Blue Ribbon Commission Meeting 6

Meeting minutes

- Thursday, January 16, 2020; 9:00 a.m. – 3:00 p.m.
- St. Thomas University Anderson Student Center, St. Paul

Participation

Participating members: Commissioner Jan Malcolm, Commissioner Jodi Harpstead, Sheila Kiscaden, Lisa Weed, Sida Ly-Xiong, Gayle Kvenvold, Jennifer DeCubellis, Shauna Reitmeier, Senator Rich Draheim, Senator Matt Klein, Sue Schettle, Representative Tina Liebling, Julia Freeman, Debra Krause

Welcome and remarks

Commissioners Jan Malcolm (MDH) and Jodi Harpstead (DHS), co-chairs of the Blue Ribbon Commission welcomed Commission members to their sixth meeting, and welcomed public participants as well. They provided an overview of staff activity since the Commission’s last meeting on December 5th.

Overview of strategies selected for development

- Michael Bailit reviewed the process for selecting strategies for development, and provided an overview of strategies selected for development. He stated that the Commission meeting would focus on discussion of the following four health care cost savings strategies:
  - Expand the DHS Encounter Alerting System
  - Non-Emergency Medical Transportation Efficiencies
  - Durable Medical Equipment and Supplies Rate Reform
  - Volume Purchasing

- Sheila Kiscaden noted that at a recent Senate meeting in Rochester, Senator Gazelka indicated that the issue of splitting up DHS is one of his top priorities. Sheila expressed concern that the BRC won’t be dealing with transformation issues until late spring – when the Legislative Session is almost done. Representative Tina Liebling remarked that transforming DHS is not part of the BRC’s charge.

- Commissioner Malcolm noted the difficulty of achieving the $100 million savings charge of the Commission, and that some transformative ideas may achieve savings over the longer term.

- Michael Bailit reviewed a document that explained the disposition of the strategies identified as priorities in November 2019 by responding Commission members. Representative Liebling requested information on why strategy #16 (VBP agreements with drug manufacturers) was not selected. Michael Bailit committed to following up after the meeting with that information.

- Michael Bailit stated that it is difficult to identify strategies that yield cost savings, and as a result, two of the strategies presented were newly created by DHS because they have the potential to yield sizeable savings.

- Jennifer DeCubellis asked if the Commission would like to coordinate strategies with proposals put forth in legislative session. The Co-Chairs responded that the Commission should press on with its work without trying to prioritize strategies that may be legislative session topics. The Commission can advise legislative decision makers, and provide progress reports on the Commission’s work. Senator Matt Klein stated that he believed the Commission will receive credit if a recommended strategy is addressed by legislative action during the 2020 session.
• Agency staff will reach out to Commission members who have expressed interest in strategy development. Krista O’Connor would like Commission members who have expressed interest in doing so to provide guidance and help inform strategy development.

• An equity review occurred for the four strategies developed for the meeting; Commission member Julia Freeman participated in these reviews.

Health care services at DHS – an overview

• Heather Petermann and Julie Marquardt of DHS presented an overview of purchasing activities at DHS. Cost drivers in health care programs are the number of people served, the services that are covered, and the payments that are made for those services. They stated that the Commission is focused on the third driver because the Commission is not looking at reducing coverage or benefits.

• Quality is an important consideration; providing better care can result in reduced costs. Patient experience is also important. If patients are actively engaged, they are better able to get a good health outcome.

• DHS utilizes two purchasing strategies: a fee-for-service (FFS) model in which DHS pays claims directly (25 percent) and a managed care model in which DHS pays managed care organizations (MCOs) (75 percent). More than 40 percent of enrollees in FFS or managed care receive services through an Integrated Health Partnership (IHP).

• In response to a question from Commissioner Malcolm, Julie Marquardt noted that DHS has access to quarterly reports that allows the agency to examine provider payments. Representative Liebling stated that legislators are uncertain of the benefits of the state’s MCO approach. Jennifer DeCubellis stated that managed care enables the State to purchase services above what is specified in the Medicaid state plan. Michael Bailit noted that this topic will be examined during the Commission’s discussion of system transformation strategies. Commissioner Harpstead stated that MCOs have been effective and have produced savings for the State over the years. Representative Liebling disagreed.

• Julie Marquardt stated that DHS’ managed care strategy offers both opportunities and challenges, adding that it provides flexibility for rate negotiation and helps with some access issues. In its recent procurements, DHS has prioritized quality, ability to pay claims, and engagement with social determinants of health.

• DHS has been paying close attention to drug costs, which represent 15-20% of the MCO capitation rate, by working on how to manage drug costs while making sure people get access to needed drugs. DHS has instituted a uniform preferred drug list across health plans and FFS program.

• DHS conducts financial auditing to see what health plans are covering; as a result of these audits, the agency sometimes finds inappropriate costs that it then takes out of the rates.

• In response to a question from Shauna Reitmeier, Julie Marquardt stated that DHS conducts quality reporting, and surveys enrollees to find out why they disenrolled from a health plan. DHS does not have a “dashboard” type report card that compares MCO performance across quality measures.

• The goal of IHPs is to align provider incentives so that they are rewarded for value instead of volume; providers share in savings when they meet cost and quality targets. DHS supports IHP providers with population health and data that enable them to identify appropriate interventions. These efforts have resulted in reductions in unnecessary services. There are currently 24 IHPs across the state. Between 2013 and 2018, IHPs achieved $401 million in cost savings, reduced emergency visits by 7% and hospital stays by 14%. These results have reduced forecast trend by 1% (from expected growth of 4%).

• Senator Klein thanked DHS for its work on IHPs, noting that they are key to improving health care in Minnesota; he further indicated that there is huge potential in this area. Heather Petermann noted there is additional opportunity; IHPs include just families and children, and not those individuals who are dually eligible. Julie Marquardt noted that IHPs are invisible to beneficiaries – they don’t find it; it finds them. Representative Liebling noted the confusing overlap between MCO and IHPs. Julie Marquardt stated that health plans have to share savings with the provider organizations; it is a complex set of moving parts and they must attribute savings appropriately so both get paid fairly.
Health care cost savings strategy presentation and discussion

- Michael Bailit provided an overview of the strategy, **Expand the DHS Encounter Alerting Service (EAS)**, which would expand the current voluntary program beyond 10 IHP providers and a limited number of other providers to a goal of 100% participation and provide real-time notification on ER, hospital, long-term care facility admits, transfers and discharges. The EAS notifies primary care providers to whom patients are attributed as well as care coordinators. The strategy would also enhance alerts to include discharge summary information. Estimated savings are to be determined in the future.

- Shauna Reitmeier commented that this strategy may be appropriate for behavioral health providers, and that use of the EAS could be mandated in provider contracts. Heather Petermann stated that EAS does currently have Certified Community Behavioral Health Clinics and Behavioral Health Homes that are participating. Julia Marquardt noted that expansion of EAS is a cost savings strategy but will entail some investments for providers to be able to use the technology.

- Sue Schettle inquired if patients have to provide consent for information to be shared. Heather Petermann said that patients provide consent when they are treated by the provider, and consent when enrolling in benefits, so additional consents are not needed.

- Jennifer DeCubellis noted that the EAS could be expanded to be used by community-based organizations. Gayle Kvenvold commented that she liked the idea of broadening this strategy to include home-and-community-based services.

- Jennifer DeCubellis noted the potential for unintended consequences; with virtual teams, not all care coordinators on a team may participate. Heather Petermann clarified that alerts do include whether other care coordinators were alerted (except if it is a 42 CFR substance use treatment facility). Commissioner Harpstead stated that alerts can be prioritized by providers; the alert system is programmable and gives the ability to coordinate care. Senator Klein asked if alert information can be integrated with the electronic health record, and Heather Petermann responded that yes, alerts may be integrated into existing EHRs.

- Gayle Kvenvold noted that they are seeing more long-term care providers using this services. She thanked the Commission for bringing this strategy forward.

- **Decision**: There was general consensus to move forward with this strategy. Commission members did not request additional information.

- Michael Bailit provided an overview of the strategy, **Non-Emergency Medical Transportation (NEMT) Efficiencies**, which would 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. Diogo Reis of DHS indicated that Utah and Wisconsin are doing this. Savings are anticipated to be greater than $10 million.

- Commissioner Malcolm asked if questions raised under equity review were intended to communicate that the strategy should not advance. Julia Freeman clarified that the questions were intended to raise concerns of possible unintended consequences. Michael Bailit suggested that these considerations could be included in the action plan.

- Representative Liebling noted a previous legislative discussion on this topic was contentious and that this was not a new idea. She added that a lot of small businesses depend on the current program. Michael Bailit commented that under the strategy, savings occur because there will be fewer inappropriate rides and that ride prices will be lower. Diogo Reis of DHS commented that the strategy was consistent but different than what a previous workgroup recommended.

- Commissioner Harpstead expressed concern regarding possible impact on rural counties. Diogo Reis indicated that there are several models available for NEMT.

- Jennifer DeCubellis stated that if people do not receive care due to lack of transportation that creates a cost, and improved access may cost more in transportation but less in health care.

- Jennifer DeCubellis commented that counties are split – some see this strategy as an opportunity, and some see themselves doing well with the status quo. She added that health plans and counties and tribes are currently not coordinating well.
Sheila Kiscaden noted that it is a responsible thing to look at statewide access and administration. She stated that this strategy should stay on the list.

Health care cost savings strategy presentation and discussion (Cont’d)

Shauna Reitmeier noted that in northwest Minnesota, transportation is a challenge. She saw both pros and cons to this strategy.

Representative Liebling asked if the strategy included patients in managed care. State staff commented that the strategy applied to the entire Medicaid program, inclusive of managed care.

Shauna Reitmeier pointed out the challenges of literacy, and ensuring that those enrolled know how to access transportation.

Representative Liebling noted that the current non-emergency medical transportation system can hardly be worse than it is, however, the proposed strategy needs to be thoughtful in its details in order to have any chance of being accepted by the legislature.

Decision: There was general consensus that this strategy merited further discussion. Commission members did not request additional information.

Michael Bailit reviewed the strategy, Durable Medical Equipment (DME) and Supplies Rate Reform, which would pay for DME and supplies at the Medicare rate for those DME and supplies for which Medicare has a rate. Currently, DHS' FFS rates are above Medicare rates. Estimated savings are to be determined in the future.

Senator Klein asked if certain providers might stop negotiating with the State, which would reduce access. Michael said that while that could happen, Medicare pays at these prices and it can maintain access.

Representative Liebling noted this strategy applies to the FFS population only. She asked what would happen on the managed care side. After being told that plans negotiate their own rates with the vendors, she noted that this practice created a “black box” effect, because the same vendor may receive different prices. She also noted potential equity issues in that DME vendors are found across the state, and expressed mixed feelings about this strategy.

Shauna Reitmeier noted that this strategy could also cause potential cost reductions in managed care. Michael Bailit commented that if the MCOs do reduce cost, that would yield greater savings.

Julia Freeman noted that the risk is that public programs become a financial loser so that members have no access. There are culturally specific providers that specialize in narrow DME markets and they could be forced to consolidate.

Debra Krause asked about the experiences of other states with this approach. Diogo Reis commented that there are states that just use Medicare rates. For the most part states have a cap on rates at Medicare.

Commission Harpstead asked about the overall market for this strategy and was informed there is a projected $86.5M in Medicaid spending in FFS for the next biennium. She noted that vendors may be more driven by Medicare business than Medicaid.

Decision: There was a general consensus to keep this strategy on the list for consideration. Staff were asked to research the potential impact of extending the proposed DME strategy to MCOs (e.g., through rate adjustment, carve-out, or a payment terms requirement).

Michael Bailit reviewed the strategy, Volume Purchasing, which would expand current volume purchasing beyond eyeglasses, hearing aids, oxygen and diabetic test strips to additional DME products and services. Potential savings are to be determined. Michael Bailit noted there is some overlap between this strategy and the previously discussed strategy.

Representative Liebling noted that when Minnesota passed legislation in 2017, volume purchasing came in at the end of the budget negotiation process, and never went through normal legislative vetting process. Gayle Kvenvold noted that the association that represents the DME providers sued. The statute was vague on how to operationalize the strategy.

Senator Klein noted that the legislative proposal never went to committee due to backlash related to personalized and intimate supplies, which may be less of an issue here.
Jennifer DeCubellis noted the need for an exception process. State staff commented that this strategy would be selected only for DME needs that are generic in scope and performance, and not for a specialized wheelchair, for example. Sheila Kiscaden commented that the strategy should include incontinence products, which are commonly needed, but often costly.

In response to a question by Representative Liebling, Commission staff explained that the strategy would entail use of a disbursing mechanism that addresses need, so, oxygen would be shipped to a person’s house, and diabetic strips would be at the pharmacy, for example. This would only be for FFS Medicaid.

Diogo Reis commented that competitive bidding is a pretty common practice to do to contain costs.

Julie Marquardt commented on the potential managed care implications, noting that the volume purchased DME and services could be a carved out service from managed care, or treated as a directed payment. This would require additional reporting/data analysis. She noted that the state does not have directed payments in managed care.

Representative Liebling expressed interest in exploring this strategy on the managed care side. Jennifer DeCubellis noted that if the State sets a different (lower) rate than what it pays today, the MCOs are likely to move in that direction.

Decision: There was general consensus that this strategy merited further discussion. Staff were asked to research additional services for potential volume purchasing and the associated financial impact of their inclusion.

When asked for feedback on the process for reviewing strategies, Sue Schettle commented that she thought that the process worked well, and appreciated receipt of information beforehand. Lisa Weed stated that she would like to receive materials sooner. Sida Ly-Xiong commented that the Commission needs feedback from stakeholders. She noted the difficulty of reviewing the strategies without that input at this stage. Michael Bailit responded that The Improve Group is going to solicit community feedback about specific strategies. Sheila Kiscaden agreed with the importance of seeking public input.

Presentation of proposed community engagement plan

The Improve Group, represented by Kylie Nicholas, Kassira Absara, and Clare Stoschek, shared background on their experience. The Improve Group then provided an overview and discussion on stakeholder and community engagement, and how this engagement will inform the strategies.

The public engagement plan will focus on two areas: intentional stakeholder engagement and community engagement. The community engagement events and presentations will make explicit the timeline and resources of this work. Facilitated conversations at the engagement events will review the goals of work.

The overall goal of The Improve Group’s work is to ensure the Commission hears perspectives from impacted communities to help make informed decisions about this work.

The Improve Group shared several core principles of its work, including to intentionally address issues of race, institutional and structural racism, discrimination and exclusion, and embody cultural humility.

The Improve Group’s work is based on national and local community engagement frameworks.

The Improve Group shared the International Association of Public Participation (IAP2) framework, which is useful for establishing a common understanding of the goals and potential range of public participation that the Commission can expect.

Considerations and limitations on this work include the timeline and budget. It will be important to hear from the people who otherwise would not be heard from. The Improve Group will work with community liaisons to achieve this.

Public engagement activities will include a public comment period at full Commission meetings, stakeholder meetings, community events, and the Commission’s public website. The Improve Group will focus on stakeholder meetings and community events, to make sure that those who don’t typically share feedback can do that.

The Improve Group proposed intentional stakeholder engagement, with an outreach invitation and engagement process for the 1-2 Commission meetings where timely public engagement will be particularly critical.
The Improve Group will conduct five community events across the state, working with community groups and liaisons with existing groups. The Improve Group will also leverage Commission contacts in these communities. The current assumption – which may change – is one community engagement event per strategy focus area. Events will be tailored to each community in terms of format, time of day, agenda, etc. The Improve Group may conduct some virtual events to make them more accessible.

**Presentation of proposed community engagement plan (Cont’d)**

- Sida Ly-Xiong asked about the distinction between “intentional” and “community,” and if the five events will be organized around strategies for which context is needed. The Improve Group staff responded that the terms “intentional” and “community” are ways of defining audiences rather than different questions. Intentional audiences are those that are emerging or those who are not explicitly otherwise included. The five community engagement events will involve invitations to make sure the Commission is reaching those who are most likely to be impacted by proposed strategies.
- Shauna Reitmeier recommended that The Improve Group explore multiple strategies at each community event, and identify the intentional people to invite or get feedback from. Julia Freeman agreed with this suggested approach, and expressed concern that the resulting group could be specific and narrow.
- Shauna Reitmeier asked if DHS or MDH staff will be present at the community events to answer specific questions. The Improve Group stated that it did not yet have an answer to this question but would work with state staff to have subject matter experts in the room. The Improve Group agreed that the strategies will need to be explained correctly and concisely.
- The Improve Group will brainstorm what it wants to learn from each community event.
- Design of the community events will take into account fair compensation for participants and partners, barriers to participation, and creating a space that is appropriate and safe for sharing.
- Sida Ly-Xiong asked about the size and scope of the events. Given that these are complex topic areas, The Improve Group viewed these events as workshops of 20-30 people.
- Julia Freeman stated that she was disappointed by the community engagement plan as it lacked detail, particularly on how community engagement would work and where Commission members could help.
- Kylie Nicholas responded that they had just received the proposed strategies and were working on the same timeline as the Commission. She stated that she appreciated the question of how Commission members can support the community engagement work.
- Sheila Kiscaden noted that some strategies will have much more impact on organizations and some will be felt directly by different communities. She encouraged The Improve Group to identify who and what groups of people will be most impacted by which strategies, and to prioritize input on those strategies.
- Gayle Kvenvold noted that some providers may include group homes where people with disabilities may live.
- In response to a question from Commissioner Malcolm, The Improve Group indicated it would use a focus group for a particular strategy if it felt it was necessary in order to get information on the impact of a strategy. Sue Schettle recommended this approach for strategies that involve disability services, as well as possibly an intentional stakeholder group (e.g., rural stakeholder group).
- In terms of next steps, The Improve Group will gather information from state staff on the strategies, and where the State has previously gathered input from communities as part of similar or related efforts. Krista O’Connor suggested that Commission members also send a list to The Improve Group of groups that would be impacted by the strategies.
- Commissioner Malcolm noted the importance of soliciting feedback not just on the individual strategies but also on the action plan in its entirety.
- Krista O’Connor noted that the full list of strategies is posted on the Commission’s website, with opportunities to register to provide public comment. A listserv provides announcements and materials.
- The Improve Group’s Kylie Nicholas stated that they were considering presenting public comment in detail at the June 6th Commission meeting.
- Maren Hulden, a representative from Legal Aid noted that the strategies are now on the website. She asked that strategies be listed on the agenda, and that meeting materials be shared via the listserv.
Public comment

- Commentary was provided by Reverend Dr. Jean Lee. She said that most of the ethnic members in her housing consortium were Asian/Pacific Islanders and said that a lot of services will touch on them.
- Reverend Dr. Lee commented that with regard to transportation, tweaking the use of bus cards could help transportation use. She suggested that bus cards would allow for greater flexibility if they could be used like a credit card and the State had a method to keep track.
- She also noted the purchasing power of the counties, and said it would help to have them undertake volume purchasing. In terms of volume purchasing, Reverend Dr. Lee suggested that upgrades can be required within service contracts; she also commented on the need for people to have the ability to return items that don’t work properly.
- Reverend Dr. Lee commented on the increased needs of stroke victims because the help they need is not being provided.
- Reverend Dr. Lee concluded by sharing that the best way to get comments is when someone is actually going through the experience. She gave the example of when a person is at the doctor’s office. This is superior to holding events. She further indicated that a person could provide comments online after they see a provider; they could learn about this option from a flyer or through their employer. There are lots of ways to get feedback rather than at a specific BRC event.

Meeting wrap-up

- Commissioner Malcolm thanked staff and the Bailit Health team. Commissioner Harpstead expressed appreciation for the engagement of Commission members.
- Julia Freeman asked her fellow Commission members to please consider participating in equity review for strategies moving forward.
- Debra Krause encouraged staff and Bailit Health to be bold in strategy development moving forward.

Next meeting

- Thursday, February 6, 2020; 9:00 a.m. – 3:00 p.m.
- Shoreview Community Center, Wedell Room, 4580 Victoria Street North, Shoreview