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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<tbody>
<tr>
<td>9:00</td>
<td>Welcome and agenda review</td>
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<tr>
<td>9:10</td>
<td>Public engagement to support the Commission’s work</td>
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<td>9:55</td>
<td>Finalizing the Commission’s Charter and initial strategy review criteria</td>
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<td>10:10</td>
<td>Equity criteria &amp; best practices for priority strategies</td>
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<td>10:35</td>
<td>Break</td>
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<td>10:45</td>
<td>What $100 million savings means for the Commission’s purposes</td>
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<td>11:15</td>
<td>National research on cost drivers and effectiveness of strategies</td>
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<td>11:30</td>
<td>Strategies: summary of submissions and upcoming review process</td>
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<td>11:55</td>
<td>Wrap-up and next meeting(s)</td>
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Public Engagement to Support the Commission’s Work
Public Engagement Framework

- State
- Blue Ribbon Commission
- The Improve Group: contracted vendor
• DHS External Relations
  • Community Relations Director
  • County Relations Director
  • Office of Indian Policy Director

• DHS and MDH Equity Directors

• DHS Cultural and Ethnic Communities Leadership Council

• MDH Health Equity Advisory and Leadership Council

• MDH and DHS Statewide listservs
Blue Ribbon Commission

- Blue Ribbon Commission Members
- Public Meetings
- (2) strategy input opportunities
- Website: [https://mn.gov/dhs/hhsbrc/](https://mn.gov/dhs/hhsbrc/)
- “contact us” opportunity
- Blue Ribbon Commission listserv
• Contract will:
  • Create opportunities for public input and feedback
  • Authentically engage community members in this important work

• Activities:
  • Targeted, intentional stakeholder engagement
  • Five community events
The Improve Group Overview

Team members & roles:
Leah Goldstein Moses, MURP, President & CEO
Kylie Nicholas, MPA, Project Lead
Claire Stoscheck, MPP, Senior Consultant
Kassira Absar, MPP, Associate Consultant

The Improve Group
Approach to Community & Stakeholder Engagement

Collaborative role with the
Public, Commission, State
and Bailit Health
Questions for Commission members

1. What does meaningful engagement look like?
2. How do we obtain it?
3. What are the implications for future meetings?
Facilitated discussion
Finalizing the Commission’s Charter and Initial Proposal Review Criteria
Equity Review Process for Priority Strategies
Objectives

• Create context and shared understanding for incorporating an equity lens to strategies

• Introduce the Equity Review Criteria Toolkit

• The use of best practices as a guide through the review process to ensure all strategies are in alignment with the commission goals.
To support the Minnesota Health and Human Services Blue Ribbon Commission’s goal of improving program efficiencies, produce savings, and promote better outcomes in health and human services, we will incorporate an equity review and best practices into the consideration of strategies.
Guiding Principles

• We promote equitable considerations across every administration to ensure Minnesotans achieve their full potential.

• We are agencies where barriers such as race, ethnicity, access, and geographic locations do not predetermine opportunities in health and human service outcomes for those we serve.
• That how the equity review is implemented and used will differ across strategies.

• To approach the equity review from an evaluative/continuous improvement perspective, as opposed to a check list. We will seek to strengthen strategies to promote equitable outcomes.

• That if the strategy works for our most vulnerable communities, it works for everyone. The reverse, however, is not true.

• That we will not let the perceived barriers prevent us from interrupting patterns of inequity.

• That use of the review may not be linear.

• That after the use of the equity review, changes in a particular strategy may not be needed.
Equity Review Criteria Tool
How does the strategy promote inclusive collaboration and engagement

• Which community does this strategy impact?

• How will you identify the geographic, racial/ethnic groups potentially affected by the strategy?

• What process will you undertake to collaborate and engage in a dialogue with communities of color (internally and/or externally) who have traditionally not been involved in the development, implementation and evaluation of the strategy?
How does the strategy reflect a consideration of community conditions and set goals for advancing equity

• Are the community conditions and/or agency inequities clearly documented? If not, what is your plan for assessing the community conditions?

• Are there goals and measures for eliminating inequity, if so what are they?

• How will goals be adjusted regularly to keep pace with changing community needs and racial demographics?

• What additional information could be added to strengthen the strategy?
How will the strategy expand opportunity and access in health and human services

• How does the strategy increase opportunity and/or access for those who historically have been excluded? This means, more explicitly, who benefits from and/or who is harmed by the strategy?

• What are the strategies to improve access for ethnically diverse communities, including immigrants and refugees? Are interpretation and translation policies helping to improve access?

• What additional information could be added to strengthen the strategy?
How will the strategy affect systemic change

• How does the strategy make changes within the organization to eliminate institutional racism?

• Does the strategy make provisions for accountability? If so, what are they?

• How does the strategy work to address and eliminate structural racism?
What activities for advancing equitable outcomes does the strategy suggest

• How does the strategy make changes within the organization to eliminate institutional barriers?

• Does the strategy make provisions for accountability? If so, what are they?

• How does the strategy work to address and eliminate structural racism?
When to use review criteria?

• Early/often

• When you know or suspect a potential barrier in strategy

• When evaluating a new strategy decision
Equity Review Discussion

• Next Steps
• How does the Commission want to be engaged in equity review process?
Questions?

Crystal Fairchild

Crystal.Fairchild@state.mn.us

651-431-2507
BREAK
What $100 Million Savings Means for the Commission’s Purposes and How Savings are Determined
(d) Savings Determination. (1) When preparing the forecast for state revenues and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget shall assume a reduction of health and human services spending of $100,000,000 for the biennium beginning July 1, 2021, until the end of the legislative session that enacts a budget for the Department of Health and the Department of Human Services for that biennium.

(2) Upon enactment of a budget for the Department of Health and the Department of Human Services for the biennium beginning July 1, 2021, the legislature shall identify enacted provisions that were recommended by or based on the recommendation of the Blue Ribbon Commission on Health and Human Services.

(3) To the extent the net savings attributable to the provisions in clause (2) for the biennium beginning July 1, 2021, are less than $100,000,000, the commissioner shall reduce the balance of the general fund budget reserve established under Minnesota Statutes, section 16A.152, subdivision 1a, by an amount equal to the difference between the savings identified in clause (2) and the assumed $100,000,000 of savings in clause (1).
Baseline Budget & Economic Forecast

• An accounting of the state’s current legal obligations to make payments and collect revenue – 16A.103

• Updated November and February each year

• Reflects current law appropriations and planning estimates for all health and human services programs in all funds

• Reflects updated projections for forecasted programs, like Medical Assistance and MinnesotaCare

• Underlying assumptions for enrollment and average cost serve as the baseline for measurement against changes to programs
Factors Considered in Evaluating Savings

• Are savings calculated relative to the state’s current economic forecast baseline?
• How was the savings calculated and using what data (state or other)?
• Would the savings accrue to the state budget or to the federal or local government or tribes, third party administrators, or individuals?
• Is federal approval required and on what timeline?
• Are there offsetting expenditures or revenues in other parts of the budget?
• Would the legislature count the savings under the Uniform Standards and Procedures for the Legislative Budget Office?
## Examples of What Can be Counted vs. Not Counted

<table>
<thead>
<tr>
<th>Counted</th>
<th>Not Counted</th>
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<tr>
<td>Clearly defined reductions to payment rates, grants or administration</td>
<td>Proposals that are consistent with what agencies are already doing and already have authority to do in current law</td>
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<td>Savings calculated using relevant data, demonstrating that savings are achievable</td>
<td>Speculative savings estimates where data is not available</td>
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<td>Secondary Impacts (i.e. returns on investment)</td>
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Questions?
Determining Fiscal Impact

Elyse Bailey, Fiscal Policy Director
The Role of Fiscal Analysis

• Goal: Calculate a proposed idea’s projected fiscal impact to the state budget.

• Each state agency is responsible for calculating the impact on their budget.

• We calculate the projected impact taking into consideration how the particular change would be implemented if it were to become law.

• This analysis does not include estimating the impact of a law change to entities outside of the state budget.

• Each proposal is considered independently of one another. However, the implementation timing and interactive impacts may change as proposals are grouped into one package.
In analyzing the estimated impact to the state of any proposed law change, we examine the following categories of considerations:
Program Considerations

Who
- Who is impacted?
- Which programs are impacted?
- Does the proposal impact spending on a grant program?

Eligibility
- Does the proposal impact eligibility criteria?
- Does the proposal impact estimated program participation?

Services
- Does the proposal add or reduce services?
- Does the change impact the availability or accessibility of particular services?
- Does the proposal impact the volume of units billed?

Rates
- Does the proposal impact how much the state pays per unit?
Program Considerations

Timing
- How would the change be implemented and when would the fiscal impact be realized?
- Would it occur immediately?
- Would it occur on a rolling basis?
- Would the fiscal impact be phased in over time based on changes in estimated supply or demand?

Roles
- Does the proposal impact provider requirements, county duties, and state oversight requirements?
• In order to implement the proposed change, would the state need any changes to its technical systems?

• If so, what system is impacted and what changes are needed?

• How long will the changes likely take?
Administrative Considerations

• Does the proposal require a change to current administrative processes?

• If so, are there administrative costs required of the state agency to implement the change? Will the agency need additional FTEs or contracts to implement the change?

• Are these costs ongoing?
Legal Considerations

• How does the proposal align with state and federal legal requirements under current law?

• Does the proposal make a change that the Department already has the authority to do?

• Does the proposed change conflict with any other current state or federal law?

• If so, does this conflict prohibit, limit or change the implementation of this proposal?
Federal Considerations

• Does the proposed change require federal approval to be implemented?

• If so, what is the likely time frame that federal approval would occur?

• What is the likelihood that the change would be approved by the federal agency? This is gathered through analyzing experiences our state has had with previous requests, guidance published by the federal agency, or other states’ experiences.
Other Considerations

- What is the effective date of the change, given all other considerations (systems, administrative, federal, etc.)?
- What is the state share and what is the federal reimbursement match for the change item?
- Are there likely interactive effects between multiple changes in the proposal?
- Long Term Impacts: Typically we provide estimates for the next two bienniums (4 years). Long-term considerations are estimated when the proposal has impact that is not realized until after the second biennium.
National Research Regarding Cost Drivers and Effectiveness of Strategies to Address Them
In July the journal *Health Affairs* reviewed what was driving health spending in the U.S. This analysis was not specific to Medicaid.

Because these factors are present throughout the U.S., (and have already been mentioned in Commission presentations), it is helpful to call them out for attention.
Waste accounts for 25% of all health care spending

Estimated Total Annual Costs of Waste (Billions)

- Failure of care delivery: $102.4 - $165.7
- Failure of care coordination: $27.2 - $78.2
- Overtreatment or low-value care: $75.7 - $101.2
- Pricing failure: $230.7 - $240.5
- Administrative complexity: $265.6
- Fraud and abuse: $58.5 - $83.9
- Total: $760 - $935

The United States provides significantly fewer resources compared to OECD median figures on hospital beds, physicians and nurses.

The difference in spending is due to prices paid in the US.

3. Consolidation and Market Power

- Three levels of market consolidation drive growth in prices
  - Provider
  - Hospital
  - Insurer
- The less competitive the market, the higher the prices.
- Monopoly hospitals can garner 12% higher prices than those with four or more competitors.

Drug prices account for between 10-15% of national health spending (even higher for commercial health plans!)

Rising costs of generic and specialty drugs were driven by new product entry.

Rising costs of brand-name drugs were driven by pricing inflation of existing drugs.

Recap from Meeting #2:
Drivers of Spending Growth in Minnesota, 2012 to 2014

- It is tempting to attribute spending growth with patients
- But: greater health care use plays a minor role in spending growth
- Three-quarter of spending increases are driven by prices

Source: MDH, Health Economics Program; Mathematica Policy Research, Cost Drivers Analysis for Privately Insured Health Care Services in Minnesota from 2012 to 2014. Excludes other professional and freestanding outpatient surgical centers.
Cost Savings Strategies: Evidence of Effectiveness in Medicaid
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Literature Conclusion</th>
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<tbody>
<tr>
<td>1. Premiums, cost sharing, and wellness incentives</td>
<td>• Research on adding premiums and cost sharing does not show reductions in Medicaid spending apart from savings associated with lower enrollment.</td>
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<td></td>
<td>• Whether wellness incentives reduce Medicaid spending is not well studied.</td>
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<td>2. Complex care management</td>
<td>• Results are promising, yet mixed and inconclusive</td>
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<td>3. Patient-centered medical homes and Medicaid-specific health homes</td>
<td>• Many studies are not Medicaid-specific, and show mixed results on overall spending. Experts agree quality improves with PCMHs.</td>
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<td>(in MN, health care homes)</td>
<td>• State-funded evaluations of health homes have shown significant decreases in use and spending; the five-year federal evaluation has not concluded.</td>
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<td>4. Use of alternative payment models</td>
<td>• Rigorous evaluations on these strategies are too limited to tell their impact</td>
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### What the Literature Tells Us about Strategies to Reduce Medicaid Spending (Slide 2 of 3)

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<thead>
<tr>
<th>Strategy</th>
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<tr>
<td>5. Tightening financial eligibility rules for long-term care services</td>
<td>• Savings are small and offset by increased administrative costs</td>
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<td>e.g., curtailing asset transfers, increasing estate recovery efforts,</td>
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<td>including retirement accounts as countable assets.</td>
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<tr>
<td>6. Promoting private long-term care insurance</td>
<td>• Microsimulation studies of potential impact find little or not effect, even far into</td>
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<tr>
<td></td>
<td>the future.</td>
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<td>7. Expanding home and community-based services</td>
<td>• Mixed, yet favorable findings</td>
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<td>8. Increased use of managed LTSS</td>
<td>• Limited evidence that managed LTSS leads to lower utilization of services, however,</td>
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<td>results from the CMS Financial Alignment Initiative demonstrations are not yet available.</td>
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Research literature provides no answer for how to reduce Medicaid spending, **but** this does not mean that strategies in the very areas without evidence are not worth pursuing.

- Some strategies do not have a strong evidence base because the strategies are too new (e.g., alternative payment models), they previously were not well-implemented, or because there is a lack of robust empirical research on the topic.

- Plenty of strategies have promise from positive research that is less rigorous than what is currently available.

- Still, it is clear that achieving sizable short-term savings without resorting to decreases eligibility or necessary services is a significant challenge. The Commission faces difficult decisions.
Cost Savings Strategies: What are States Currently Pursuing to Reduce Medicaid Spending
1. **Delivery system reform**, including focusing upon:
   - Aligned quality and payment to support integrated care
   - Direct risk-based provider contracting arrangements
   - Use of value-based payment models

2. Aggressive **value-based purchasing requirements of state MCOs**, including mandating or encouraging use of value-based payment arrangements

Source: 2019 Emerging Trends in Public Programs, UnitedHealthcare
3. Strategies to reduce Medicaid spend on *prescription drugs*, including:
   - New payment arrangements for PBMs, greater oversight of PBMs, and drug pricing transparency
   - Use of a preferred drug list
   - Leveraging purchasing power and creating value-based purchasing arrangements

4. Focus on strategies to improve *care for complex populations*
   - Criminal justice involved
   - Mothers and children

Source: 2019 Emerging Trends in Public Programs, UnitedHealthcare
5. Focus on strategies to reduce **opioid abuse**
   - Work to prevent overdose deaths
   - Expanding access to MAT and SUD inpatient treatment
   - Encouraging alternatives to opioids

6. Focusing on root causes of poor health outcomes – **social determinants of health**
   - Development of screening tools, using Medicaid dollars to reduce effects of SDOH, encouraging providers through VBP to engage with non-health care partners to address SDOH
7. **Integration of health and social services** to provide care and services more holistically.
Strategies
Number of Proposals by Submission Source

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<tr>
<th>Source</th>
<th>Proposals</th>
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<tr>
<td>Bailit Health</td>
<td>11</td>
</tr>
<tr>
<td>DHS</td>
<td>13</td>
</tr>
<tr>
<td>MDH</td>
<td>18</td>
</tr>
<tr>
<td>Public</td>
<td>203</td>
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</table>
Transform the health and human services system 25%
Increase admin. efficiencies/program simplification 25%
Address significant cost drivers 24%
Reduce waste in admin./service spending 14%
Advance health equity 12%

Distribution of Strategies by Focus Area
Fiscal Impact of Submitted Strategies

- Cost savings: 71%
- New costs: 18%
- Budget neutral: 11%
Strategy submissions were due by November 3\textsuperscript{rd}

The next steps will be to:

• prioritize strategies for development;
• present prioritized strategies to Commission (webinar)
• develop the strategies, and
• present the developed strategies to the Commission beginning on December 19\textsuperscript{th}, and then every other week into May.
Why prioritize?

Many strategies have been submitted. There is neither sufficient staff time to develop all of the proposals, nor Commission time to review all of the proposals.

For this reason, it is necessary to select those proposals that appear most promising for investment of staff resources in strategy development.
Commission members are invited to review all submitted proposals and to indicate which proposals they feel are most deserving for development.

Commission members will receive an online survey to indicate their priorities.

A webinar on 11/21 will review State selection of priorities following consideration of Commission member priorities and State staff assessment.
November 21 Webinar: Review strategies, prioritization, next steps

December 5 Webinar: Health equity

Blue Ribbon Commission Meeting 5

Thursday, December 19, 2019
9:00 am – 12:00 pm (hold)
time and location determined by 11/7 engagement discussion