Welcome

Jodi Harpstead
Commissioner
Department of Human Services

Jan Malcolm
Commissioner
Department of Health
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Welcome and agenda review</td>
</tr>
<tr>
<td>9:10 a.m.</td>
<td>Overview of strategies selected for development</td>
</tr>
<tr>
<td>9:40 a.m.</td>
<td>Health care services at DHS – an overview</td>
</tr>
<tr>
<td>10:10 a.m.</td>
<td>Health care cost savings strategy presentation and discussion</td>
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<tr>
<td>11:10 a.m.</td>
<td>Break</td>
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<tr>
<td>11:20 a.m.</td>
<td>Health care cost savings strategy presentation and discussion</td>
</tr>
<tr>
<td>12:20 p.m.</td>
<td>Break to pick up lunch</td>
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<tr>
<td>12:30 p.m.</td>
<td>Health care cost savings strategy presentation and discussion</td>
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<tr>
<td>1:30 p.m.</td>
<td>Presentation of community engagement plan</td>
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<tr>
<td>2:15 p.m.</td>
<td>Public comment</td>
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<tr>
<td>3:00 p.m.</td>
<td>Wrap-up and next meeting</td>
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Overview of Strategies Selected for Development
The statute charges the Commission to create an action plan that will, at a minimum, include strategies to:

1. **Transform the health and human services system** to a) improve program efficiencies, b) produce savings, and c) promote better outcomes for all Minnesotans;

2. **Increase administrative efficiencies and improve program simplification** within health and human services public programs, including: examining the roles and experience of the State, counties and tribes in delivering services, and identifying any conflicting and duplicative roles and responsibilities among the health and human services agencies, counties, and tribes;

3. Identify evidence-based strategies for addressing the significant cost drivers of State spending on health and human services, including the medical assistance program, in order to **reduce health and human services expenditures with net savings of $100M in the next biennium** (July 1, 2021 – June 30, 2023);

4. **Reduce waste** in administrative and service spending in health and human services through, including but not limited to misuse and overuse of health care services, fraud reduction, and improved program integrity; and

5. **Advance health equity** across geographies and racial and ethnic groups, in part, by addressing disparities in access, and disparities in outcomes.
• With over 200 unique strategy submissions, it has been necessary to prioritize those that will be presented and discussed over the next nine meetings.

• Prior to our last meeting on 12/5, Commission members were asked to indicate which strategy submissions were of greatest interest. 13 members responded and we reviewed the strategies of greatest Commission interest during that meeting.

• Following that 12/5 meeting, Bailit Health, DHS and MDH independently performed the same prioritization exercise.

• Those strategies that were of highest priority interest to at least one entity (Commission, Bailit Health, DHS or MDH) were then discussed one at a time in multi-agency meetings led by Bailit Health.
• The strategy review process employed the criteria adopted by the Commission on 11/7:
  • possess a high probability of achieving the aim of the defined focus area that the proposal strategy addresses;
  • be subject to the influence of government action;
  • be feasible to implement, both administratively and politically;
  • advance health equity, or at a minimum, not contribute to health inequities or disparities, nor negatively impact individual and community health status, consumers in private marketplaces, quality of care, or access to necessary care, and
  • not result in benefit reductions.
Bailit Health estimates that there will be time to present and discuss between four and seven strategies per Commission meeting, depending upon:

- how much discussion transpires with each presented strategy
- how much time is required for other agenda topics

For now, we have estimated 45 minutes per strategy.

An introductory, educational presentation for each focus area will be provided to Commission members with a basic grounding on the subject matter at each meeting.
• When selecting strategies for development, Bailit Health and the interagency work group used the submissions as a conversation starting point.
  • In some cases there were multiple strategy submissions on a common topic that staff felt should best be considered together to create an integrated strategy (e.g., strategies regarding pharmacy and strategies regarding MnChoices*).
  • In some cases the submitter bundled multiple strategies, of which only some met Commission criteria.
  • In some cases staff felt that the strategy warranted consideration but belonged in a different focus area than that indicated by the submitter (e.g., waste reduction, and not cost savings).

• Some of the strategies that received the most Commission member interest were prioritized for development, but not all. For example, some strategies prioritized by the BRC for cost savings were assessed as unlikely to meet MMB and legislative criteria for cost savings in the next biennium.

* MnChoices is DHS' web-based application that integrates assessment and support planning for Minnesotans who need long-term services and supports.
The process of selecting cost savings strategies proved the most difficult.

Many strategies that stakeholders – and not just Commission members – assessed as likely to generate cost savings were evaluated as unlikely to do so in the next biennium, or to not meet MMB and legislative criteria for recognizing savings.

For this reason, DHS staff had to identify additional strategy options that would be more likely to generate savings. These can be found in the list of prioritized strategies. Two will be discussed today.

Even with these additions, achieving the $100M savings requirement called for by the Legislature will be challenging.
Overview of Strategies Selected for Development

• A reference document was sent to Commission members to provide the rationale for why specific, high priority, strategies were not selected for development.

• The full list of strategies selected for development is included in meeting materials for reference.

• Commission members are invited to contact Krista with any questions or concerns they wish to discuss.

• Commission meetings 6-14 will be dedicated to strategy review and discussion.

• During each meeting we will discuss strategies specific to a focus area, although on occasion there may be a strategy that crosses focus areas.
• Today’s meeting and the next meeting (on 2/6) will focus on health care strategies to contribute to the $100M savings directive.

• The following two meetings (on 2/21 and 3/6) will focus on strategies for disability services and services for older adults to contribute to the $100M savings directive.

• These four meetings will be our most difficult and the least “fun”, since someone’s savings is someone else’s income.
Reminders

• Strategy selection was determined using the approved criteria with the goal of advancing strategies that would meet the Commission’s charge.

• Selection of strategies for development does not indicate State agency advocacy, endorsement or support.

• State staff have helped develop strategies as technical assistance, similar to what they provide for legislator-initiated proposals.
• During our 12/5 meeting some Commission members expressed interest in participating in strategy development.

• Because the strategies prioritized for development and presentation at today’s meeting were not selected until right before Christmas, and then limited time was available to develop them, we were unable to engage interested Commission members.

• Going forward, however, Krista will be in touch with those expressing interest to discuss your desired level of participation as we plan for future meetings.
The health care cost savings strategies we will discuss today are as follows:

1. Expand the DHS Encounter Alerting System (initial submission: #127)
2. Non-Emergency Medical Transportation Efficiencies (initial submissions: #8, #215 and #389)
3. Durable Medical Equipment and Supplies Rate Reform (initial submission: #420)
4. Volume Purchasing (initial submission: #419)

Each strategy underwent an equity review, which is embedded in the strategy template. The result of this review was a set of considerations for the Commission to contemplate.

Please note that after the equity review, changes in a particular strategy may not be needed. However, procedures associated with that strategy may need to be created or enhanced to ensure equitable outcomes can be achieved.

Before discussing these strategies, we will briefly review DHS health care services purchasing and past efforts to generate savings in this area.
Cost drivers in health care programs

Eligibility  Services  Payments

Strategies addressing these may impact quality
Cost drivers in health care programs

Quality

- Better quality = better health outcomes (and sometimes higher costs in the short term)

Patient experience

- Effective patient engagement = better health outcomes
How Minnesota purchases health care for enrollees

- DHS processes claims and pays providers directly.

Fee for service (25%)

- DHS pays managed care organizations (MCOs) to provide benefits to enrollees. MCOs process claims and pay providers.

Managed care organizations (75%)

- More than 40% of enrollees in fee for service or managed care receive services through an IHP.

Integration Health Partnerships (IHP)
Current cost-saving purchasing initiatives

Managed care

Integrated Health Partnerships
Managed care
Competitive contracting in managed care

- Determines which health plans participate in the Medical Assistance and MinnesotaCare programs
- Health plans respond to a request for proposals issued by DHS
- DHS, the Department of Health and counties score the proposals to determine who will be offered a contract
  - Evaluate quality and service delivery
  - May include price components
- Final decision made by DHS commissioner as the single state Medicaid agency
Administrative levers in managed care

• Health care cost trends
  • Encounter claims
  • Financial reporting
• Drug costs
  • Uniform preferred drug list
• Financial auditing
• Contract compliance
• Monitoring complaints with ombudsman
Managed care cost savings

Medicaid average capitation rate for families and children: 2000-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg. Capitation</th>
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<tbody>
<tr>
<td>2001</td>
<td>$231</td>
</tr>
<tr>
<td>2002</td>
<td>$259</td>
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<tr>
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<td>2015</td>
<td>$364</td>
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<tr>
<td>2016</td>
<td>$327</td>
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<td>2017 (Initial)</td>
<td>$338</td>
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Integrated Health Partnerships
Integrated Health Partnerships results

2013 to 2018

Cost savings
$401 million

People served
460,000+

Emergency room visits
Down 7%

Hospital stays
Down 14%
IHPs across Minnesota

- 47% of enrollees in Greater Minnesota
- More than 500 different provider locations
- More than 10,000 individual practitioners
Integrated Health Partnerships savings

![Graph showing annual savings and cumulative savings from 2013 to 2018.]

Annual Savings
Cumulative savings

2013 2014 2015 2016 2017 2018

-$\text{ }$50,000,000
$100,000,000
$150,000,000
$200,000,000
$250,000,000
$300,000,000
$350,000,000
$400,000,000
$450,000,000

$\text{ }$
• Medicaid families and children managed care contracts had lower than expected rates in 2020 with a state share savings of:
  
  • **$40 million** in FY20-21 biennium
  
  • **$73 million** in FY22-23 biennium

• Reducing the assumed rate trend from 4% to 3% beginning in 2021 results in a state share savings of:
  
  • **$4 million** in FY20-21 biennium
  
  • **$49 million** in FY22-23 biennium
Opportunities

• Long-term care:
  • Leverage managed care more?
  • Use direct provider contracting?

• Social determinants of health:
  • Improve health outcomes
  • Contribute to savings
Goal: Reduce costs while maintaining quality for Minnesotans
Questions?
Health Care Cost Savings Strategy Presentation and Discussion
• Our objective for this portion of the meeting is for you to receive an explanation of the strategy, and then have an opportunity to:
  • Ask questions
  • Debate the merits of the strategy relative to the Commission’s charge

• You will be asked to indicate your degree of support for the strategy. If there is strong support or opposition, we will so note. **You need not come to agreement today.** We will revisit these strategies in the spring.

• As a reminder, the Commission’s charter indicates that:
  • Inclusion of a specific strategy into the final Action Plan will be made by consensus without vote, unless a vote is requested.
  • The complete Action Plan will require majority approval.
I. Problem Statement

- Providers have historically lacked notification of when their patients arrive at an emergency room, inpatient hospital unit or long-term care facility.
- Fragmented care is costly, of poor quality and contributes to poor patient experience.
- IHP providers have asked for admission, discharge and transfer alerts to support their efforts to manage their patient populations.
II. Recommended Strategy

• Expand the current voluntary program (www.mneas.org) beyond 10 IHP providers to 100% participation and provide real-time notification on ER, hospital, long-term care facility admits, transfers and discharges. Notify primary care providers to whom patients are attributed as well as care coordinators.

• Enhance alerts to include discharge summary information.

III. Anticipated Benefits

• Savings to be determined by DHS staff.

• Improved care coordination, reduced ER and hospitalization rates, reduced hospital readmission penalties and increased provider shared savings.
IV. Supporting Evidence

• Providers have been requesting the information and informal feedback to date from participating providers and patients has been positive.

• Medicare beneficiaries who had transitional case management following a discharge had a significantly lower overall mean cost ($3,358 vs. $3,033). Also, studies indicate that if necessary follow-up care is not provided after an ER or hospitalization, recovering patients are more susceptible to complications and illness, resulting in worse health outcomes and costly readmissions.

• Other states have implemented similar programs.

• A pending new CMS interoperability rule is anticipated to require hospitals to share alerts as a condition of Medicare and Medicaid participation.
V. Administrative Implications

- DHS would need to work with Audacious Inquiry (MN’s health information vendor) and MDH to connect the MN EAS to the national e-health exchange.

- DHS and MDH would need to coordinate efforts with the E-Health Advisory Committee and align with the Health Information Exchange Taskforce’s recommendations.

- CMS would need to grant approval and would provide 90% matching funds.

- The full implementation process, including provider onboarding, would take 12-18 months from initiation.
VI. Equity Review Considerations

• This strategy will support equity, because a) persons most impacted will be those with high ER use, including persons with mental illness and the homeless, and b) some providers disproportionately serving these populations haven’t been able to take advantage of this e-health opportunity.

• How is cultural competency being considered?

• Does the strategy have unintended consequences?

• Does the strategy make provisions for accountability?
VII. Anticipated Challenges

• Provider systems would need to prioritize health IT resources. This may be more challenging for providers in multiple states and border communities.

• Providers may identify new patient care coordination needs to address.
Break
I. Problem Statement

- There is fragmented and inconsistent service delivery for Medical Assistance and MinnesotaCare because NEMT is currently administered by counties, tribes, the State and managed care plans.

- A 2017 federal audit found 75% of audit records did not comply with state and federal requirements – and required payment of $1.9M to CMS.

- Costs are higher than they would be using a uniform program administrator, based on the experience of other states.
II. Recommended Strategy

• Create a uniform NEMT program for all members using a single program administrator contracted with a per member per month payment model.

• The administrator would contract with drivers, negotiate rates and coordinate rides.

III. Anticipated Benefits

• Savings anticipated to be greater than $10 million.

• Improved program integrity and more consistent user experience through application of uniform performance standards and contract oversight.
IV. Supporting Evidence

• Other states have successfully implemented the model and achieved savings.

• Program integrity reviews have shown use of a program administrator increases the likelihood that rides are appropriate.

V. Administrative Implications

• An RFP process could be required and could be completed within 12 months of legislative authorization.
VI. Equity Review Considerations

• Will the changes promote geographic access?

• What are the possible unintended consequences?

• How will the strategy promote equitable outcomes to those who receive Minnesota Care and Medical Assistance and who utilize NEMT?

• Will those who receive rides be impacted by the change, and if so, how?

• Does this strategy make provisions for accountability?

• Will the strategy incorporate cultural competency training that includes language considerations?
VII. Anticipated Challenges

• Transitioning enrollees to a new administrative program structure.
• Current transportation providers may feel threatened by the change.
• Counties may object to program responsibility being taken from them.
I. Problem Statement

• DHS DME and supplies fee-for-service rates are currently 3-13% above Medicare rates and are administratively complex for DHS and providers.

• Current authority to pay Medicare rates is limited to specific supplies (those subject to an upper payment limit).

II. Recommended Strategy

• Pay for DME and supplies at the Medicare rate for those DME and supplies with Medicare rates.
III. Anticipated Benefits

• Savings to be determined. Estimate $1-$10M off the $87M DHS anticipates spending annually on DME in DHS’ fee-for-service program in SFY 2020-21.

IV. Supporting Evidence

• Available evaluation evidence generally suggests maintained Medicare beneficiary access to services and satisfaction for DME and supplies paid at the Medicare rates.
V. Administrative Implications

• DHS would need to make changes to its claim payment system following legislative authorization.

VI. Equity Review Considerations

• What is the impact to those who receive Medical Assistance?

• What are the possible unintended consequences?

• What are the possible population impacts including on the older adult population?

• Evaluation of the strategy suggests the need to incorporate an itemized list of the cost for durable medical equipment.
VII. Anticipated Challenges

• Current DME providers may feel threatened by the change.
Break to pick up lunch
I. Problem Statement

• National research and DHS experience indicate that savings may be achieved for these services through use of alternative purchasing strategies.

II. Recommended Strategy

• Expand current volume purchasing beyond eyeglasses, hearing aids, oxygen and diabetic test strips to additional DME products and services.

• Recommended services include enteral nutrition, standard wheelchairs and walkers, and wound care supplies. Could also be extended to additional products and services (e.g., incontinence supplies).
III. Anticipated Benefits

• Savings to be determined. Estimate $1-$10M off the $87M DHS anticipates spending annually on DME in DHS’ fee-for-service program in SFY 2020-21. Savings would be reduced for this strategy if DME and Supplies Rate Reform is implemented.

IV. Supporting Evidence

• DHS has successfully used this strategy for other DME.

• The federal Office of the Inspector General has recommended states volume purchase adult incontinence products.

• Although CMS’s monitoring activities have limitations, they indicate that Medicare beneficiary access and satisfaction have not been affected by competitive bidding.
V. Administrative Implications

- The RFP process would be required and could be completed within 6-9 months of legislative authorization.
VI. Equity Review Considerations

• What is the impact to individuals who access health care services through Medical Assistance and MinnesotaCare fee-for-service and utilize Durable Medical Equipment, specifically to those who have varying abilities? What are the benefits and burdens?

• What are the unintended consequences?

• Embed an equity analysis in the RFP process, specifically in rating and scoring.

• Partnering with diverse vendors could advance equitable outcomes.

• Ensure community and stakeholder engagement.
VII. Anticipated Challenges

• Providers may feel threatened by the change. Implementation of legislatively directed volume purchasing of adult incontinence products (2017) resulted in a lawsuit and 2019 legislative prohibition of such purchasing.

• Recipients may need to work with a new vendor to access volume-purchased products and services. Those products and services may be a change from those used presently, but they would be comparable.
Proposed Community Engagement Plan
The Improve Group Team

• Kylie Nicholas
• Claire Stoscheck
• Kassira Absar
• Leah Goldstein Moses
Overview of The Improve Group’s Activities

Intentional stakeholder engagement

Community engagement
Decision-Making Process

- Stakeholder feedback
- Community engagement frameworks
- Spectrum of participation
- Facilitated conversation about engagement events
- Stakeholder engagement strategy selection
• Create a space for **impacted communities to provide feedback** on proposed strategies

• Ensure the **Commission hears perspectives from impacted communities** to help make informed decisions about this work

• Develop **feedback loops** so communities know how their input was used
Core Principles

• **Intentionally address** issues of race, institutional and structural racism, discrimination and exclusion, and embody “cultural humility”

• **Culturally-appropriate and community-informed**

• **Full transparency**

• **Safety**, both physical and emotional, are prioritized

• **Partnerships**, collaboration, and co-creation

• **Community members are recognized** for their contribution and have ownership

• **Fair compensation**
## Public Participation Goal

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<tr>
<th>INFORM</th>
<th>CONSULT</th>
<th>INVOLVE</th>
<th>COLLABORATE</th>
<th>EMPOWER</th>
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<td>To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.</td>
<td>To obtain public feedback on analysis, alternatives and/or decisions.</td>
<td>To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.</td>
<td>To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.</td>
<td>To place final decision making in the hand of the public.</td>
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### Promise to the Public

- **We will keep you informed.**
- **We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced decisions.**
- **We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public influenced the decision.**
- **We will look to you for advice on innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.**
- **We will implement what you decide.**

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**IAP2 Spectrum of Public Participation**

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<tr>
<td>To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.</td>
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Considerations

• Timeline
• Budget
• Reach
• Decision-making power
• Level of participation
Public Engagement Activities

• Full commission meetings are open to the public

• Request(s) for Public Comment

• Stakeholder meetings, community events, and/or focus groups

• Written comment at commission meetings and/or via public website

• Public website

• Blue Ribbon Commission listserv for announcements and updates
For Commission meetings:

• Develop an intentional outreach invitation and engagement process for 1-2 meetings where timely public engagement is particularly critical

• Recommending activities for engaging stakeholders during meetings to maximize the quality and depth of public comment periods
Community Engagement Events: Overview

• Five events throughout the state
• Partnerships with community groups and liaisons
• Soliciting feedback on recently-released strategies
• Tailored events dependent on community needs
Community Engagement: What We Want To Learn

• What **benefits** do the engaged communities anticipate from the strategies?

• What **inequities or disparities** does the strategy either mitigate or reinforce?

• What should the commission know about **the impacts of this strategy** on the engaged communities?

• What **changes to the strategies** do the engaged communities recommend?
Community Engagement Events: Design

• Create space that is appropriate and safe for sharing
• Provide fair compensation for participants and partners
• Address barriers to participation
• Full transparency
Next Steps

- Develop intentional stakeholder engagement strategies for upcoming meetings
- Finalize selection criteria for community engagement events
- Identify partners and community liaisons
- Community engagement events (February – May)
Public comment

Please...

• Provide your name and organization

• Indicate if your comments are connected to a specific strategy

• Limit comments to 5 minutes

• Provide any supplemental written comment to Krista
Thursday, February 6, 2020

BRC Meeting 7

9:00 a.m. - 3:00 p.m.

Shoreview Community Center, Wedell Room

4580 Victoria Street North, Shoreview

Focus:

• Cost Savings Strategies for Health Care (Continued)