about whether breast milk can be used under Medicaid as a resource. Dr. Zavoski.

REP. ABERCROMBIE (83RD): Dr. Z., just introduce yourself even though most of us know you, please. Thank you.

DR. ROBERT ZAVOSKI: Good morning. Rob Zavoski, Medical Director of the Department of Social Services and pediatrician, 25 years practice experience. You speak about breast milk very well and is better than many I've heard recently. The challenge we have is that, and I sat on a committee with Sam S. in the federal government last year that looked at this very question. And, the challenge is that the federal Medicare and Medicaid rules are etched in federal law and are very specific and were written many years ago and did not foresee many of the new healthcare trends that are happening today, this being one of them, but technology trends, etc.

And, it becomes a challenge and under the federal rules, breast milk is considered a food, not a nutritional supplement, etc. And, furthermore, the way we pay for newborn care in the nursery,

particularly in the NICU with prematures, is that we pay a bundled rate and so technically the payment for the food, nutritional supplements, etc., are included in that bundle grade. So, again for both reasons, we couldn't support this legislation. As the Commissioner said, we are four-square in favor of breastfeeding and all the benefits that derive from breastfeeding and they're lifelong benefits, but we can't pay for it as a medical supply.

REP. CASE (63RD): Can I ask a followup questions?

REP. ABERCROMBIE (83RD): Yes.

REP. CASE (63RD): Thank you. Is there any other supplements that a newborn who is unable to receive milk from its birth mother, is there anything else out there that an infant could receive that would be as good as breast milk to help prevent immune issues?

DOCTOR ROBERT ZAVOSKI: The answer to that is no. There's nothing as good as breast milk. There are other nutritional supplements and medical supplements that we do pay for and provide, but again, despite all of the good things and wonderful things that breast milk does, it's still considered a food under the full – it's food under federal rules.

REP. CASE (63RD): So, we're kind of discriminating against mothers who cannot breastfeed in a sense? Okay. Thank you very much. Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chairman, and thank you, Commissioner, and just before you leave because I was gonna ask, so when you said there are

supplements that Medicaid will cover, are those pharmaceutical supplements?

DOCTOR ROBERT ZAVOSKI: There are nutritional supplements. I guess there are some pharmaceutical supplements if somebody's having trouble with electrolytes, etc., but with most preemies, I think most of the supplements are more caloric.

REP. HUGHES (135TH): Interesting. Okay. So, thank you, Commissioner. Thank you very much, Doctor. Commissioner, thank you for your test. I'd like to talk to you a little bit deeper about H.B. 7123 concerning telephone wait times for persons contacting the Department of Social Services. You said something about the second quarter in 2019, an RFP, can you --?

COMMISSIONER RODERICK BREMBY: Yes.

REP. HUGHES (135TH): Talk more about that?

COMMISSIONER RODERICK BREMBY: Absolutely. So, what we worked on over the last year has really been about process change within the organization. What we were wanting to do more quickly than now was upgrade the technology that we have. We have an IVR, interactive voice response system, that allows us to channel calls more appropriately to where they could best be answered. The current technology is limited in that we can't drive a certain type of call to the right location or the right worker as efficiently as we would like to nor could we set up a Tier One call center, for example, one that we pay for along with Access Health to take the initial call to handle all of the light touch questions and then forward the rest of the questions back to the benefits centers for resolution.

REP. ABERCROMBIE (83RD): Okay. Fair enough on that. Thank you. Moving on to H.B. 7165, AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. So, maybe you're not aware of this, but there are currently six states that do cover breast milk under Medicaid, New York being one of them. So, maybe what we need to do is take a look at how they're able to get this covered under Medicaid. I understand what you're saying about the bundled rate that we do for hospitals, but I think it's – I think it's unfair to mothers that have preemies that are given breast milk and a fortifier when they're born and then at some point when they come out of the hospital have to transfer to formula, so I think that we should take a look at how other states have been able to pay for the service. I know you're trying to say something, go ahead.

COMMISSIONER RODERICK BREMBY: Yes. We will explore this. What we know, what we know, is that Medicaid dollars cannot be used, but we believe this may be a relationship with managed care organizations who pool other resources to make sure that this is provided as a way of providing that holistic support for the people who they are serving. In the same way, we know that there's some states that are providing other types of supports for their Medicaid members that Medicaid will not pay for through the managed care entity, so let's – let's explore this and see if there's a different way, but --.

REP. ABERCROMBIE (83RD): Yeah. I think it's real – I'll be honest with you, I didn't know a lot about this. I know that we've been in contact – I've been in contact with Yale and CCMC because they currently have this as a common practice because especially with preemies they don't have the opportunity to be

with a midwife attending her care actually has her midwife when things go well and her midwife plus a physician in case of possible or actual complications. Midwife-attended women have access to more care, not less, and therefore, reimbursement should be set equitably rather than at a cumulatively discounted rate. Medicare corrected the inequity back in 2011 and Connecticut is the only state in New England which has yet to make this adjustment. Thank you for your time.

REP. ABERCROMBIE (83RD): Thank you for your testimony and thank you for your work. Sit for a moment [laughter]. Don't think you're off the hook. Questions? Seeing none. Thank you. You did a great job. Nobody's got any questions.

ELIZA HOLLAND: Thank you so much.

REP. ABERCROMBIE (83RD): Now, we're gonna go back to the elected officials. Representative Frey.

REP. FREY (111TH): Thank you, Chairman Moore and Chairman Abercrombie and Ranking Member Case and everybody else. This is almost like déjà vu. I noticed speaker Raymond [phonetic] in here earlier. I first filled – 21 years ago as a freshman, I was on an insurance committee and Speaker Raymond was then Chairman and had to do with medically necessary infant formula, so this is kind of going full circle, but I wanted to, with your permission, turn my moment over to Di Masters who is a constituent who brought this issue to my attention. Di, please go ahead.

DI MASTERS: Thank you very much and I want to thank you very much. My name is Di Masters and first of all want to thank you all for your service to the

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state. I'm here because I wrote the original language for the bill, a very modest version of the bill which Representative Frey introduced which was Medicaid coverage for the human donor breast milk and I'm here now to ask for your attention and full support for H.B. 7165. I returned to graduate school to finish my Master's in Public Health. During my research, I discovered a gap in coverage, health equity in maternal and infant wellness that could and should be addressed which has an impact on our most fragile citizens.

Some premature babies in our state are being denied the nutrition that they could digest, human donor milk, because hospitals cannot afford the cost. When these fragile infants are fed complex commercial formula, they're exposed to painful and life-threatening disease which is necrotizing enterocolitis which is – has a very high death rate. You'll hear more about it later this afternoon when experts come. You may have gotten a lot of letters on it. They're underdeveloped and they just cannot digest that.

What they can digest is breast milk. All of these infants should have food that they can tolerate, but there's more to the story to understand. Connecticut has infant and maternal health statistics, especially among minority populations, that must be addressed and I was very encouraged, Senator Moore, to hear you say that. This bill is part of the solution. With infant mortality among black infants well over twice the rate of white infants in this state, and maternal mortality rates for black mothers shamefully out of proportion and statistics that show us that black mothers will deliver their babies prematurely. We need to begin

to put in place good simple solutions when we find them and as soon as we can.

This bill with help to improve the quality of life, reduce morbidity and mortality among premature populations, and on a pragmatic level and to your point, Madam Chairman, the outcomes of the state will be a positive cost benefit analysis. The modern technology advances ensure that babies that are born very prematurely have an increased possibility for survival. These vulnerable infants are in critical need of human milk to further protect their survival, health, and development; however, women who deliver prematurely have not experienced the physiological and hormonal changes of a full-term gestation, and therefore, typically require additional support to begin to produce milk and to build and maintain an adequate supply to meet the infant's needs.

And, yes, milk is a food, but it is also nutritionally required for very early premature babies. It's the only thing that they can really digest without causing them harm. The use of human milk in feeding a premature infant is a health equity issue in Connecticut as premature births occur at a much higher rate among African-American mothers and it's also a public health priority because disease can be prevented by providing this nutrition.

Although these infants comprise only 12 percent of all births, they contribute to about 35 percent of infant deaths. Donor human milk is a critical intervention to prevent morbidity, mortality, complications in treatment, improving health outcomes in the short and long term, and decreasing

the length of stay for hundreds of vulnerable infants each year. The lowest neonatal Intensive Care Unit costs among the very low birth weight infants who receive the highest average daily doses of human milk for days one through 28 are those that get the most human donor milk. Human milk feedings for very low birth weight infants reduces the risks and the associated costs of late onset sepsis and necrotizing enterocolitis. The mothers of all vulnerable babies seek the best path for their babies healing, growth, and development. This population deserves our best support which includes the availability and use of human milk feeding. The opportunity presented by this bill empowers families to know that their infant will be able to gain the nutrients they need and deserve life-saving donor milk. I thank you for your service and I thank you for your consideration of this important bill.

SENATOR MOORE (22ND): Thank you for your testimony. Any questions, comments?

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. Thank you for that information. I'm very interested in the subject and I'm just trying to seek more information and I don't know if you would have it. Representative Abercrombie did talk a little while ago about other states that offer the program. Are you familiar with the other states and exactly how does the program work? How is the milk transferred from the mother, who is donating it, and how does it get to the other infant that needs it? Would you know the process? Would you be able to talk on it and explain it?

DI MASTERS: Well, I possibly know the process. I was a breastfeeding mother of seven, but so I

delivered my own, but I am very, very familiar with the human milk thing because it's northeast which is here and they'll be speaking later today so they'll give you complete information it, but mothers all over the state of Connecticut are donating milk, if you want me to explain, and then they'll probably correct some of the things I say.

There are five milk depots in Connecticut. So, women who have milk to donate, produce their milk, they take it to the depot. It then is transferred to a processing facility where it's pasteurized and it's then delivered to the hospitals that are participating. Now, if I've left out some steps or I have missed – missed some bits in there, the experts will be more than happy to fill you in 'cause they'll be speaking later today.

REP. MASTROFRANCESCO (80TH): Thank you.

REP. FREY (111TH): Just a couple of things. Although I've never lactated, I didn't receive breast milk. There are six states plus D.C. who Medicaid covers donor breast milk. New York was the last state to go on board and they included it in their 2017-2018 state budget and it continues there today and it never went challenged. Basically, it's overseen by the Commissioner of Health in the state of New York and when infants meet certain criteria and receive written medical order, they're eligible to receive the donor breast milk. In some cases, it's fortified. In some cases, it is not.

REP. MASTROFRANCESCO (80TH): Thank you for that. I'll be interested in this afternoon to hear them. Hopefully, I'll be here. I have another meeting to attend – to learn more about it. I'm curious, does the breast milk lose a lot of nutrition as it goes

through the process? We've heard testimony and know that it's best when it's given right away, so I'll be interested to hear that testimony, but thank you.

REP. FREY (111TH): I went through it 21 years ago. I mean, obviously breast milk is the absolute best. The bill that we did 21 years ago was when an infant is born and can't accept the mother's breast milk, can't accept formula, can't accept any other form other than what's – it's really strange, it was prescribed – had to be prescribed by doctor, but it is not technically a description, so therefore, insurance companies didn't cover it. So, it was requiring – and if they didn't have this type of formula, they would end up being in the hospital with internal bleeding and whatnot and malnourished, so the insurance company – Speaker Raymond was here earlier. He dropped in – sorry, he left, but he was Chairmen of the Insurance Committee as I mentioned and help me pass that that first year. The insurance companies ended up embracing it and years later we actually extended it to years – year five. It's one of the situations were kids do outgrow, but in this case with NICU babies, those who are very young, this donor milk is so important.

REP. MASTROFRANCESCO (80TH): Thank you for that information. Sure.

DI MASTERS: Oh, I'm so sorry. If I could just add that the CDC, the WHO, and the American Pediatric Association all endorse breast milk either from the mother or donor breast milk as soon as the baby's born, no matter how early, because it's the most important nutrient and it's fully endorsed.

REP. MASTROFRANCESCO (80TH): Thank you. I would agree that it's very important. I look forward to

hearing more testimony and getting more educated on the subject

DI MASTERS: We are fully prepared to completely answer your question.

REP. MASTROFRANCESCO (80TH): Thank you.

REP. CASE (63RD): Thank you, Representative Frey, for bringing this up. A question for you going along with the questions that Gale just asked. I won't do her last name. So, when you have breast milk, you're talking a four-hour shelf life if it's just sitting around after it's been pumped, correct? Okay, so the stuff that you're taking, it's frozen, because I know it's good up to four days in the refrigerator and then you can freeze it. I was just curious how this milk, is it taken fresh or is it taken frozen?

DI MASTERS: The donor mothers freeze their milk and it's taken to the depot and so it's --.

REP. CASE (63RD): I haven't gotten into that process of freezing yet, so --.

DI MASTERS: That's your next step.

REP. CASE (63RD): Okay. So, it's taken frozen and then it's pasteurized as it's frozen. I try to use up as much as I can.

DI MASTERS: Nutrients are spared.

REP. CASE (63RD): Good. So, it's frozen right away?

DI MASTERS: Right away.

REP. CASE (63RD): Sorry. I might not have enough to use.

DI MASTERS: It's pumped, frozen, transported.

REP. CASE (63RD): Good. Okay. I was just curious 'cause we were – so, a mother who overproduces or wants to give would have to freeze the milk right away before it went to the pasteurization for it to be used for this process?

DI MASTERS: Yes.

REP. CASE (63RD): Thank you.

REP. FREY (111TH): We do have some experts coming in this afternoon and we can address that issue.

REP. CASE (63RD): Can't wait, Representative Frey [laughter].

REP. ABERCROMBIE (83RD): I am so impressed. You did that with a straight face. Any further questions or comments? And, we're not taking this lightly. Believe we, we do understand the importance and I have to say I reached out to Yale that sent me a lot of information on this and I was just blown away with the statistics.

REP. FREY (111TH): And, I appreciate from the get-go your proactiveness in this – in our earliest conversations so thank you very much.

REP. ABERCROMBIE (83RD): Our pleasure. Our pleasure. Seeing no further questions. Thank you so much.

DI MASTERS: I can't thank you enough. I really appreciate this, thank you.

REP. ABERCROMBIE (83RD): Our pleasure. We're gonna go back to the public, three minutes. Arielle. Is

midwifery student in Connecticut, I have seen the impact of unequal reimbursement rates on my patients.

All of the clinics that I have been involved with have had to increase the number of patients that they see in a typical office day in order to make enough money to keep their doors open. This leads to reduction in the quality of care and disproportionately affects communities of color. Many of my classmates are planning to leave the state after graduation. After utilizing the resources available in Connecticut for their training, many will be looking for jobs in nearby states such as Rhode Island, New Hampshire, Vermont, Maine, and Massachusetts, states in which Medicaid payment for midwives is equitable to that of physicians. Equitable reimbursement from Medicaid would incentivize more midwives to stay in Connecticut, again improving access to care. For these reasons, I strongly urge the committee to support this bill. Thank you for your time.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Questions? And, you did it under three minutes. Good job. Seeing none. Thank you so much for your testimony. Steve Hernandez.

HB 7165
HB 7121
SB 898

STEVE HERNANDEZ: Good afternoon, Senator Moore, Representative Abercrombie, Ranking, and other esteemed Members of this Committee. My name is Steve Hernandez. I'm the Executive Director of the Legislator's Commissions on Women, Children, and Seniors and Equity and Opportunity. I'm joined today by Rosa Rada who is our 2Gen Fellow and the way we met, she's also a food fellow, a food and security expert I should say. So, we're gonna be

testifying on three separate bills; 7165 on Medicaid coverage for donor breast milk; H.B. 7121 on SNAP; and then S.B. 898.

So firstly, on H.B. 7165, I won't belabor just the fact that we support wholeheartedly the expansion. I take to heart the testimony of the Commissioner that the definition, the federal definition or food or the federal definition of breast milk is that breast milk is food, but when you think about Johns Hopkins best advice on breast milk and the fact that not only -- not only does it prevent and also supplement early nutrition and early development, but it also prevents infections. It has many disease fighting factors. It helps to prevent mild to severe infections and hospitalizations. Breastfed babies have fewer digestive, lung, and ear infections. Babies born early, those who are premature and who are also breastfed, are also less likely to get serious infection of the intestines called necrotizing enterocolitis. And finally, if your baby gets an infection while breastfeeding, the infection is likely to be less severe. There's so many other reasons that breast milk can be medically necessary. And, then I think the question for us as a state is, will we join our other sister states in signaling to the federal government that the recognition of breast milk should be – or that breast milk should be defined as medically necessary in certain circumstances and I would go a step further. I would say that under certain medical conditions, breast milk should also be covered by our private insurers. So, I commend you for bringing this bill to the attention of the public and the attention of this – of this body and we support that bill. Rosa.

ROSA RADA: Sure. Thank you, Steven. Thank you, Senator Moore and Representative Abercrombie and the rest of the Committee for allowing us to testify. I'll be testifying on H.B. 7121 so that's the act that would change supplemental nutrition assistance – I'm sorry. Rosa Rada, the 2Gen Legislative Fellow. This is the act that would change the issuing schedule for SNAP benefits from once a month to twice a month. And, Commissioner Bremby had made an excellent point that federal law currently through the 2008 farm bill doesn't allow for states to administer more than once a month, but there's many states throughout the country that have changed the issuance schedule itself, so I'll be speaking to that larger issue.

So, currently at 437,530 Connecticut residents, a third of which are children, experience food insecurity. SNAP, the largest nutrition assistance program in the state, acts as a primary domestic safety net for families experiencing financial hardship. So, changing the issuing schedule for benefits, while seemingly minute and bureaucratic, offer an opportunity to support our state's food retailers while improving food access and equity for our residents. So, according to the USDA, a majority of SNAP recipients spend their benefits within the first two weeks of receiving them. Since many states, Connecticut included, issue SNAP benefits at the same time each month, grocery stores also experience a spike in sales and then quickly a drop at the – later in the month. That is when SNAP customer's budgets are depleted.

So, given that grocery stores pay significant fixed costs to operate and generally experience low profit margins, such a retail cycle presents challenges.

In our cities and rural town where it's most concentrated food insecurity and lack of access to healthy affordable food, both grocers and residents lose out. Changing the issuing schedule for benefits would smooth business cycles for food retailers, especially those in economically distressed areas of the state while allowing them to provide a more continuous stocking of fresh produce and staple items.

While this is a relatively simple and inexpensive policy solution versus say offering tax credits to grocery stores, there is much room for error. In 2015, Maryland changed their SNAP benefit schedule from a 10-day period to a 24-day period, but due to bureaucratic mistakes and a failure to consider literacy and numeracy levels, language needs, and housing status, the SNAP recipients – a large portion of SNAP recipients did not get notice of the change, so benefits went unused, residents went hungry, and businesses lost money.

So, the Commission on Women, Children, and Seniors supports effort to expand food access and equity while supporting local economies and small businesses; however, we urge the Committee if you do decide to change the issuing schedule, to provide clear instructions to the Department of Social Services so that they may carefully and thoughtfully implement such a change.

STEVE HERNANDEZ: And finally, on raised bill 898, I wanna focus on a couple of components of the raised bill that I think are worth emphasizing. And, one is cultural competence. The other one is language accessible and then the third is owned by people of color or at least run by people of color. Those

DR. JEFF BARTLETT: Good afternoon, Senator Moore and Members of the Committee. My name is Dr. Jeffrey Bartlett and I am the Medical Director of Neonatology for Western Connecticut Health Network which includes Danbury Hospital, Norwalk Hospital, and New Milford Hospital. I want to thank Representative Frey for raising the critical issue of regulation and reimbursement for donor human milk and to the Committee for including such an important issue in today's meeting.

I wholeheartedly support the intent of H.B. 7165, but in order for the bill to have the intended impact on Connecticut's most vulnerable infants, the legislation must be changed. At all of the NICUs at which I practice, we strive to provide the best care possible for each child we treat. This includes a focus on nutrition and providing a human-based diet to the greatest extent possible. In our NICUs, we work with mothers to help them provide milk for their babies either by breastfeeding or by pumping.

Unfortunately, for many of our very low birth weight infants, a mother is often unable to provide her own milk for a period of time or to a volume at which her baby needs. In these cases, the baby is fed with donor human milk. At the Danbury and Norwalk Hospitals, we use donor human milk purchased from Prolacta, a milk bank based in California which is not a member of HMBANA. For our very low birth weight babies who are so small they fit into the palm of your hand, we supplement donor human milk along with a human milk-based human milk fortifier which is known as the exclusively human milk diet and is crucial to meeting the nutritional and caloric needs of our tiniest babies. It is a particularly critical component for our care of our

very low birth weight babies because it delays the introduction of cow's milk into these babies' diet which reduces the chance of them developing a life-threatening disease called necrotizing enterocolitis by approximately 80 percent. The results we have seen from the exclusively human milk diet are quite literally life-changing. Our babies are growing stronger more quickly than ever before. Feeding intolerance, which often leads to disruption in feeding plan, insertion of an invasive peripherally inserted central catheter for nutritional support, and has symptoms that overlap with necrotizing enterocolitis has been reduced dramatically.

The use of an exclusively human milk diet in our very low birth weight infants has resulted in a reduction in the incidence of necrotizing enterocolitis. Additionally, the length of time to reach full feeds and that a baby remains on intravenous nutrition has been reduced in our units. Each of these also has the potential to reduce the length of time each infant stays in the NICU. I realize that my time to testify today is limited, so I will allow others to provide further education and information on the importance, efficacy, and cost reductions resulting from exclusively human milk diet. However, I do want to leave you with one takeaway.

As physicians, one of the most frustrating experiences that we encounter is having our hands tied when we know the best treatment for our patients. In the case of neonatologists, we spend weeks and months with our patients. We know these babies and what they need to survive and thrive. With this legislation, the Committee has the chance to greatly improve the availability of critical

therapies for Connecticut babies regardless of their birth date or location or of their socioeconomic status, but in order to do this effectively, I urge you to ensure two things. First, that this legislation also covers human milk-based human milk fortifier so that our most fragile babies that require an exclusively human milk diet can receive it, and second, to ensure that milk reimbursement by the state includes milk from the Department of Health Certified Banks which ensure donor milk is of the highest possible quality. This will allow each hospital to procure donor milk based on specific needs and clinical decision-making. Thank you for your time.

REP. WILSON PHEANIOUS (53RD): Thank you, Doctor. I have a question. I don't know if you heard Commissioner Bremby's remarks, but he indicated that this couldn't be – that the donor breast milk could not be paid for with Medicaid dollars because it was considered food and there might have to be alternate ways of paying for milk. There was no dispute about the fact that it was the most appropriate thing for babies. It was just that Medicaid couldn't pay for it. I'm wondering, are you aware of other hospital settings where perhaps in other states or where they are in fact using this as a Medicaid expense?

DR. JEFFREY BARTLETT: Yes. I believe that there are six or eight states where this is being covered by Medicaid.

REP. WILSON PHEANIOUS (53RD): I'd be very interested in your information on that because if they can do it in one state, they can do it in all states. That's call the United States of America [[laughter], so I'm just interested in what the

difference is in either their state plan or why it does not appear to be coverable in Connecticut at least according to DSS. So, if you have that information, if you can give me that information, I would appreciate it.

DR. JEFFREY BARLETT: Sure. I mean, the states that I have listed are New York, New Jersey, Tennessee, California, Michigan, Missouri, Texas, and Washington D.C.

REP. WILSON PHEANIOUS (53RD): Okay. Thank you. Thank you very much. Are there other questions, please?

REP. MASTROFRANCESCO (80TH): Thank you, Dr. Bartlett. That's your name?

DR. JEFFREY BARTLETT: Yes.

REP. MASTROFRANCESCO (80TH): Thank you for coming and testifying. Do you know how many in the state of Connecticut, how many babies are born where the mom cannot provide milk for the baby where they have to go to a bank? Any idea what the number is in Connecticut?

DR. JEFFREY BARTLETT: No. I don't know the specific number. I don't know if somebody else has that information, but --.

REP. MASTROFRANCESCO (80TH): That's okay. I didn't know if you would happen to have that number, and in your experience, when they cannot – where the mom, mother, cannot provide milk, the hospital gives them an alternative, a supplemental – what is the proper treatment I guess for the baby?

DR. JEFFREY BARLETT: Sure. For those babies, the tiniest babies that are at risk, we would give donor human milk and that option is offered in various forms depending on which hospital you're at. At Danbury and Norwalk Hospitals, we use Prolacta which is a donor human milk and at other hospitals there are donor human milk from the Human Milk Bank in North America.

REP. MASTROFRANCESCO (80TH): So, they are having – they are using donor milk right now and it's paid for through their private insurance or is it just part of the hospital bill?

DR. JEFFREY BARTLETT: It's just part of the hospital bill.

REP. MASTROFRANCESCO (80TH): So, it's part of the hospital bill now. And, is the – is the intent possibly to have the mom go home and be able to still continue to get the donor milk so she can continue to feed her baby?

DR. JEFFREY BARTLETT: From our standpoint, ensuring that they get donor human milk in that critical time period where they're at risk for invasive procedures and necrotizing enterocolitis and feeding intolerances is most important.

REP. MASTROFRANCESCO (80TH): Okay.

DR. JEFFREY BARTLETT: But, you know, anything – continues into the outpatient --.

REP. MASTROFRANCESCO (80TH): Right. Okay. Thank you. Did you have numbers or --?

DR. JEFFREY BARTLETT: Yeah. So, 1.5 percent of all babies, 1.1 percent of non-Hispanic whites, 3 percent [crosstalk].

REP. MASTROFRANCESCO (80TH): [[laughter] I'm trying to write this down. It was 1.5 percent of all. Go ahead.

DR. JEFFREY BARTLETT: Of all babies, 1.1 percent of non-Hispanic white, 3 percent of non-Hispanic black, and 1.5 percent of Hispanic.

REP. MASTROFRANCESCO (80TH): So, what does that come out to number-wise?

DR. JEFFREY BARTLETT: So --.

REP. MASTROFRANCESCO (80TH): And, I'm just looking at Connecticut, so we're – so I understand.

DR. JEFFREY BARTLETT: I mean, that's --.

LEISL SHEEHAN: So, these are babies that are born under 1,500 gm, so in Connecticut we were looking at --.

REP. WILSON PHEANIOUS (53RD): Can you just tell us who you are for the record, please.

LEISL SHEEHAN: I'm sorry. I'm Leisl Sheehan with Proactive Bioscience. It's – so it's – we're looking at 513 babies in Connecticut according to the CDC in 2017.

REP. WILSON PHEANIOUS (53RD): We still don't even know who you are for the record.

LEISL SHEEHAN: Sorry. Leisl Sheehan with Proactive Bioscience. We make the human milk-based fortifier.

REP. WILSON PHEANIOUS (53RD): Thank you.

DR. JEFFREY BARTLETT: So, I think the question that you had was how many moms cannot produce breast milk?

REP. WILSON PHEANIOUS (53RD): Right, that would be effected that need to have this – that deliver – the babies that are in the NICU unit, I guess.

LEISL SHEEHAN: Sure. So CDC and Humana will testify later. Someone from Humana will testify and I'm not sure what numbers she has. The CDC doesn't track moms that can't breastfeed. They track preterm births and not – most moms that are preterm birth can't breastfeed, but not all. So, the numbers we have are the amount of babies in Connecticut that are preterm babies that would've likely --.

REP. MASTROFRANCESCO (80TH): That need human, but I guess my point is, if the mother can produce the milk, obviously you want her to do that. It's the best thing for the baby. The purpose of this bill is for people who cannot. Am I wrong with that? Am I correct?

LEISL SHEEHAN: Yes.

REP. MASTROFRANCESCO (80TH): So, that's why I'm trying to determine how many babies are affected because the mother cannot produce because it correlates directly to this legislation.

LEISL SHEEHAN: Right.

DR. JEFFREY BARTLETT: So, someone from Humana would have better numbers on that, but we're saying that all of these babies – all of these 513 babies would qualify, if they were born at Danbury or Norwalk Hospital for human milk-based human milk fortifier

which is a way to supplement the calories in human milk.

REP. MASTROFRANCESCO (80TH): Right. And, I'm just trying to find out, out of that 513, how many of those 513 babies would need donor milk because the mother cannot provide it. That's all I'm trying to figure out.

DR. JEFFREY BARTLETT: A large portion of them may need it for the first days of life. I would say 30 to 40 percent of the babies that we – that we treat have moms that cannot produce enough milk in the first days of life, so they got donor breast milk for a short period of time. There's an even small percentage of those – of the overall moms that would need donor human milk for a longer period of time.

LEISL SHEEHAN: If depends on if and when the mom's milk comes in, so some babies need just donor human milk, some need – they have mom's own milk and they need human milk-based fortifiers mixed with mom's own milk and some are gonna need both, so it depends on if and when mom's milk comes in. The numbers that we have and that the CDC tracks are related to the babies that are born that would be eligible for the milk.

REP. MASTROFRANCESCO (80TH): Okay.

LEISL SHEEHAN: Not the mom that gets the milk that has her milk --.

REP. MASTROFRANCESCO (80TH): And, a lot of it – it's possible that some of these babies the mom would just take care of them and feed them and they're okay. Just doing the breast milk from the mom.

LEISL SHEEHAN: Sometimes the mom can provide milk, but the younger the baby's born the less likely the mom's gonna be able to provide milk. It depends on each mom.

REP. MASTROFRANCESCO (80TH): It does. Okay. That's just not the number I was looking for, but I certainly understand. Thank you very much.

REP. WILSON PHEANIOUS (53RD): Any further questions? Thank you very much for your testimony. Okay. I'm gonna just go out of order to accommodate some here. I'd like to call Dr. Victoria Niklas, please. Oh, I'm sorry. Excuse me. It's Martha Dawson that I need – oh. She's like well. Yeah, that was the – okay. That's too bad.

DR. VICTORIA NIKLAS: Well, thank you. Good, late afternoon, Senator Moore and Wilson Pheanious for having us today. I'm Dr. Victoria Niklas as mentioned. I am the Vice President for Medical Innovation and Communication at Prolacta BioScience. I've been in that position for three years, previously as the Chief Medical and Scientific Office. I also mentioned that, like Dr. Bartlett, I'm also a practicing neonatologist and have over 20 years of experience caring for those critically ill babies that we've spoken to.

I want to echo the gratitude I have for Representative Frey introducing this bill obviously addressing a very critical issue and thank you to the Committee for considering it. As you're all aware and has been summarized earlier that doctors and experts agree that the breast milk is the best source of nutrition. The American Academy of Pediatrics endorses it as well as the American Academy of Pediatrics states that preterm newborns

should receive a fortifier to make that milk nutritionally sufficient to allow not only growth, but also to support development. So, the low birth weight babies in the Neonatal Intensive Care Unit, human milk feeding is critically important, but the piece where Prolacta comes in is that fortified breast milk is critically important and Prolacta manufactures a human milk-derived fortifier so the diet of those babies can be exclusively human milk so that all of the important bioactives and proteins and so on can be enriched. This is important as Dr. Bartlett said because it is important in the reduction of diseases like necrotizing enterocolitis as well as reducing the time a baby has to be on parental nutrition and there were other factors mentioned. So, while I can testify at length on the benefits of those, one request that we have that the Committee consider is that this bill would require that all of the donor milk that's provided under this bill would actually be monitored by an agency other than the Human Milk Banking Association of North America, and while we all have products that are beneficial to these babies, the states that monitor human milk that were mentioned earlier use the Department of Health as that agency. We would make that recommendation. There are several banks that provide donor milk in the industry and more will be coming forward and we believe that this should be regulated by an uninvolved party.

So – and of course, Havana produces a very good and high quality product and we partner with them particularly their milk can be fortified with the human milk fortifier, but it cannot substitute for the role of a governmental agency, so I wanted to make one other presentation about the number of moms

in a Critical Care Intensive Care Unit that are able to provide breast milk, so if you look at the human milk feeding rates in the Neonatal Intensive Care Unit, it generally falls far short of that of babies in the normal nursery, and depending upon the hospital depending on the mothers that are there, rates can be as low as 10 percent, so there's a tremendous need to have a donor milk supply. I wanted to mention that.

So, I think we all share in the goal at improving and increasing the availability of human milk for Connecticut's neediest patients and the amendments that I and others have requested today would only improve that, and therefore, improve the clinical benefit of human milk, particularly by pairing it with the human milk fortifier. By taking these two key steps, I think Connecticut will be at the forefront of these vital issues nationally. So, I'd like to thank you for your time and the opportunity to testify for you and I'm happy to answer any questions that you may have. I'd also like to mention that Dr. Dawson had to leave because of a critical – not that she missed her flight and she was going to in her testimony – has been submitted – and she was going to review that the National Nurses – National Black Nurses Association actually has submitted a resolution on the exclusive human milk diet and this is critically important because of the higher risk of future newborns in the minority populations, so I thank you for your time and I'll take any questions.

REP. WILSON PHEANIOUS (53RD): Thank you very much. I'm just wondering, did you say that the doctor left some materials.

DR. VICTORIA NIKLAS: That was part of her testimony. She submitted it as part of her testimony.

SENATOR MOORE (22ND): Okay. All right. So, we will review that then.

REP. WILSON PHEANIOUS (53RD): Do you have any questions? Do either of you have any questions? Okay.

SENATOR MOORE (22ND): I'm sorry. I wanted to ask you, where are you from?

DR. VICTORIA NIKLAS: Los Angeles.

SENATOR MOORE (22ND): So, you traveled here for this testimony?

DR. VICTORIA NIKLAS: Yes, I have.

SENATOR MOORE (22ND): So, I just wanna say how much – you know, three minutes is not a lot of time considering you spent that much time to come here, but I wanted to say that it doesn't matter how much time you spend. It's the fact that you did come and you believe in this means a lot and that you've come that far to give this testimony. We understand how important it is. I'm very grateful for the person who's brought this legislation to us and I think we've learned a lot, more than – I'm way past that age of worrying about breast milk for a baby [laughter], but I have – I'll probably have grandchildren – well, I have grandchildren old enough now, but I'll have grandchildren in the future that this will be really important for. I hope they don't have to use it, that they're not a preemie, but it's a great opportunity to hear so many voices come and speak so passionately and know

so much about something that we've not had a conversation about before, right?

And, so I think – you know, I think that's the great part of this that we're learning and that we're – there's a lot of things we can't change right away, but there are some things that we can work on right now and get it changed and it will affect generations, so thank you so much for coming.

DR. VICTORIA NIKLAS: You're very welcome. Thank you.

REP. WILSON PHEANIOUS (53RD): One more question. Please go ahead.

REP. HUGHES (135TH): Thank you, Chairwoman, and would you speak a little bit more about the access to these products as you say in underserved communities that – I'm thinking about rural hospitals. I'm thinking about – well, yeah. I'm just thinking about whether this legislation would increase the availability to those that aren't the primary centers for neonatals.

DR. VICTORIA NIKLAS: Yes. So, there'd be absolutely no reason why it wouldn't and I'm sure that Dr. Bartlett can speak to some of these smaller hospitals in Connecticut, but there's absolutely no reason why the product can't be delivered to every preterm newborn born in the United States of America.

REP. HUGHES (135TH): Yeah. That's really important because I'm just thinking incidentally of several moms I knew who they weren't preterm babies, but they weren't able to – she wasn't able to produce milk for a while, so you never how, and how do we

plan on that except to have really quick access to those products for those babies and that's what I'm wondering about is getting that availability especially to underserved communities.

REP. WILSON PHEANIOUS (53RD): Okay. Hearing no further questions and I thank you very much for your testimony.

DR. VICTORIA NIKLAS: Thank you.

REP. WILSON PHEANIOUS (53RD): I'm going to go back to the officials list for Mr. Juan Candelaria briefly. Thank you, Representative.

JUAN CANDELARIA: I'll make it fairly quickly. Good afternoon. Abercrombie, Senator Moore, and Members of the Committee. I submitted written testimony so I'm not gonna read that testimony. I think you heard earlier today from the advocates in regards to the bill. I'm here in support of – sure, Representative Juan Candelaria from New Haven. [Laughter] Juan Candelaria. I'm here to testify and support S.B. 898, AN ACT ESTABLISHING HISPANIC FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND.

So, I've submitted written testimony. I'm not going into details of the testimony. I think you've heard all that from the advocates, but I think it was important for me to stand up here and really tell you in a nutshell what this – what we're trying to accomplish and basically it's to help these nonprofits build capacity, improve operational efficiencies for long-term fiscal sustainability. A lot of these nonprofits, when you look at that HRD line item, that has been flat funded for years. We have seen cuts from the recisions and holdbacks in

don't mean lousy, but compared to my budget and theirs, it's – to me, it's a lot of money. For them, it's a [inaudible 5:52:44] and I don't have the capacity to write a federal grant. I don't have the capacity to do searching for grants, but I know I do the work on the ground. So, I understand where you are and I just wanted to say how passionate they were and the woman from the Hispanic Federation, very passionate and very clear and she had great representation here today and we all paid attention. So, thank you.

JUAN CALENDARIA: Thank you so much.

REP. WILSON PHEANIOUS (53RD): If there are no further questions, we will excuse him. Our next person will be Dr. Maushumi Assad. I hope I haven't butchered your name too badly [laughter].

DR. MAUSHUMI ASSAD: It's a little bit easier. Maushumi Assad. Thank you, Representative Abercrombie, Senator Moore, and the Committee for allowing me to testify today. I'm an attending neonatologist at Winchester and Boston's Children's Hospital. As of recently, I completed my Neonatal/Perinatal Fellowship at the University of Connecticut and CCMC. So, perhaps the most relevant for today is that I published a clinical study that demonstrates the value of the exclusive human milk diet on very low birth weight babies which is the diet that Dr. Bartlett had mentioned, mother's own milk, or donor milk along with the fortifier. So, I'm testifying in support of the intent of H.B. 7165. So, according to the CDC, there's 55,000 very low birth weight infants born in the U.S. every year. We talked about 513 of these being in the state of Connecticut, so clinical research has shown

that this high risk population has specific nutritional needs which is why we can't provide mother's own milk or donor milk alone. So, by fortifying this milk, we're better able to manage the metabolic needs and promote optimal growth.

The most common fortifier that is currently used in NICUs is cow's milk based. It contains proteins that can cause feeding intolerance and also increase the incidence of necrotizing enterocolitis or NEC which is the devastating intestinal infection. Both of these complications are devastating in many ways. It can lead to increased length of stay and NEC in particular is an extremely costly complication. So, different studies have estimated average hospitalization costs due to NEC are as high as $216,000 per infant and it's between $500 million and one billion in the U.S. to care for these babies long term.

So, it can be quite costly. The alternative is to use, for the low birth weight infants and exclusive human milk diet which includes this fortifier that's donor-milk based. Despite the numerous benefits of this diet, NICUs aren't providing this diet due to the high associated costs, so that study that I published shows that in fact hospital costs can be decreased overall by decreasing the time to full feeds, hospital stay. In addition to that, it has the additional benefit of decreasing other significant morbidities such as retinopathy of prematurity and bronchopulmonary dysplasia and sepsis. So, despite the increased upfront cost, my research shows that providing this can actually lower overall hospital costs and improve clinical outcomes. So, providing optimal nutrition during this critical period is important for improving

their long-term outcomes, and based on this research and our findings, I strongly encourage you to recognize the benefits and further promote its use in the preterm population and amending the bill to include Medicaid reimbursement for this fortifier as well. Thank you for your time and the opportunity to testify today.

REP. ABERCROMBIE (83RD): Can you – do you know how other states – so OLR had told us that there was about six states that were able to get I assume either a state plan amendment or waiver to include this as a Medicaid reimbursement. Do you know anything about that?

DR. MAUSHUMI ASSAD: I don't. I know the states that Dr. Bartlett had mentioned that are covering, but I don't know how exactly that happens.

REP. ABERCROMBIE (83RD): Okay. And, then – and then, the second question is, for the fortifier, right? So, what is the cost of the breast milk and then what is the cost for the fortifier that goes in it?

DR. MAUSHUMI ASSAD: So, per baby, it can be about $1,000 for the fortifier.

REP. ABERCROMBIE (83RD): Per what, hon? Per what? Per – is it?

DR. MAUSHUMI ASSAD: I don't know the actual --.

REP. ABERCROMBIE (83RD): Like how do you measure? Is it formula for a week, a month, a year? How – how do you do that?

DR. MAUSHUMI ASSAD: Sorry, $10,000 per baby for the entire course, so that would be their time from

admission to discharge which usually you're not – sorry, let me go back a little bit. So, they're not on the fortifier their entire length of stay. It's just 'til they're a few months old basically. Once they get to full feeds at about 34 to 36 weeks, they're transitioned to formula and not necessarily still on that donor milk-derived fortifier.

REP. ABERCROMBIE (83RD): Okay. So, let me just – let me say back what I think you said, okay? "Cause I'm not a doctor. I don't play one on TV. Okay? [Laughter]. So, Gale, wait. Wait 'til you see these late nights. This is just early for us. So, what you're saying is, is a preemie baby is born, right? Depending on how preemie the baby is – I apologize for not using the right terminology, right? They decide that the breast milk is the best procedure to go forward. They decide that because of the condition, of the nature of the baby, what's going on with the baby's body, you have to do a fortifier, right? So, you're saying that if you do that for say four weeks, right, that that's the amount of money that you're saying for the fortifier for that amount of time. When a baby gets discharged, right, so you go by is it weight or a number of weeks or both, is the measure you use to see when the baby doesn't need that anymore?

DR. MAUSHUMI ASSAD: Usually weight and age of the baby.

REP. ABERCROMBIE (83RD): So, it's both?

DR. MAUSHUMI ASSAD: Gestational age. It's both, yeah.

REP. ABERCROMBIE (83RD): Oh. Okay. All right. You gotta talk in layman terms.

DR. MAUSHUMI ASSAD: Sorry. Yeah. Age and weight.

REP. ABERCROMBIE (83RD): Don't laugh over there in the corner [laughing]. Okay. So, then – so then, once you stop – so, do these babies stay on the breast milk without a fortifier at some point, so say you do reach, right, the weight or the number of weeks, right? Are some of these babies staying on breast milk and then do any of these babies go home continuing to use breast milk or do you – do most of them get transferred on to a formula?

DR. MAUSHUMI ASSAD: So, they will continue on breast milk, but in addition, will have a formula that will supplement the extra calories and increased calcium and phosphorus that they need for bone growth.

REP. ABERCROMBIE (83RD): So, -- so. Oh, you mix them together or how do you --?

DR. MAUSHUMI ASSAD: You can. You can mix it together. You can also have them exclusive breastfeeding if mom's are able to breastfeed and then just have a couple bottles of formula in order to make a good amount of their daily intake in order for good growth.

REP. ABERCROMBIE (83RD): Oh, so you can do – so you can – and, listen, I find this really fascinating, so thanking you for taking the time. These guys know I was like so anxious in this. So, you can have a mother that gets donor milk through the hospital, right, and then her milk comes in and she can transition when she brings the baby home to her own milk.

DR. MAUSHUMI ASSAD: Yes.

REP. ABERCROMBIE (83RD): Interesting. They're agreeing. Okay. Thank you. Thank you for that. I really appreciate it.

REP. WILSON PHEANIOUS (53RD): Are there any other questions? Senator Moore. Oh, I'm sorry. We'll let Senator Moore go first and then --.

SENATOR MOORE (22ND): So, just out of curiosity, have you seen an increase in the need of – for this because of the opiate crisis that those babies might be preemie and there might be a greater need?

DR. MAUSHUMI ASSAD: That's good question. I don't – I can't speak from – but, yeah.

REP. WILSON PHEANIOUS (53RD): Are there any other further questions? Oh, I'm sorry. Yes. Thank you.

REP. MASTROFRANCESCO (80TH): I wanted to touch up on followup on what Representative Abercrombie was talking about, the cost. And, I guess I'm a little confused like the Representative – this is a learning process for me as well, certainly not an area that – I'm far too old for breast milk, but anyway [laughter], so the donor breast milk, there's two components. You have the donor breast milk and then you have the fortifier, correct, which is Prolacta?

DR. MAUSHUMI ASSAD: Yes.

REP. MASTROFRANCESCO (80TH): Is that the brand name?

DR. MAUSHUMI ASSAD: That is the brand name.

REP. MASTROFRANCESCO (80TH): Of the --.

DR. MAUSHUMI ASSAD: Of the fortifier.

REP. MASTROFRANCESCO (80TH): Of the fortifier, okay. So, you had mentioned something about a cost of approximately $10,000. Is that for the donor milk or is that for the fortifier?

DR. MAUSHUMI ASSAD: Yes.

REP. MASTROFRANCESCO (80TH): And, $10,000 will get you how long and how much?

LIESEL SHEEHAN: Sure. Renegotiating with Prolacta for the record, so $10,000 is the average course of treatment for the fortifier and that course of treatment, of course, depends on how premature the baby is, how long it need the fortifier, but I think it's around $230 a day for the fortifier. That does not include donor milk. Most of the time our fortifier is mixed. The ideal situation is that it's mixed with mom's own milk as she can pump. If she can't, most often it's mixed with donor milk which comes from HMBANA the vast majority of the time and I know HMBANA gets --.

REP. MASTROFRANCESCO (80TH): I'm sorry, comes from where?

LIESEL SHEEHAN: The Human Milk Banking Association of North America, one of their milk bands and I know Amy will testify on their behalf shortly so she can talk about their milk. Prolacta has a very small donor milk business that only certain hospitals use. That donor milk is around $9 an ounce. It is a higher cost because of the processing that Prolacta does and they do extra testing and quality measures. Normally, I think you're talking about $4 or $5 an ounce, but I know the name and I can clarify that for you. The fortifier is the bigger cost, right. We would say that's where you see a lot of the cost

savings as well and that's what Dr. Assad's study talks about. That's where you see the $10,000.

REP. MASTROFRANCESCO (80TH): So, the fortifier is about $230 a day?

LIESEL SHEEHAN: Correct.

REP. MASTROFRANCESCO (80TH): And, the donor milk is about how much a day average?

LIESEL SHEEHAN: It depends on the baby growth, right, because as the baby grows they need more, so it's priced by ounce, so that's a little harder to say how – by day, so there you'd measure it by ounce. So, it varies.

REP. MASTROFRANCESCO (80TH): How much is it per ounce?

LIESEL SHEEHAN: Again, it depends on where you obtain the donor milk, so Prolacta's is about $9 an ounce. The HMBANA donor milk is about half of that. We can clarify.

REP. MASTROFRANCESCO (80TH): I'm sorry. Can you say that brand again, what is it?

LIESEL SHEEHAN: It's the Human Milk Banking Association of North America.

REP. MASTROFRANCESCO (80TH): Okay. So, it's about $9 an ounce.

LIESEL SHEEHAN: That's Prolacta's – Prolacta is $9 an ounce.

REP. MASTROFRANCESCO (80TH): Okay. So, I'm just trying to figure out cost-wise, so the goal here is to have the Medicare pay for the donor milk or the fortifier? Or Medicaid, sorry. Excuse me. I keep

saying that – Medicare. Medicare, clearly we don't need any breast milk [laughter]. Medicaid.

LIESEL SHEEHAN: We would like for Medicaid to cover both. Not every baby that needs donor milk needs fortifier, only some, and we would like for the bill to cover the donor milk and the fortifier so that babies that need this exclusively human milk diet, such as the donor milk and fortifier, can receive exclusively the human milk diet. That allows the physician to make the decision if they need just the fortifier – I mean, sorry. I mean just the donor milk or [inaudible 6:6:16].

REP. MASTROFRANCESCO (80TH): And, I think you mentioned that for the average time that the baby is on the fortifier, and average I know every baby is different, but they're --.

LIESEL SHEEHAN: Probably three to four weeks.

REP. MASTROFRANCESCO (80TH): Oh, three to four weeks. I thought it was longer 'cause you said the cost would be approximately $10,000 and at $250 a day that wouldn't --.

LIESEL SHEEHAN: The smaller the baby, the longer the baby would be on it, so it's by --.

REP. MASTROFRANCESCO (80TH): It's about an average, though. Okay. Thank you very much. I feel much more educated now on the topic.

REP. ABERCROMBIE (83RD): So, Representative, I will send you – so I reached out to Yale to find out the measures that they use, how they pay for it, and how many – what they average. So, I've got the information, the criteria that's used. I haven't gotten the information as to how many moms that they

normally do within a year, but I'll make sure that we send that information around for the whole Committee. Yeah. Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chair. Just – just for cost comparison for the Committee and you may or may not know this, but do you know how much it costs for instance for a – for a children with hemophilia to have the – well, the medication, the injection every other day? Do you know how much that is?

DR. MAUSHUMI ASSAD: No.

REP. HUGHES (135TH): It's $3,000 for – per dose, so just to give it in terms of comparison, in terms of what we're talking about for the life of a baby to get back on track versus a lifetime of life-saving dose that's equitable, so yeah.

DR. MAUSHUMI ASSAD: Thank you for that.

REP. HUGHES (135TH): FYI. Thank you.

REP. ABERCROMBIE (83RD): Thank you. Okay. So, I just wanna make sure. So, Dr. Victoria is not testifying or is she? You already did. So, now we're on to Dr. Martha Dawson. Okay. Dr. Jim Moore. So, this is the guy that's got the answers 'cause I saw him shaking his head over there. Thank you for sticking around to testify today. We do appreciate it.

DR. JIM MOORE: My pleasure. Senator Moore, Representative Abercrombie, and Members of the Human Services Committee, I want to thank you for the opportunity to share my thoughts on H.B. 7165, THE ACT CONCERNING MEDICAID COVERAGE FOR DONOR MILK. My name is Dr. James Moore. I'm the Division Chief for

Neonatology for Connecticut Children's Medical Center and that includes the University of Connecticut as well and that we are submitting this testimony in support of the proposed legislation because of the significant health benefits, many of which you've already heard for our neonatal patients. In addition to the reduction and cost of care of these neonates that comes directly from the use of human donor milk.

Before I comment on the bill, I do want to mention that our statewide newborn services network allows our neonatologists, our neonatal nurse practitioners, our PAs, to share their expertise with families and care for babies at 11 different hospitals within the state of Connecticut from Putnam to Hartford to Norwalk. Specifically, I'd like to now address donor human milk which is obviously extremely important in the field of newborn care. Increasing human milk usage has become a focus in pediatrics and neonatology based on substantial positive literature-based evidence and in a textbook of neonatal nutrition and in policy statements from the American Academy of Pediatrics, it is clear that human milk should be used for preterm babies as best practice because it improves health outcomes.

Human milk, and this may address the Representative's question, is much more than nutrition. It is living tissue and actually in Australia and in Europe it is treated as a tissue rather than nutrition or a food product. This living tissue, in addition to the sugars and proteins and fats that most of us think about for human milk, is actually made up of hundreds of components that are vital to newborn health. Some

of these include immunologic factors such as antibodies, leukocytes, and proteins that together actually prevent infections.

Human milk also contains hormones that promote organ growth and development. None of this is present in formula. The full array of proteins, hormones, and cellular signals that are contained in human donor milk are too extensive to list here, but the key message that I'd like to get across is that human milk or human donor milk is actually specifically designed for human babies and that we have – it has many more benefits than just getting them to grow. Human donor milk, when used in the Newborn Intensive Care Unit, you heard some of this already from Dr. Bartlett, improves tolerance to oral feeds and has been shown to reduce NICU stays anywhere between one to four days. In fact, there are more than 53 literature-based studies in just the last 11 years that have either shown improved tolerance, reduced length of stay, or reduced instances of a catastrophic GI tract infection called necrotizing enterocolitis which we've now heard about a couple of times. NEC affects up to 10 percent of all babies admitted to NICUs that have weights of less than 1,500 gm. Of those babies that develop NEC, mortality can approach 50 percent in infants that require surgery.

For survivors and this gets to the long-term point, is that they often have lifelong problems, and most importantly, neurodevelopmental disabilities that often require and become a burden to the families. Using human milk instead of formula can reduce the rate of NEC by up to 50 to 80 percent. This impact can lead to immediate savings that you heard about that can total into the hundreds of thousands and

that otherwise would've been babies that had developed it, and more importantly to me, it improves their long-term health outcomes.

I'd like to conclude with a very personal story. A number of years ago, I did take care of a family and that mother had a baby that was born 13 weeks early at 27-weeks' gestational age. This little boy transitioned from mom's milk to formula because mom was unable to keep up. Her supply was inadequate. One week later, this baby developed necrotizing enterocolitis and died of complications of this intestinal infection. Two years almost to the day, this mother delivered a second 27-weeker. This time, it was a girl. She was able to actually get mom's milk for a period of time, and when mom's milk became insufficient, the hospital that they were at was able to use donor milk. Unfortunately, their policy said that they had to stop at a month. Unfortunately, within two days after this baby was transitioned to formula, this baby developed NEC and almost died. Each time this mother presented to us, and I happened to be actually the physician for both times, that on the second time this mother asked how could this happen again?

I will be transparent. NEC is a very complex disease, and while we don't fully understand all the contributing factors, what we do understand is that human milk is the only intervention we have in neonatology to reduce the incidence of it. It is best practice to supply preterm babies with mother's own milk, or if not available, to use human donor milk when mom's milk is not available. Unfortunately, and this was I think another question earlier, we still have families in our state that could benefit from this therapy – human donor milk,

unfortunately, is not offered in all the NICUs across Connecticut because of the cost and I would urge you to approve H.B. 7165 so that we can extend this vital intervention to all babies that need it. And, I want to thank you for your consideration of our position. And, to the question of how other states did it, I most recently before I became Division Chief at Connecticut Children's, I was actually the Medical Director at Dallas Children's in Texas. They passed this law because of it being a living tissue as opposed to nutrition.

REP. ABERCROMBIE (83RD): So, they were able to get Medicaid to pay for it under a different definition?

DR. JIM MOORE: Correct.

REP. ABERCROMBIE (83RD): Interesting. Okay. So, my second question to you – thank you so much for your testimony. So, currently private insurance doesn't pay for this either. Is that correct?

DR. JIM MOORE: I believe that's correct.

REP. ABERCROMBIE (83RD): So, at CCMC, what measure do you use to decide if you're going to – 'cause I would assume what we're talking about it you're donating, right, this product for these babies. So, how do you determine which babies get this breast milk and which don't? How do you make that determination, and then the second part of that question is, how do you pay for it?

DR. JIM MOORE: Exactly. First, we do not discriminate. All preemies get either mom's own milk or have the donor milk offered. On rare occasion, there is a couple of the moms here and there that may actually decline, but we use donor

milk or human milk for all of her our preemies that are essentially less than 34-weeks' gestation. As far as how we pay for it, Connecticut Children's, as I'm sure you're aware, takes care of maybe more than 15 percent of all kids in Connecticut covered by Medicaid, and that we have spent nearly $90 million on free and uncompensated care. To your exact question of Connecticut Children's Unit and the NICU here, we spend somewhere between $60 and $75,000 a year on donor milk alone. We do not use the fortifier for the simple case of that we cannot afford it. But, we do use donor milk because we believe whatever we can offer, we will. Many of our families come from inner city Hartford and other areas as well. We believe that it is best practice and we try to adhere to the American Academy of Pediatrics policy.

REP. ABERCROMBIE (83RD): So, I would assume that Yale and Yukon probably do the same thing.

DR. JIM MOORE: Yale I believe does do the same thing. Yukon is actually – the NICU is actually Connecticut Children's. They're one and the same.

REP. ABERCROMBIE (83RD): Oh, they are?

DR. JIM MOORE: Yes, they are.

REP. ABERCROMBIE (83RD): Oh, I didn't realize that. Okay. That's interesting. Okay. Questions? Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chair, and Thank you for your testimony. This really broadens like we said our learning curve very much and I love as I suspected the redefinition of mother's milk and fortifier as tissue which indeed, of course, it is

biologically. Do you – and again, I think it's just really important to put this into perspective in terms of cost. So, are you aware that when like tissue is donated that the recipient usually has to take some kind of injection for antirejection? So, do you know how much [inaudible 6:19:12] is as an injection?

DR. JIM MOORE: I do not know.

REP. HUGHES (135TH): It's $10,000 per injection. And, that is required so that the recipient doesn't reject the donated tissue especially in the early stages. So again, I think this is really cost-effective to provide when we think about.

DR. JIM MOORE: I want to state that you do not need antirejection medication for human donor milk.

REP. HUGHES (135TH): Right. Even more cost effective. Right? It's a win-win. I think it's a bargain. So, can you send, and we'll give you a card, can you send our clerk a total amount of what you average a year for the donor milk and then how often you have to use a fortifier? I mean, it is automatic for you, and if you don't, could you just give us those numbers because this is the challenge that we face, right? So, the way we do our appropriations budget and the way we pay for things is that we don't take into consideration what it costs to not do the right thing. We can only work with what's in front of us. So, if it's gonna be 100,000 a year, we have to put 100,000 in the budget. So, I need, and I've asked the same thing from Yale and I haven't gotten it yet, we need solid numbers what we're talking about 'cause I can't get this bill out of this Committee, right? It's gonna have to go to appropriations without any background

information, so please if you could send me that, I would really appreciate it.

DR. JIM MOORE: To answer the second part which was the fortifier, all preterm babies require fortifier, all. They are not able to sustain themselves on breast milk alone. In addition to the additional calories, they need the additional calcium and phosphorus for bone growth and others that breast milk in and of itself is not capable of doing with the volumes that these babies can tolerate.

REP. ABERCROMBIE (83RD): Sort of like giving an elderly person Ensure.

DR. JIM MOORE: Exactly.

REP. ABERCROMBIE (83RD): That's kinda in my brain how I – how I figure it out. Thank you. Any questions? Yes. Representative Mastrofrancesco.

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. I was trying to get figure numbers before, basically how many premature babies are born in Connecticut and I think the number I got – was it 515? There's approximately 515. Do you have any further numbers knowing like how many of those out of the 515, to Representative Abercrombie's point, trying to get some numbers together – how many of those babies born premature would be Medicare – Medicaid. Jeez. I keep saying Medicare. I'm so far beyond that for this topic. How many of the 515 would be Medicaid eligible? Just trying to get some cost figures in your head and you did mention as well that insurances do not pay, correct? Or they'll pay for the first 30 days, the private --.

DR. JIM MOORE: The – the – I think – sorry. Let me be clear. I am not aware that private insurance pays. That doesn't mean that they don't. I'm just – I'm in the background, but in other states it does. I'm just not aware of Connecticut at this point. Fortunately, being in an academic center, I'm not necessarily involved in counting the money, but I do know that was being Medical Director of Connecticut Children's NICU as well that we do offer donor milk to all comers either way and we look it as essentially eating that cost because it is the best thing for these children.

REP. MASTROFRANCESCO (80TH): Right, yeah. In my mind, it doesn't really matter whether they're on Medicaid or if they're a private insurance. A baby is a baby and we need to do what we can to take care of them. That's why I was just curious because this one specifically was for Medicaid, so just curious.

DR. JIM MOORE: Yeah. Realistically, obviously the numbers vary by county. In our own population, we actually here in Hartford have a fairly high rate of Medicaid where some of the other hospitals around the state have lower. There's also big discrepancies. In the rates of prematurity between whites and African-Americans, it's almost twice as common for prematurity to occur in African-Americans, so there is a variety of different things to consider, but the total of medication, it would be something I would have to look up and then I could give you the numbers for what the cost would probably be.

REP. MASTROFRANCESCO (80TH): That'd be great. Thank you very much for your testimony.

DR. JIM MOORE: Thank you.

REP. ABERCROMBIE (83RD): Thank you so much. I look forward to getting that information from you. Dr. Naomi Bar-Yam. Thank you. You know what happened, they separated, so I'm not sure how many of there -- if it's two words or one. Thank you for being here.

DR. NAOMI BAR-YAM: Okay. Thank you. I'm gonna try to keep this short 'cause I know everybody wants to go home. So, thank you to all the Members of the Committee for this opportunity to share my thoughts in support of H.B. 7165. My name is Naomi Bar-Yam. I'm the Executive Director of Mother's Milk Bank Northeast and I'm the immediate past President of the Human Milk Bank Association of North America and we would strongly encourage Connecticut to join with the seven other states and Washington, D.C., that currently provide Medicaid funding for donor milk.

And, each of those laws is different. I'm happy to send you the legislation. I mean, I have them in my files for each of those states, so I'm happy to send that to you. Medicaid coverage for donor milk in Connecticut will save both lives and healthcare dollars. Mother's Milk Bank Northeast is a nonprofit community milk bank operating under the safety guidelines of the Human Milk Banking Association of North America. We are Connecticut's primary milk bank and we serve eight Connecticut hospitals.

On a community level, we have five milk depots which are drop off locations throughout the state, and since 2011, we have nearly 700 Connecticut mothers who have been screened to be milk donors. Babies born as we have heard weighing less than 1,500 gm, which is about 3.4 pounds, are at the highest risk for developing NEC. About one-third of the babies

with NEC can be treated medically, about one-third requires surgery to remove part of their intestines that have died, and about one-third do not survive. Multiple research studies over decades as we have heard tell us that human milk is important in preventing and mitigating the severity of NEC. Between 5 percent and 7 percent, although someone just said about 10 percent, of premature babies will develop NEC, so in Connecticut each year, an estimated between 500 and 600 babies are born at less than 1,500 gm. Of those, between 30 and 35 or so will develop NEC.

Our research indicates that providing donor milk to babies until they reach 1,500 mg would cost between $300,000 and $350,000 per year and I have a little bit more details in the written testimony. This assumes that babies do not receive any of their own mother's milk which is rarely the case. Often mothers are able to provide something. If one conservatively estimates that the human milk diet reduces NEC by 50 percent, and as before it can be higher than that, this measure would prevent 15 to 18 cases of NEC per year. NEC treatments average $225,000 per patient, so to add that all up, an investment of $300,000 to $350,000 for donor human milk will save $3.3 to $4 million dollars to treat NEC.

These calculations are NICU costs only, do not measure the long-term effect, and costs of the developmental delays and short gut syndrome which we've heard often affect NEC patients. It has been well documented, and I don’t have the exact numbers – we're still working on getting those as other people are, that low income and families of color have much higher rates of premature birth, NEC, and

infant mortality. They're also more likely to be treated in safety net hospitals as we've heard which in turn are less likely to use donor milk because it is not covered by Medicaid. So, Medicaid coverage for pasteurized donor human milk will save lives and money and ensure more equitable access to quality care in Connecticut.

Mother's Milk Bank Northeast is eager to work closely with the Human Services Committee and other committees that become involved on really refining the details of this bill, so please call upon us. We have us and at the milk bank we have the expertise of a large and very dedicated and wonderful Research and Medical Advisory Board, some of whom are here in Connecticut really in the service of the citizens of Connecticut. Thank you.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Questions? Thank you for waiting to testify. We really do appreciate it. Ann Marie. She's not here either? So, that concludes everyone that has signed up to testify. If there's any -- . Okay. So you must've signed up late because I have the list of earlier, so Kaley, you wanna go get the list, please? So, why don't we do this. Do you guys wanna come up together? Are you friends or --? Okay. Okay. That's fine. Just checking.

SENATOR MOORE (22ND): So, I met you all very earlier in the day. You were looking for the room, right? I'm the one who told you go look for the table, but it was – I thought you – but, I thought you said you were going to be meeting in a room later. I thought maybe you thought there was something after this, so I am the one that gave you

the directions, all right? But, you've been here quite a while.

REP. ABERCROMBIE (83RD): Okay. So, Stephanie DiMarco is first. Where's Stephanie? Okay. And, then Natalie and then Marissa.

STEPHANIE DIMARCO: Hi. Good afternoon, Madam Chair and Members of the Committee. My name is Stephanie DiMarco and I'm speaking in support of H.B. 7165. I am a mother to two beautiful children and a milk donor. This is my daughter, Willamina. Sorry. She was born two years ago at only 24-weeks' gestation, so she's one of those 515 babies that was born in 2017 weighing less than 1,500 gm. While waiting to see my daughter for the first time and recovering from childbirth, I was encouraged to start trying to pump milk. Since she was born so early, the nursing staff wasn't sure if and when my body would start producing milk.

They did stress how important it was that I try. I was incredibly fortunate that my milk came in right away. On my first trip to the NICU, I was so, so proud that I had a few drops of precious colostrum to bring with me. I continued pumping religiously every two hours and I brought progressively larger containers of milk with me to the NICU. After I was discharged, I drove back and forth from New Britain to St. Francis multiple times a day to see my first born child and bring little bottles of milk with me. On her seventh day of life, the amazing nursing team told me that I could start freezing my milk at home because I had already brought in so much milk to the NICU. I was the champion of milk at the St. Francis NICU.

Sadly, Mina's lungs were too weak to survive the infection that she developed and we made a devastating decision to remove her from life support at 12 days old. And, my story could end here. I could've asked the NICU to dispose of that milk. I could've emptied out my freezer and I could've worked to let my milk dry up. And, I almost did. I woke up that first night after my daughter died covered in tears and milk and I didn't know what to do. I pumped a little bit to relieve some of that pressure and I poured the milk down the drain. And, then I sat on my kitchen floor and I sobbed because it felt like I was pouring away the only thing that I was able to do right for my daughter. I was pouring away our connection. I was pouring away my motherhood.

The next morning I found a little hope. When you leave a hospital for the last time without a baby, you get a tiny box of memories and a folder with some pamphlets on grieving. In that folder, there was also a card for Mother's Milk Bank Northeast and I thought, maybe they'll want some of this frozen milk. I spoke to the wonderfully kind and supportive intake coordinators at the milk bank and they told me how incredibly important human milk is for premature babies and I chose to donate the frozen milk I already had and continue pumping through my daughter's due date. For 16 weeks, I faithfully pumped. I got up multiple times a night. I sat wait for what was probably days of my life making milk for babies that I'll never meet.

My husband washed all those tiny pump parts for me multiple times a day. It was an incredibly large part of our grieving process and it is something that I will be proud of for the rest of my life.

You've heard from earlier speakers on the statistics on breast milk and necrotizing enterocolitis in preemies. You know that it is medicine for these tiny fighters, but I want you to really understand what the statistics about breast milk and NEC really mean. A premature baby that receives breast milk, whether from their mom or a donor like me, is 79 percent less likely to develop necrotizing enterocolitis. They are 79 percent less likely to develop a condition that can easily kill them. Their parents are 79 percent less likely to have to pick a funeral home. They're 79 percent less likely to decide if their child should be buried or cremated. They're 79 percent less likely to only be able to introduce their child with a picture. They're 79 percent less likely to spend the rest of their lives grieving their precious baby.

I was able to donate over 1,000 ounces of breast milk because my daughter, Willamina, was here and made me a mom. I donated because with each ounce given to another baby, her legacy lives on. I donated because her life, no matter how brief, matters. My son, Octavius, was born four months ago full term and I'm proud to say that for his big sister's second birthday, we sent in our first donation of 150 ounces. Between my two babies, I have donated over 10 gallons of breast milk and done my part to help other babies live. I'm asking you to please do your part and ensure that Medicaid covers donor breast milk. Thank you. Sorry to bring the room down.

SENATOR MOORE (22ND): I appreciate your courage to bring this to us with such passion. And, I'm considering Willamina as an angel for all those other babies that you were able to – but, I think it

was quite generous 'cause you could've waddled, you could've felt sorry, you could've said why me, you could've just stayed in your bedroom, thrown the pillow over your head, and just stayed there, but you didn't. You did something and you do hold us to that standard of you want us to do something also. So, I thank you for doing that and I gotta tell you, we're on board. We're just gonna figure out how we do this. You've built a really great case of why this is important. I mean, when I consider we knew – most of us – didn't know a thing about this and that you've come here with this information and built a really strong case of why we need to do this. I'm quite sure everybody here is gonna try to do the best they can to make this happen. We just have to tweak it to figure out how we – how we get it done. All right?

STEPHANIE DIMARCO: Thank you.

SENATOR MOORE (22ND): So, thank you. And, so Natalie. I don't know how you follow that. I'm sorry. I'm sorry.

SENATOR HASKELL (26TH): I just wanted to very briefly thank you so much for sharing your story and for your patience. These hearings can be exceptionally long and it is I think clarifying, at least for those of us like myself who don't know very much about this issue, to hear your story.

STEPHANIE DIMARCO: You're not a huge lactator? [Laughter]

SENATOR HASKELL (26TH): No. Not exactly. So, I really am so grateful for not only your service to the community, but also your service here today in --.

STEPHANIE DIMARCO: Thank you so much.

SENATOR HASKELL (26TH): -- helping us understand the impressive importance of this issue.

STEPHANIE DIMARCO: Thank you.

SENATOR MOORE (22ND): Thank you. Natalie. Thank you.

NATALIE MARTIN: I don't know how I follow that, but hi. Members of the Committee, thank you for giving us all the time to speak today on this important bill. I know it's been a long day and I don't know how to follow that really, so I will be brief. My name is Natalie Martin. I live in West Hartford. I'm here today in support of bill 7165. I am also a proud former donor of breast milk to the Mother's Milk Bank Northeast. After having my first healthy baby daughter, I began to educate myself on the many live-saving benefits of breast milk which you've heard about so far today.

A few years later after my second daughter was born, I sought out the Milk Bank Northeast in Newton, Massachusetts, to donate my over-supply because I know how important it is for medically fragile and premature babies to receive this breast milk. I'm fortunate enough to sit here today and say that if either of my daughters had needed donor breast milk, my husband I would have been able to afford it, but we know that that's simply not the case for so many. As referenced in my written testimony, low income and families of color have a greater risk of having a baby born prematurely and these are the babies that are going to benefit the most from this bill.

Years ago, I was proud to send my ounces of milk to the milk bank and today I'm proud to sit before you and advocate for our babies who need access to this life-saving liquid gold as badly. And, being a milk donor was actually only the beginning of my journey with the Mother's Milk Bank Northeast. Last summer, along with Marissa, we were instrumental in bringing a milk depot to our very own Yukon Health right in Farmington. This milk depot is making it easier for our greater Hartford donating moms to get their milk to the bank and joins five other depots across our state.

This only furthers our reach and our awareness on this – on the incredible benefits of donor milk and I'm grateful now to have joined the Board of Directors for the Milk Bank to continue to give a voice here in Connecticut for our most fragile babies. So, thank you for listening to me and everybody else and for your time.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Questions? Seeing none. Thank you so much. Thank you for what you do. Marissa.

MARISSA MERLO: It started as good morning and then went to good afternoon. Now, it's good evening, Members of the Human Service Committee. My name is Marissa Merlo and I'm from Wethersfield, Connecticut. I'm here in support of Bill No. 7165, AN ACT CONCERNING MEDICAID COVERAGE OF DONOR BREAST MILK. I am the Lactation Consultant at Yukon Health in Farmington with a background in neonatal nursing stemming back to 2003. Along with Natalie Martin who just spoke, we worked over the summer to bring a milk depot to Yukon Health. Since its opening, which we coincidentally opened during world

breastfeeding month, I'm thrilled to share that we have collected and shipped out just shy of 10,000 ounces of breast milk, an incredible feat, and shows that there is a clear need and interest in our area for donor milk.

Every day throughout my nursing career, I encountered and worked closely with babies and families who would directly benefit from donor breast milk and specifically the coverage applied through this bill. As a Lactation Consultant, I'm aware of the benefits of breast milk. That goes without saying. Breast milk can increase neurological function. It drastically decreases the risk of ear infections and GI disturbances during the first year of life just to name a few. And, those are really the benefits of a term baby receiving breast milk. To reference the written testimony that Naomi spoke of earlier, one-third of babies who develop NEC will die. Research has shown that human breast milk can prevent these deaths. During my time as a NICU bedside nurse, I personally cared for a number of babies who, unfortunately, did not have access to donor milk. As a result, I have attended more than one infant funeral due to complications of NEC.

Breast milk truly does save lives. These deaths could have been prevented if only a donor milk program had existed at the time. Unfortunately, many hospital budgets, especially those in urban communities, simply cannot take on these costs. This is why I'm here supporting this bill. Thank you so much for your time.

REP. ABERCROMBIE (83RD): Thank you. Thank you for what you do. So, the milk bank that you talked about that you have now at Yukon, right --.

MARISSA MERLO: Depot.

REP. ABERCROMBIE (83RD): So it's depot – sorry. So, do you distribute that to CCMC and Yale or does it say – is it – the amount that you have just cover what you have?

MARISSA MERLO: No. That milk actually can circulate back to CCMC and Yale, but the milk we collect actually has to go to the milk bank, the Mother's Milk Bank in Boston, right outside of Boston to be pasteurized and processed and then it's shipped to over 80 hospitals throughout northeast.

REP. ABERCROMBIE (83RD): Oh, so it doesn't come right back in to the district even though you're --.

MARISSA MERLO: Not necessarily. It goes everywhere.

REP. ABERCROMBIE (83RD): Okay. So, there isn't a system in place that says if you donate it, somehow you get X amount back. It's just a gesture of donating it?

MARISSA MERLO: It's all good will.

REP. ABERCROMBIE (83RD): Okay. Questions? Senator Moore.

SENATOR MOORE (22ND): Thank you. So, we're just trying to figure out. So, people are donating it, but there must be a cost in the shipping and sending it and getting it processed.

MARISSA MERLO: Absolutely. That's covered by the Mother's Milk Bank Northeast.

SENATOR MOORE (22ND): So, then I'm gonna wait – I'm gonna ask Dr. Moore to come back up just so I can ask a question about that.

MARISSA MERLO: Do you want Dr. Moore? Do you – you probably want Naomi.

SENATOR MOORE (22ND): No. Yes. So, thank you very much.

MARISSA MERLO: You're welcome.

SENATOR MOORE (22ND): I think I just like hearing Dr. Moore. Dr. Moore. [Laughter] I think that's – that's what it was. Dr. Moore? You know, some people get elected and they think it makes them smarter than everybody else, but I come up here and I pick up a doctorate, you know? [Laughter] So, my question – we're just trying to figure out how much – what we need to ask for in the way of budget-wise for bringing this out and Representative Abercrombie just said maybe we just need to pay for the fortifier. And, but now – but I'm hearing.

DR. NAOMI BAR-YAM: No. The milk – hospitals that use it do cover it, but as you heard from Dr. Moore and others, there are hospitals who just cannot cover those costs.

SENATOR MOORE (22ND): But are – but ours do. But, I did hear it at the end of your – at the end of the previous testimony that some hospitals wouldn't be able to take on the cost of it. Is that correct?

DR. NAOMI BAR-YAM: Exactly.

SENATOR MOORE (22ND): So, but I also heard that it was covered in the hospital bill.

DR. NAOMI BAR-YAM: Some hospitals do. Each – my experience working with a lot of hospitals is that each hospital finds their own way to cover it, but it also sometimes forces them to really limit what they can cover and how long they can give these babies donor milk and so you end up cutting the babies before what would be ideally from a medical perspective.

REP. ABERCROMBIE (83RD): Representatives, any questions? Are you good? Go ahead if you'd like.

REP. MASTROFRANCESCO (80TH): I was just concerned when the last person testified said that hospitals cannot afford it. Do you know if any hospital has refused and a baby has died because of not getting the --?

DR. NAOMI BAR-YAM: We hear about the hospitals that use donor milk 'cause they come to us. We talk to hospitals and some of them do not – say they just can't cover the cost or they can only cover minimal costs for a short amount of time and we've heard that there are babies who do die because the --.

REP. MASTROFRANCESCO (80TH): Because the hospital would not --.

DR. NAOMI BAR-YAM: Because they can't. Hospitals are pretty stretched financially and the hospitals – the safety net hospitals, which are hospitals that – that serve higher populations of Medicaid and uninsured, are even on tighter budgets than other hospitals and so they are the ones that are – we know from CDC data that about 75 percent of the

hospitals in the country use donor milk under some circumstances. Of the 25 percent less, a disproportionate number of them are safety net hospitals that just – that have – that have a higher population of those premature babies, higher mortality rates, have higher morbidity rates, have higher prematurity and NEC rates, but they – they don't have the wherewithal to cover the costs of the donor milk.

REP. MASTROFRANCESCO (80TH): Okay. Thank you very much.

DR. NAOMI BAR-YAM: Thank you.

REP. ABERCROMBIE (83RD): You're welcome. Thank you so much for your presentation and thank you again to all of you for staying all day. No. We understand. It's a long day and I'll be honest, this is a short day compared to some of our hearings, so we do appreciate you being here. That concludes every --. So, first, before she says something let's include everyone that signed up [laughter]. Did I miss anybody? No. Senator Moore.

SENATOR MOORE (22ND): We have to do a better job of scheduling because the physicians usually have a reception outside this door at 5:00, right? And, it would have been great, especially for people who traveled here to meet other people who are here today, but I just want to say from the bottom of my heart, I so much appreciate your expertise and the work that you're doing and coming here bringing this to us. I think I have got a lot more to learn, but I think that we have a lot of information to work through. So, thank you.

Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
February 28, 2019

Good morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick L. Bremby, and I am the Commissioner of the Department of Social Services.

I am pleased to appear before you to offer remarks on several of the bills on today's agenda.

SB 836 - AN ACT HOLDING HARMLESS MEDICAID CLIENTS AND PROVIDERS AFFECTED BY AGENCY COMPUTER ERRORS

Section 1 of this bill permits a provider, that is subject to audit by the Department, to provide documentation that errors concerning payment and billing resulted from "the implementation of any new computer system by the Department of Social Services." The Department respectfully submits that this new language is overly broad. It is not clear what is meant by "any new computer system." The Department is open to discussion with the proponents of this bill to better understand the specific issue that this bill is attempting to resolve.

Section 2 of the bill requires the commissioner to grant or continue benefits "when there is credible evidence that the implementation of a new computer system at the Department of Social Services caused delays or errors that prevented an individual from providing timely, accurate information necessary to determine eligibility for assistance." The Department opposes section 2 of this bill as it contradicts federal and state laws that require the verification of eligibility prior to granting or issuing benefits. Failure to comply with requirements regarding the issuance of benefits can result in penalties in the millions of dollars.

While the Department is aware that some client cases were affected during the early stages of the recent implementation of ImpaCT, the new eligibility management system, the number of issues affecting client benefits has significantly declined since 2016. Furthermore, there is already a process in place to address client concerns. Applicants and recipients of benefits may appeal any department decision that aggrieves them, including the termination or denial of benefits. When appropriate, the Department issues underpayments or provides retroactive medical coverage in the event that a hearing officer determines that the Department made an error that resulted in incorrect termination or issuance of benefits.

In light of these reasons, the Department must oppose this bill.

SB 837 - AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES

The Department of Social Services appreciates the intent of this legislation, however we believe any fee increase should be tied to improvements in clinical outcomes. The care provided to pregnant women in Connecticut must be better.

Currently, the Department pays for over 16,000 deliveries annually or 47% of all births in Connecticut. The Department's policy of paying nurse midwives, nurse practitioners and physician assistants at 90% of the physician's fee schedule dates back for as long as we have records of our fee schedules.

We suspect that the original reason for this policy was to recognize the more extensive training that physicians receive in comparison to nurse practitioners, nurse midwives and physician assistants. In addition to 4 years of medical school, physicians undergo a minimum of 3 years of residency training, often supplemented by fellowship specialty training. Further, physician's training is standardized nationally, as are the national medical board exams and the specialty exams for board certification.

In contrast, nurse midwives undergo 2-4 years of midwifery training before being eligible to take the national certification exam. Nurse practitioners generally have a 2-year training Masters level program, possibly followed by doctoral training or specialty training; physician assistants similarly complete a 2-3 year Masters level program possibly followed by supplemental training. Nationally, training standards and curricula for these providers are more variable as compared to physicians' training.

Further, the average debt carried by a medical school graduate in 2016 was $190,000 with 25% of graduates having debt in excess of $200,000. In contrast, the American Association of Colleges of Nursing estimates that the typical graduate level nurse incurs between $40,000 and $55,000 in debt for their training.

Despite the differences in training, experience and debt between physicians and nurse midwives, the Department also recognizes the difference in the comparison of clinical outcomes between nurse midwives and obstetrician gynecologists. Numerous studies show that, when compared head to head, the outcomes of women and infants served by a nurse midwife are as good as if not superior to those served by an obstetrician. The most comprehensive independent review, by the Cochrane Foundation, found nurse midwives' outcomes were significantly superior. More recent studies comparing states where midwives are a more routine and accepted part of obstetric care are shown to have better maternal and infant outcomes than states where physicians and hospitals dominate care.

The Department of Social Services believes that equalizing fees paid to midwives and obstetricians is an idea whose time, clinically, has come. The financial impact of this legislation, however, would be substantial, not only due to the extra payments to nurse midwives, but because nurse practitioners and physician assistants will expect their fees to be increased, as well. Because of these increased expenditures, the Department cannot support this bill.

I would like to state, however, that the Department firmly believes that any increase should be held to a value-based system that rewards and incents improved outcomes- and that obstetricians should be held to the same standard. Connecticut has the dubious distinction of having some of the poorest maternal outcomes and highest maternal death rates among adjoining states. The March of Dimes Preterm Birth Report Card gives each of our neighboring states a B grade, whereas Connecticut merits only a C. We can do better, but only by measuring and paying for better care. The Department's Obstetrics Pay-for-Performance program is a start down this road, paying participating obstetrics providers for earlier and better pre- and post-natal care, use of medications to prevent preterm births, and for a full term, spontaneous, vaginal delivery. A continuation of that practice will continue to better the outcomes of our mothers and newborns.

SB 898 - AN ACT ESTABLISHING THE HISPANIC AND FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND

The Department's mission reads as follows, "We, along with our partners, provide person-centered programs and services to enhance the well-being of individuals, families and communities." In accordance with that mission the Department delivers and funds a wide range of programs and services as Connecticut's multi-faceted health and human services agency. We serve approximately one million residents of all ages in all 169 Connecticut cities and towns and support the basic needs of children, families, older and other adults, including persons with disabilities. Services are delivered through 12 field offices, central administration, and online and phone access options as well as through our various partners across the state to ensure access across the state.

The outcome of this bill does not align with the Department's mission. The bill as written will direct the funding from the Human Resource Development - Hispanic Programs account that has traditionally been used to provide direct services to our most vulnerable populations to a fund that would be used to build the service capacity of certain nonprofit organizations that meet the proposed definition of "eligible community based organization".

The Human Resource Development - Hispanic Programs funds have been used to support services such as classes for English as a second language, employment services, certified nurse's aide program, client advocacy, literacy training, and service plan development to achieve goals such as permanent housing and treatment for substance use disorder. These are direct programs and services that assist clients in achieving self-sufficiency in the community. This bill would

redirect those funds from the support of direct client programs and services to instead be used to improve operational efficiencies and adopt strategies for long-term fiscal sustainability of "eligible community based organizations".

The Department supports and understands the value and importance of a strong and viable network of non-profit providers. Without our nonprofit partners we would not be able to support the various service needs of our communities. We do not, however, agree that the funds in the Human Resource Development – Hispanic Programs account should be diverted from direct client services to support the economic development of a nonprofit provider. There are more appropriate resources within the state for the development and support of our non-profit providers. Specifically, Governor Lamont's budget for fiscal year 2021 includes an allocation of $25 million dollars for the nonprofit grant program administered through the Office of Policy and Management. This program, established in 2013, awards grants-in-aid to selected private, nonprofit health and human service organizations to improve the efficiency, effectiveness, safety and accessibility of the delivery of health and human services. Further, the Department of Economic and Community Development is the state's lead agency for economic development and would be a more appropriate agency to assist with support for our nonprofit partners.

Finally, as the Governor's budget does not include funding for this bill, we must oppose SB 898.

SB 899 - AN ACT CONCERNING CHILDREN WHO TRANSFER FROM HUSKY A TO HUSKY B HEALTH CARE COVERAGE

This legislation seeks to establish a system to 1) standardize documentation for prior authorization and reauthorization of HUSKY B services, 2) set a timeline for these authorizations and reauthorizations to be completed, 3) immediately notify providers when a child's coverage changes from HUSKY A to HUSKY B, 4) retroactively pay for authorized services provided in good faith after a child moves from HUSKY A to HUSKY B, and 5) ensure that these services are paid for in a timely fashion.

The Department opposes this legislation. While children do move between HUSKY A and HUSKY B, the numbers are minimal. During a six month period last year, only 1% of children newly enrolled in HUSKY A moved to HUSKY B. Among those who transitioned, few children experienced difficulty in receiving services and only a small number of providers experienced issues with receiving payment for services. This is due, in part, to the providers having the capability to follow the eligibility changes through the Automated Eligibility Verification System (AEVS). This system allows providers to obtain on-line, real time access to the eligibility information sought by this bill.

Although HUSKY A and HUSKY B are similar in most respects (shared physician, inpatient and outpatient hospital, and behavioral health coverage and network), they differ in a few respects;

HUSKY B covers different medications (due to different rebate arrangements), fewer home nursing benefits, and only a defined length of physical, occupational and speech therapy sessions per diagnosis.

The first provision of this bill would require standardized documentation for authorization requests. This is in direct conflict with Connecticut General Statutes § 17b-259b which defines medical necessity and requires all authorization decisions to be "based on an assessment of the individual and his or her medical condition."

Regarding the second provision, our administrative services organizations (ASOs) are contractually obligated to meet timeliness standards for the review of all requests for authorization and reauthorizations. In the case of OT and PT, initial requests have a 2 business day turn-around time and re-authorizations have a 14 calendar day turn-around time. If the ASO requires additional information to complete their review, the review must be completed within 20 business days.

The last three provisions in the legislation would require the Department to notify providers of a child's change in coverage, to retroactively pay for services provided in good faith that should not have been provided because of a change in coverage, and to ensure that payments are made in a timely fashion. While the Department does not have the capability of notifying a provider that a child has transitioned from HUSKY A to HUSKY B, each provider has the capability through the Automated Eligibility Verification System to validate a child's eligibility, real-time. Providers should be checking member eligibility for every date of service and when submitting any necessary authorization requests, as validating a patient's eligibility before a service is provided would ensure that the service was covered. In addition. covered services that are properly billed in accordance with the provider agreements for all of our participating Medicaid providers ensure prompt payment. The Connecticut Medical Assistance Program pays clean claims, in full, every two weeks. In contrast, most payors make monthly payments to providers.

For all of these reasons, the Department must oppose this legislation.

HB 7121 - AN ACT CONCERNING SEMI-MONTHLY TRANSFERS OF SUPPLEMENTAL NUTRITION BENEFITS.

This bill requires the distribution of Supplemental Nutrition Assistance Program (SNAP) benefits twice per month. As a threshold matter, the Department notes that federal law (Food, Conservation, and Energy Act of 2008) prohibits agencies from issuing SNAP benefits more than once per month absent special circumstances.

In addition to the legal limitations, the Department believes that providing the full monthly benefit allotment at one time allows households to maximize flexibility when managing food budgets within the time, transportation and other constraints that low-income households often

face. Split issuances would likely require some families to make unwanted additional trips to the grocery store each month, thereby reducing the amount of time they can spend working, attending school or job-training programs, or being with their family. Other households, such as households with elderly members, households with individuals with disabilities, and households receiving small benefit amounts can also benefit from being able to minimize the frequency of shopping trips. In addition, split issuances limit households' ability to take advantage of the cost discounts that can be realized by buying in larger volumes.

The Department would also incur costs to implement this proposed change, including, but not limited to, costs for: modifying our computer system, changing the phone and messaging systems, rewriting client notices, informing and educating clients of the issuance schedule change, and changing file transfer processes with our EBT card vendor.

The Department notes that states have flexibility in managing the distribution of SNAP benefits by "staggering" distribution of monthly benefits among households over more days of the month, rather than issuing all monthly benefits to all SNAP households on the same day. Connecticut currently issues benefits on the first, second and third day of each month. Nationally, the issuance schedule varies widely between states. Ten states or territories disburse all SNAP benefits on one day, including many of our New England counterparts (Rhode Island, Vermont, New Hampshire). 22 states have a disbursal range of less than 10 days, including Connecticut, and 8 have a disbursal range of 18 to 22 days. Of note, however, is that no other state or territory offers a split issuance. When the State of Michigan attempted to do so in 2008, a survey of SNAP recipients found that 59 percent preferred continuing to receive their benefits once per month with only 35 percent favoring a twice-a-month system.

For these reasons, the Department must oppose this bill.

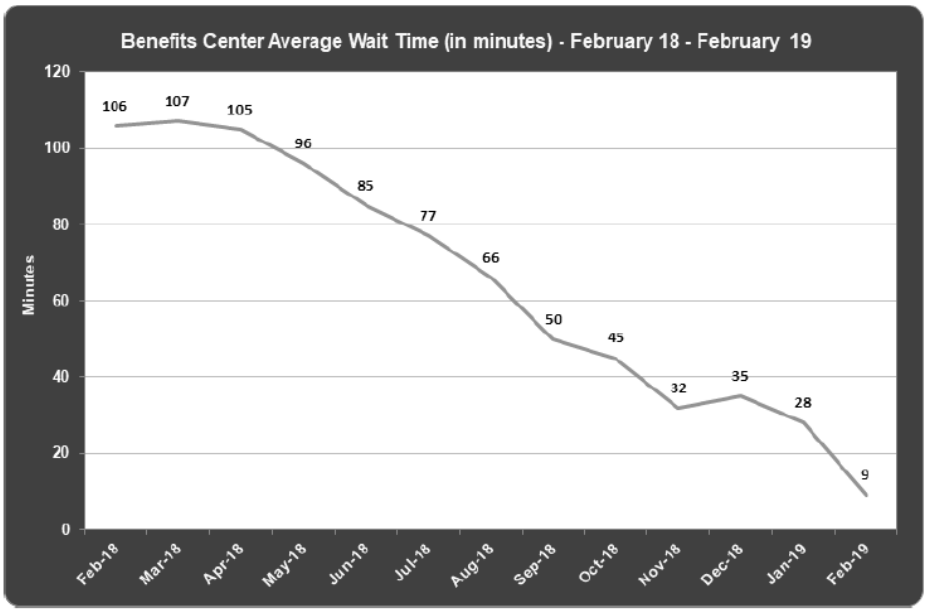
<u>HB 7123</u> - AN ACT CONCERNING TELEPHONE WAIT TIMES FOR PERSONS CONTACTING THE DEPARTMENT OF SOCIAL SERVICES

This bill requires the Department of Social Services to increase staffing, resources, and telecommunications technology in an effort to ensure that wait times for calls to the Department's Benefits Centers do not exceed 60 minutes.

The Department has several concerns with this bill. Foremost, there is no need for the bill given the Department's recent performance. The Department also has concerns about provisions in the bill that conflict with federal law, as well as the potential for increased costs to the state budget.

Over the last year, the Benefits Centers have experienced a steady decrease in wait times. In January 2018, the average wait time was 100 minutes while the average wait time in January 2019, was 28 minutes. The current average wait time for February 2019 is approximately 10 minutes. Below is a graphical depiction of the improvement.

DSS Benefits Center Data as of 2/28/19



It is also worth noting that applicants and beneficiaries are not required to call the Department when applying for or renewing benefits. In addition to the Benefits Centers, beneficiaries have the option to seek assistance in person at any one of our 12 field offices, as well as the ability to access services online or via mail.

The Department does not currently have the technology to link attempted phone calls with client eligibility data. Integrating systems to realize this concept would have a significant cost and would raise federal data security concerns. This does not mean that the Department is not pursuing technology enhancements. As the next phase of our modernization efforts, the Department is actively working on a large-scale infrastructure and software upgrade to our Benefits Center technology. The Department anticipates a final proposal from vendors by the second quarter of 2019.

The bill also seeks to prevent any beneficiary of the Department's assistance programs from having their benefits reduced or terminated if that person placed a call to the Department but was unable to speak to staff within 60 minutes of placing the call. This aspect of the bill conflicts with federal laws that require eligibility to be established and verified prior to the issuance of benefits, including the fully federally funded Supplemental Nutrition Assistance Program. Failure to comply with federal laws that require verification of eligibility prior to the issuance of benefits could result in sanctions and financial penalties to the State of Connecticut.

Last, but not least, this bill will require State expenditures to ensure compliance with the bill as currently written. There would be costs for systems upgrades, additional technology features and ongoing maintenance of those additions. There could also potentially be expenses in the form of added eligibility staff, additional office space and the operational and administrative costs needed to support that staff.

The Department understands that nobody wants to wait in line, and we are committed to continuous improvement in our client experience. Given our demonstrated commitment to reducing call wait times, the conflict with federal law, and the potential costs to the State, the Department cannot support this bill.

HB 7165 - AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK

The Department of Social Services wishes to offer our strongest endorsement of breast feeding for all newborns. After loving parents, breast feeding is one of the best ways to start a newborn on their life's journey.

Through the Connecticut Medical Assistance Program, we provide medical assistance and medically necessary services to 23% of the state's citizens including our most vulnerable citizens. Among these services are many nutritional supplements and artificial nutritional products to treat or help treat many medical conditions.

Breast milk is neither a nutritional supplement nor an artificial nutritional product to treat a medical condition; breast milk is food. Were Medicaid to cover this food, we would need to cover all other foods. In addition, federal law does not allow us to cover breast milk or any other type of food, because food does not fall within the federal definition of medical assistance that may be covered under Medicaid. See 42 U.S.C. § 1396d(a).

Second, this legislation would mandate that breast milk be a covered benefit for newborns "on an inpatient basis in a hospital." Medicaid pays for hospital inpatient services using an all-inclusive Diagnosis-Related Group (DRG) methodology which pays the hospital a fixed fee according to the patient's diagnosis(es). Different DRGs are priced differently depending upon the average cost to care for each diagnosis. For example, care for a community-acquired pneumonia in the absence of other complications would pay less than care for a heart attack that required treatment with an invasive procedure. DSS would therefore not pay the hospital more were we to cover donated breast milk or any other new service. The payment levels are all-inclusive and adjusted based upon national cost estimates.

The Department of Social Services supports breast feeding, but must oppose this legislation.

HB 7166 - AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID BENEFICIARIES

The Department of Social Services thanks the members of the Committee for your interest in and continued support for our Medicaid members. However, we believe that HB 7166 is not necessary as the proposed requirements are already incorporated in the Department's Non-Emergency Medical Transportation (NEMT) contract with the current provider, Veyo.

Testimony before the Connecticut Human Services Committee
Regarding HB 7165, An Act Concerning Medicaid Coverage for Donated Breast Milk
Maushumi Assad, MD, MPH
February 28, 2019

Good afternoon, Representative Abercrombie, Senator Moore, and Memnbers of the Committee. Thank you for the opportunity to testify today. My name is Dr. Maushumi Assad, and I am an attending neonatologist at Boston Children's Hospital. I also recently completed a neonatal-perinatal fellowship at the University of Connecticut. Perhaps most relevant for today, I performed and published a clinical study that demonstrates the value of an exclusive human milk diet for very low birthweight babies; that is, a diet that includes donor human milk along with a human milk-based human milk fortifier. I thank Chairwoman Abercrombie and the Members of the Committee for the opportunity to speak today in support of the intent of HB 7165.

According to the CDC, there are 55,000 very low birthweight infants born in the US every year. Clinical research has shown that this high-risk population has specific nutritional needs requiring more nutrition than a mother's own milk or donor milk can provide alone. By fortifying the milk fed to very low birthweight babies, physicians are able to better manage the babies' metabolic needs and help promote optimal growth. The most common fortifier currently used in the majority of NICUs is derived from cow's milk, which contains proteins that can cause feeding intolerance and may also increase the incidence of necrotizing enterocolitis, or NEC, a life-threatening intestinal disease. Both of these complications lead to increased length of stay, and NEC in particular has been shown to be a devastating and extremely costly complication. Studies have estimated average hospitalization costs due to NEC are as high as $216,666 per baby, and the total annual estimated cost of caring for babies with NEC is between $500 million to $1 billion in the United States. And, of course, not all babies survive NEC.

The alternative to using cow's milk-based fortifiers for very low birthweight infants is an exclusive human milk diet, which as I mentioned, is the use of mother's own milk or donor human milk that is fortified with a human milk-based fortifier. An exclusive human milk diet helps avoid many of the complications brought on by the early introduction of cow's milk proteins, and helps improve feeding tolerance and lower the incidence of NEC.

Despite the numerous benefits of an exclusive human milk diet, many NICUs are currently not providing this diet due to the high associated costs. I performed and published a study that demonstrates that an exclusive human milk diet can be cost effective. The results of our study in fact show that an exclusive human milk diet decreases overall hospital cost by decreasing feeding intolerance, time to full feeds and hospital stay in very low birth weight infants. An exclusive human milk diet has also been shown to have an additional benefit of decreasing other significant morbidities such as retinopathy of prematurity, bronchopulmonary dysplasia and sepsis. In other

words, despite the increased up-front costs of donor human milk and human milk-based fortifiers, my research shows that providing them can lower overall costs, while improving clinical outcomes.

Providing optimal nutrition for very low birthweight infants during this critical time period of rapid growth is important for improving their long-term outcomes. Based on current research and our findings, I would strongly encourage you to recognize the benefits of an exclusive human milk diet and further promote its use in our premature infants by amending this bill to include Medicaid reimbursement for human milk-based human milk fortifiers, in addition to donor milk.

Thank you for your time, and the opportunity to testify today. I welcome any questions, and look forward to working with the Committee and the Department of Public Health to ensure a bill that will benefit Connecticut's most vulnerable population.

Testimony before the Connecticut House Human Services Committee
Regarding HB 7165, An Act Concerning Medicaid Coverage for Donated Breast Milk
Jeffrey Bartlett, DO
February 28, 2019

Good Afternoon Chairwoman Abercrombie, Senator Moore, and Members of the Committee. My name is Dr. Jeffrey Bartlett, and I am the Medical Director for Neonatology in the Western Connecticut Health Network, which includes Danbury, Norwalk, and New Milford Hospitals.

I want to thank Representative Frey for raising the critical issue of regulation and reimbursement for donor human milk, and to the Committee for including such an important issue in today's hearing. I wholeheartedly support the intent of HB 7165, but in order for the bill to have the intended impact on Connecticut's most vulnerable infants, the legislation must be changed.

At all of the NICUs in which I practice, we strive to provide the best care possible for each child we treat. This includes a focus on nutrition and providing a human milk-based diet to the greatest extent possible. In our NICUs, we work with mothers to help them provide milk for their babies, either by breastfeeding or by pumping. Unfortunately, for many of our very low birthweight infants, a mother is often unable to provide her own milk for a period of time or to a volume at which her baby needs. In these cases, the baby is fed with donor human milk.

At the Danbury and Norwalk Hospitals, we use donor milk purchased from Prolacta, a milk bank based in California, which is not a member of HMBANA. For our very low birthweight babies, who are so small they fit in the palm of your hand, we supplement donor milk with a human milk-based human milk fortifier, also made by Prolacta. This combination of donor human milk along with a human milk-based human milk fortifier is known as the exclusively human milk diet, and it is crucial to meeting the nutritional and caloric needs of our tiniest babies. It is a particularly critical component of our care for very low birthweight babies because it delays the introduction of cow's milk into these babies' diets, which reduces the chance of the infant developing a life threatening disease called necrotizing enterocolitis by nearly 80 percent.

The results we have seen from the exclusively human milk diet are, quite literally, life changing. Our babies are growing stronger more quickly than ever before. Feeding intolerance, which often leads to a disruption in the feeding plan, insertion of an invasive peripherally inserted central catheter for nutritional support, and has symptoms that overlap with necrotizing enterocolitis, has been reduced dramatically. The use of an exclusively human milk diet in our very low birth weight infants has resulted in a reduction in the incidence of necrotizing enterocolitis. Additionally, the length of time to reach full feeds and that a baby remains on intravenous nutrition have been reduced in our units. Each of these also has the potential to reduce the length of time each infant stays in the NICU.

I realize that my time to testify is limited today, so I will allow others to provide further education and information on the importance, efficacy, and cost reductions resulting from the

exclusively human milk diet. However, I do want to leave you with one take away: As physicians, one of the most frustrating experiences we encounter is having our hands tied when we know the best treatment for our patients. In the case of neonatologists, we spend weeks and months with our patients. We know these babies and what they need to survive and thrive. With this legislation, the Committee has the chance to greatly improve the availability of critical therapies for all Connecticut babies, regardless of their birth date or location, or their socioeconomic status. But in order to do so effectively, I urge you to ensure two things: first, that this legislation also covers human milk-based human milk fortifier, so that our most fragile babies that require an exclusively human milk diet can receive it; and second, to ensure that milk reimbursed by the state includes milk from Department of Health certified banks which ensure donor milk is of the highest possible quality. This will allow each hospital to procure donor milk based on their specific needs and clinical decision making.

Again, I want to thank you, Chairwoman Abercrombie, Senator Moore, and Members the Committee for taking up such an important issue. I welcome any questions you may have and look forward to a continued conversation.

Mothers' Milk Bank Northeast
Share the Health

Testimony to the Human Services Committee regarding
House Bill 7165, An Act Concerning Medicaid Coverage for Donor Breast Milk
February 28, 2019

Senator Moore, Representative Abercrombie, members of the Human Services Committee, thank you for the opportunity to share my thoughts about House Bill 7165, An Act Concerning Medicaid Coverage for Donor Breast Milk. My name is Naomi Bar-Yam, Executive Director of Mothers' Milk Bank Northeast, representing my organization together with board members Natalee Martin of West Hartford, Elizabeth Brownell of Bloomfield, and Sarah Taylor of Madison. I am submitting this testimony in support of this proposed legislation because Medicaid coverage of donor milk will save the lives of Connecticut babies and save the state of Connecticut money. We strongly encourage Connecticut to join the seven other states and Washington, DC currently providing Medicaid funding for donor milk.

Mothers' Milk Bank Northeast is a nonprofit community milk bank operating under the guidelines of the Human Milk Banking Association of North America (HMBANA). Similar to a blood bank in operation and protocols, a nonprofit milk bank provides donated, pasteurized human milk to babies in fragile health. Mothers' Milk Bank Northeast is the primary nonprofit milk bank serving Connecticut. Among the 80+ hospitals we serve in the Northeast region are Yale New Haven Medical Center, Connecticut Children's Medical Center, Bridgeport Hospital, Hospital of Central Connecticut, Manchester Memorial Hospital, Middlesex Hospital, Saint Francis Hospital and Medical Center, and St. Vincent's Medical Center.

We also have strong community support in Connecticut, with milk depots (drop-off locations) at Acelleron Medical Products (Guilford), Connecticut Childbirth and Women's Center (Danbury), UConn Health (Farmington), and Catholic Charities, Diocese of Norwich (Norwich and New London locations). Since 2011, nearly 700 Connecticut women have volunteered for screening as milk donors.

In addition to lives saved and better short- and long-term health outcomes for premature babies, donor human milk saves health care dollars over the short and long term.

An estimated 1.4% to 1.7% of babies are born weighing less than 1500 grams (3.3 pounds), putting them at highest risk for necrotizing enterocolitis (NEC), a disease with a high mortality and morbidity rate largely affecting premature babies. According to the Centers for Disease Control, 36,015 babies were born in Connecticut in 2016, which means that an estimated 504 to 612 babies were born at less than 1500 grams.

It is estimated that a baby born at 30 weeks gestation (of what should be a 40-week pregnancy) and 1000 grams (2.2 pounds) will require 5,484 ml of enteral (tube feeding) nutrition until he or she reaches 34.4 weeks and 1500 grams. At a cost of $0.133 per ml / ~$4.00/ ounce, the cost of pasteurized donor human milk (PDHM) is $729 per baby in need. For the same amount of formula at $0.27/ml / ~ $ 0.81/ounce) the cost is $114 per baby in need.

With **500-600 babies in Connecticut** born below 1500 grams, it is estimated that PDHM will cost between $367,416 and $446,454 per year. When subtracting formula costs already incurred, PDHM costs an additional **$292,774 to $355,817 per year**, to feed babies until 34.4 weeks and 1500 grams. This assumes that babies do not receive any of their mothers' own milk, which is rarely the case. Most mothers are able to provide some milk for their babies, from small amounts to 100%.

NEC is a serious and costly illness. About 1/3 of babies with NEC can be treated medically, 1/3 require surgery to remove parts of the intestine that have died, and 1/3 do not survive. Multiple research studies over decades tell us that human milk is an important factor in preventing and mitigating the severity of NEC. It is estimated that 5-7% of premature babies will face NEC some time in their hospital stay.

In Connecticut, at an average of 6% NEC rate, **between 30 and 37 babies will have NEC each year**. **NEC averages $225,000 to treat**. If one conservatively estimates that a human milk diet can reduce NEC by 50%, a human milk diet will prevent 15-18 cases of NEC per year. **An investment of $292,774 to $355,817 for donor human milk will save the state $3,375,000 - $4,050,000 to treat NEC**. **These calculations are NICU costs only and do not measure the long-term effects and costs** of developmental delays and short gut syndrome that often affect premature babies who have had NEC.

Bill 7165, An Act Concerning Medicaid Coverage for Donor Breast Milk, will provide much-needed coverage for life-, health- and money-saving donor human milk for our most vulnerable and fragile citizens. It has been well documented that **low-income and families of color have higher rates of premature birth, NEC, and infant mortality. They are more likely to be treated in safety net hospitals, which are less likely to use donor milk, because it is not covered by Medicaid** and their budgets are stretched even more thinly than more affluent hospitals. Medicaid coverage for pasteurized donor human milk will save lives and money for the state of Connecticut. It will also ensure more equitable access to quality health care for all its citizens.

Mothers' Milk Bank Northeast is eager to work closely with the Human Services Committee on refining the details of this bill. Please call upon us and draw upon the expertise of the esteemed physicians and researchers on our Medical and Research Advisory Boards, in service of the citizens of Connecticut.

Respectfully submitted,

Naomi Bar-Yam, PhD, ACSW, Executive Director; naomi@milkbankne.org, 617-527-6263
Natalee Martin, MS, Board of Directors; West Hartford, CT
Elizabeth Brownell, PhD, MA, Research Advisory Board; Bloomfield, CT
Sarah Taylor, MD, MSCR, Medical Advisory Board; Madison, CT

Testimony before the Connecticut House Human Services Committee
Regarding HB 7165, An Act Concerning Medicaid Coverage for Donated Breast Milk
Martha Dawson, DNP, RN, FACHE
February 28, 2019

Good Afternoon, Representative Abercrombie, Senator Moore, and Members of the Committee. My name is Dr. Martha Dawson. I am an Assistant Professor the University of Alabama at Birmingham's School of Nursing. I have over 40 years of experience in practice, academia and health care leadership. I sit here today wearing not just my nursing hat, but also in my role as a long-time and proud board member of the National Black Nurses Association (NBNA). The NBNA represents the voice of some 280,000 nurses with 113 chapters nationwide, including two in Connecticut. Our mission is, "to advocate and implement strategies to ensure access to the highest quality of healthcare for persons of color." NBNA have sponsored two resolutions supporting breastfeeding and safe human donor milk, including milk-based fortifier.

I am here to testify in support of HB 7165, but also to request crucial amendments that will improve its efficacy. This is an issue that NBNA takes extremely seriously. Not only are African American women 60 percent more likely to have a premature infant, but their infants suffer the highest mortality rate in the nation. My colleagues and I consider it our obligation to give them what they deserve, which is every fighting chance to a quality life.

One of, if not the most, critical parts of giving extremely preterm infants a fighting chance is ensuring that they receive a diet that provides their tiny bodies with the nutrients and calories they need to catch up on the weeks and months they have missed in their mother's womb. Our goal is to have policies that allow the growth of these infant bodies and brains to become strong and healthy infants, not just to strive, but to thrive.

Accordingly, the NBNA supports equal and expanding access not only to pasteurized donor milk, but to a human milk-based fortifier for those most fragile premature infants. Only by providing mother's own milk or donor milk **plus** an essential human milk-based fortifier can these infants grow and have a chance at optimal health outcomes. The alternative, as you have heard, are cow's milk-based fortifiers, which increase the chances of complications like necrotizing enterocolitis, or NEC. **(a serious bacterial infection in the intestine that can cause the death of intestinal tissue and progress to blood poisoning).**

The evidence both in the literature and in our clinical practice demonstrates a direct correlation between the use cow's milk products and development of the devastating, and often terminal NEC. By contrast, with the use of an all human milk diet, we not only reduce NEC by 77%, but we also decrease many other comorbidities such as sepsis, retinopathy, bronchopulmonary dysplasia and feeding intolerance. By preventing these adverse events, we are able to decrease the length of stay and overall cost by as many as nine NICU days.

By supporting donor milk without human milk-based fortification, the state would be negating the very benefit of what you are trying to achieve. The added benefits of human milk-based fortifier are essential to a healthy start for African American Medicaid preemies. Your approach to address the health care of premature infants must give providers and mothers a choice of the best care possible.

Donor milk especially for at risk babies in the NICU should have no barrier such as finance to life saving nature intended milk.

Jennifer Maldonado

Support HB 7165
620
Act Concerning Medicaid Coverage for Donor Breast Milk

49 Vista Avenue
Danbury, CT 06811
February 28,2019

Good Afternoon

My name is Di Masters

I am here because I wrote the original language for this bill which was introduced by Rep. John Frey asking that Medicaid cover the cost for Human Donor Breast Milk and I am here to ask that you give your attention and full support to HB 7165. I fully support Bill Number 7165: An Act Concerning Medicaid Coverage for Donor Breast Milk.

I returned to graduate school to finish my Masters in Public Health. During my research, I discovered a gap in coverage, health equity, and maternal and infant wellness that could and should be addressed, which has an impact on our most fragile citizens. Some premature babies in our state are being denied the nutrition that they can digest, human donor milk, because hospitals cannot afford the costs. When these fragile infants are fed complex and commercial formula, they are being exposed to painful, and life threatening disease because of complications. They are underdeveloped and they can't digest the stuff. All of these tiny infants should have food that they can tolerate, but there is more to this story to understand.

Connecticut has infant and maternal health statistics, especially among minority populations that must be addressed, and this bill is part of the solution. With infant mortality among black infants well over twice the rate of white infants, and maternal mortality rates for black mothers also shamefully out of proportion, and knowing that a black mother is statistically more likely to prematurely deliver her infant, we need to begin to put in place good, simple solutions when we find them, and as soon as we can. This Bill will help to improve quality of life, reduce morbidity and mortality among the preterm population and result in a positive cost benefit analysis.

As modern technologies advance, the babies who are born very preterm have increased possibilities for survival. These vulnerable infants are in critical need of human milk to further protect their survival, health, and development.

Women who deliver preterm have not experienced the physiologic and hormonal changes of a full-term gestation and, therefore, typically require additional support to begin producing milk

(12.4%), followed by American Indian/Alaska Natives (10.2%), Hispanics (10.1%), whites (8.4%) and Asian/Pacific Islanders (8.2%) (Kothari et al., 2016; Purisch & Gyamfi-Bannerman, 2017).

Testimony of James Moore MD, Ph.D. of Connecticut Children's Medical Center
to the Human Services Committee regarding
House Bill 7165 An Act Concerning Medicaid Coverage for Donor Breast Milk
February 28, 2019

Senator Moore, Representative Abercrombie, members of the Human Services Committee, thank you for the opportunity to share my thoughts about House Bill 7165 An Act Concerning Medicaid Coverage for Donor Breast Milk. My name is Dr. James Moore, Division Chief for Neonatology at Connecticut Children's Medical Center. We are submitting this testimony in support of this proposed legislation because of the significant health benefits to our neonatal patients, in addition to the reduction in cost of care of these neonates that comes directly from the use of human donor milk.

Before commenting on the bill, I want to provide some background about Connecticut Children's. We are a nationally recognized, 187-bed not-for-profit children's hospital driving innovation in pediatrics. With over 2,600 employees and over 1,100 on our medical staff, we are the only hospital in the State dedicated exclusively to the care of children. Through our partnerships with adult hospitals and primary care providers across Connecticut, we are able to offer a continuum of care for children, from primary prevention to complex disease management, closer to their home. Last year alone, Connecticut Children's directly cared for more than 15% of all kids in Connecticut covered by Medicaid and spent over $90 million on free and uncompensated care. As the primary pediatric teaching hospital for the University of Connecticut School of Medicine and the Frank H. Netter MD School of Medicine at Quinnipiac University, we trained 284 medical students, 375 physician residents, and 71 physician fellows last year. We are also the primary pediatric research partner of The Jackson Laboratories.

Our statewide newborn services network allows our neonatologists, NNPs and PAs to share their expertise with families at eleven hospital locations from Putnam to Hartford to Norwalk. Our virtual health network, the State's only pediatric telehealth service, allows us to reach even more children in their communities. In 2019, this resource will enhance our partnership strategy and allow more families to benefit from the unique expertise of Connecticut Children's clinicians, through provider e-consults and virtual visits for patients, connecting their children to the programs and services that will help them grow, learn and succeed.

Donor breast milk is extremely important in the field of newborn care. Increasing human milk usage has become a focus within Pediatrics and Neonatology, based on substantial literature evidence. In every textbook on neonatal nutrition, and also in policy statements from the American Academy of Pediatrics, it is clear that human milk should be used for preterm babies as a best practice because it improves health outcomes. Human milk is much more than strictly

nutrition; it is a living tissue. In addition to sugars, proteins and fats, human milk is actually made up of hundreds of other components that are vital to newborn health. Some of these include immunologic factors such as antibodies, leukocytes (a type of white blood cell), and proteins such as Lactoferrin that together help prevent infections. Human milk also contains hormones that promote organ growth and development. The full array of proteins, hormones and cellular signals that are contained in human donor milk are too extensive to list here but the key message is that human milk and human donor milk are specifically designed for our human babies and have many more benefits than just getting them to grow.

Human donor milk, when used in the Newborn Intensive Care Unit (NICU), improves tolerance to oral feedings, and has been shown to reduce NICU length of stays by up to 3-4 days per patient. In fact, there are more than 53 studies just in the last 11 years that have shown improved tolerance, reduced length of stay and reduced instances of a catastrophic GI tract infection called Necrotizing Enterocolitis or NEC for short. NEC affects up to 10% of all babies admitted to NICUs that have birth weights of less than 1500 grams. Of those babies that develop NEC, mortality can approach 50% in infants that require surgery. For survivors of NEC, they often have lifelong problems including neurodevelopmental disabilities. Using human milk instead of formula can reduce the rates of NEC by 50% or more. This impact can lead to immediate savings of more than $40,000 for each baby that otherwise would have developed NEC, and improves their long-term health outcomes.

I want to conclude with a personal story. A number of years ago, I took care of a family that had a baby born 13 weeks early at 27 weeks' gestational age. This little boy transitioned from Mom's milk to formula because mom was unable to keep up her supply. One week later he developed NEC and died of complications from the infection in his intestines. Two years later this same mom had a second 27-week infant. This little girl was able to get Mom's milk in the beginning and then received donor milk for nearly a month. Unfortunately, the hospital where she was receiving care transitioned this little girl to formula and 2 days later she developed NEC and almost died. I was working at that time at the Level IV NICU in the local referral hospital and each time this mom had to come to us with her children, she looked at me and asked how could this happen again. While NEC is a complex disease, and we do not fully understand all of the contributing factors, human milk is the only intervention we have in Neonatology to reduce its incidence. It is best practice to supply preterm babies with their mother's own milk, or human donor human milk when Mom's own milk is not available.

Unfortunately, we still have many families that do not benefit from this therapy. Human donor milk it is not offered at all NICUs across Connecticut because of the cost. I urge you to approve House Bill 7165 so we can extend this vital intervention to all babies that need it.

Thank you for your consideration of our position. If you have any questions about this testimony, please contact Jane Baird, Connecticut Children's Senior Director of External Relations, at 860-837-5557.

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February 26, 2019

Dear Connecticut General Assembly Committee for Human Services:

Thank you so much for your attention to CT bill 6897 022019 "An Act Concerning Medicaid Coverage for Donor Breast Milk". Very preterm infants (born <32 weeks' gestational age) are at risk for a devastating disease called necrotizing enterocolitis (NEC). NEC occurs in 5-7% of very preterm infants and, sadly, a third of those infants will die and another third will have long-term complications such as Short Gut Syndrome or neurodevelopmental delay.

With this rate of NEC, approximately 30 Connecticut very preterm infants develop NEC per year and, of those, ten die. Mother's milk is a powerful intervention to avoid NEC. However, mother's milk is not always available due to maternal medications or difficulties with milk supply. Therefore, many very preterm infants must receive a substitute for mother's milk. Pasteurized donor human milk is a substitute. Studies show a 60% reduction in the rate of NEC when infants receive donor human milk instead of formula. Therefore, if having donor human milk available to all Connecticut very preterm infants would drop the NEC rate by 60%, 18 infants would avoid NEC each year, and, of those, 6 deaths would be avoided.

Due to the protection from NEC, the American Academy of Pediatrics recommends donor milk to be accessible to all very preterm infants. At Yale New Haven Children's Hospital, we were compelled by the evidence to initiate a donor human milk program in 2011. The fact that, eight years later, donor human milk is not available to very preterm infants in all Connecticut hospitals is a real disparity in preterm infant care. The annual cost to Yale New Haven Hospital is $34,000 which is well below the $225,000 published cost of one case of necrotizing enterocolitis.

Donor human milk for all Connecticut very preterm infants, has the potential to decrease disease, save lives, and save money. Please continue your support for this bill that is critical for Connecticut children.

Sincerely,

Sarah N. Taylor, MD, MSCR
Associate Professor
Director of Clinical Research

Mark R. Mercurio, MD
Professor
Chief of Neonatology

Matthew Bizzarro, MD
Professor
Medical Director, Yale NICU Network

(see second page)

Matt Drago, MD, MBE
Assistant Professor

Emily C. Gritz, MD
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Steven M. Peterec, MD
Associate Professor

Soo H. Kwon, MD, MHS
Assistant Professor

Testimony before the Connecticut House Human Services Committee
Regarding HB 7165, An Act Concerning Medicaid Coverage for Donated Breast Milk
Viktoria Niklas, MD
February 28, 2019

Good Afternoon, Chairwoman Abercrombie, Senator Moore, and Members of the Committee. My name is Dr. Victoria Niklas, and I am the Vice President of Innovation and Medical Communication at Prolacta Bioscience.

I want to echo the other witnesses' gratitude to Representative Frey for introducing HB 7165, which addresses such a critical issue, and the Committee for considering it.

As you're all aware, doctors and experts agree that a mother's breast milk is the best source of nutrition for a newborn baby. The AAP, the American Academy of Pediatrics, recommends breast milk be the sole source of food for all newborns from birth until six months. For a variety of reasons, however, not all mothers can provide milk to their babies in sufficient quantities, whether due to an inability to produce breastmilk, adoption, surrogacy, or other complications. In these cases, the use of donor human milk is prudent.

For very low birthweight babies in the NICU, the need for human milk is highest. During the last trimester, unborn babies receive vast amounts of nutrition through the umbilical cord. Very premature infants miss this crucial nutrition, and their dietary needs are greater than what breast milk alone can supply. For this reason, the AAP recommends that babies weighing less than 1,500 grams receive fortified milk.

This is where Prolacta enters the picture. Prolacta makes a human milk-based human milk fortifier. While this title is long, it is essential to understanding the product's importance. Without human milk-based human milk fortifier, a very low birthweight baby is at an increased risk of developing necrotizing enterocolitis, or NEC, and suffering from delayed neurological development and other complications that can significantly and permanently impact the baby's quality of life, if the baby is able to survive its time in the NICU.

As you have heard already, our fortifier is mixed with either mom's own pumped milk, or donor human milk, creating the exclusively human milk diet. While I could testify at length on the benefits of the exclusively human milk diet, I know that I am time limited today, and would like to focus on another request for the Committee to consider as you review this bill.

As drafted, the bill would require all donor human milk for which the state provides reimbursement to come from a milk bank accredited by the Human Milk Banking Association of North America, or HMBANA. While Prolacta does have a donor milk product in use at both Danbury and Norwalk hospitals, among others, other hospitals use HMBANA's donor milk with Prolacta's fortifier, which, of course, still results in an exclusively human milk diet.

Prolacta and HMBANA are two of several organizations in the human milk industry, and while we compete in some places, we work closely in others. That being said, there are several other players entering the human milk industry – some of whom have high quality and standards, and some of whom do not. This is an industry that will only continue to grow, as science helps us identify additional uses for human milk, like treating pediatric cardiac patients.

HMBANA produces a good product with high quality, and Prolacta is proud to partner with them in many hospitals, including in Connecticut. However, we believe that the Connecticut Department of Public Health is the more appropriate licensing agency for any milk bank providing donor milk or fortifier in the state, independent of the reimbursement issue. While HMBANA does wonderful work, it cannot substitute in the role of a governmental regulatory agency.

Again, I want to thank Representative Frey for introducing this bill, and the Committee for considering it. We all share the goal of increasing the availability of human milk for Connecticut's neediest infants. The amendments I and others have requested today will both improve the clinical benefit of the human milk we provide in the NICU, by pairing it with human milk-based human milk fortifiers, as well as help ensure the quality and safety of all the milk procured in the state, by introducing licensure from the Connecticut Department of Public Health. By taking these two key steps, Connecticut can be at the forefront of this vital issue.

I thank the Committee for your time and the opportunity to testify today and am happy to answer any questions you may have. We look forward to working with the Representative Frey and the Committee to refine the legislation and ensure that Connecticut's most vulnerable babies have access to these lifesaving products.

To Whom It May Concern:

I fully support Bill Number 7165: An Act Concerning Medicaid Coverage for Donor Break Milk. In alignment with the HP2020 recommendations of rates of breastfeeding initiation, increasing breastfeeding duration and supporting needs of infant care, access to breast milk is extremely important to infant health outcomes.

The opportunity presented by this bill empowers women to know that their infant would be able to gain the nutrients they need and deserve through lifesaving donor milk to increase their health for their lifetime. Personally, it is very validating for me to know as a future mother that my infant is potentially able to receive donor milk if I for some reason and unable to provide it to them myself. This is a very empowering and reassuring aspect to my future as a mother, and as a public health professional.

Thank you for bringing this important issue forward and hearing testimony.

Best,

Chelsea Ortiz

Connecticut Commission on Women, Children *and* Seniors
CWCS

CEO
Commission on Equity and Opportunity

Testimony of the Commissions on Women, Children & Seniors and Equity & Opportunity Submitted to the Human Services Committee February 28, 2019

RE: HB 7165, An Act Concerning Medicaid Coverage for Donor Breast Milk, and H.B. 7121, an Act Concerning Semi-Monthly Transfers of Supplemental Nutrition Benefits.

Senator Moore, Representative Abercrombie, Ranking and other distinguished members of the Human Services Committee, thank you for the opportunity to provide testimony on the above referenced bills. My name is Steven Hernández and I am the Executive Director of the Commissions on Women, Children & Seniors and Equity & Opportunity. I am joined by our 2GEN legislative fellow, Rosa Rada.

Regarding **H.B. 7165**, this Act would increase access to donor milk in medically necessary scenarios. In many of these scenarios, donor milk is a lifeline. UNICEF states that donor milk significantly reduces the risk of adverse health outcomes like necrotizing enterocolitis (NEC) and sepsis. In addition to being extremely beneficial, donor breast milk is also extremely expensive at about $4-5 per ounce. This price puts it out of reach for many families in need. Though donor milk is costly, providing insurance coverage for it saves states money by averting the highly expensive costs of treating NEC and other preventable disease.

According to the American Pregnancy Association, “Donated breast milk is very safe; it comes from mothers that have pumped more milk than their own baby can eat. Before mothers can donate milk, they are tested for any illness that could pass through their breastmilk. Each container of milk is also tested for harmful bacteria.

The donor milk is then pasteurized to eliminate any infecting organism that could be present in the milk. A small percentage of nutritional and immunological properties are destroyed by pasteurization, but pasteurized milk retains many of its beneficial properties. It contains tremendous special properties that cannot be duplicated by commercial milk formulas.”

New York, California, Missouri, Kansas, Texas, Utah, and Washington D.C. all have similar statutes in place. Connecticut needs to follow suit in order to protect this extremely vulnerable infant population and their families from negative health outcomes and an undue cost burden.

Regarding **H.B. 7121**, this Act would change the issuance schedule of Supplemental Nutrition Assistance Program (SNAP) benefits from once a month to twice a month. Currently, 437,530 Connecticut residents, about a third of which are children, experience food insecurity. SNAP, the largest nutrition assistance program in the state, acts as the primary domestic hunger safety net for families experiencing financial hardship.

This change in issuance schedule for benefits, while seemingly minute and bureaucratic, offers an opportunity to support our state’s food retailers while improving food access and equity for our residents.

Connecticut Commission on Women, Children and Seniors
CWCS

CEO
Commission on Equity and Opportunity

According to the USDA, a majority of SNAP recipients spend their benefits within the first two weeks of receiving them. Since many states – Connecticut included – issue SNAP benefits at the same time each month, grocery stores often experience a spike in sales at the beginning of the month and then a sharp decrease once SNAP customer's budgets are depleted. Given that grocery stores pay significant fixed costs to operate and generally experience low profit margins, such a retail cycle presents challenges. In our cities and rural towns, where there is the most concentrated food insecurity and lack of access to healthy, affordable food, both grocers and residents lose out.

Changing the issuance schedule for benefits would smooth business cycles for food retailers, especially those in economically distressed areas of the state, while allowing them to provide a more continuous stocking of fresh produce and staple items.

While this is a relatively simple and inexpensive policy solution, versus say, offering tax credits to grocery stores, there is much room for error. In 2015, Maryland changed their SNAP benefit schedule from a 10-day period to a 24-day period, but due to bureaucratic mistakes and a failure to consider the literacy and numeracy levels, language needs, and housing status of their SNAP recipients, a large portion of SNAP recipients did not get notice of the change. Benefits went unused, residents went hungry, and businesses lost money.

CWCS supports efforts to expand food access and equity while supporting local economies and small businesses. However, we urge the Committee to provide clear instructions to the Department of Social Services so that they may carefully and thoughtfully implement such a change.

Thank you for your attention, and we look forward to working with you on these issues and answering any questions.

To Members of the Human Services Committee:

I am writing in **support** of Raised Bill 7165: AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. I am a breastfeeding mother, a Breastfeeding Counselor with the Connecticut Chapter of Breastfeeding USA, and a member of the national Breastfeeding USA board of directors. I am a New Haven resident.

Having breastfed my own four children, I am well aware of the benefits of breastmilk; the science is also quite clear on this point. Two of my children had brief NICU stays; while I was able to provide breastmilk for them, knowing that donor milk was an option made those early days a bit easier. I am proud to have been able to share my milk with other babies and families in need through HMBANA milk banks.

Although all children benefit from breastmilk, for medically fragile and premature infants breastmilk is literally life saving in many cases. Passage of this bill would demonstrate our state's commitment to our neediest neighbors; **one's economic situation should not determine whether one is able to receive the best quality health care. And providing breastmilk to medically fragile and premature infants IS the best healthcare.**

I have confidence that the committee with not only support sending this bill forward, but that all members of the committee will rally support for its passage.

Sincerely,
Meredith N. Sinclair, Ph.D.
New Haven

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Meredith N. Sinclair
meredithnsinclair@gmail.com

Connecticut HB 7165
An Act Concerning Medicaid Coverage for Donor Breast Milk

Testimony of Faren Tang
Reproductive Justice Scholar and Associate Research Scholar in Law
Yale Law School
faren.tang@yale.edu

February 27, 2019

Thank you for the opportunity to submit testimony in favor of Connecticut HB 7165, An Act Concerning Medicaid Coverage for Donor Breast Milk.

My name is Faren Tang and I am a resident of New Haven and a Reproductive Justice Fellow and Associate Research Scholar at Yale Law School, where I teach the Reproductive Rights and Justice Project clinical course. I specialize in legal issues affecting reproductive rights including the rights of pregnant and parenting people. I have also been a breast milk donor through Mothers' Milk Bank Northeast, a nonprofit milk bank accredited by the Human Milk Banking Association of North America.

My testimony here reflects my own views, and does not represent the institutional views of Yale Law School.

Medicaid Coverage for Donor Milk is a Reproductive Justice Issue

Access to donor breast milk is a key health issue for the sickest infants. Access to breast milk is most critical for premature and ill babies. Systemic social injustice, particularly along lines of race, is reflected in rates of prematurity and babies with low birth weight. Controlling for income and education levels, health outcomes for black infants are significantly worse for black babies than white babies in the U.S., a disparity likely attributable to the health impacts of living with the stress of anti-black racism. *See, e.g.*, *Why Black Women, Infants, Lag in Birth Outcomes*, NPR (July 8, 2011), https://www.npr.org/2011/07/08/137652226/-the-race-gap; *see generally* Dorothy Roberts, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY (2011).

Providing Medicaid reimbursement for medically necessary donor breast milk will ensure that the most vulnerable babies are not denied access to potentially lifesaving nutrition because of their parents' inability to pay costs as high as $3.00-$5.00 per ounce for properly screened and pasteurized donor milk. *Why is Donor Milks so Expensive*, LACTATION Matters (Nov. 8, 2013), https://lactationmatters.org/2013/11/08/why-is-donor-milk-so-expensive/. The cost could easily add up to hundreds of dollars per week or thousands each month.

Medicaid reimbursement for human breast milk is an important step in ensuring that all babies, regardless of their parents' income level, have access to medically necessary nutrition. It is a step toward closing disparities in both class and race-related health outcomes for infants, which is a key aspect of robust reproductive justice.

Medicaid Coverage for Donor Breast Milk Will Encourage Donors

When work and school required me to be away from my own baby, I expressed far more milk than he could use. I had a freezer full of breast milk that I knew was critically needed by other babies, but I was also a solo parent of a new baby and a full-time law student. Deciding where to donate my milk was a daunting task during an already overwhelming time.

I wanted my milk to go to babies who needed it most, so I was torn between donating to a milk bank that would direct my milk to the most medically needy babies, and informal donation directly to parents, which would make my milk accessible to parents who could not afford to pay the high processing fees to a donor milk bank.

Ultimately, I decided to donate my milk to a nonprofit bank accredited by the Human Milk Banking Association of North America, but my decision would have been much easier had I been assured that Medicaid recipients could access my milk through a bank.

Medicaid reimbursement for human donor milk may encourage justice-minded potential donors like me to donate their milk to an accredited milk bank, since they can be assured it will go to the medically neediest babies regardless of their parents' financial means.

CONNECTICUT
Breastfeeding Coalition

Testimony to the Human Services Committee regarding
House Bill 7165 An Act Concerning Medicaid Coverage for Donor Breast Milk
February 28, 2019

Dear members of the Human Services Committee, thank you for the opportunity to share the following testimony on behalf of the Connecticut Breastfeeding Coalition in favor of AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. I support this proposed legislation because of the positive impact providing Medicaid coverage of donor milk will have on Connecticut's mothers and babies.

The Connecticut Breastfeeding Coalition is a nonprofit organization whose mission is *to improve Connecticut's health by working collaboratively to protect, promote and support breastfeedin*g. We work to assure access to lactation care and services, promote breastfeeding as a normal and preferred method of feeding, and to protect, promote and support breastfeeding mothers. This includes, but is not limited to, providing expertise and support of education, evidence-based best practices, and legislation.

Human milk is the most natural and beneficial source of nutrition for babies, especially for premature, high-risk infants. In preterm infants, human milk feeding is associated with lower risks of several life-threatening diseases, including necrotizing enterocolitis (NEC)[1]. However, breastfeeding from birth shows even better infant health outcomes against NEC, mothers of preterm infants, especially infants of low birth rates, are met with unexpected challenges to initial breastfeeding. These challenges may be related to maternal stress, disability, and inadequate milk supply.

Preterm birth disproportionately affects women of color. In the March of Dimes' 2016 Premature Birth Report Card, Connecticut received a C-grade for its 9.4% overall preterm birth rate. The report card demonstrates significant racial/ethnic disparities in preterm births (e.g., 12.2% of all preterm births by black women in the state compared to 8.6% among white women). The inherent health risks of premature birth, coupled with well-documented disparities in income and education among families of color, support the need to invest in the best nutrition – donor breast milk – from the start.

Providing Medicaid coverage for donor breast milk can result in improved infant growth rates, lower infant morbidity and mortality rates, reduced health disparities, and cost-savings.

The Connecticut Breastfeeding Coalition is willing to lend its expertise to working with the Human Services Committee on this bill.

Respectfully submitted,

Michele L. Vancour, PhD, MPH
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[1] Kantorowska, A., Wei, J.C., Cohen, R.S., Lawrence, R.A, Gould, J.B., Lee, H.C. (2016, March). Impact of Donor Milk Availability on Breast Milk Use and Necrotizing Enterocolitis Rates. *Pediatrics, 137*(3), 1-8. DOI: 10.1542/peds.2015-3123.