Welcome

Jodi Harpstead
Commissioner
Department of Human Services

Jan Malcolm
Commissioner
Department of Health
<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>9:00 a.m.</td>
<td>Welcome and agenda review</td>
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<tr>
<td>9:20 a.m.</td>
<td>Overview of public input on final draft and goals for the meeting</td>
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<tr>
<td>9:30 a.m.</td>
<td>Final equity review assessment</td>
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<tr>
<td>9:50 a.m.</td>
<td>Cost savings strategies: healthcare</td>
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<tr>
<td>10:20 a.m.</td>
<td>Break</td>
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<tr>
<td>10:30 a.m.</td>
<td>Cost savings strategies: LTSS for persons with disabilities and older adults</td>
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<tr>
<td>10:50 a.m.</td>
<td>Strategies focused on waste, including fraud and program integrity</td>
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<td>11:05 a.m.</td>
<td>Strategies focused on administrative efficiencies and simplification</td>
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<td>11:20 a.m.</td>
<td>Strategies focused on health equity</td>
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<td>11:50 p.m.</td>
<td>Incorporation of public comment in final report</td>
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<tr>
<td>12:20 p.m.</td>
<td>Wrap-up, next steps and timelines</td>
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Housekeeping Details

- We are using the WebEx platform for today’s meeting.

- Please mute your line to reduce background noise.

- Please use the “raise your hand” feature if you wish for the Commissioner to call upon you.
  - Click on the Raise Hand button, which will place a small hand icon next to your name in the participant list. This will alert us that you wish to be called upon.

- Please unmute your line when you wish to speak.

- If you have a question or request, please enter it into the Q&A box in the top right-hand panel.
  - Indicate if your request is for everyone, or for the Bailit Health moderator.
Overview of Public Input and Goals for the Meeting
During the month of July, the Commission engaged in an unprecedented effort to reach out and collect public input:

- Comment collection tool on the Commission website – nearly 100 submissions
- July 15 public webinar – 142 participants
- Virtual town halls, and listening sessions
- American Cancer Society, Alzheimer’s Association, Area Agencies on Aging, Cultural and Ethnic Communities Leadership Council, DHS Dental Services Advisory Committee, Diverse Elders Coalition, Doctors for Health Equity, MN Community Measurement, MN Consortium of Citizens with Disabilities, MN Health Action Group, MN Leadership Council on Aging, This is Medicaid, Tribal Health Directors
## Overview of Public Input (2 of 2)

### Cost Savings Strategies: Health Care

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Number of Comments</th>
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<tbody>
<tr>
<td>Implement Uniform Administration of NEMT</td>
<td>34</td>
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<tr>
<td>Expand Use of the MN Encounter Alerting Service</td>
<td>31</td>
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<tr>
<td>Require MCO Competitive Price Bidding</td>
<td>24</td>
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<td>Establish Prescription Drug Affordability Commission</td>
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<tr>
<td>Create Uniform Pharmacy Benefit</td>
<td>21</td>
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<tr>
<td>Expand Volume Purchasing for DME</td>
<td>19</td>
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<tr>
<td>Modify Certain DME Payment Rates to Match Medicare</td>
<td>16</td>
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<tr>
<td>Establish Prescription Drug Purchasing Council</td>
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<tr>
<td>Improve Compliance with TPL Requirements</td>
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### Cost Savings Strategies: LTSS for Persons with Disabilities and Older Adults

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<th>Strategy</th>
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<tbody>
<tr>
<td>Update Absence Factor in Day Services</td>
<td>35</td>
</tr>
<tr>
<td>Require Medicare Enhanced Home Care Benefit</td>
<td>28</td>
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<tr>
<td>Update Value Based Reimbursement in Nursing Facilities</td>
<td>21</td>
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<tr>
<td>Curb Residential Costs in Disability Waivers</td>
<td>20</td>
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<tr>
<td>Change Disability Waiver Family Foster Care Rate</td>
<td>10</td>
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<tr>
<td>Housing Opportunities for People with AIDS (HOPWA)</td>
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<td>Home and Community Based Services Settings Rule</td>
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<td>Appropriation</td>
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### Administrative Efficiencies and Simplification Strategies

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<tr>
<th>Strategy</th>
<th>Number of Comments</th>
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<tbody>
<tr>
<td>Improve MnCHOICES and LTSS Processes</td>
<td>23</td>
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### Health Equity Strategies

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<tr>
<th>Strategy</th>
<th>Number of Comments</th>
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<tbody>
<tr>
<td>Improve Dental Access in Public Health Care Programs</td>
<td>37</td>
</tr>
<tr>
<td>Ensure Equitable Access to Aging, Disability Programs</td>
<td>28</td>
</tr>
<tr>
<td>Redesign Targeted Case Management</td>
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### Waste, Including Fraud and Program Integrity, Strategies

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<tr>
<th>Strategy</th>
<th>Number of Comments</th>
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<tbody>
<tr>
<td>Align State and Federal Health Care Privacy Protections</td>
<td>23</td>
</tr>
<tr>
<td>Pursue Fraud, Waste, or Abuse Prevention Enhancements</td>
<td>17</td>
</tr>
<tr>
<td>Reduce Low-Value Services in Minnesota</td>
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Goals of Today’s Meeting

1. Share the final equity review assessment
2. Provide a recap of the public input received for each strategy
3. Solicit feedback on how public input should be reflected in the report
4. Consider a proposed change to the dental strategy

We will not be considering changes to the strategies – they remain as-is per discussion at the last Commission meeting.
Blue Ribbon Commission Equity Assessment

Crystal Fairchild | Director of Equity and Inclusion

Health Care Administration
To support Minnesota Health and Human Services Blue Ribbon Commission’s goal of improving program efficiencies, producing savings, and promoting better outcomes in health and human services, an equity assessment and best practices were incorporated to the final report and public input.
• We promote equitable considerations across every administration to ensure Minnesotans achieve their full potential

• We will be an agency where barriers such as race, ethnicity, access, and geographic locations do not predetermine opportunities in health and human service outcomes for those we serve
**Equity lens**: metaphor describes the possibility of seeing our policies, practices, programs, and budget allocations in new and revealing ways that will lead to actionable change.
The assessment process utilized seven steps for building racial equity lens, provided by Government Alliance on Racial Equity (GARE).

- **Know the History**: Consider historical events that have negatively impacted communities of color and indigenous groups. Acknowledge them and create space for communities to share as to not repeat the same mistakes.

- **Develop the strategy**: What is strategy decision under consideration? What are the desired results and outcomes?

- **Monitor Data**: What is the data? What does the data tell us? Are they disaggregated by race?

- **Engage the community**: How have communities been engaged? Are there opportunities to expand engagement?

- **Analysis and strategies**: Who will benefit from or be burdened (intent vs. impact) by the strategy? What are strategies for advancing racial equity or mitigating unintended consequences?

- **Implementation**: What is your plan for implementation?

- **Accountability and Communication**: How will you ensure accountability, communicate, and evaluate results?
Equity Assessment Process

- Educate on equity issues and raise consciousness
- Promote inclusive collaboration and engagement
- Assess community conditions and set goals for affecting desired community impact
- Expand opportunity and access for individuals
- Affect systemic change
Equity Assessment
Key Takeaways

Crystal Fairchild, HCA Director of Equity and Inclusion
• What were the most important community outcomes related to the strategies proposed and commission report?

• What needs or opportunities were identified during the assessment phase of this process?

“Community engagement is vital to improving access to services. Increasing access to services for more people who need services.”

“The report needs to address how service access will not only be assessed but also remedied for marginalized communities.”
How do the strategies and or the report benefit or burden the community in terms of equity?

- Over half of the public input (60%) suggests the use of an equity lens and the need for further health equity evaluation
- Authentic engagement prior to the development of strategies
- The Commission vision to address inequity and health disparities through health and human services system transformation where race no longer predetermines health outcomes
• Public Input

• Priority Strategy Identification and Development

• Equity Review Process

• Community Engagement

• Strategies for Consideration
No decisions about policies that effect the lives and health outcomes of Minnesotans can be just and equitable if it does not involve those most impacted.
Equity Recommendations

• Review short and long term efforts in proposed strategies that yield equitable outcomes

• Track impact of strategies on communities overtime to analyze the community condition

• Transparency and Accountability: ensure ongoing conversations with the community, and intentional interagency and stakeholder collaboration

• Lead with race: dismantling racist barriers will lead to improved lives
Questions?

Crystal Fairchild
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651-431-2507
Cost Savings Strategies – Healthcare
1. Implement Uniform Administration of Non-Emergency Medical Transportation (34 comments)

- Comments in support noted the potential for improved access for older adults (especially in rural areas), as well as for individuals with disabilities and low-income populations, individuals with mental illness, and those with vision loss.

- Three professional associations voiced opposition, expressing concern over potential payment shifts from providers to the new vendor, and uncertainty over the role of counties.

- Constructive comments expressed hope that a redesigned system would improve ridership experience, but several expressed concern that the strategy would inadvertently decrease access to care.

- Several comments urged the Commission to examine the previous work of the NEMT Advisory Committee.
2. Modify Certain Medical Assistance DME Equipment Payment Rates to Match Medicare Rates (16 comments)

- This strategy received no supportive comments.
- Commenters expressed concern that further reductions to DME reimbursement for the Medicaid population would have a devastating impact on providers serving the Medicaid population.
- Others said that individuals with disabilities would lose access to specialized medical equipment.
- Several noted concern regarding the potential impact on rural communities.
- One constructive commenter supported consistent payment rates, but felt that this strategy merits additional analysis to ensure it does not limit access to needed DME services.
3. Expand Volume Purchasing for DME (19 comments)

- **The majority of comments expressed opposition** to this strategy.
- Many expressed concern that this strategy would limit access to specialized DME products for individuals with disabilities.
- Several noted that adoption of this strategy could put some DME providers out of business, particularly in rural areas of the state.
- Several referenced DHS’ prior experience in trying to shift incontinence supplies to volume purchasing, and the resulting strong opposition.
- One comment said the disability community worked with DHS and the legislature in 2018 and 2019 to address concerns related to volume purchasing, and asked DHS to refer to those stakeholder conversations.
4. Expand Use of the MN Encounter Alerting Service (31 comments)

- The majority of comments expressed enthusiastic support.

- Comments noted the benefits of this strategy, including:
  - Better care coordination across systems of care, and with social service agencies and community supports, and
  - Improved timeliness of communications, especially with emergency departments.

- One comment recommended that the State offer training to providers as the alert system is brought online.
• **This strategy did not generate many comments**, and the comments the Commission received expressed neither support nor opposition.

• A TPL vendor submitted a five-page letter that may be helpful to state staff in the event this strategy is pursued.
A handful of comments expressed support for this strategy.

Several comments expressed opposition and recalled DHS’ prior experience with MCO competitive price bidding.

The majority of commenters offered constructive feedback, with numerous commenters urging caution to ensure that competitive price bidding doesn’t result in a reduction in provider reimbursement rates.
7. Create Uniform Pharmacy Benefit (21 comments)

• The majority of comments expressed support, noting this strategy would:
  • Boost the State’s ability to negotiate the cost of prescription drugs for enrollees across public programs, and
  • Expand the State’s authority to negotiate drug prices for all state agencies.

• Several opposing comments noted that the strategy lacked evidence or would undermine existing processes in place within MCOs.

• Several comments advocated for improved ability of consumers to provide input to the preferred drug list, as well as transparency of list and process.
8. Establish Prescription Drug Purchasing Council (16 comments)

• The majority of comments expressed supported for the strategy, noting that it would be beneficial for citizens of the state, particularly older individuals who have difficulty affording prescriptions.

• Several comments noted that prescription drugs are a significant health care cost driver and that a Purchasing Council would improve their affordability.

• Several comments noted the need for transparency in terms of the Council’s meetings and deliberations.
9. Establish Prescription Drug Affordability Commission (23 comments)

- Like the previous strategy, the majority of comments offered strong support.

- Those supporting the strategy noted that prescription drug affordability is a perennial issue for the citizens of Minnesota, particularly the elderly and vulnerable.

- Those opposing the strategy expressed concern that such a Council would cap or unilaterally set prices for certain prescription drugs.
Cost Savings Strategies –
LTSS for Persons with Disabilities and Older Adults
• The Commission received relatively few comments on this strategy, with several expressing support and noting that the goals of the grants have been achieved.

• An opposing comment said the grants are still needed to fill a funding gap and to provide technical assistance to help organizations achieve sustainability.

• One comment suggested that a health equity lens be used to evaluate this strategy and the potential impact on BIPOC and LGBTQ communities.

• Another comment advocated for an independent state audit of the strategies to monitor how funds are being distributed, account for savings, and ensure actions are not having negative consequences.
• **Most comments opposed this strategy** – no comments in support were received. Voiced concerns included the following:

  • the strategy would create additional hardships for providers during a time when finances are already strained due to the impact of COVID-19

  • any rate cuts would further strain the workforce, creating additional challenges recruiting and retaining providers and staff.

  • access to and quality of care would diminish due to rate reductions and diminished provider ability to provide services.

  • the data used by DHS to inform the strategy are flawed and there have been repeated requests to re-examine the data.

  • providers have little control over absences and the strategy would result in exceptions that would create additional administrative costs.
• Comments in support of the strategy noted the importance of the Life Sharing services in promoting individual choice, person-centeredness, and community-based living.

• Opposing comments expressed concern about the impact on family foster care provider financial stability if there were rate cuts.

• Constructive comments urged evaluation of the strategy using a health equity lens, and recommended targeting resources to providers of color to meet the needs of children of color receiving foster care services.

• Several commenters requested additional clarity on the rate methodology, citing concerns about financial stability, and the timing of rate changes.
13. Curb Residential Costs in Disability Waivers
(20 comments)

• The Commission received more opposing than supportive comments. Some expressed a mix of support and opposition to the different strategy components.

• Comments in support welcomed the new initiative and a robust screening process to promote independence and choice. Several said moving / service planning assistance is integral. They also noted the benefit of continuity in services before and after a move, and the potential for savings.

• Comments in opposition expressed concern about the lack of housing options and noted the strategy could result in increased homelessness or institutional care. They also opposed reducing statewide capacity when people move given limited housing options, and expressed concern that the residential billing framework may produce provider losses. There was also a comment urging equity lens application.
• The majority of comments supported this strategy.

• Comments in support noted that the strategy would expand access to services and promote independence, individual choice, and community-based living, allowing people to age in place.

• The single opposing comment expressed concern that the strategy offers an untested approach that will result in increased premiums.

• A number of the constructive comments expressed concern about the cost implications of adding benefits and urged additional analysis to ensure stable premiums for members, and sufficient rates for providers.
The majority of comments opposed this strategy, expressing concern about the financial stability of nursing facilities especially at a time when they are experiencing financial hardships due to COVID-19.

- Additional concerns included potential workforce strains resulting from reduced nursing facilities revenues, and the viability of rural nursing homes.
- Some doubted the strategy would improve quality and efficiency, citing mixed evidence.

Comments in support stated that the strategy will incentivize improved quality of care.

Constructive comments noted that additional research may be needed to determine the best reimbursement methodology for nursing facilities.
Strategies Focused on Waste, Including Fraud and Program Integrity
• A handful of comments supported the strategy and none opposed it.

• Comments in support noted that better internal processes and a strengthened regulatory framework would be beneficial and could achieve savings.

• The majority of comments were constructive and offered specific suggestions, including the need to revamp whistleblower laws, to fund cultural competence training, and to perform an external racial equity review of investigations before expanding these efforts.

• Several comments discussed the importance of targeting fraud accurately, and many expressed concern that the strategy could inequitably target individuals and providers based on race and unfairly punish overburdened providers.

• Several comments emphasized the need for process change over simply hiring more investigators.
17. Reduce Low-Value Services in Minnesota (20 comments)

• Half a dozen comments supported the strategy and the balance were constructive.

• A number of the constructive comments expressed concerns about the definition of “value,” and urged the Commission to carefully consider the process of defining “low-value services.”
  • Many urged the Commission to seek broad and diverse participation in further developing this strategy.

• Several comments expressed concern that the strategy did not provide enough detail to allow for meaningful feedback.
There was enthusiastic support for this strategy across stakeholder groups, with only one comment expressing opposition.

Comments noted that this strategy would reduce administrative burden and improve care coordination, health outcomes, and access for clients with records in multiple states or health systems.

Many comments expressed frustration at Minnesota’s uniquely burdensome privacy requirements. Some noted that the burden falls even more heavily on underserved communities and communities suffering from health disparities.

The one opposing comment expressed concern about limitations on patients’ current right of access to their mental health records, which is not granted by HIPAA and about the impact on the Family Involvement Law, which allows information sharing with caretakers providing support to individuals with mental illness.
Strategies Focused on Administrative Efficiencies and Simplification
• This strategy received strong support with no opposing comments.

• Comments in support noted that a simplified process would improve the experience of members and promote person-centered care.
  • Many noted a streamlined process could reduce delays in assessment and enrollment in waiver programs, confusion among individuals, and administrative burden on agencies.

• A handful of comments offered constructive input, with one comment urging caution to avoid shifting costs to counties and tribes.

• Some comments noted the guide could assist members with understanding their options and acknowledged that it may be difficult to simplify a complex policy.
20. Ensure Equitable Access to Aging and Disability Service Programs (28 comments)

• **The majority of comments supported this strategy;** there were no opposing comments.

• Comments in support of the strategy noted the stark disparities in access to services between white people BIPOC within the State’s aging and disability service programs.

• Several comments highlighted the need to consider all underserved populations. Comments noted the absence of the LGBTQ community from the Commission’s charge to advance health equity and urged inclusion of this community in reduction of health disparities.

• Other comments included:
  • Emphasis on the importance of a community engagement initiative, viewed as core to this strategy.
  • Recommendation for diversification of the workforce alongside these efforts.
  • Recommendation for listening to communities, detailing plans for data collection, and planning out how service access will be assessed and remedied.
21. Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports (19 comments)

• **Two-thirds of the comments received by the Commission expressed support; none opposed.**

• Several comments in support of this strategy applauded the goal of allowing individuals earlier access to targeted case management, and also to streamline the process. Some also noted that this would reduce disparities.

• Several noted the strategy has been discussed by various groups for years without leading to any meaningful change, and they expressed hope that the legislature would finally act.

• One comment expressed concern that the current survey tool does not allow for rates that would cultivate a competitive workforce and allow financial sustainability. Another recommended using FQHC cost-based reimbursement principles when establishing a new targeted case management rate methodology.
More than half of the comments supported this strategy, noting the important linkage of dental health to overall health. Others noted the historically low reimbursement rates for dental providers, preventable dental-related emergency room visits, and limited access to dental care for children and older adults – particularly in rural areas.

Comments in opposition stated that this strategy offers a one-size-fits-all approach that doesn’t address the unique needs of various populations, or recognize existing local efforts.

A number of comment expressed concern over funding loss to Critical Access Dental (CAD) providers, and the potential for increased overall spending and decreased access.

Several commenters expressed support for a rate increase, provided that it could be done without negatively impacting CAD providers.
Dental Access Strategy: additional sub-strategy
I. Problem Statement

1. There is poor access to children's oral health care.

2. Minnesota lacks a coordinated statewide oral health delivery system that integrates and tracks Collaborative Dental Hygiene Practice and community and clinic-based dental services.
II. Recommended sub-strategy components

1. Integrate, align, and implement oral health strategies developed by the Association of State and Territorial Dental Directors (ASTDD) into the Whole School, Whole Community, Whole Child (WSCC) model.

2. Create regional reach by coordinating and collaborating with Minnesota Department of Education, local public health, school districts, and schools with oral health services.

3. Eliminate administrative barriers for dental hygienists in collaborative practice to provide preventive services in schools.
Component 1: Integrate Oral Health Into the WSCC Model

Integrate oral health into the 10 components of WSCC

1. Physical education and physical activity
2. Nutrition environment and services
3. Health education
4. Social and emotional school climate
5. Physical environment
6. Health services
7. Counseling, psychological and social services
8. Employee wellness
9. Community involvement
10. Family engagement
Component 2: Create State & Regional Reach and Coordination

• Leverage existing school-based/school-linked oral health programs and partnerships such as State Health Improvement Partnerships (SHIP), Minnesota Department of Education (MDE), local public health, school districts to build upon and expand oral health activities

• Minimize duplication of work, improve collective impact and allow customization to address unique needs of children/schools/communities
Component 3: Eliminate Administrative Barriers for Dental Hygienists

- Add oral health screening and risk assessments to the Minnesota Health Care Programs benefit set
  - Will expand use with under-served children
  - Aimed at improving care coordination and appropriate preventive services (DSAC 2019 recommendation)

- Make direct reimbursement from MHCP to Collaborative Practice Dental Hygienists
  - Will expand use with under-served children
  - Aimed at increasing the sustainability of this model
Key Implementation Activities

• Engage key state and regional stakeholders and communities

• Establish a Minnesota School Oral Health Program Advisory Group

• Hire and train collaborative practice dental hygienists and other state and regional staff necessary for community engagement and to plan, design, implement and evaluate the program

• Conduct a needs assessment/SWOT analysis

• Develop communication and sustainability plans

• Create a Dental Access Grant process

• Conduct process and outcome evaluation which will include cost and cost-effectiveness analysis
Increasing children’s dental access through a coordinated, statewide school-based oral health program (3 of 8)

III. Anticipated Benefits

- Quality of life
- Education metrics
- Oral-systemic disease
- Healthcare spending
- Oral health disparities
Increasing children’s dental access through a coordinated, statewide school-based oral health program (4 of 8)

IV. Supporting Evidence

1. Improving Oral Health Through WSCC

2. Use of Collaborative Practice Dental Hygiene Model
IV. Supporting Evidence (cont’d)

3. Use of Collaborative Dental Access Program Model


V. Administrative Implications

- Proposes changes to Medicaid policy to reimburse hygienists for oral health/caries risk assessment
- Requires administrative change permitting hygienists to be a “pay-to-provider”
- Requires building a statewide school-based oral health infrastructure that coordinates education, health and oral health efforts and fosters quality improvement
- Leverages activities and reach of existing school based oral health service providers and other programs such as SHIP and local public health agencies to build upon and expand school-based oral health services at the regional and state levels
VI. Equity Review (conducted by MDH)

• The Minnesota School Oral Health Program will reach children throughout Minnesota based on dental need/risk, including children from rural locations and Dental HPSAs, children of color and American Indians and children with disabilities.

• The project uses a community-based participatory approach to program development, implementation and evaluation which builds health equity consideration into its efforts.
VII. Anticipated Challenges

- As each Minnesota agency and independent school districts has its respective priorities for school, it will take some time to build relationship and trust for a shared agenda towards improving the oral health and school readiness of children.

- The innovative workforce model of a dental hygienist in a collaborative practice is under-utilized in Minnesota. There were 5,760 dental hygienists (33% of the oral health workforce) in 2019 and only 4.6% had collaborative practice agreements.

- This strategy requires Medicaid policy to add reimbursement for oral health/caries risk assessment to include direct reimbursement as a ‘pay-to-provider’ for Collaborative Dental Hygiene Practice. Additional cost is likely to be offset in the long run by lower cost of timely preventive care and resulting decrease in disease burden.
Reflecting public input in final report

• How would Commission members like to see public input reflected in the report?
  • Individual synthesis summaries for each strategy as proposed?
  • Modified or other approach?
The Commission is scheduled to meet on September 18 for the final time, in preparation for the scheduled October 1 report submission.

Members will receive the final draft report in advance of the meeting.

The purpose of the meeting will be to vote to confirm that the final report accurately reflects the work of the Commission.
Wrap-up
Thank you!

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