Blue Ribbon Commission Meeting #2: Meeting Minutes
Thursday, October 10, 2019; 9 a – noon
EnVision Hotel, Saint Paul South, Legacy Room 1
701 Concord St S, South St Paul, MN  55075

Participation
Participating members:  Jennifer DeCubellis, Rich Draheim, Jennifer DuPuis, Nona Ferguson, Julia Freeman, Jodi Harpstead, Sheila Kiscaden, Matt Klein, Debra Krause, Gayle Kvenvold, Tina Liebling, Jan Malcolm, Shauna Reitmeier, Sue Schettle, Joe Schomacker, Lisa Weed

Welcome and Remarks
Commissioners Jan Malcolm (MDH) and Jodi Harpstead (DHS), co-chairs of the Blue Ribbon Commission, welcomed the Commission to its second meeting, and welcomed public participants as well. Commissioner Malcolm introduced Michael Bailit of Bailit Health Purchasing, the vendor contracted to facilitate and support the Blue Ribbon Commission.

Commissioner Harpstead reviewed the meeting agenda, and noted that the meeting would provide foundational information on statewide health care data, as well as information specific to Department of Human Services-administered programs.

Three Commission members attending a meeting for the first time introduced themselves and conveyed their priorities.

- Julia Freeman, Senior Organizer for Voices for Racial Justice, said that she would bring her experience working with communities impacted by health disparities and uplifting their voices. She said her priority was investment to address the social determinants that give rise to disparities. She encouraged adoption of an equity lens to the Commission’s work.
- Shauna Reitmeier, the Chief Executive Officer of Northwestern Mental Health Center, defined her priority areas as disability services, improving health outcomes and looking at the continuum of care for persons with disabilities.
- Sue Schettle, the Chief Executive Officer of the Association of Residential Resources in Minnesota (ARRM), described her priority areas as equity and access for rural Minnesota for behavioral health. She recommended thinking about how to make the Department of Human Services a data-driven department, how to integrate systems and structures within the Department, and how to align resources within an integrated care model.

Commissioner Malcolm explained that the meeting’s presentations would focus on health care and health care spending. She explained that a future meeting presentation will focus on health and public health.
Minnesota Statewide Health Overview

Stefan Gildemeister, State Health Economist and Director of the Health Economics Program at the Minnesota Department of Health, provided an overview of demographic trends, health care trends, drivers of health care spending and health disparities in Minnesota. The Commission’s October 10th Meeting 2 slide set includes Stefan Gildemeister’s presentation.

Stefan noted that despite some very positive characteristics of health coverage and health care quality in Minnesota, health care spending trends are worrisome.

Stefan explained the need to distinguish the elements of price (input costs, mark-up, and mix of services) and utilization. He then reviewed the following data:

- Preliminary Minnesota Department of Health analysis indicates that in 2017 Minnesota spent $50 million on health care - 5.8% more than the prior year. This represents 14.3% of the economy and about $9,000 per person. Health care spending has been doubling every 10 years. Annual growth was about 3.7% over the last decade and growth is expected to speed up in the coming years.
- Stefan said there is no “right” amount of health care spending. Spending reflects preferences and beliefs. Health care is paid for through taxes, foregone wages, premiums and through out-of-pocket payments.
- Health care spending represents about 40% of state spending, excluding spending associated with public employee health benefits. As spending grows in health care, it causes redistribution from other state spending. The same trends influence employer spending on health care benefits, i.e., cost growth results in redistribution of total compensation and greater employee assumption of costs. Minnesota household spending for health care grew over 50% between 2012 and 2017. This may be the reason that 1 in 5 Minnesotans decided to forego care in the last 12 months (2017 Minnesota Department of Health survey). Increasingly employees are not taking up health insurance coverage when it is offered to them. Stefan explained that this behavior is a result of the high costs of care.

Stefan explained what drives health care spending:

- Spending is concentrated among a small high-cost population with heterogenous needs - 5% of individuals account for 56% of spending. Because of their heterogeneity, designing care models for them is complex.
- The greatest percentage of spending is associated with hospitals. He said that the greatest concern, however, is associated with long-term care spending due to the aging population and prescription drugs.
- Regarding prescription drugs, Stefan encouraged consideration of both drugs that are administered in office settings and retail prescriptions, noting the former are very expensive, without competition, and growing in use. He encouraged looking at the pricing of new high-cost biologic drugs.
- Health care spending is largely driven by labor, and jobs keep growing in health care, even through recessions. Stefan noted that capital expenditures are also growing. He encouraged Commission members to ask whether the capital investments are constructive.
- Hospital markets in Minnesota are concentrated and are becoming more so. This effects prices.
- Insurers and hospitals have accumulated large amounts of capital.
- Most professional spending is on specialty care and not primary care.
- Most spending growth (two-third to three-quarters) has been due to price growth.
• There is considerable waste in health care spending - 25% or more.
Stefan closed by sharing the following observations and recommendations:
• Spending growth has historically been resistant to downward change for multiple reasons:
  o All health care spending represents someone’s income.
  o Savings are hard to track and sometimes they accrue to someone other than the party that
    made the investment to generate them.
  o The health care market doesn’t work efficiently
  o Past efforts at cost containment have focused on medical care (short-term) and not on health
    (long-term).
• Recommendations
  o Don’t go looking for “silver bullets,” but instead focus on multiple smaller initiatives.
  o Accept that there will be losers.
  o Recognize that there may be a need for upfront investments.
  o Recognize that there is evidence that some strategies work.
  o Recognize that strategies to address costs, equity, chronic disease management, and to ensure
    access may not always align.

Discussion: Responding to Minnesota Statewide Health Overview
Michael Bailit, Commission facilitator, asked the Commission members to reflect on what they have heard in
light of the Commission’s charge. He then reminded them of that charge:
  By October 1, 2020 the Commission must produce an Action Plan “for transforming the health and human
  services system to improve a) program efficiencies, b) produce savings, and c) promote better outcomes for
  Minnesotans.”
That action plan must at a minimum recommend:
• strategies to increase administrative efficiencies and improve program simplification within health and
  human services public programs, including examining the roles and experience of counties and tribes in
  delivering services and identifying any conflicting and duplicative roles and responsibilities among health
  and human services agencies, counties, and tribes;
• approaches to reducing health and human services expenditures (net savings of $100 million), including
  identifying evidence-based strategies for addressing the significant cost drivers of state spending on
  health and human services, including the medical assistance program;
• opportunities for reducing fraud and improving program integrity in health and human services; and
• statewide strategies for improving access to health and human services with a focus on addressing
  geographic, racial, and ethnic disparities.
Commission members shared the following feedback:
• Senator Klein shared that four things struck him during Stefan’s presentation: 1) hospital costs are a
  cost driver, 2) prices are a large cost driver, 3) the impact of waste, and 4) the small percentage of the
  population driving health care costs.
• Shauna Reitmeier said that Stefan’s recommendation to look to small targets instead of one big win
  resonated with her.
• Sue Schettle reflected that since we know the population is aging, we need to be proactive with the
  elderly population about what they want so as to reduce waste once they enter the health care system.
Julia Freeman noted that the analyses of Minnesota’s successes were not stratified by race. She also reported being struck by the impact of pricing, especially in light of her experience being a diabetic and having to buy insulin.

Representative Schomacker said that he noted that 28% of people who don’t have health insurance don’t know why. He found this to be concerning, and said it suggested a bigger story. In addition, he said that the presentation highlighted for him that the small high-cost population is where the Commission would focus its attention. He added that wasteful spending was something to look at, including the Minnesota Health Care Records Act. Finally, he recommended that the scope of practice issue needs to be reviewed, adding that we are currently training people in things they can’t practice.

Lisa Weed said that she was struck by the costs to individuals and families, and that employers costs have been growing less quickly than employee costs. She recommended attention be given to the issue of provider pricing.

Nona Ferguson suggested looking at insurance literacy, and why people aren’t selecting coverage. She also recommended supporting efforts for providers to work at the top of their license and addressing scope of practice questions. Finally, Nona said the Commission needed to question whether to cap investments in hospitals and ensure that such investments are necessary.

Gayle Kvenvold said she was struck by the growth of health care jobs, and asked if MDH could unpack its analysis further? She noted that there are many low-paying jobs in health care, Gayle also asked whether the Commission was looking at regulatory requirements as part of its exploration of administrative simplification opportunities.

Jennifer DeCubellis supported Gayle, noting that regulations impact administrative costs. She added that she is surprised by the role of price growth on spending growth.

Representative Leibling commented that much of the presentation content was familiar to her. She was struck that there are so many pieces we need to push, and expressed worry that the Commission will get lost “in the weeds.” She expressed a desire to unpack waste, fraud and abuse.

Commissioner Malcolm stated that she understood the Commission’s charge to be broad. She conveyed the Commission’s need to decide what will be most helpful to the legislature and the governor. She added that hopefully we can discuss small changes in the context of a larger vision, but admitted it will be a challenge to focus the Commission’s time.

Commissioner Harpstead commented that she thought getting agreement on focusing on small targets would be helpful.

Sheila Kiscaden noted that the slide describing the impact of high-cost individuals on total spending struck her because she saw the same slide 15 years ago. She observed that the politics about making changes here are really challenging. She pointed to pricing, demographic trends, administrative complexity, fraud and market concentration as all something for the Commission to consider. Sheila said she mostly agreed with looking at waste, hospitals and market concentration, but felt Minnesota needed to plan for the future with older demographics. She closed by observing that as a society we can’t say we want everything, and we can’t continue to refuse to make the “tragic choices.” She asked whether Minnesotans were willing as a state to make those choices.

Debra Krause encouraged attention to tackling price variation. She added that fraud and abuse also needed attention.

Representative Liebling expressed her belief that Minnesota needs a big transformation, and not a bunch of little ones.
Michael closed the conversation by asking what additional information the Commission members want, if any, related to Stefan’s presentation, and invited them to convey any requests after the meeting.

DHS Programs and Budget Overview

Dave Greeman, Department of Human Services Budget Director and Alex Kotze, Department of Human Services Chief Financial Officer, provided an overview of the populations served by the Department, the Department’s programs and budget, and the Department’s cost drivers and spending trends. The presentation focused on spending by program, populations served, forecasts and where growth is occurring. The Commission’s October 10th Meeting 2 slide set includes Dave Greeman’s presentation.

Dave reviewed Department of Human Services spending:

- Medical Assistance (Medicaid) spending was $12.3 billion in fiscal year 2019 (half of which was federally funded), with an average monthly cost per enrollee of $909 (range of $350-$7300 by population group). Approximately 1.1 million Minnesotans are served by the program.
- MinnesotaCare is considered a Basic Health Plan under the Affordable Care Act, so the federal government provides subsidies worth 95% of the tax credits. Federal funding covers 87% of expenditures. Enrollees cover 8% of expenditures through premiums. The State Health Care Access Fund covers the balance (5%). This will rise due to the reinsurance fund. There are 83,000 enrollees and expenditures were $59 million in fiscal year 2019 ($460/month per enrollee).
- The Minnesota Family Investment Program (MFIP) provides cash assistance. It served 30,000 families in fiscal year 2019. The average monthly payment is $771. Enrollment swings up and down based on the economy.
- General Assistance provides $203/month for adults who don’t qualify for the Minnesota Family Investment Program. Most are temporarily on the program while awaiting Social Security Administration disability determination. Enrollment has been fairly flat at 23,000, with a fiscal year 2019 budget of $49 million.
- Minnesota Supplemental Aid serves 31,000 people at $41 million in fiscal year 2019.
- Housing Support Serves 21,000 people at $681/month for $168 million in fiscal year 2019. Spending has been increasing due to enrollment.
- Chemical Dependency Treatment Services provides residential and non-residential services. The budget has been growing 6% per year due to the opioid epidemic. Total expenditures were $224 million in fiscal year 2019.
- Child Care Assistance helps pay for childcare. The program supported 16,000 families in fiscal year 2019, with expenditures of $269 million.
- NorthStar supports children in families receiving foster care and kinship care. The program costs $212 million at an average monthly cost of $948 with about 19,000 families served. The program is growing in enrollment by 19% per year because it is transitioning in kids from a legacy non-forecasted program.
- Direct Care and Treatment Services has a budget of $400 million and serves about 12,000.

Julia Freeman asked for a breakdown of Dave’s data by race.

Alex reviewed who is served by Department of Human Services’ programs. She began by noting that about 20% of Minnesotans are covered by Medical Assistance or MinnesotaCare.

- 14,000 in Nursing Facilities
• 70,000 in Home and Community Based Services
• 85,000 in Minnesota Family Investment Program
• 16,000 in childcare
• 429,000 in Supplemental Nutrition Assistance Program
• 54% of Medical Assistance beneficiaries reside in the seven-county Metro area. The percentage of the population covered by Medical Assistance varies by region, ranging from 18.0% (Southeast) to 23.8% (Northwest).
• The Medical Assistance population is made up 65% by families with children, 19% by adults without children, and 16% by older adults and persons with disabilities.
• The over-65 population will grow as a percentage of the Medical Assistance population between 2015 and 2070 from 15% to 22%.
• The racial composition of the Medical Assistance population does not mirror the state population. For example, 13.8% of beneficiaries are African-American while 6.6% of the statewide population is African-American (but large unknown group (27.6%)

Senator Draheim asked for spending broken out by region.

DHS Programs and Budget Overview (Cont’d)

Dave continued with a review of spending.

• HHS spending has been 42-44% of the all-funds budget for the past several years. This statistic is inclusive of Department of Human Services, Minnesota Department of Health and the health boards, but 97% of the spending is associated with Department of Human Services. This spending represents only 30% of the General Fund budget, however, because of the federal match received for Medical Assistance.
• Fiscal year 2019 HHS spending was $18.277 billion. Most of this spending (77%) represents entitlements with budget allocation set by legislature using Department of Human Services forecasts. The remaining spending includes:
  ○ Grants sent out by Department of Human Services to counties, tribes, and others: 7%
  ○ Technical activities: flow-through funds to counties
  ○ Fiduciary activities: Funds collected by DHS and then distributed. This consists primarily of child support.
  ○ Policy: 3%
  ○ Direct care and treatment: 3% (but representing 4200 of 7000 Department of Human Services Full Time Equivalents)
• Spending by Fund:
  ○ Federal $9.3 billion
  ○ General Fund: $6.4 billion
  ○ Special Revenue (licensing fees): $793,000
  ○ Child Support Enforcement: $658,000
  ○ Health Care Access Fund: $514,000
  ○ Temporary Assistance for Needy Families and Other: $600,000
• Total spending has been growing

Alex reviewed forecasted program spending.
• Medical Assistance: long-term care and home and community-based services: 34%
• Medical Assistance: Families with Children: 21%
• Medical Assistance: elderly and disabled basic care: 20%
• Medical Assistance: adults with no children: 13%
• Minnesota Care: 3%
• Other: 8%
• Federal match varies by Medical Assistance population
  ○ Adults without children: 93%
  ○ Other Medicaid: 50%
• Older adults and persons with disabilities represent a disproportionate percentage of spending.
• All Medical Assistance funds are trending upward, with spending associated with long-term care waivers growing most significantly. Cost/enrollee is growing dramatically for Long Term Care facilities. Spending is also growing for waivers, but it is a much less expensive model than nursing facilities ($4766/month vs. $8197/month).

Dave identified long-term services and supports as the real cost driver. He said that this spending is comprised of home and community-based services (including personal care attendant services and home care) and long-term care facilities (including nursing facilities and intermediate care for persons with developmental disabilities). This spending growth is due to both increasing enrollment and rising average cost per recipient, especially in nursing facilities. There has been huge growth in community program enrollment with a much smaller reduction in facility enrollment.

Jennifer DeCubellis asked if Department of Human Services can break out the cost of direct services vs. administrative costs per person. Dave said he would look into whether Department of Human Services can do so.

Julia Freeman asked whether Department of Human Services possesses comparative quality data for community and facility settings.

Gayle Kvenvold asked for a breakdown of waiver costs by waiver type.

Dave shared that waiver spending is split across four waivers:
  • Developmental Disability: $1.5 billion and growing 6.4% per year, mostly due to enrollment growth
  • Community Access for Disability Inclusion: $1.0 billion and growing 9.6% per year due to enrollment growth because a prior enrollment cap was lifted
  • Elderly: $447 million growing and 7% per year
  • Personal Care Attendant: $1.0 billion and growing 7% per year

Dave said that nursing facility spending is $1.0 billion growing 7.3% per year due to price increases, with enrollment dropping.

Commissioner Harpstead commented that the last several slides presented by Dave indicated spending growth could have been worse if Minnesota didn't move people from facilities to the community.

Discussion: Responding to DHS Programs and Budget Overview
Commission members shared the following feedback:
Representative Liebling said she would like to see a breakout of long-term care spending growth in terms of people served vs. service cost.

Gayle Kvenvold commented that Minnesota has been working on long-term care for some time. She encouraged reflection on what has been learned over the past 30 years from rebalancing, integrated service delivery and managed care.

Representative Schomacker asked if Department of Human Services needs to consider a federal maintenance of effort. Dave confirmed that it did.

Julia Freeman requested a discussion of the impact of people cycling on and off of State-administered programs.

Sheila Kiscaden responded to Julia, observing that she thought Julia was discussing the administrative burden on the recipient, adding that she had heard about this from families.

Sheila Kiscaden said that she liked Gayle’s suggestion that the Commission reflect on what it has learned from past efforts at bending the cost curve. She noted that as a county, Olmstead spends a lot of money on eligibility reassessments. She shared that Olmstead County has some facilities that have decided they no longer want to deliver care because of the workforce shortage. Sheila said that if we can’t sustain four-person group homes for some people (e.g., ventilator dependent), we should reconsider the model.

Gayle Kvenvold encouraged the Commission to keep in mind the nursing facility payment change in 2015 when it reassesses nursing facility cost trends.

**Meeting Wrap-up**

Commissioner Harpstead thanked the Commission members for their participation in the meeting. She invited questions following the meeting to be shared with Krista, as well as thoughts about how to tackle the Commission’s charge.

Shauna Reitmeier requested the ability of Commissioner members to participate remotely as winter approaches.

Sheila Kiscaden asked about the community input sessions. Krista O’Connor responded by explaining that State staff will be seeking input from the Commission after DHS completes negotiations with another vendor to conduct this work. She noted that there will be formal opportunities for public comment, including one at the end of the meeting period.

**Next Meeting**

Thursday, October 24, 2019; 1pm – 4pm
Spirit Mountain; Moosehead Room
9500 Spirit Mountain Place, Duluth, MN 55810