Welcome

Jodi Harpstead
Commissioner
Department of Human Services

Jan Malcolm
Commissioner
Department of Health
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Welcome &amp; remarks</td>
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<tr>
<td>1:10</td>
<td>Minnesota Department of Health programs</td>
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<tr>
<td>1:40</td>
<td>Facilitated discussion</td>
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<td>1:55</td>
<td>Commission charter</td>
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<td>Process for soliciting and developing proposals</td>
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<td>3:05</td>
<td>Criteria for selection of proposals</td>
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<td>Sequencing of topics for Commission consideration</td>
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<td>3:55</td>
<td>Next meeting</td>
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</tbody>
</table>
Blue Ribbon Commission Members

Jennifer DeCubellis
Director of Human Services and Public Health
Hennepin County

Rich Draheim
Senator (20, R)
Senate

Jennifer DuPuis
Associate Director
Fond du Lac Nation Human Services

Nona Ferguson
Vice President of Economic Assistance and Aging Services
Wilder

Julia Freeman
Senior Organizer
Voices for Racial Justice

Jodi Harpstead
Commissioner & BRC co-chair
MN Department of Human Services

Sheila Kiscaden
Commissioner
Olmsted County

Matt Klein
Senator (52, DFL)
Senate

Debra Krause
Vice President
Minnesota Health Action Group

Gayle Kvenvold
President and CEO
LeadingAge Minnesota

Tina Liebling
Representative (26A, DFL)
House of Representatives

Sida Ly-Xiong
National Program Manager
Nexus Community Partners

Jan Malcolm
Commissioner & BRC co-chair
MN Department of Health

Shauna Reitmeier
Chief Executive Officer
Northwestern Mental Health Center

Sue Schettle
Chief Executive Officer
Association of Residential Resources in Minnesota (ARRM)

Joe Schomacker
Representative (22A, R)
House of Representatives

Lisa Weed
Executive Vice President
SEIU Healthcare Minnesota
MDH Mission:

“To protect, maintain and improve the health of all Minnesotans.”
Public Health in Minnesota

Minnesota Rankings: Good News (On Average)

1st Fewest cardiovascular deaths per 100,000
1st Fewest premature deaths per 100,000
1st Lowest rates of physical & mental distress
3rd Developmental screening
4th Lowest uninsured rate
4th Lowest rate of diabetes
4th Senior health
5th Lowest rate of low birthweight infants
6th Prenatal care

SOURCE: UNITED HEALTH FOUNDATION
Public Health in Minnesota

Minnesota Rankings: Bad News

34th  Tdap immunizations
35th  High school graduation rate
40th  Homeless families per 10,000
42nd  Homeless family households
46th  Infant child care costs
46th  Excessive drinking

SOURCE: UNITED HEALTH FOUNDATION
Minnesota Rankings: Unacceptable

- Minnesota has some of the worst health disparities in the nation

- Compared to whites AND to peer populations in other states, our populations of color and American Indians experience:
  - Shorter life spans
  - Higher rates of infant mortality
  - Higher incidences of diabetes, heart disease, and cancer; and
  - Poorer general health
What Determines Our Health?

Social and Economic Factors (education, employment, income, family, community) - 40%

Health Behaviors (tobacco, diet, alcohol, sexual activity) - 30%

Physical Environment (environmental quality; built environment) - 10%

Clinical Care (access & quality of care) - 10%

Genes and Biology - 10%
Total Investment in Health and Human Services

- In OECD, for every $1 spent on health care, about $2 is spent on prevention and other social services.
- In the U.S., for every $1 spent on health care, about 55 cents is spent on prevention and other social services.

**Expenditures as a % of GDP**

<table>
<thead>
<tr>
<th>Country</th>
<th>Medical Care Expenditures</th>
<th>Public Health and Social Services Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>11.9</td>
<td>21.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>11.8</td>
<td>21.1</td>
</tr>
<tr>
<td>Austria</td>
<td>10.3</td>
<td>20.5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>10.6</td>
<td>20.1</td>
</tr>
<tr>
<td>Denmark</td>
<td>10.1</td>
<td>19.8</td>
</tr>
<tr>
<td>Germany</td>
<td>10.7</td>
<td>18.4</td>
</tr>
<tr>
<td>Belgium</td>
<td>9.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Italy</td>
<td>8.7</td>
<td>19.8</td>
</tr>
<tr>
<td>Finland</td>
<td>9.4</td>
<td>18.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>12.0</td>
<td>14.8</td>
</tr>
<tr>
<td>Portugal</td>
<td>10.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Hungary</td>
<td>7.9</td>
<td>17.7</td>
</tr>
<tr>
<td>United States</td>
<td><strong>16.3</strong></td>
<td><strong>9.1</strong></td>
</tr>
<tr>
<td>Norway</td>
<td>8.9</td>
<td>16.3</td>
</tr>
<tr>
<td>Greece</td>
<td>9.6</td>
<td>15.5</td>
</tr>
<tr>
<td>Spain</td>
<td>8.3</td>
<td>15.5</td>
</tr>
</tbody>
</table>

**SOURCE:** Bradley et al., 2011
**Public Health in Minnesota**

**Health Care/Human Services (DHS)**

1. Providing medical treatment to a child with measles
2. Enrolling people in health insurance to ensure chronic disease treatment
3. Treating people with addiction or overdose in hospital or program

**Public Health (MDH)**

1. Teaching parents about the value of immunizations
2. Working with local governments to reduce prevalence of chronic disease
3. Addressing root causes of alcohol abuse, suicide, etc.
We can’t afford to treat our way out

• Spending related to chronic conditions is projected to soar by 2025. Compared to 2015:
  • Chronic conditions (among age 60+) spending will grow by 70% – reaching $16.9 billion/year
  • Hypertension-related spending will grow by 50% to $8.2 billion/year
  • Dementia-related spending will jump 60% - up to $417 million/year
• Of great concern: rising rates of chronic disease prevalence across many conditions in most age groups

SOURCE: MDH LEGISLATIVE REPORT (FORTHCOMING)
The MDH Budget
Expenditure History FY 2013-18 (in millions)
Sources and Uses of All Funds

Sources
- Federal (48%)
- General (18%)
- License & Fees (10%)
- Health Care Access (6%)
- All Other (18%)

Uses
- Grants, Aids & Subsidies (61%)
- Other Operating (13%)
- Compensation (26%)
Public Health in Minnesota

State and Local Partnership
Minnesota Department of Health

Health Improvement
- Child & Family Health
- Health Promotion & Chronic Disease
- Community Health

Health Protection
- Environmental Health
- Infectious Disease Epidemiology, Prevention & Control
- Public Health Lab

Health Systems
- Health Policy
- Health Regulation
- Office of Medical Cannabis

Health Operations
- Financial Management
- Human Resources
- Facilities
- MNIT@MDH*

$193m federal
$87m state
$280m total

$49m federal
$51m state
$100m total

$18m federal
$142m state
$161m total

$0.5m federal
$40m state
$40.5m total
Health Improvement Services

- American Indian Health
- Family Home Visiting
- Maternal and Child Health
- Supplemental Nutrition Programs (WIC)
- Health Promotion
- Cancer Control and Sage Programs
- Injury and Violence Prevention
- Chronic Disease & Environmental Epidemiology
- Emergency Preparedness
- Health Equity
- Statewide Health Improvement Initiatives
- Local Public Health
### Health Improvement By The Numbers

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>181,000</td>
<td>Infants, children &amp; pregnant women with a healthier start thanks to food/nutrition services providing by WIC Program</td>
</tr>
<tr>
<td>12,000</td>
<td>At-risk families supported through home visiting, boosting health and reducing future need for social services</td>
</tr>
<tr>
<td>600,000</td>
<td>Opioid pills not used by program participants last year thanks to eight community opioid prevention projects</td>
</tr>
<tr>
<td>11,692</td>
<td>Low-income women screened for breast/cervical cancer</td>
</tr>
<tr>
<td>116</td>
<td>New cancer cases found &amp; treated early thanks to the screening</td>
</tr>
<tr>
<td>150</td>
<td>Community-based organizations receiving support for reducing health disparities</td>
</tr>
</tbody>
</table>
### Health Protection Services

<table>
<thead>
<tr>
<th>Drinking Water Protection</th>
<th>Wellhead Protection</th>
<th>Food, Pools and Lodging</th>
<th>Indoor Air</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Surveillance &amp; Assessment</td>
<td>Newborn Screening</td>
<td>Environmental Lab</td>
<td>Infectious Disease Lab</td>
</tr>
<tr>
<td>Vaccine Preventable Diseases</td>
<td>STDs, HIV and TB Prevention</td>
<td>Healthcare Associated Infections</td>
<td>Foodborne, Waterborne, Vectorborne &amp; Zoonotic Diseases</td>
</tr>
</tbody>
</table>
Health Protection By The Numbers

7,000 Public drinking water systems tested

12,000 Food managers certified, helping to keep our food safe

1,408 Cases of Lyme disease investigated

67,127 Newborns screened for rare, treatable disorders like congenital heart disease and hearing loss

84,091 Tests conducted for virus or microbe contamination

111* Minnesota reports of severe lung injury investigated

* Report total of October 22, 2019
Health Systems Services

- Health Economics
- Adverse Events Reporting
- Health Information Technology
- Rural Health and Primary Care
- Vital Records
- Office of Medical Cannabis
- Health Facility Complaints Investigation
- Health Facility Licensing and Certification
- Home Care & Assisted Living Licensure
- Case Mix Review
- Health Occupations Licensing
- Mortuary Science Licensure
### Health Systems By The Numbers

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18,157</td>
<td>Patients enrolled in state medical cannabis program</td>
</tr>
<tr>
<td>600,000</td>
<td>Birth and death certificates issued</td>
</tr>
<tr>
<td>$20 million</td>
<td>Value of grants and loan forgiveness awards distributed statewide, supporting recruitment of health professionals in rural and underserved areas</td>
</tr>
<tr>
<td>4,200</td>
<td>Health care facilities and providers monitored for safety and quality</td>
</tr>
<tr>
<td>6,700</td>
<td>Health professionals’ qualifications reviewed/regulated</td>
</tr>
</tbody>
</table>
The Impact of Public Health in Minnesota
25 of the 30 years of life gained in the 20th Century resulted from public health accomplishments such as vaccines, antibiotics, food safety, fluoridation, and tobacco use prevention strategies.
The Value of Vaccines

- Each dollar spent on routine childhood immunization yields on average $10 in direct and indirect savings to society over the child’s lifetime.
- Immunization of children born in 2009 will prevent nearly 42,000 early deaths and 20 million cases of disease nationwide.
- Broad use of vaccines has cut incidence of vaccine-preventable diseases by more than 85%.
  - 1980: Smallpox eradicated from globe.
  - 1991: Polio eradicated from Western Hemisphere.
BUT Vaccine-Preventable Diseases are Returning

Measles in Minnesota, 2017

- 75 cases of measles
- Ages 3 months to 57 years
- 71 (91%) unvaccinated
- 21 (28%) hospitalized
- 8,940 people exposed, over 600 excluded from child care or school
Youth Combustible Cigarette Use is Down

- Results from the 2019 Minnesota Student Survey showed conventional cigarette smoking continued to fall
- The 2019 rates are the lowest ever recorded by the survey
But e-Cigarette Use Continues to Rise

- Among 8th grade students, e-cigarette use doubled from 2016 to 2019
- 1 in 4 11th graders now use e-cigarettes
- Students in all grades surveyed now use e-cigarettes and vapes at 5 times the rate of conventional cigarettes

<table>
<thead>
<tr>
<th>Grade 8</th>
<th>Grade 9</th>
<th>Grade 11</th>
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</thead>
<tbody>
<tr>
<td>5.7%</td>
<td>9.3%</td>
<td>16.3%</td>
</tr>
<tr>
<td>11.1%</td>
<td>17.1%</td>
<td>26.4%</td>
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Percent of students who vaped in past 30 days

2016 2019
• Focuses on population health

• May address changes in social/physical environment, highlight participation & empowerment, emphasize context & include systems approach

• Rather than changing individual characteristics, focuses on *population health* - the health outcomes of a group of people
SHIP Supports Health Across the Lifespan

Healthy Eating in Schools
- 471,300 students
- 1,200 schools & districts

Health Care Settings
- 3.5 million people
- 300 Health Care sites

Active Living in Communities
- 4.4 million people
- 410 communities

SHIP data: August 15, 2015 to August 31, 2018
Producing Results

**Obesity Rates Before and After Coordinated Statewide Obesity Efforts**

- **Before 1999:**
  - Yearly increase: 0.99 percentage point

- **After 2017:**
  - Yearly increase: 0.45 percentage point

**Smoking Rates Before and After Coordinated Statewide Smoking Efforts**

- **Before 1999:**
  - Yearly decrease: 0.27 percentage point

- **After 2017:**
  - Yearly decrease: 0.77 percentage point

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**Key**

- **Obesity (Actual)**
- **Obesity (Projection, had trend continued)**
- **Smoking (Actual)**
- **Smoking (Projection, had trend continued)**

MDH analysis based on CDC BRFFS, 1999-2017
Producing Results

**Obesity**
- ~135K fewer obese Minnesotans
- $2,708 in excess spending per obese person
- $3656 million in averted spending

**Smoking**
- ~124K fewer Minnesotans who smoke
- $2,032 in excess spending per current smoker
- $252 million in averted spending

**Combined**
- Obesity: $366 million in averted spending
- Smoking: $252 million
- Total: $618 million in averted spending
The Public Health Quandary: Prevention Often Invisible
Additional budget information is attached and can also be found under “Health” on MMB’s website:

• The Federal Women, Infants and Children (WIC) program provides healthy food and nutrition services to over 181,000 pregnant women, infants, and young children.
• Home visiting services provided to more than 12,200 at-risk families.
• Almost 35,000 children with special health needs and their families connected to supports and services.
• Prenatal, parenting, child safety, and other support services provided to more than 15,500 pregnant or parenting women.
• Family planning counseling services provided to more than 41,000 low-income or high-risk individuals.
• Teen pregnancy prevention efforts reached more than 29,500 teens.

Share of Agency Budget

32%

Funding Sources

General
Federal
Other
Fee Revenue
Health Promotion and Chronic Disease

- Screened 11,692 low-income women for breast and/or cervical cancer in 2017 and detected 116 new cases of cancer.
- Trained 101 people statewide to provide diabetes prevention classes to those at heightened risk.
- Funded 8 community opioid prevention projects that helped participants reduce use by 600,000 pills in 2018.
- Trained more than 16,000 people on evidence-based suicide prevention curricula.
- Our statewide registry of newly-diagnosed cancer cases registered 29,847 cases in 2015.
- 25,162 Minnesotans with a traumatic brain or spinal cord injury received services in 2017 through MDH grant-funded programs.

Share of Agency Budget

Funding Sources

General
Federal
Other
• Support our local public health system of 51 community health boards.
• Distribute $103 million per biennium to local and tribal governments, hospitals, and community-based organizations to support local public health activities, emergency preparedness activities, local initiatives to improve health, reduce tobacco use, and to eliminate health disparities.
• Provide support and guidance on reducing health disparities to more than 150 community-based organizations from populations of color and American Indian communities.
• Coordinate emergency preparedness and response activities between state (MDH), community health boards, and 8 regional health care preparedness coalitions.
• Collect, analyze, and communicate health-related data.

Share of Agency Budget

Funding Sources

General  Federal  Health Care Access

Other
Health Policy

- Minnesota Health Access Surveys measure changing percentage of uninsured Minnesotans each year, demonstrating the impact certain health care policies can have on health insurance coverage.
- Minnesota All Payer Claims Database supports evidence-based research on health policy impacts.
- Nearly $20 million in grants and loan forgiveness awards distributed statewide, supporting recruitment of health professionals in rural and underserved communities and a stronger health care infrastructure.
- Office of Vital Records issues more than 600,000 birth and death certificates annually and facilitates certification of over 99% of death records online, making them available to families more quickly.

Share of Agency Budget

- 19%

Funding Sources

- General
- Federal
- Medical Education & Research
- Health Care Access
- Other
Health Regulation

• Monitor 4,200 health care facilities and providers for safety and quality.
• Review qualifications and regulate more than 6,700 health professionals.
• Monitor nine health maintenance organizations and three county-based purchasing organizations that provide health care to 1.1 million Minnesotans.
• Maintain a registry of more than 60,000 nursing assistants.
• Inspect 560 funeral establishments and license 1,300 morticians.
• Register more than 3,400 spoken language health interpreters.

Share of Agency Budget

Funding Sources

General  Federal  Fees  Other
Medical Cannabis

- Approved the enrollment of 15,794 patients and authorized 1,250 healthcare practitioners to certify patients as of mid-2018.
- Oversees 2 manufacturers and 8 cannabis patient centers in Minnesota.
- Added post-traumatic stress disorder as a qualifying medical condition on December 1, 2016, Obstructive Sleep Apnea and Autism Spectrum disorder on December 1, 2017, and Alzheimer's on December 1, 2018.

Share of Agency Budget

0.3%

Funding Sources

<table>
<thead>
<tr>
<th>General</th>
<th>Fees</th>
</tr>
</thead>
</table>
Environmental Health

- Test drinking water at more than 7,000 public water systems.
- Ensure safe food, drinking water, lodging, and swimming pools in 23,000 establishments statewide.
- Promote healthy indoor environments and the reduction of unnecessary radiation exposure for over 11,000 facilities and individual contractors.
- Certify 12,000 food managers each year and support 35,300 active food managers.
- Regulate annually the installation of 6,000 new wells and the sealing of 7,000 wells no longer in use.

Share of Agency Budget

7% Funding Sources

- General
- Federal
- Fees
- Other
Infectious Disease

Share of Agency Budget

6%

Funding Sources

General
Federal
Fees
Other
Public Health Laboratory

- Screen for rare disorders in newborn babies, including hearing loss and critical congenital heart disease. In FY2018 the lab screened 67,127 newborns for 61 rare treatable disorders.
- Provide testing for contaminants in the environment and to evaluate exposures to contaminants in people. In FY 2018, the lab received 40,507 samples and performed 116,304 analyses.
- Provide testing for viruses and other microbes that make people sick, as well as look for outbreaks related to food and water. In FY 2018, the lab performed 84,091 tests on 44,907 samples.

Share of Agency Budget

4%

Funding Sources

General
Federal
Fees
Other
Health Operations Bureau

- Oversee and guide nearly $325 million in outgoing grants to 500 unique grantees.
- Review and release 45 separate legislatively-mandated reports.
- Provide human resource services to over 1,500 MDH employees in 10 locations across Minnesota.
- Process more than 25,500 payment transactions and execute 1,700 contracts and grant agreements for MDH programs each year.
- Provide information technology services support for 250 software applications, 256 servers, and 2,070 personal computers.

Share of Agency Budget

Funding Sources

General Other

Federal
Facilitated Discussion
Commission Charter – Proposed Elements
Duties. By October 1, 2020, the Commission shall develop and present to the legislature and the governor an action plan for transforming the health and human services system to improve program efficiencies, produce savings, and promote better outcomes for Minnesotans.
The action plan must include, but is not limited to, the following:

1. 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;

2. approaches to reducing health and human services expenditures, including identifying evidence-based strategies for addressing the significant cost drivers of state spending on health and human services, including the medical assistance program;

3. opportunities for reducing fraud and improving program integrity in health and human services; and

4. statewide strategies for improving access to health and human services with a focus on addressing geographic, racial, and ethnic disparities.
Limitations. In developing the action plan, the Commission shall take into consideration the impact of its recommendations on: 1) the existing capacity of state agencies, including staffing needs, technology resources, and existing agency responsibilities; and (2) the capacity of county and tribal partners.

The Commission shall not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.
1. The Commission recognizes that change to the status quo is a likely outcome.

2. In its deliberations, the Commission will be honest about who will be impacted by any cost containment or system reform strategies, and how, and give attention to both winners and losers.

3. The Commission will recommend a balance of nearer-term and longer-term initiatives.

4. The Commission will be transparent with respect to the criteria for strategy selection, design and proposed implementation of recommended strategies.
Charter: Member Responsibilities

1. Members must participate in good faith and act consistently with the Commission’s charge.

2. Members represent their organization and are expected to coordinate with their organizational colleagues so that they speak for their organizations when engaging in Commission discussion.

3. Members must be available to devote the time needed to perform the roles and responsibilities of the Commission, review all meeting materials in advance of meetings, complete pre-meeting and follow-up tasks as requested by the Commission or its staff, participate in the development and review of work plan deliverables, and provide advice and guidance to staff as requested.
4. Members may not send a representative to a meeting in their place.

5. Members must be respectful of other members, staff, and audience members. They must listen to each other to seek to understand the other’s perspectives, even if they disagree.

6. The Co-Chairs may remove members who are not meeting these obligations, including regular meeting attendance, or who are not qualified, and may appoint new members, as needed.
1. Members agree that transparency is essential to the Commission’s deliberations. Members are expected to include both the Co-Chairs and Commission staff in written communications commenting on the Commission’s deliberations from/to interest groups; these communications will be included in the public record.

2. Written comments to the Commission should be directed to Commission staff and will be distributed by Commission staff to the full Commission. Written comments will be posted to the Commission’s public site if appropriate and made publicly available if requested.
3. While not precluded from communicating with the media, Commission members agree to generally defer to the Co-Chairs for all media communications related to the Commission process and its recommendations.
1. A majority of voting members constitutes a quorum.

2. A Commission member may participate by telephone for purposes of a quorum, but only if operationally feasible for a given meeting.

3. Meetings will be conducted in a manner deemed appropriate by the Co-Chairs to foster collaborative decision-making and consensus building. Robert’s Rules of Order will be applied when appropriate.
4. Meetings are public and therefore are subject to the Open Meeting Law.

5. Supports, including accommodations for Commission members with disabilities, will be available for members who need them.

6. The Co-Chairs may, in their sole discretion, require a Commission member to recuse him or herself from review of specific matters in the event of a perceived or actual conflict of interest.
1. A consensus decision-making model will be used to facilitate the Commission’s deliberations and to ensure that the Commission receives the collective benefit of the individual views, experience, background, training and expertise of its members.

   • Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.

2. Members agree that consensus has a high value and that the Commission should strive to achieve it. Decisions on Commission recommendations will be made by consensus of all present members unless voting is requested by a Commission member. Voting shall be by roll call.
3. Final action on Commission recommendations for the action plan will require an affirmative vote of the majority of the Commission members.

4. If no consensus is reached on an issue for proposed Commission recommendation, minority positions will be documented.
   • Those with minority opinions are responsible for proposing alternative solutions or approaches to resolve differences.

5. Members will honor decisions made and avoid re-opening issues once resolved.
Process for Soliciting and Developing Proposals
Proposal ideas will come from the following sources
Criteria for Selection of Strategies for Analysis and Proposal Development
Using a standardized process, Bailit Health & State staff will review proposals to assess whether they should be presented to the Commission as a strategy recommendation. Proposal concepts should:

1. possess a high probability of achieving the aim of the defined focus area that the proposal addresses;

2. be subject to the influence of government action;

3. be feasible to implement, both administratively and politically;

4. 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

5. not result in benefit reductions.
Key Questions to Ask for Each Potential Strategy

1. How will the proposal concept achieve its identified aim?

2. Is there reason to believe that the strategy will be effective? (e.g., has it been applied successfully in Minnesota or in another state? Is there research documenting its effectiveness?)

3. Will the impact be one-time or sustained?

4. How difficult will it to implement the change given state resources and stakeholder support/opposition and capacity?

5. How long will it take to implement?
Key Questions to Ask for Each Potential Strategy (Cont’d)

6. Does it create an administrative burden or additional staff costs?
   a. for the State?
   b. for counties?
   c. for providers?
   d. for MCOs?
   e. for members?
   f. for other affected entities?

7. What steps are required?
   a. regulatory change?
   b. statutory or rule change?
   c. waiver or State Plan Amendment?
   d. procurement?
   e. new technical infrastructure (built in-house or procured)
# Proposed Sequencing of Topics (Slide 1 of 2)

<table>
<thead>
<tr>
<th>Date</th>
<th>Agenda Topics</th>
</tr>
</thead>
</table>
| 11/7  | • Commission charter and criteria (finalize)  
• Application of an equity lens to all strategy discussions  
• Plans for community engagement  
• Presentation: The Improve Group  
• What research says re: Medicaid cost drivers and strategies to address them |
| 11/21 | • No meeting. Staff meet with Commissioners to review proposal development.                                                                   |
| 12/5  | • No meeting. Staff meet with Commissioners to present proposals.                                                                           |
| 12/19 | • Past DHS and MDH activity and State task forces and commissions targeted at the Commission’s five aims (focus areas)  
• Aim #3 strategy presentation: health and human services expenditures (LTC)                                                                  |
<p>| 1/16  | • Aim #3 strategy presentation: health and human services expenditures (LTC)                                                                     |
| 2/6   | • Aim #2 strategy presentation: administrative efficiencies and simplification                                                                |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Agenda Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/20</td>
<td>Aim #4 strategy presentation: waste, including fraud and program integrity</td>
</tr>
<tr>
<td>3/5</td>
<td>Aim #3 strategy presentation: health and human services expenditures (health care)</td>
</tr>
<tr>
<td>3/19</td>
<td>Aim #3 strategy presentation: health and human services expenditures (health care)</td>
</tr>
<tr>
<td>4/2</td>
<td>Aim #5 strategy presentation: disparities reduction</td>
</tr>
<tr>
<td>4/16</td>
<td>Aim #1 strategy presentation: system transformation</td>
</tr>
<tr>
<td>5/7</td>
<td>Aim #1 strategy presentation: system transformation</td>
</tr>
<tr>
<td>5/21</td>
<td>Prioritization of strategies for inclusion in the Action Plan</td>
</tr>
<tr>
<td>6/4</td>
<td>No meeting: develop first draft of action plan for Commission review</td>
</tr>
<tr>
<td>6/18</td>
<td>Review draft Action Plan</td>
</tr>
<tr>
<td>9/xx</td>
<td>Commission vote on final Action Plan</td>
</tr>
</tbody>
</table>
Blue Ribbon Commission Meeting 4
Thursday, November 7, 2019
9:00 am – 12:00 pm
Amherst H Wilder Foundation
451 Lexington Parkway North
St. Paul, MN  55104