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**Blue Ribbon Commission kick off meeting: Meeting Notes**

Thursday, September 26, 2019; 9 a – noon
Union Depot, Red Cap Room – 2nd floor
214 E 4th Street, St. Paul, MN

**Participation**
Participating members included: Jennifer DeCubellis, Rich Draheim, Jennifer DuPuis, Nona Ferguson, Jodi Harpstead, Sheila Kiscaden, Matt Klein, Debra Krause, Gayle Kvenvold, Tina Liebling, Sida Ly-Xiong, Jan Malcolm, Joe Schomacker, and Lisa Weed

**Welcome and remarks**
Commissioners Malcolm (MDH) and Harpstead (DHS), co-chairs of the Blue Ribbon Commission, opened the meeting. The Commission’s charge, strategies and limitations were reviewed.

**Introduction of Commission members & priority areas**
Each Commission member had an opportunity to introduce themselves, provide a brief overview of their relevant experience and identify one to three priority areas that the commission should explore to accomplish the Commission’s charge. Priority areas included:

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<th>Member</th>
<th>Priority Areas</th>
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| Jennifer DeCubellis| • Long term and short-term strategies to make HHS accessible with disparities as a focus.  
                         • Fiscal responsibility. Money needs to go to people we serve, and every dollar counts.  
                         • Simplify administration of system. Too much $ goes to administration; system needs to work better for people, and money should go to services, not administration. |
| Rich Draheim       | • Focus on costs and transparency                                                                                                              |
| Jennifer DuPuis    | • Tribal health; availability of services  
                         • Addressing disparities and equity with resources  
                         • Simplifying administration of systems and reducing administration costs                                                             |
| Nona Ferguson      | • Reducing administrative costs  
                         • Grow workforce to support needs; CNAs PCAs, etc.                                                                                      |
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| Julia Freeman         | - Incorporate the voice of consumers impacted  
                       - Understand the impact of people entering poverty later in life due to healthcare/support needs |
| Jodi Harpstead        | - Include voices and experiences from communities most impacted by disparities in health and human services  
                       - Conduct Racial Equity Impact Assessments for budget solutions  
                       - Consider all social determinants and root causes in decision making - to understand where wise investments can produce savings, where cuts could produce additional costs, and the relationship between areas that may be budgeted separately |
| Sheila Kiscaden       | - Better Health “Healthy people cost less”  
                       - Wrap around Social Determinants of Health (SDOH)  
                       - Equity; ensuring availability to everyone |
| Matt Klein            | - Use of metrics to ensure we are getting the results we want  
                       - Strengthen partnership between counties & state; and providers, etc.  
                       - Make the system more efficient and effective; with focus on prevention |
| Debra Krause          | - Examine pharmaceutical industry  
                       - Hospital payment incentives; global payments; quality metrics  
                       - Modernization of information technology |
| Gayle Kvenvold        | - Collaboration; improving health for all Minnesotans  
                       - Data & measurement; targets, goals, outcomes  
                       - Optimize the assets our state has; MNCM, APCD, ICSI |
| Tina Liebling         | - Integrated service delivery; primary, acute, LTC, etc.  
                       - LTC Financing reform; and promising new financial models that leverage both public and private dollars  
                       - Treat care giving as a value career; workforce issues |
| Sida Ly-Xiong         | - Simplify our system for the user & government  
                       - Improved health care security, access and value for all Minnesotans  
                       - Shared vision on how to move Minnesota forward; based on facts; that will withstand political shifts |
|                       | - Community leadership – what could it look like, how could we fund it  
                       - Making sure we do no harm; examine assumptions for $100,000,000 cost reductions; who benefits, who is left out? |
- Engagement of those most impacted, and strive to understand their lived experiences

**Jan Malcolm**
- Breaking down silos; continuum of care
- Equity in health
- Community prevention strategies

**Shauna Reitmeier** (provided in writing)
- Create a vision and mission for the State of MN in regards to the health and safety (vulnerable children and adults) of its residents
  - Integrate systems and structures (internal and cross departments, staff and processes) to implement the functions and responsibilities to achieve the vision and mission. This leads to administrative efficiency and reduced costs
- Become a data driven department (quantitative and qualitative) that values the voice of the consumer, for accountability and quality
- Align financial resources to the mission and to quality/accountability vs. one time funding or grants for core functions/services

**Sue Schettle** (provided in writing)
- Reducing administrative burdens and redundancies; simplify programs and increase efficiencies
- Improve health outcomes
- Focusing in on the continuum of care; breaking down silos

**Joe Schomacker**
- Streamlining administration of programs; eligibility
- Examine role of public health in reducing health care costs
- Explore the smaller opportunities and consider $100,000,000 a floor
- Understand how federal government can support or prevent activities

**Lisa Weed**
- Examine previous MNCare/MA expansion efforts; consider direct contracting with providers
- Prescription drug costs; Examine OneCare proposal
- Administrative spending in nursing facilities; excessive growth in administrative costs; turnover in ownership; out of state ownership, etc.

**Discussion: guiding principles**

The Commission brainstormed the principles that would be important to guide the work of the commission. They discussed scope, concerns or barriers to the Commission accomplishing its charge, and elements needed for success. A summary of this brainstorming session is below.
Guiding principles/values

Bi-partisan

- Long term support is needed for action plan recommendations
- Be upfront and explicit on what is needed to achieve bi-partisan support
- What is needed for legislative members to be able to defend and present to legislature
- Determine how the Blue Ribbon Commission measures success; incremental and at the end
- Determine how Minnesota values impact recommendations
- Increased transparency

Equity

- Be clear about who is served by programs, who is utilizing services
- be clear on what we mean by equity; what is mean by reduced disparities gap

Access

- Educate on available services
- Choice vs meaningful/value added/health improvement due to choice; best practices on choice; what choices produce better health outcomes
- Understand choice and connectedness to Minnesota values

Health and wellbeing

- How can individuals be supported to no longer need programs, if they are able; examine the programs and support systems and how they work/don’t ‘work for people
- Overcoming barriers with effective strategies that meet the needs of Minnesotans
- Programs should support self-sufficiency when an option
- Two populations that have a growth in health care spending are persons with disabilities and the aging population; these groups will continue to need services
- Supporting healthy lives from cradle to grave
- Utilization of technology to support health

Data

- Shared set of factual data and can support the recommendations put forward
- Reward positive outcomes utilizing metrics and measurements
- Explore best practices/systems showing promise

Fiscal

- Be smart on how the dollars are spent; financial investments must be productive; dollars invested in services that produce outcomes/high value services
- Understand the difference between administrative costs and service cost
- Investments with measureable outcomes; value
- Minimize low-value services
- Understand why specific investments show specific outcomes (positive and negative)
- Streamline processes to obtain value; lean or sigma six analysis
• Reduction of duplicative processes; elimination of waste (30% of health care is waste); simplification of process
• Workforce capacity for change; both short and long-term strategies
• Investments in the current, status quo system
• How is “savings” measured (MMB) vs bending the cost curve vs other savings, quality metrics/health care outcomes

Scope
• What programs are within the scope of this Commission
• What populations are within the scope of this Commission
• Will the scope include public program beneficiaries and/or all Minnesotans

Process comments
• Conflicting schedules with meeting times and locations during session
• Request made for a call in option

Next steps
The next meeting will include a statewide health care overview, and information on the DHS budget. Facilitated discussion will support the Commission members in understanding this information and how it relates to the charge of the Commission. Several background documents will be sent to the Commission members for review prior to the next meeting.

Next Meeting
Thursday, October 10th from 9a – noon
enVision Hotel Saint Paul South
Legacy Room 1
701 Concord Street South
South St Paul, MN  55075
Blue Ribbon Commission Meeting #2: Meeting notes
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:
  - All health care spending represents someone’s income.
  - Savings are hard to track and sometimes they accrue to someone other than the party that made the investment to generate them.
  - The health care market doesn’t work efficiently
  - Past efforts at cost containment have focused on medical care (short-term) and not on health (long-term).

- Recommendations
  - Don’t go looking for “silver bullets,” but instead focus on multiple smaller initiatives.
  - Accept that there will be losers.
  - Recognize that there may be a need for upfront investments.
  - Recognize that there is evidence that some strategies work.
  - 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 of 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
Blue Ribbon Commission Meeting #3: Meeting Notes
Thursday, October 24, 2019; 1pm – 4pm
Duluth, Minnesota

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

Welcome and Remarks
Commissioners Jan Malcolm (MDH) and Jodi Harpstead (DHS), co-chairs of the Blue Ribbon Commission, welcomed members to the Commission’s third meeting, and welcomed public participants as well.

Overview of Minnesota Department of Health Programs
Assistant Commissioner Marie Dotseth and Deputy Assistant Commissioner Margaret Kelly presented an overview of Minnesota Department of Health (MDH) programs.

- Marie explained that Minnesota performs very highly on a number of public health measures relative to other states. Overall Minnesota ranked as the 7th healthiest state in the most recent United Health Foundation rankings. Yet, Minnesota ranks poorly on some other measures, e.g., homelessness-related measures, excessive drinking and health disparities for populations of color and American Indians.
- Marie explained that social economic factors are the greatest contributors to health status, with health behaviors ranked second. Clinical care represents a comparatively small contributor. She also explained that the United States spends more on health care and less on social services when compared to other countries. Finally, she observed that public health spending in Minnesota, and in the United States, is dwarfed by health care spending.
- Marie argued that health care treatment alone will not improve population health in Minnesota due to growing prevalence of chronic illness.
- Commissioner Malcolm emphasized that whereas health care focuses on individual-level interventions, public health focuses on community-level interventions.
- Margaret reviewed MDH’s budget, which has grown about one percent annually. Most spending growth has come from larger federal grants and legislative funding. MDH’s budget is not driven by entitlement spending. Margaret explained that 61 percent of MDH spending is for grants, one quarter is for staff compensation, and the balance (13 percent) is for other operating costs.
- Margaret explained that public health in Minnesota is a local responsibility, with 51 Community Health Boards serving the state’s 87 counties. MDH provides guidance, advice, tools, and consultation, but local boards do the work, and also provide resources.
• Commissioner Malcolm noted that public health successes result in public health concerns being kept out of the view of the public. She added that MDH is a leading public health innovator nationally.

Discussion of Minnesota Department of Health Programs
• Julia Freeman asked for disaggregated data by racial population in order to increase equity consciousness, and noted this will be very important during future conversations of spending cuts. She wondered if the reported public health gains were experienced across all racial groups. Julia noted that racial and economic disparities go hand in hand. Julia asked about the working poor and the recidivism rate, e.g., those who go off Medical Assistance, and then cycle back on.
• Shauna Reitmeier reiterated the need for disaggregation of data as a routine practice for all presentations. Shauna noted that the Department of Human Services (DHS) did not provide information on where its total spending goes, including administration, as MDH did. She wondered if there was room to align MDH and DHS work to reduce administrative costs.
• Lisa Weed asked if MDH could estimate the savings that could be achieved through full immunization. Commissioner Malcolm said that such an estimate could be developed.
• Sue Schettle asked how much the Departments work together currently and whether there is room for increased integration. Commissioner Harpstead responded that the Departments were created law by law. She added that more could be done to require DHS contractors to address SDOH, and thereby integrate services and programs.
• Commissioner Malcolm said that there are different programs aiming at the same problems with different populations. She acknowledged that it can be hard to lift one’s head up to look at how efforts can be better integrated, e.g., vaping and teen mental health. She added that the Governor is looking for this type of thinking from the Commission.
• Senator Klein asked for an estimate of potential savings through reduced tobacco use, noting that such a reduction would also address disparities since there is higher tobacco use among people of color.
• Sheila Kiscaden said that the Commission needs to focus on long-term care, since that is the true cost driver, and also at other big cost drivers.
• Jennifer DuPuis asked for information on spending in areas where performance is strong vs. in areas where performance is poor.

Review of Draft Committee Charter
Michael Bailit, Commission co-facilitator, reviewed the Commission’s statutory charge, noting that the Commission has a large scope of work with many charges. The Commission has a general charge of transforming the health and human services system, with multiple more specific charges including identifying $100 million savings in next biennium. Michael reviewed elements of a draft Committee charter, including members’ responsibilities, communications, operating procedures, and consensus process and voting. The Commission will review a revised charter at its next meeting following consideration and incorporation of Commission member input.

Discussion of Draft Committee Charter
• Sheila Kiscaden commented that the charter should include discussion of roles and relationships; the issue is not just efficiencies, but also how things are structured for a longer-term impact. She suggested
that the Commission should look at how other states are structured; for example, in Ohio, the state determines eligibility.

- **Sheila Kiscaden** commented that in the Commission’s aim to address waste/fraud, there is no mention of “process improvements” or “use and development of data analytics,” noting that both are relevant. She suggested that by using data analytics, we can learn more about the high-cost users.

- **Julia Freeman** noted that it seems premature to agree to the Commission’s aims without any data to analyze, particularly with regard to “identifying evidence-based strategies.” She said that the Commission needs to hear directly from those impacted, and without this engagement there is a lack of authenticity.

- **Lisa Weed** noted the importance of increasing transparency, and that at a prior meeting there was discussion of improving purchasing efficiencies and reducing price variation. Michael replied by saying that price variation fell under waste reduction and committed to providing a definition of waste at a future meeting. Lisa suggested that the Commission should look at providers who receive funds from the state – look at those providers who make people come back and get more services and tests that they may not need.

- Another Commission member expressed interest in looking at efficiencies in terms of provider use and pharmaceuticals being prescribed. Michael noted that this topic relates to misuse and overuse.

- In terms of effectiveness of various strategies, a Commission member noted that different divisions within agencies have process improvement data, and it would be helpful to have access to this.

- Another Commission member felt the term “effectiveness” is missing from the Commission’s charge.

- **Gayle Kvenvold** would like to have the criteria discuss workforce limitations and take into account state agencies and their capacity, as well as the capacities of counties and tribes.

- **Sheila Kiscaden** asked if there will be time to reconsider a strategy when new information becomes available. There was agreement to make provision for such instances.

- Commission members agreed that a roll call voting process will be important in supporting the transparency of the Commission’s work.

### Discussion of Process for Soliciting and Developing Proposals

Beth Waldman, Commission co-facilitator, explained that the State expects to receive a large number of proposals, noting the template that was previously distributed to Commission should be used by members and may also be used by the public.

- **Sida Ly-Xiong** said that the word “proposal” is problematic, as people assume it is a bid solicitation.

- **Julia Freeman** said the requirement for web-based submissions is a barrier to authentic community engagement.

- Sida Ly-Xiong asked about funding. Commissioner Harpstead clarified that there is no money to fund proposals.

- **Sheila Kiscaden** suggested asking for strategies and actions for what the Commission should consider. Sheila also shared her experience with another commission that invited people with lived experience to provide comment at the beginning of every meeting, and provided time for public forums as well.

- **Beth** said the comments regarding use of the word “proposal” were well taken, and what we were seeking was “strategies.”
• Beth explained that the State’s idea is to categorize submitted strategies and combine them with those generated by the State, and then prioritize them for development and presentation to the Commission.
• Gayle Kvenvold asked if the November 3 submission date is final. Beth explained that later submissions won’t necessarily be dismissed, but staff will need to prioritize and start developing strategies this month.
• Commissioner Malcolm said she would rather get a concept, and asked for a supplemental, clarifying communication to the public be distributed by Commission staff.

**Discussion of Criteria for Selection of Proposals**
Beth described five proposed criteria for the initial review of proposals.

• A few members expressed concern that the criterion “not contribute to health inequities or disparities” was not stated as “contribute to health equity.” Michael Bailit noted that contribution to health equity may not be feasible for every strategy. Lisa Weed said the criterion should be applied to every strategy.
• Julia Freeman expressed concern that there could be no benefit reductions if there were gains elsewhere.
• Sheila Kiscaden expressed interest in a criterion of readiness, i.e., ease of achievement.
• Beth reviewed proposed questions to be asked with respect to each potential strategy.
• Jennifer DeCubellis asked that the Commission members see all of the submitted strategies, including those not selected for further development. Beth confirmed that Commission staff will do so.
• Lisa Weed asked that input be gathered from program participants about strategy impact.
• Gayle Kvenvold asked that the source of the strategies be identified for the Commission.
• Commissioner Harpstead said that she would give more credibility to ideas that reflect community input, and that those ideas would receive more points from her when ranking.
• Julia Freeman asked that there be an effort to identify communities that did not provide strategies.
• In response to a question from Sida Ly-Xiong, Beth indicated that the proposed criteria and key questions would be provided with the supplemental communication requested by Commissioner Malcolm.
• Lisa Weed asked that patients be added to question #6, and Jennifer DeCubellis asked that tribes be added as well.
• Sheila Kiscaden observed that DHS and MDH don’t have the resources to conduct continuous process improvement. Commissioner Harpstead said DHS kicked off a Six Sigma program aimed at developing quality improvement skills within DHS. As a result, she felt the agency was in a good place in terms of process improvement expertise, but agreed that its information systems need to be better.

**Proposed Sequencing of Topics for Commission Consideration**
Beth reviewed a proposed series of agenda topics for the remaining Commission meetings, and proposed that Commission meetings be held closer to Metro area with exception of one meeting in Rochester. Commissioner Malcolm said that it will be necessary to remain flexible in terms of ordering the future agenda topics.

• Sida Ly-Xiong asked for ability of Commission members to participate in staff-led strategy prioritization process.
• Beth explained that short-term strategies will be discussed first, and long-term strategies later.
• Sheila Kiscaden asked if there will be feedback to those who submitted proposals. She expressed concern about people feeling disrespected, if they don’t receive a response. Others agreed with Sheila.
• Shauna Reitmeier suggested that after strategies are reviewed, scoring be shared with Commission members.
• Julia Freeman expressed interest in participating in strategy review process with respect to equity strategies.
• Lisa Weed said meetings need to take place across the state because rural communities feel ignored.

Meeting Wrap-up
Commissioner Harpstead and Commissioner Malcolm committed to sharing all proposals with Commission members, and to reconsidering Commission member participation in the initial proposal review process.

Next Meeting
Thursday, December 19, 2019; 9:00am – 12:00pm
Blue Ribbon Commission Meeting #4: Meeting Notes
Thursday, November 7, 2019; 9am – 12pm

Participation

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

Welcome and Remarks

Commissioners Jan Malcolm (MDH) and Jodi Harpstead (DHS), co-chairs of the Blue Ribbon Commission, welcomed members to the Commission’s fourth meeting, and welcomed public participants as well. The Commissioners noted that the meeting agenda included discussion of several topics that were previously prioritized by Commission members, as well as scoring and selection of strategies to include in the Commission’s final recommendations to the state legislature. The Commissioners also noted that the meeting agenda included an overview presented by the Bailit Health team of the strategies received and next steps.

Public Engagement to Support the Commission’s Work

Krista O’Connor provided a brief overview of the public engagement effort, noting the importance of engaging community members in the work of the Commission. She stated that existing state agency infrastructure will help support the public engagement process, including DHS External Relations, DHS and MDH Equity Directors, DHS Cultural and Ethnic Communities Leadership Council, the MDH Health Equity Advisory and Leadership Council, and MDH and DHS Statewide Listservs.

Blue Ribbon Commission meetings are open to public. Krista O’Connor identified two opportunities for public input that have been incorporated into the Commission’s timeline. First, the Commission included opportunity for public input to strategy development, and more than 200 strategies were submitted by members of the public via the Commission’s website. Second, the Commission’s draft report will be available for public comment. The Commission’s website also offers opportunity for contact via email.

Krista O’Connor welcomed Kylie Nicholas, The Improve Group’s project lead. The Improve Group is a local research firm, contracted by DHS to support the Commission in its effort to create opportunities for public input and feedback, and authentic engagement of community members. In addition to targeted, intentional stakeholder engagement, there will be five community events. The Improve Group will be examining how
potential policy changes could impact community members. Kylie Nicholas introduced members of her team, and described the firm’s “community responsive approach,” i.e., learning what each community needs. She noted the importance of creating open inviting spaces for community input; each community event may look different with the goal being authentic engagement. The Improve Group will work with Commission to identify their questions related to each strategy.

- Jennifer DeCubellis asked about the timing of The Improve Group’s work. Kylie Nicholas said she expected the engagement events to take place this winter, with timing of these events to be determined.
- Julia Freeman expressed concern that the staff of The Improve Group, based on the staff photo in slide set, lacks diversity. Julia Freeman expressed concern that communities of color and indigenous groups may not be comfortable with The Improve Group staff. Kylie Nicholas noted the staff photo was out of date, and said they spend a lot of time partnering with community groups and liaisons. She promised that The Improve Group will work with partners to ensure representation. Julia Freeman asked if The Improve Group’s relationships with community partners are statewide, and Kylie Nicholas assured the Commission that they are.
- Sheila Kiscaden asked how decisions on the public engagement events will be determined in terms of location and balance of urban versus rural areas.
- Sida Ly-Xiong noted that providing resources to underrepresented populations to offset their time is a good approach (e.g., travel vouchers, childcare stipends, etc.). Kylie confirmed that there are resources allocated for such approaches in their budget.

Commissioner Malcolm noted The Improve Group contract had been executed only recently, and promised to engage the Commission in some of these planning steps and sharing how public engagement will be achieved.

Discussion of Public Engagement to Support the Commission’s Work

Krista O’Connor invited the Commission members’ input on what meaningful public engagement looks like, how to obtain it, and what are the implications for future meetings. She said this input would be used to finalize The Improve Group’s strategy.

- Representative Liebling commented that strategies need to be stated in ways that make impacts on community members clear, and requested that jargon be avoided in development of the strategies.
- Julia Freeman asked that the community principles she provided be shared.
- Nona Ferguson asked that The Improve Group partner with members of community as means of sharing the economic benefit of its contract.
- Sheila Kiscaden reiterated there needs to be a balance of outreach to urban and rural areas. She asked that the impact on those providing services be considered.
- Jennifer DuPuis expressed skepticism as to how diverse the five community events can be. She suggested that members of community be included as co-presenters and/or facilitators of these events.
- Gayle Kvenvold asked that events be timed so that Commission has adequate time to respond to input received.
- Jennifer DeCubellis noted the importance of age and disability representation.
• Sida Ly-Xiong asked the Commission to consider information that the state has previously received from communities across the state. How will this engagement process be different so that Commission can be responsive?
• Commissioner Harpstead asked that public input be included in final report of Commission, and not just as a mention that the Commission held public events.
• Shauna Reitmeier noted an opportunity for the Commission to conduct individual conversations with members of public. She stated that a safe environment for candid conversations is important, using a trauma-informed lens.
• Senator Draheim noted that there are members of public in the room who could contribute to the Commission’s work.
• Sida Ly-Xiong asked that the Commission be intentional about asking for public participation at meetings.
• Representative Liebling noted that moving Commission meetings to locations across state will not ensure diversity.
• Jennifer DeCubellis said that community engagement needs to be intentional at each meeting and suggested starting and ending each meeting by soliciting input from public in attendance.
• Shauna Reitmeier requested information on location and timing of each public engagement meeting so that Commission members may attend if they wish.

Finalizing Commission Charter and Strategy Evaluation Criteria

Michael Bailit reviewed changes to the Charter and Strategy Evaluation Criteria suggested by Commission members at the October 24th meeting. For the Charter, Commission members reached consensus to accept the proposed edits. Michael Bailit clarified that the purpose of applying criteria is to identify strategies for further development. In response to the following comments, he promised to produce another draft of the criteria for consideration.

• Jennifer DeCubellis noted that there was a grammatical error on key question #4.
• Sheila Kiscaden asked that word “new” be removed from question #7.e.
• Representative Liebling asked that the implementation cost be made more explicit in question #4.
• Commissioner Harpstead noted that the difficulty of determining savings for transformative strategies.
• Sheila Kiscaden asked that the criteria include consideration of ease and speed of implementation.
• Julia Freeman said she would appreciate addition of a criterion that considers unforeseen circumstances.
• Jennifer Dupuis said she would like criteria to identify if there are population-specific impacts.

Equity Review Process

Crystal Fairchild, DHS’ Equity Inclusion Director, presented equity review criteria, which were drafted based on best practices. She shared context for incorporating an equity lens into strategy review, and welcomed the Commission’s feedback. Krista O’Connor announced that there will be a webinar that will delve further into the topic of health equity; the webinar will take place on December 5th. Shauna Reitmeier requested that the webinar be recorded.
• Krista O’Connor stated the equity review tool will be incorporated in evaluation of strategies. Julia Freeman noted that the DHS tool is similar to hers. She commented that the equity criteria need to be applied to each strategy, and also to the Commission’s final decisions.
• Jennifer DeCubellis asked the equity criteria be incorporated as a key element of strategy evaluation.
• Sida Ly-Xiong noted that the equity tool lacks consideration of root causes. In addition, she noted that who answers the questions and who provides input are important considerations. She wondered how the tool will be used in a transparent way during initial review of 200+ strategies. Crystal Fairchild envisioned using the tool in an evaluative manner, and conducting root cause analysis after information is received from the evaluation.
• Michael suggested using equity criteria not only for review, but also during strategy development. There will be logistical challenges in incorporating an equity review given the necessary pace of strategy development, but the Commission could build in dedicated equity reviewers who are not strategy-specific subject matter experts but who offer equity expertise.
• Sida Ly-Xiong asked that MDH’s and DHS’ existing resources, such as DHS’ Cultural and Ethnic Communities Leadership Council (CELC) and MDH’s Health Equity Advisory and Leadership Council, be incorporated into the review process in a more intentional way. Krista will explore this at the next CELC meeting.

**What $100 Million Savings Means for the Commission’s Purposes**

Angela Vogt, Executive Budget Manager at Minnesota Management and Budget (MMB), reviewed the means by which MMB will examine and calculate savings as related to the Commission’s charge. Angela explained that legislatively, to the extent the net savings enacted for the biennium beginning July 2021 are less than $100 million, MMB is then directed to reduce the balance of the general fund budget reserve. Angela explained that MMB counts savings by following the process the agency has taken in past when reviewing fiscal notes. She described factors considered in evaluating savings, including how savings were calculated, whether the savings accrue to the state budget, federal or local government or tribes, if federal approval is required, if there are offsetting expenditures or revenues in other parts of budget, and whether the legislature would count the savings under the Uniform Standards and Procedures for the Legislative Budget Office.

Angela Vogt provided examples of what can be counted and what cannot be counted as savings. Proposals that can be counted as savings include: 1) clearly defined reductions to payment rates, grants or administration; and 2) savings calculated using relevant data demonstrating that savings are achievable. Examples of proposals that cannot be counted towards savings include: 1) proposals that are consistent with what agencies are already doing and already have authority to do in current law; 2) speculative savings estimates where data are not available; and 3) secondary impacts (i.e. return on investment). Commissioner Malcolm noted the importance of the examples that Angela provided relative to proposals that may not be counted toward savings, and commented on the difficulty of not getting credit for work the agency is already doing or wishes to undertake.

Angela noted that there will be a continuing dialogue as to what counts toward savings. If an idea is something the agency is already doing, then MMB will examine whether it will produce savings or not. Michael Bailit questioned the exclusion of strategy proposals for activities that the agencies are not currently undertaking but have authority to do; Angela explained that in this case, MMB’s practice is to require supporting legislation in order to count any savings associated with these proposals.
- Senator Klein requested of Angela the exact language on making secondary impact determinations. He noted that it will be difficult to be visionary as transformative proposals tend to have upstream costs, but downstream benefits (e.g., improved vaccination for vulnerable populations).
- Commissioner Malcolm noted if we are not achieving goals of an agency and can close some gaps and make service improvements, then this is making the type of improvements called for by the legislation.
- Representative Liebling noted that in last session there was proposal to cover some uncovered services for children with asthma. The fiscal note for this proposal showed net savings. So in this case, the evidence was strong, but she noted that evidence is not always a “bright line;” Representative Liebling hoped we can advocate around what evidence is for a given strategy.

Elyse Bailey, DHS’ Fiscal Policy Director, reviewed how DHS determines fiscal impact and how fiscal notes are prepared by DHS. She noted that the agency calculates projected impact by taking into consideration how a particular change would be implemented if it were to become law.

Angela Vogt stated that the calculation of $100 million savings depends on which of the Commission’s recommendations the legislature selects, and that these savings are only one piece of the Commission’s work.

- Sheila Kiscaden expressed surprise, noting that the state staff have described a legislatively driven process, and she is concerned about that. Ms. Kiscaden noted that the changes she had envisioned the Commission would recommend (e.g., delivering services more efficiently) are not legislatively driven.
- Shauna Reitmeier noted that improvements in health have far ranging positive impacts that she is concerned won’t be accounted for in the calculation of savings described by MMB.
- Jennifer DeCubellis noted that some legislative changes may require simple edits to secure a fiscal note.

Commissioner Harpstead reiterated that achieving $100 million is only one of the Commission’s charges. The Commission may elect to forward proposals that are not counted toward the $100 million target. Commissioner Malcolm concurred, noting that the Commission needs to be mindful of language related to $100 million savings, but it should not constrain the Commission either. She expressed her desire for the Commission to produce positive results for the health of Minnesotans that are not just accounting shifts. She suggested that in the Commission’s report, the Commission advise as to how to do scorekeeping differently for long-term changes.

**National Research on Health Care Cost Drivers and Strategies to Address**

Michael Bailit identified the top cost drivers of health care spending in the United States, including waste, prices, consolidation and market power, and rising prescription drug prices. He reviewed strategies to reduce Medicaid spending and the literature on these strategies. He noted that the research literature provides no answer for how to reduce Medicaid spending, but that strategies that lack evidence may still be worth pursuing. Sida Ly-Xiong inquired if savings that the Commission can count are primarily Medicaid. Michael Bailit responded that since the majority of spending in the state’s budget is on medical assistance, the answer was “yes.”
Strategies: Summary of Submissions and Upcoming Review Process

Michael Bailit noted that the Commission received 203 strategies from the public via the Commission’s website across the following focus areas: transform the health and human services system (25 percent); increase administrative efficiencies (25 percent); address significant cost drivers (24 percent); reduce waste in administrative and service spending (14 percent), and advance health equity (12 percent).

The next steps will be to sift through the strategies, utilizing the criteria (in finalized form) in order to identify strategies that are worthwhile to invest staff resources in order to present to Commission. Michael Bailit indicated that Commission members will receive a raw compilation of all strategies for their review, and members will be asked to identify those strategies they find particularly compelling.

Senator Klein stated that he was adjusting his expectations of the Commission, asking if the Commission proposes strategies that will be difficult to gain political support – is that a legitimate outcome for this Commission? Commissioner Malcolm responded “yes” and noted that the required savings can be delivered by use of budget reserve, and while that is not a desirable outcome, ultimately responsibility rests with the legislature.

Sue Schettle reiterated her request to receive materials a week in advance.

Commissioner Malcolm noted that at some point it will be difficult to continue inviting new ideas, although the Commission is not yet at that point. The Commissioners thanked state agency staff and the Bailit Health team.

Next Meeting

Thursday, December 19, 2019; 9:00am – 12:00pm, Eastern Metro
Blue Ribbon Commission Meeting 5

Meeting Notes

- Thursday, December 5, 2019; 9:00 a.m. – 12:00 p.m.
- Woodbury, Minnesota

Participation

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

Welcome and remarks

Commissioner Jan Malcolm (MDH), co-chair of the Blue Ribbon Commission welcomed Commission members to their fifth meeting, and welcomed public participants as well. She noted that there would be expanded opportunity for public comment during Commission meetings going forward, and acknowledged supporting Commission staff and consultants. She then reviewed the planned agenda for the meeting.

Review and discussion of Commission approach

- Commissioner Harpstead (DHS), co-chair of the Blue Ribbon Commission, reviewed the Commission’s charge, including the five focus areas in the legislation around which the Commission’s work is being organized. She noted that state agency staff would develop strategies that meet the Commission’s charge, independent of whether they are strategies that are endorsed by state agencies.
- Commissioner Malcolm noted tension across the five focus areas, including a tension between generating $100M in savings in the next biennium and developing longer-term, transformative strategies.
- Commissioner Malcolm noted the key values and principles discussed at the Commission’s first meeting. She encouraged Commission members to consider these values and principles when discussing how to develop strategies.
- Commissioner Harpstead reviewed reactions heard from Commission members during and following each of the first four meetings. She acknowledged that the Commission’s scope of work and timeline would challenge efforts to examine strategies both broadly and deeply. She then invited comment from Commission members.
  - Julia Freeman said she had heard community feedback encouraging adoption of some strategies that will have impact, but will not save money.
  - Jennifer DeCubellis supported Julia’s statement, adding that the Commission should look at both impactful short-term strategies as well as strategies that set the stage for future transformation.
  - Sheila Kiscaden encouraged the Commission to remember its broad charge of transforming the health and human services system. She noted dramatic changes in the state’s population and economy and asked the Commission to consider how to address these changes. She advocated for consideration of the state’s needs in 20 years (not just in two years) for flexible, value-based services.
  - Gayle Kvenvold said that she has heard feedback about the narrow definition of “cost savings” for the Commission, and an argument that money sometimes needs to be spent in order to be saved.
• Sida Ly-Xiong agreed that the Commission should think in terms of both the short and long-term. She also advocated for not engaging consumers by the structure of the five focus areas, but in terms that are more relevant for consumers.

• Commissioner Malcolm proposed an approach for conducting future Commission work based on Commission member feedback, including meetings held in the Metro area, which take place on Fridays during the legislative session, longer meetings (six hours in duration) to provide more time for stakeholder engagement via public comment, provision of necessary contextual information for the strategies, and adequate strategy contemplation.
  - Representative Liebling asked that Commission staff arrange for more than one microphone at all future meetings to facilitate conversation.
  - Sue Schettle asked if future meetings could be recorded, and/or managed with call-in capability for members who cannot be physically present.
  - Julia Freeman asked how the Commission intends to allow public comment to be delivered by people residing in rural communities if all the meetings are to take place in the Metro area.

• Commissioners Harpstead and Malcolm described a proposed approach for reviewing strategies, and the need to prioritize. They also reviewed the criteria adopted by the Commission on 11/7 for strategy prioritization.

• Commissioner Harpstead asked Commission members to notify Commission staff if they would like to participate in the development of any of the strategies, and distributed a form for members to express their interest.

• Commissioner Harpstead reviewed a proposal to conduct an equity review of each strategy prior to presentation. She invited Commission members with interest in participating in the equity review process, or in the design of a community engagement strategy, to indicate that interest to Commission staff on the aforementioned form.

• Commissioner Malcolm reviewed the information previously provided by Minnesota Management and Budget (MNMB) staff regarding “countable” savings, and acknowledged the frustration these limitations create for Commission members. Commissioner Malcolm noted that budget scoring would also be performed in the future by the Legislative Budget Office, and no longer solely by the executive branch.

• Representative Liebling discussed Minnesota’s involvement in Results First, a foundation-supported effort to apply evidence in public policy development. She said that MNMB has access to this database, but it is not well utilized by the legislature. She encouraged use of this resource by the Commission in its work.

**Overview of submitted strategies**

• Beth Waldman provided an overview of the 250+ strategies submitted to DHS for Commission consideration, noting the variety of sources from which they were submitted. Beth noted that the strategies were grouped by focus area, as defined by the submitter. She reviewed the most common themes of the strategies submitted within each focus area.

**Strategies of Commission interest for development and Commission consideration**

• Michael Bailit provided an overview of feedback received from Commission members on the strategies. He expressed appreciation when noting that 13 of the 17 members reviewed the catalogue of strategy submissions, and provided input on which strategies they felt warranted development and Commission consideration.

• Michael cautioned that the top strategies reviewed during the Commission meeting have not yet been reviewed in terms of each strategy’s viability, nor does the Commission yet know the extent to which the priority strategies identified by the Commission members contribute to the Commission’s $100M savings target.

• Michael reviewed the broad strategy categories of greatest interest to the Commission members:
  - Eligibility: 45 (“votes” for strategies identified as addressing eligibility policy)
  - Payment Reform: 41 votes
  - Pharmacy: 32 votes
MnCHOICES: 21 votes
Program Coordination: 16 votes
Chronic Illness Care: 15 votes
Technology: 12 votes
Eliminate or Replace MCOs: 11 votes

Michael noted that these eight categories not only captured the most priority votes, but also the most “top 10” votes. The only exception was Oral Health, which received eight priority votes, but four “top ten” votes.

Michael explained that Bailit Health created subcategories after a careful review of all strategies. He reviewed strategies that had garnered the highest number of votes from among the 13 Commission members who provided their votes, as follows.

- Strategy #16 (7 priority votes): Utilize value-based payment agreements with drug manufacturers to reduce the costs of prescription drugs.
- Strategy #15 (6 priority votes): Increase oversight of PBM pricing.
- Strategy #192 (6 priority votes): Reduce skyrocketing Rx prices.
- Strategy #205 (6 priority votes): Regulate pharmaceutical prices in Minnesota.
- Strategy #49 (5 priority votes): Improving health care delivery for individuals transitioning out of jail or prison.
- Strategy #100 (5 priority votes): Expediting the Waiver Reimagine initiative and realigning decision-making authority from the Lead Agencies to DHS.
- Strategy #133 (5 priority votes): Program process improvements.
- Strategy #138 (5 priority votes): Reduce MA eligibility assessment.
- Strategy #105 (5 priority votes): Increasing access of home and community-based services for older adults.
- Strategy #140 (5 priority votes): Flat rates coupled with reinvestment – health care.
- Strategy #275 (5 priority votes): Pilot hospital global payments.

Michael noted that seven pharmacy strategies received priority votes from Commission members. He noted that of the technology strategies, the majority related to administrative efficiency with some offering a wholesale review of technology, and others a very narrow approach. Likewise, health system transformation strategies varied from narrow to broad.

Julia Freeman stated that it would be better to see which Commission members voted for which of the prioritized strategies. Michael Bailit said that he could provide Julia with the information she was seeking.

Michael Bailit commented on Strategy # 322, DHS Strategic Planning 2018-2020, noting that the description of the strategy is narrower in scope than the title suggests; the strategy would define “wellbeing” so that DHS can assess its services in terms of the attainment of wellbeing by the people it serves. Julia Freeman and Sheila Kiskaden noted that a baseline definition of “wellbeing” would be helpful.

Sida Ly-Xiong commented on the difference between those strategies that are within the state’s own discretion and those requiring legislation. She noted that some strategies are overlapping, and some seem like they could be grouped together. She commented that the Commission would need to be nimble between the overall and individual strategy prioritization.

Michael Bailit reviewed next steps and the need to start developing strategies. He proposed that strategy development reflect the broad feedback received by the Commission, and that it take into consideration those strategies that received the most votes. Bailit Health will lead an effort with MDH and DHS staff to go through strategies and identify which to develop (including some that are short-term in focus and some that are long-term) and bring forward for Commission consideration.

Michael Bailit proposed that when selecting strategies for development, Bailit Health and agency staff would consider what the Commission members identified as priorities, the endorsed selection criteria, Bailit Health’s experience in other states, and DHS and MDH staff technical information and expertise. This effort would result in a short list of strategies for exploration at each Commission meeting. He noted that in some
cases, there might be a recommended strategy that an agency is already implementing and which does not need the legislature to act. Bailit Health will work with staff to develop the proposals; each strategy will go through an equity review, and then Bailit Health will present the strategies to the Commission members for consideration.

- Michael Bailit proposed that each Commission meeting begin with an orientation on the topic of the day, e.g., disability services, followed by presentation of each strategy one at a time with ample discussion time. Commission members will be asked to indicate whether they support a strategy, if they wish to remove it from consideration or if they are unsure. Michael said that it is anticipated that in some cases, Commission members will need Bailit Health and agency staff to come back to the next meeting with additional information to inform the Commission’s review.

- Jennifer DeCubellis noted that a legislative strategy might be required in some instances to force to a fiscal note and thereby obtain recognition of savings associated with a strategy. Michael Bailit expressed agreement.

- Representative Liebling commented that it would be helpful to separate those strategies that have the potential to contribute to the $100M savings target and those that are transformational and longer-term strategies. Michael Bailit responded to Representative Liebling’s suggested approach by explaining that the organizing principle for prioritizing strategies for discussion at upcoming Commission meeting can be modified to ensure initial focus on cost-savings strategies specific to health care, disability services and services for older adults.

- Gayle Kvenvold asked how public input would be considered in development of strategies. Michael Bailit responded that the Commissioners’ had previously requested a broader public comment opportunity at each Commission meeting. This will begin at the next meeting, and will be combined with strategic outreach effort outside of Commission meetings to get feedback on strategies prioritized by the Commission.

- Sue Schettle asked if all strategies would be available to the public. Krista O’Connor replied that as the strategies are developed, templates for the strategies would be placed on BRC website in advance of Commission meetings.

- Gayle Kvenvold noted the transformational aspect of Strategy #388 (value-based reimbursement for nursing facilities) in that it rewards nursing facilities for performance.

- In reviewing the strategies to advance health equity that had been prioritized by the Commission members, Commissioner Malcolm noted that there is significant work to do in health equity. She stated that the Commission might wish to note that this topic held particular resonance for the Commission and that it may wish to note other venues and partners for generating a longer list of ideas to address.

- Julia Freeman stated that health equity is not a “bucket” or category of strategies, rather, health equity is a necessary shift in mindset. She noted that some strategies were specific to populations and clearly target equity issues. In fact, every strategy has some sort of impact on health equity. Michael Bailit responded by noting that staff and the Commission will look at every strategy with a health equity lens, in addition to reviewing strategies that were recommended solely for promoting health equity.

- Michael Bailit reviewed next steps and noted that selection of strategies for development does not indicate agency advocacy, endorsement or support.

- Gayle Kvenvold commented on the potential for conflict of interest among individual Commission members for some strategies and asked for clarification as to expectations for Commission members. Michael Bailit suggested that for those Commission members with special interest in certain strategies but also related subject matter expertise, they should be able to participate in the conversation, but should prospectively acknowledge to the other Commission members any conflict with respect to a specific strategy under consideration.

- Commissioner Malcolm stated that it would be important to have written and other testimony from stakeholders.

- In response to a question, Elyse Bailey commented that the latest budget forecast would affect how strategies are costed out.
• Julia Freeman noted the importance of Sue Schettle’s expertise and input when discussing disability strategies. She asked that Sue provide her guidance and expertise in written form if she is unable to attend a Commission meeting where these strategies are discussed; Sue expressed her willingness to do so.

• Jennifer DeCubellis asked that background information on programs be shared with the Commission in advance. She asked whether background presentations could be offered outside of the Commission meeting times to allow more discussion times during the Commission meetings themselves. Elyse Bailey indicated her willingness to provide documentation when available.

• Representative Liebling agreed that providing background documents would be helpful. She noted that the non-partisan house research entity also has relevant documents and the Office of Legislative Auditors has program evaluations. She commented on the issue of how the budget forecast impacts the Commission’s charge, noting that it will impact how things are costed out, but it will not change the $100M savings target.

Public comment

• Maureen Holden of the Disability Law Center asked if there was a means for engaging stakeholders during development of strategies. She noted that the Center would like to make its expertise available. Krista O’Connor responded that The Improve Group would engage with communities and individuals.

• Commissioner Malcolm said she would consider this question, noting the need to balance the timeline with soliciting expertise of Commission members and stakeholders into development of strategies. Commissioner Harpstead invited submission of technical assistance to the strategies reviewed during the Commission meeting.

Meeting wrap-up

• Commissioners Malcolm and Harpstead noted that future meetings would allow for more extended opportunity for public comments. The next Commission meeting will take place on January 16. In the interim, a webinar on health equity will take place for Commission members on December 13. Commissioners Harpstead and Malcolm thanked the Commission members for their participation and investment in the Blue Ribbon Commission.

Next meeting

• Thursday, January 16, 2020; 9:00 a.m. – 3:00 p.m.
Blue Ribbon Commission Meeting 6

Meeting Notes

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

Participation

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

Welcome and remarks

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

Overview of strategies selected for development

- Michael Bailit reviewed the process for selecting strategies for development, and provided an overview of strategies selected for development. He stated that the Commission meeting would focus on discussion of the following four health care cost savings strategies:
  - Expand the DHS Encounter Alerting System
  - Non-Emergency Medical Transportation Efficiencies
  - Durable Medical Equipment and Supplies Rate Reform
  - Volume Purchasing
- Sheila Kiscaden noted that at a recent Senate meeting in Rochester, Senator Gazelka indicated that the issue of splitting up DHS is one of his top priorities. Sheila expressed concern that the BRC won’t be dealing with transformation issues until late spring – when the Legislative Session is almost done. Representative Tina Liebling remarked that transforming DHS is not part of the BRC’s charge.
- Commissioner Malcolm noted the difficulty of achieving the $100 million savings charge of the Commission, and that some transformative ideas may achieve savings over the longer term.
- Michael Bailit reviewed a document that explained the disposition of the strategies identified as priorities in November 2019 by responding Commission members. Representative Liebling requested information on why strategy #16 (VBP agreements with drug manufacturers) was not selected. Michael Bailit committed to following up after the meeting with that information.
- Michael Bailit stated that it is difficult to identify strategies that yield cost savings, and as a result, two of the strategies presented were newly created by DHS because they have the potential to yield sizeable savings.
- Jennifer DeCubellis asked if the Commission would like to coordinate strategies with proposals put forth in legislative session. The Co-Chairs responded that the Commission should press on with its work without trying to prioritize strategies that may be legislative session topics. The Commission can advise legislative decision makers, and provide progress reports on the Commission’s work. Senator Matt Klein stated that he believed the Commission will receive credit if a recommended strategy is addressed by legislative action during the 2020 session.
• Agency staff will reach out to Commission members who have expressed interest in strategy development. Krista O’Connor would like Commission members who have expressed interest in doing so to provide guidance and help inform strategy development.
• An equity review occurred for the four strategies developed for the meeting; Commission member Julia Freeman participated in these reviews.

Health care services at DHS – an overview

• Heather Petermann and Julie Marquardt of DHS presented an overview of purchasing activities at DHS. Cost drivers in health care programs are the number of people served, the services that are covered, and the payments that are made for those services. They stated that the Commission is focused on the third driver because the Commission is not looking at reducing coverage or benefits.
• Quality is an important consideration; providing better care can result in reduced costs. Patient experience is also important. If patients are actively engaged, they are better able to get a good health outcome.
• DHS utilizes two purchasing strategies: a fee-for-service (FFS) model in which DHS pays claims directly (25 percent) and a managed care model in which DHS pays managed care organizations (MCOs) (75 percent). More than 40 percent of enrollees in FFS or managed care receive services through an Integrated Health Partnership (IHP).
• In response to a question from Commissioner Malcolm, Julie Marquardt noted that DHS has access to quarterly reports that allows the agency to examine provider payments. Representative Liebling stated that legislators are uncertain of the benefits of the state’s MCO approach. Jennifer DeCubellis stated that managed care enables the State to purchase services above what is specified in the Medicaid state plan. Michael Bailit noted that this topic will be examined during the Commission’s discussion of system transformation strategies. Commissioner Harpstead stated that MCOs have been effective and have produced savings for the State over the years. Representative Liebling disagreed.
• Julie Marquardt stated that DHS’ managed care strategy offers both opportunities and challenges, adding that it provides flexibility for rate negotiation and helps with some access issues. In its recent procurements, DHS has prioritized quality, ability to pay claims, and engagement with social determinants of health.
• DHS has been paying close attention to drug costs, which represent 15-20% of the MCO capitation rate, by working on how to manage drug costs while making sure people get access to needed drugs. DHS has instituted a uniform preferred drug list across health plans and FFS program.
• DHS conducts financial auditing to see what health plans are covering; as a result of these audits, the agency sometimes finds inappropriate costs that it then takes out of the rates.
• In response to a question from Shauna Reitmeier, Julie Marquardt stated that DHS conducts quality reporting, and surveys enrollees to find out why they disenrolled from a health plan. DHS does not have a “dashboard” type report card that compares MCO performance across quality measures.
• The goal of IHPs is to align provider incentives so that they are rewarded for value instead of volume; providers share in savings when they meet cost and quality targets. DHS supports IHP providers with population health and data that enable them to identify appropriate interventions. These efforts have resulted in reductions in unnecessary services. There are currently 24 IHPs across the state. Between 2013 and 2018, IHPs achieved $401 million in cost savings, reduced emergency visits by 7% and hospital stays by 14%. These results have reduced forecast trend by 1% (from expected growth of 4%).
• Senator Klein thanked DHS for its work on IHPs, noting that they are key to improving health care in Minnesota; he further indicated that there is huge potential in this area. Heather Petermann noted there is additional opportunity; IHPs include just families and children, and not those individuals who are dually eligible. Julie Marquardt noted that IHPs are invisible to beneficiaries – they don’t find it; it finds them. Representative Liebling noted the confusing overlap between MCO and IHPs. Julie Marquardt stated that health plans have to share savings with the provider organizations; it is a complex set of moving parts and they must attribute savings appropriately so both get paid fairly.
Health care cost savings strategy presentation and discussion

- Michael Bailit provided an overview of the strategy, Expand the DHS Encounter Alerting Service (EAS), which would expand the current voluntary program beyond 10 IHP providers and a limited number of other providers to a goal of 100% participation and provide real-time notification on ER, hospital, long-term care facility admits, transfers and discharges. The EAS notifies primary care providers to whom patients are attributed as well as care coordinators. The strategy would also enhance alerts to include discharge summary information. Estimated savings are to be determined in the future.
- Shauna Reitmeier commented that this strategy may be appropriate for behavioral health providers, and that use of the EAS could be mandated in provider contracts. Heather Petermann stated that EAS does currently have Certified Community Behavioral Health Clinics and Behavioral Health Homes that are participating. Julia Marquardt noted that expansion of EAS is a cost savings strategy but will entail some investments for providers to be able to use the technology.
- Sue Schettle inquired if patients have to provide consent for information to be shared. Heather Petermann said that patients provide consent when they are treated by the provider, and consent when enrolling in benefits, so additional consents are not needed.
- Jennifer DeCubellis noted that the EAS could be expanded to be used by community-based organizations. Gayle Kvenvold commented that she liked the idea of broadening this strategy to include home-and-community-based services.
- Jennifer DeCubellis noted the potential for unintended consequences; with virtual teams, not all care coordinators on a team may participate. Heather Petermann clarified that alerts do include whether other care coordinators were alerted (except if it is a 42 CFR substance use treatment facility). Commissioner Harpstead stated that alerts can be prioritized by providers; the alert system is programmable and gives the ability to coordinate care. Senator Klein asked if alert information can be integrated with the electronic health record, and Heather Petermann responded that yes, alerts may be integrated into existing EHRs.
- Gayle Kvenvold noted that they are seeing more long-term care providers using this services. She thanked the Commission for bringing this strategy forward.
- Decision: There was general consensus to move forward with this strategy. Commission members did not request additional information.
- Michael Bailit provided an overview of the strategy, Non-Emergency Medical Transportation (NEMT) Efficiencies, which would create a uniform NEMT program for all members using a single program administrator contracted with a per member per month payment model. The administrator would contract with drivers, negotiate rates and coordinate rides. Diogo Reis of DHS indicated that Utah and Wisconsin are doing this. Savings are anticipated to be greater than $10 million.
- Commissioner Malcolm asked if questions raised under equity review were intended to communicate that the strategy should not advance. Julia Freeman clarified that the questions were intended to raise concerns of possible unintended consequences. Michael Bailit suggested that these considerations could be included in the action plan.
- Representative Liebling noted a previous legislative discussion on this topic was contentious and that this was not a new idea. She added that a lot of small businesses depend on the current program. Michael Bailit commented that under the strategy, savings occur because there will be fewer inappropriate rides and that ride prices will be lower. Diogo Reis of DHS commented that the strategy was consistent but different than what a previous workgroup recommended.
- Commissioner Harpstead expressed concern regarding possible impact on rural counties. Diogo Reis indicated that there are several models available for NEMT.
- Jennifer DeCubellis stated that if people do not receive care due to lack of transportation that creates a cost, and improved access may cost more in transportation but less in health care.
- Jennifer DeCubellis commented that counties are split – some see this strategy as an opportunity, and some see themselves doing well with the status quo. She added that health plans and counties and tribes are currently not coordinating well.
Sheila Kiscaden noted that it is a responsible thing to look at statewide access and administration. She stated that this strategy should stay on the list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Presentation of proposed community engagement plan**

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

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

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

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

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

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

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

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

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

Presentation of proposed community engagement plan (Cont’d)

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

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

Meeting wrap-up

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

Next meeting

- Thursday, February 6, 2020; 9:00 a.m. – 3:00 p.m.
- Shoreview Community Center, Wedell Room, 4580 Victoria Street North, Shoreview
Blue Ribbon Commission Meeting 7

Meeting Notes

- Date & time: Thursday, February 6, 2020, 9:00 a.m. – 3:00 p.m.
- Location: Shoreview, Minnesota

Participation

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

Welcome and remarks

- Commissioners Jodi Harpstead (DHS) and Jan Malcolm (MDH), co-chairs of the Blue Ribbon Commission welcomed Commission members to their seventh meeting, and welcomed public participants as well. Commissioner Malcolm congratulated Jennifer DeCubellis on her appointment as CEO of the Hennepin Health System. Commissioner Harpstead reviewed the agenda for the meeting.
- Commissioner Malcolm described Governor Walz’s and Lt. Governor Flanagan’s new One Minnesota plan, which identifies Minnesota’s future needs and reflects a year of listening to state citizens. She reviewed the One Minnesota plan mission and vision, the latter being that Minnesota will be the best state in the country for children to grow up. The plan includes a set of seven “guiding principles” or values, and five priority focus areas, each of which has specific goals and associated measures.
- Commissioner Harpstead explained that each agency is working to identify how it can contribute to the goals of the One Minnesota plan; agencies are submitting their plans for such contributions, which include inter-agency efforts.
- Commissioner Malcolm reviewed examples of goals from the One Minnesota plan that have relevance to the Commission’s work.

Follow up topics from prior meetings

- Michael reviewed follow-up items from the January 16th Commission meeting, and noted that the State is working on these items and will provide follow-up information at a future meeting.
- The Improve Group’s engagement plan will be shared with Commission members soon and the plan will be on the agenda for approval at the 2/21 meeting.
- Michael Bailit stated that the focus of the February 6th Commission meeting is to continue with health care cost savings strategies.

Background presentation: third-party liability

- Geneva Finn, Manager of DHS’ Special Recovery Unit, provided a background presentation on the topic of third-party liability, and described the work of DHS’ Health Care Integrity and Accountability Division in ensuring that Medicaid is the payer of last resort. The Health Insurance Recovery Unit works to discover when other insurers should serve as the primary payer on claims rather than Medicaid, describing this as
cost avoidance work. The Tort Recovery Unit recovers money from non-health insurance sources, including from workers’ compensation, settlements from no-fault, third-party auto, medical malpractice and homeowners’ insurance, and product liability class action-lawsuits. The Special Recovery Unit supervises and trains local agencies in recovery resulting from estate claims.

- Geneva Finn added that the largest share of savings was that resulting from the work of the Health Insurance Recovery Unit, and accounted for almost $1 billion in 2019. Savings resulting from the work of the Tort Recovery Unit and Special Recovery Unit are smaller and the issues surrounding recoveries within these units are more legally complicated. Nevertheless, there are opportunities for increased savings resulting from tort recoveries and special recoveries, she added.

- Representative Liebling asked about DHS’ ability to enroll individuals in other insurance. Geneva explained that this is practice permitted by CMS. DHS will pay the premium if it would cost less than being covered by DHS. Beth Waldman explained that when the State pays only the employee share of a group premium, it could be cost-effective to the State.

- Debra Krause asked about the staff assigned to this function. Geneva replied that there are about 45 staff total, and additional staff employed by counties.

- Jennifer DeCubellis encouraged development of a system that would improve recoveries across the State, and that would not solely focus on DHS’ work in this area. She also identified inefficiencies associated with having DHS, MCOs and counties all pursuing recoveries dollars. Geneva Finn noted that counties are allowed to keep half of the non-federal share of any costs they recover. She also noted that they are hearing from counties and county attorneys that they want more training. Jennifer DeCubellis reiterated Geneva Finn’s comment to clarify that counties are asking for more specialized training. Geneva Finn replied in the affirmative.

- Lisa Weed asked if individuals lose care through these recovery efforts. Geneva Finn replied that nobody should go without care due to DHS’ cost avoidance efforts.

**Background presentation: MCO competitive price bidding**

- DHS Deputy Assistant Commissioner Julie Marquardt presented information regarding how DHS procure for managed care services for 75 percent of the Medical Assistance population. She provided an overview of the managed care procurement process, whereby managed care organizations respond to a request for proposals (RFP) issued by DHS. DHS, the Department of Health and counties score the proposals submitted by bidders to determine who will be offered a contract; the scoring process includes evaluation of quality and service delivery, and may include price components. The final decision is made by the DHS Commissioner, representing the single state Medicaid agency.

- Julie Marquardt explained that Minnesota implemented managed care long before most states, in 1985. DHS began price bidding in 2011 in the Metro area, which generated $1 billion in savings. A second price bid was conducted in 27 counties in 2014, and then again, in 2015 for a statewide procurement, which generated $450 million in savings. The 2015 managed care procurement was the most recent.

- Julie Marquardt noted that CMS released new Medicaid managed care regulations in 2016, which give cause for DHS to reconsider how it conducts procurements. For example, CMS requires competitive bids with proposal reviewers free from conflict, and views county-based purchasing and MCOs as the same.

- She concluded by noting that the Office of the Legislative Auditor found that the last procurement had no significant shortcomings.

**Health care cost savings strategy presentation and discussion**

- Jennifer DeCubellis identified a potential conflict with this strategy, in her role as CEO of Hennepin County Health System, which is both a health plan and a provider of health care services. Shauna Reitmeier acknowledged that her organization contracts with MCOs.
• Beth Waldman described the strategy, **MCO Competitive Price Bidding**, which would continue competitive pricing bidding, but add an upper rate limit on rates paid to MCOs contracted to serve Families and Children populations.

• Beth Waldman explained that rates have to be actuarially sound and when states bid rates, they are confirming that those rates are actuarially sound. The MCOs’ bid rates are for the first year, but the rates are then increased annually. She added that current rates are in the lower end of the actuarially sound range, but DHS finds year-over-year increases to be too high for program sustainability.

• Beth described the proposed strategy, which would include an upper rate limit (ceiling) for competitive price bids, and would allow a bidder to go below that ceiling as long as it is still within the actuarially sound rate range and the bidder can still meet contract requirements. Under this strategy, DHS would apply this approach to procurements scheduled for 2022 and 2023. She noted that savings are estimated to be $1 to $10 million, with longer term impact because the base rate would be lower in future years than what it would have been. The strategy would not require significant additional administrative effort.

• Beth Waldman stated that past competitive bidding suggests that this could be a successful strategy.

• The equity review identified considerations for future strategy implementation, should the strategy be implemented.

• Possible challenges include the ability of MCOs to operate within a rate lower than the rate ceiling, or the legislature creating exceptions for certain MCOs, which would reduce savings.

• Shauna Reitmeier asked about the impact on a rural frontier area. Could DHS have different rate formulas for setting the ceiling? If so, would that reduce savings?

• Julie Marquardt responded that DHS currently has five different geographic rating regions, but indicated that the state could change that number. She added that she believes there are opportunities for savings, but there is no guarantee.

• Shauna Reitmeier said that the strategy made sense, but worried about its possible impact on service access and MCOs ensuring access.

• Representative Liebling observed that the challenge of this strategy is in how it is implemented. She expressed interest in knowing where MCOs would reduce spending to achieve lower rates, and the impact on enrollees, for example in access to dental care. She also asked about when the actuarially sound calculations are made, what goes into that calculation? She further asked if we are figuring in, for example, that only 25% will have a dental visit in a year, or do we assume 100% will? Representative Liebling stressed that the problem is, as policy makers, they never really know what they are paying for; so if we do this, she really wants to know the details – if we make cuts, are we cutting into the actual care? Julie Marquardt responded that rates would be modified if dental utilization improved.

• Sue Schettle asked about how DHS would assess outcomes. Julie Marquardt explained that DHS uses a number of quality metrics to assess MCO quality, and has seen improvements. It is unclear how to attribute those changes to MCOs given other environmental factors, e.g., IHPs and Medicare payment changes. Julie Marquardt indicated that the way the rates are is dependent on the experience of the plan. If we are doing anything to change that “experience,” it will increase costs because more people will access a particular service (i.e. dental care).

• Lisa Weed asked what protections are in place if a bidder was to bid too low and then leave the program. Julie Marquardt confirmed that this happened in the past with Medica. She said that MCOs can always decide to terminate their contract. When this occurred in the past, enrollees were transferred to other plans that were licensed to provide services in counties served by the departed plan. Beneficiaries were then given a choice of plans in which to re-enroll.

• Jennifer DeCubellis expressed concern that MCOs may pass rate cuts onto providers because of low rates. She encouraged DHS to look for administrative gains that produce savings and that do not compromise care delivery; she also urged consideration of unintended consequences. She cautioned that DHS should proceed carefully with development of this strategy.
• Debra Krause expressed concern that reductions in MCO rates may negatively impact other Minnesotans by causing increased rates to the commercial or individual markets.

• Commissioner Harpstead observed that DHS has influence on technical bid requirements, and how much weight is placed on the price bid as part of the proposal evaluation.

• Representative Liebling and Jennifer DeCubellis said that DHS must ensure that commitments made by a bidder in its proposal are met.
  • Regarding the MCO strategy competitive price bid strategy, Representative Liebling said that it needs further “mining.” Gayle Kvenvold asked for more consideration of unintended consequences associated with the strategy. Commissioner Harpstead noted that DHS has already done competitive price bidding. Jennifer DeCubellis commented that those serving public programs now have very thin margins, and so great care should be taken with this strategy.

Health care cost savings strategy presentation and discussion - continued

• Beth Waldman provided an overview of the strategy, Improve Compliance with Third-Party Liability, which proposes to offer training to counties and to private attorneys, and to produce associated resource materials. She explained that county prosecutors are typically not trained to enforce third-party liability (TPL) statutes, and personal liability attorneys may not be aware of the need to bring in Medicaid.

• Beth Waldman explained that anticipated savings are modest and are estimated at $1 million, but the strategy would increase cost avoidance accountability too. She noted that attorneys have expressed interest in this assistance, and a county survey identified the need for education. This strategy would require some DHS agency time and limited financial resources.

• Beth Waldman stated that the equity review identified considerations associated with possible future implementation.

• Beth Waldman noted that the possible challenges associated with this strategy are limited, and are primarily associated with the time it would require of DHS and county staff, and of private attorneys.

• Geneva Finn, an attorney in DHS’ Special Recovery Unit, explained that the savings estimate is modest because of limited knowledge about what additional potential savings may exist. She noted that a previous educational effort achieved approximately $5 million in savings.

• Lisa Weed asked if there would be cost savings if people were allowed to pay back the State right away rather than wait until the death of a surviving spouse. Geneva Finn stated that Minnesota law requires just that, but the State has not been able to implement the practice, as CMS has not permitted it.

• Representative Liebling asked if there was an opportunity to enlist the courts earlier, perhaps when attorneys sign off when filing a case. This approach would rely less on attorney awareness or recall. She also asked about more proactively identifying individuals for whom the State purchases coverage.

• Sue Schettle asked how many people are subject to the tort process. Geneva Finn replied that it would be a small portion of the Medical Assistance population.

• Geneva Finn stated that the TPL function is a complex one for states to administer, and the process of enrolling people in other coverage especially so. Commissioner Malcolm wondered if the function should be centralized. Geneva Finn indicated that it is centralized in most states. Beth Waldman said that Massachusetts administers the function centrally.

• Commissioner Harpstead asked whether it would be better to invest more and generate greater savings, either through expanding the proposed effort, or centralizing the recovery function.

• Jennifer DeCubellis commented that counties believe that lack of resources is the biggest problem in rural Minnesota, and recommended consultation with the Minnesota County Attorneys Association. Metro probate attorneys also recommended a mentoring program, particularly for newer attorneys.

• Representative Liebling voiced support for the TPL strategy, but noted that people dislike having money pulled back from them. She also advised that the Commission should be aware of the sensitivity around this issue.
• **Decision:** There was consensus to retain both the Improve Compliance with TPL and MCO Competitive Price Bidding strategies for further consideration.

**Public comment**

• Commentary was provided by Reuben Moore, CEO, Minnesota Community Care, the State’s largest Federally Qualified Health Center.

• Mr. Moore noted a fundamental flaw in health care funding in terms of its lack of support for primary care. He stated that there should be a requirement for minimum dollars invested in primary care by MCOs, and that these investments should be aimed at at-risk communities. He recommended that the State place a requirement on MCOs to allow for an innovative billing model that would account for services that have greater impact on social determinants of health (SDOH). He urged the State to undertake innovative efforts to reduce SDOH, and suggested regulating such efforts through the competitive bidding process.

• Shauna Reitmeier asked Mr. Moore for examples of partnerships between Minnesota Community Care and the MCOs. He urged MCOs to build innovative networks and fund those providers that are improving access to at-risk communities. Mr. Moore noted that the state could develop a Center of Excellence for addressing SDOH, including community mental health centers (CMHCs), FQHCs, and others in the community, to reduce the total cost of care for Medicaid beneficiaries.

• Jennifer DeCubellis thanked Mr. Moore for his comments and stated that health plans tend to focus their efforts on emergency department utilization, but less so on wellness and primary care.

• Commissioner Harpstead noted that her 90-day plan for the Minnesota Department of Human Services includes a focus on addressing SDOH.

• Sida Ly-Xiong asked Mr. Moore what the minimum spending should be on primary care. Mr. Moore noted that should spend at least $200 million on primary care. In determining, the exact amount should consider not just, what is currently spent in CHCs alone, but also at CMHCs and dental care, to ensure that providing appropriate support to primary care, mental health and dental care.

• George Klauser, Executive Director, the ALTAIR Accountable Care Organization, commented on the MCO competitive price bidding strategy. The Altair ACO is a collaborative of community service providers and a health care practice serving 19,000 individuals with intellectual, developmental and mental health disabilities, primarily offering Home and Community Based Services (HCBS). He noted the lack of discussion on how to incorporate value-based designs or payments into the competitive price bidding strategy. His vision of value-based design incorporates person-centered outcomes, and entails engaging all stakeholders. He has observed contracts that place reimbursement at risk, and align reimbursement with clearly stated population health goals.

• Commissioner Harpstead noted that the State can incorporate desired outcomes in the MCO bidding process, and that the State has the ability to match those outcomes to its priorities.

• Jennifer DeCubellis noted that value-based payment often means paying for services that are not traditionally paid for in fee-for-service Medicaid. She wondered whether an innovation code that reflects such services could be developed.

• Mr. Klauser urged the Commission to consider new emerging ideas, particularly those with direct impact on individuals and at-risk communities.

**Pharmaceutical spending background presentation**

• Stefan Gildemeister, Director of the Health Economics Program at the Minnesota Department of Health, provided an overview of Minnesota’s spending on prescription drugs. He noted that prescription drugs account for an increasing share of state health care spending, and said that medical prescription drug costs are an increasing source of growth in total spending whereas retail prescription drug costs have grown relatively modestly in recent years.
Stefan Gildemeister described a variety of factors contributing to increased attention on rising prescription drug costs, including low brand prices at market entry (and regular increases); industry practices focused on maintaining revenue, an increase in populations benefiting from prescription drug therapies, and stalled congressional and federal action. Seniors and the chronically ill face the highest burden of out-of-pocket spending for prescription drugs.

Stefan Gildemeister shared data indicating that groups that are more likely to forego filling a prescription due to cost include the uninsured, young adults, lower income individuals and some minority groups. Statewide, the rate of Minnesotans who did not fill a prescription was 9 percent in 2017, and 16 percent for those with a chronic condition.

Stefan Gildemeister described several prescription drug initiatives in Minnesota, including the Governor’s Subcabinet Working Group and the Task Force on Lowering Pharmaceutical Drug Prices.

Jennifer DeCubellis asked what the Commission could learn from other countries in terms of efforts to control the rising costs of prescription drugs. Stephan Gildemeister noted that countries differ in how they pay for prescription drugs; however, there are several models from which the Commission can learn. In Germany, a regulatory body reviews prescription drugs and their costs. Germany also utilizes a reference pricing system based on the therapeutic value of a prescription drug. He noted that CalPERS recently implemented reference pricing for select medications covered under its pharmacy benefit as a means of addressing rising prescription drug costs.

Jennifer DeCubellis asked if the Commission could examine layers of administration and organizational structure to identify where it is not adding value. Stephan Gildemeister responded that upsetting the system would be transformational and the State would want to do intentionally.

Representative Liebling asked if the United States subsidizes the prices of prescription drugs in other countries because our citizens pay higher prices. Stephan Gildemeister stated that this is unlikely, but that the system certainly forces pharmaceutical companies to earn less revenue in other markets.

Health care cost savings strategy presentation and discussion - continued

Michael Bailit provided an overview of the strategy, Uniform Pharmacy Benefit in Public Healthcare Programs, noting that spending on prescription drugs in Minnesota is rising at a rate much higher than growth in the number of prescriptions. He stated that increases in prescription drug spending have been significantly more rapid in the state managed care pharmacy benefit than for the FFS benefit.

Michael Bailit described the recommended strategy, which would move management of the pharmacy benefit fully to DHS for Medical Assistance beginning in January 2022, with the aim of both reducing costs and increasing transparency. Currently, pharmacy benefits are administered either by DHS or by the MCOs through their Pharmacy Benefit Managers.

Michael noted that savings have not yet been estimated by DHS staff, and will vary based on whether the State can start before January 2022. He noted that West Virginia recently implemented this strategy and experienced significant savings. He stated that the strategy involves an administrative cost to DHS for increased prior authorization volume.

Senator Klein asked a question about the source of savings from this strategy. Chad Hope of DHS responded that West Virginia primarily experienced savings resulting from elimination of administrative fees that were previously paid to MCOs.

Jennifer DeCubellis expressed concern about prior authorizations and potential changes to the system. She noted that when control of this benefit reverts to DHS, the State may lose local innovations at the county level, for example, making a patient’s prescriptions visible to providers, as is the practice at Hennepin County.

Representative Liebling noted that prior authorization is a one-time issue at implementation. Jennifer DeCubellis observed that there might be sustained savings from prior authorizations if DHS is more restrictive in its approach than MCOs.
• Debra Krause asked about potential disruptions to patients from this strategy. Chad Hope noted that the primary risk of disruption would be at the outset when the system transfers from MCOs to the State, particularly at the time of initial prior authorization. He also noted that if a pharmacy were part of an MCO network but not in Medicaid, then the pharmacy would need to enroll in Medicaid.

• Representative Liebling stated that sometimes pharmacists pay higher prices for prescription drugs than they are able to sell for. Chad noted that it is not uncommon to hear an individual claim that reimbursement is below costs because there are different ways that pharmacies acquire prescription drugs, but in general, the national average acquisition cost is the salient data point.

• **Decision:** Commission members agreed to retain this strategy for continued consideration.

### Health care cost savings strategy presentation and discussion - continued

• Michael Bailit provided an overview of the strategy, **Prescription Drug Purchasing Council**, noting that all payers of health care benefits have experienced increasing pressure from the high and rising cost of prescription drugs. The market for pharmaceutical products fails to operate effectively and transparently.

• This strategy would establish a legislatively chartered group comprised of officials from across state agencies, counties, cities and other public entities to conduct an inventory of prescription drug spending in the State, identify opportunities (and boundaries) for greater collaboration on purchasing of prescription drugs, and support development of strategies to leverage prescription drug benefit purchasing within existing statutory authorities, and also to develop legislative proposals to address statutory barriers.

• Michael Bailit noted that both Delaware and New Mexico passed legislation to create similar interagency groups, although results associated with these efforts are not yet available.

• Challenges associated with this strategy include that the potential savings are unknown. In addition, statutes and existing contract provisions may prevent the collaboration and data sharing envisioned by this strategy. Michael Bailit said that this strategy could also result in fewer choices in terms of a narrower pharmacy benefit.

• Jennifer DeCubellis commented that once legislation is created for such a council, it would be difficult to then remove it; she suggested that enabling legislation include a sunset clause.

• Stefan Gildemeister commented that early conversations across agencies have been helpful, and he believed there was a potential benefit to this strategy.

• Debra Krause noted that the strategy is potentially disruptive, but that it is aligned with the premise of combined purchasing power, and said that it is a good proposal.

• Shauna Reitmeier asked if the council could expand beyond purchasing, i.e. by examining the efficacy of drug therapies for example. She also commented on the composition of the council, and noted that it should include pharmacists or others who understand drug therapies. She expressed support for Jennifer DeCubellis’ suggestion of a sunset clause.

• Jennifer DeCubellis asked about the costs associated with the Council. Stefan Gildemeister commented that if the council requires legal advice or data modelling then it would be more costly. Michael Bailit stated that before final decisions are made on the strategies the Commission would need to include a specific understanding of associated costs and potential savings.

• **Decision:** Commission members agreed to retain this strategy for continued consideration.

### Health care cost savings strategy presentation and discussion - continued

• Michael Bailit provided an overview of the strategy, **Establish Rx Affordability Commission**, noting that over 130,000 Minnesotans paid $1,000 or more out-of-pocket for prescription drugs in 2013, and that rates of Minnesotans foregoing filling a prescription due to cost are on the rise.

• This strategy was derived from a bill submitted by Senators Klein, Jensen and Draheim during the last legislative session. The strategy would establish a Prescription Drug Affordability Commission that would
assess for certain drugs, whether the wholesale acquisition cost would lead to affordability challenges for
the state health care system or to high out-of-pocket costs for patients. The Affordability Commission
would establish an upper reimbursement limit to apply, as permitted, to all purchasers and payer
reimbursement for drugs dispensed to or administered to individuals in the State. The Affordability
Commission would also be tasked with identifying instances of price gouging for referral to the Minnesota
Attorney General.
• Michael Bailit stated that in terms of potential savings, the Affordability Commission is a new area of public
policy, and savings estimates are unknown. While Maine and Maryland passed similar legislation, the
impact is not yet known.
• Michael Bailit commented that a potential challenge of this strategy might be its impact on access. In
addition, the Affordability Commission would require technical and rigorous analysis and who would do that
is unclear.
• Senator Klein commented on the impetus for the Commission, noting that the market for prescription drugs
produces innovation and he did not wish to suppress innovation but added there is a moral obligation to
make drugs affordable. He noted the similarity of the Affordability Commission with the state’s public
utility commission.
• Representative Liebling noted that this strategy is concerned with the lack of affordability of existing drugs,
and that the Affordability Commission may wish to concern itself with the affordability of new prescription
drug therapies.
• Michael Bailit stated that the Affordability Commission is an attempt to regulate the prescription drug
market where it has been unable to do so on its own.
• Senator Draheim commented that the proposed Affordability Commission was not focused solely on pricing.
He noted that addressing the cost impact of Pharmacy Benefit Managers as a strategy the legislature has
already tackled.
• Stefan Gildemeister noted the importance of building technical expertise into the Affordability Commission.
• Shauna Reitmeier noted that the three prescription drug strategies could be packaged together as they
seem interconnected. Together, the three strategies would be transformational. Jennifer DeCubellis
commented that the three strategies might involve some of the same participants. Representative Liebling
added that the State could start with one of the strategies and then expand upon it.
• **Decision:** Commission members agreed to retain this strategy for continued consideration. They discussed
the possibility of bundling the three pharmacy strategies presented during February 6th Commission
meeting, but did not wish for any one of the three strategies to impede the advancement of the others.

**Meeting wrap-up**
• Commissioners Malcolm and Harpstead adjourned the meeting.

**Next meeting**
• Friday, February 21, 2020; 9:00 a.m. – 3:00 p.m.
• Orville L Freeman Building, 625 Robert Street North, St. Paul
Blue Ribbon Commission Meeting 8

Meeting Notes

- Date & time: Friday, February 21, 2020
- Time: 9:00 a.m. – 3:00 p.m.
- Location: Orville L Freeman Building, 625 Robert Street North, St. Paul

Participation

Participating members: Commissioner Jan Malcolm (MDH), Deputy Commissioner Doug Annett (DHS), Jennifer DeCubellis, Jennifer DuPuis, Nona Ferguson, Julia Freeman, Representative Tina Liebling, Sida Ly-Xiong, Sheila Kiscaden, Debra Krause, Gayle Kvenvold, Sue Schettle (by telephone), Representative Joe Schomacker, Lisa Weed

Welcome and agenda review

Commissioner Malcolm welcomed Commission members and members of the public. Commissioner Malcolm introduced DHS Deputy Assistant Commissioner Doug Annett, representing Commissioner Jodi Harpstead who was unable to attend the meeting. Commissioner Malcolm provided an overview of the agenda, and noted that the Commission previously elected to retain all nine strategies discussed at prior Commission meetings for further consideration and possible adoption.

Follow up topics from prior meetings

- Michael Bailit said that as state staff complete responses to Commission members’ requests from previous meetings, he will share those responses at future Commission meetings.
- Michael Bailit said that a Commission member asked previously about the value-based purchasing for prescription drugs strategy and why it had not been selected as a priority strategy for consideration by the Commission. In response to the Commission member’s query, he noted challenges with value-based purchasing arrangements for prescription drugs, particularly in identifying appropriate performance metrics. He also noted value-based purchasing for drugs is part of another strategy that the Commission is considering, the establishment of a prescription drug purchasing council.

Community engagement plan update

- The Improve Group’s Kylie Nicholas reported that she and her colleagues had prepared a revised community engagement plan based on feedback from the February 6th Commission meeting, and that the revised plan included information on the Commission’s work to engage stakeholders and details of the community engagement events.
- Kylie Nicholas stated that there will be a community engagement event following the May 21st Commission meeting, with the goal of gathering input from this event for sharing at the June 4th Commission meeting.
- Kylie Nicholas said that The Improve Group will focus engagement activities on communities most impacted by the Commission’s cost savings strategies, particularly individuals with disabilities receiving services from the State, older adults receiving services from the State, and individuals receiving assistance through Medicaid. The revised plan includes questions that will guide discussion at community events.
- Kylie Nicholas said that she would provide information on invitation criteria for the community events at a future Commission meeting.
- Gayle Kvenvold asked how The Improve Group will identify community liaisons. Kylie Nicholas stated that The Improve Group will rely on its established relationships with community groups that serve the three populations most impacted by the Commission’s cost savings strategies.
• Sheila Kiscaden asked how The Improve Group will gather feedback from counties and tribes. Kylie Nicholas responded that The Improve Group is focused on collecting feedback from communities and that state staff are working to ensure counties are aware of the work of the Blue Ribbon Commission. Commissioner Malcolm said that it will be incumbent on state staff to collect the perspectives of counties and tribes.

• Lisa Weed asked for sufficient notice of community engagement events. Kylie Nicholas said she will share the dates of community engagement events with Commission members once those dates are finalized, and said that one of the community events will be a virtual meeting. She said that The Improve Group will make arrangements for individuals who lack mobility and who need transportation to events.

• Sida Ly-Xiong asked if there are any incentives for individuals to participate in the community events. Kylie Nicholas stated that The Improve Group has a sizeable budget for incentives and will be working with community liaisons to determine the appropriate level of incentive for each community.

• Gayle Kvenvold asked how input from stakeholders will be factored into the Commission’s decision making, and how much weight should be given to this input. For example, if stakeholders are overwhelmingly opposed to a strategy, how should the Commission members weigh this feedback? Commissioner Malcolm responded that the Commission’s task is to describe for the legislature the pros, cons, and rationale of each recommended strategy, and also to communicate the input the Commission received from both the public and from stakeholders. Commissioner Malcolm added that the Commission will need to assess the input it receives, and determine how best to incorporate this input into its deliberations; she said that the Commission may need to be flexible and consider an additional community event.

• Sida Ly-Xiong noted that the toolkit provided by The Improve Group lacks background information on each focus area and asked if there is a way to share this information as part of the community engagement effort. Commissioner Malcolm promised that state staff would review this request.

• Representative Liebling agreed that the Commission has benefited from the background presentations, and noted that it is the responsibility of the legislature to understand the context for each strategy. She added that by collecting comments from communities, the Commission is communicating that it cares about their input. She noted that while the Commission will not be able to address everyone’s needs, community input will enable the Commission to filter out unacceptable approaches.

• Julia Freeman stated that it will be important for community members to understand how their voices and input will be factored into the Commission’s deliberations.

• Michael Bailit noted that the Commission is waiting to finalize strategies until the end of its process in part so that it can consider input from the public and feedback received from the community events.

• Sheila Kiscaden said that the Commission’s charge is to make recommendations, and it will be up to the legislature to make decisions and translate selected strategies into legislative proposals. She urged the Commission to incorporate pros, cons and implementation issues into its final recommendations.

• Nona Ferguson said the process by which the Commission is considering strategies seems rushed, and that stakeholders will wish to influence the Commission’s decision making.

• Assistant Commissioner Doug Annett commented that the Commission needs to be open to input from the community, even when it is negative.

• Julia Freeman stated that she supports moving forward with the revised community engagement plan, as long as the input provided by Commission members at the February 21 meeting is incorporated.

• **Decision:** The Commission voiced its support for The Improve Group to move forward with the revised community engagement plan.

**Background presentation**

• Natasha Merz, Director, DHS Disability Services Division, provided a background presentation on Minnesota’s disability services programs, including the history and evolution of disability services at the national level and how individuals experience the system in Minnesota. She also provided a high-level overview of the rate setting system for disability services and future direction for these services.

• Natasha Merz noted that in the 1950s, most people with disabilities who used long-term services and supports (LTSS) received them in an institutional setting. She provided a timeline of milestones in the
movement in Minnesota to deinstitutionalize services for people with disabilities, and noted that since the 1980s, attitudes and expectations have continued to shift.

- Natasha Merz explained that the 1999 Supreme Court Olmstead decision interpreted the 1990 Americans with Disabilities Act (ADA), and affirmed that states had to create systems that met the needs of individuals with disabilities. Minnesota’s Olmstead plan was approved in 2015, and envisions a Minnesota where people with disabilities have the opportunity to live near families and friends, to live as independently as possible, and to participate in community life.

- Natasha Merz said that another key federal driver that has influenced how Minnesota delivers services to the disabled is the 2014 regulation for disability and other waiver services published by The Centers for Medicare & Medicaid Services (CMS), which requires person-centered service planning, conflict-free case management, and settings that are home and community based.

- Natasha Merz defined LTSS as services available to support people with disabilities and older adults. She said that home-and-community-based-services (HCBS) are a subset of LTSS and are cost-effective alternatives to institutional care that enable people with disabilities to participate in community life.

- Natasha Merz stated that DHS offers programs to support people with a variety of disabilities: developmental disabilities, chronic medical conditions, acquired traumatic brain injuries, mental illnesses, and physical disabilities. She said that more than 94 percent of people receive DHS LTSS services in their homes and communities, rather than in institutions. Minnesota has experienced increased demand for HCBS, and the system is serving people with higher intensity needs. She noted that the population using HCBS is more racially and culturally diverse than the overall Minnesota population, and that the average monthly cost of people served in HCBS is dramatically lower than for people served in institutions.

- Elyse Bailey noted that DHS has to continually prove to CMS that the State’s total costs under waiver are less than total cost had the population been institutionalized.

- Natasha Merz explained that to access HCBS, a person must have an assessment that identifies their needs, determines their eligibility and identifies their preferred services. Individuals who use HCBS must also go thru a separate Medical Assistance (MA) eligibility determination. She noted that DHS is exploring how to align MA and HCBS eligibility determination processes.

- Representative Liebling asked for clarification as to how the assessment process varies (if at all) between that administered by county versus by the State. Natasha Merz said that the assessment process is complicated and variable based on skills of person administering the assessment, leading to service variation across counties.

- Natasha Merz explained that prior to MnCHOICES, there were three separate paper-based assessments, adding that one goal of MnCHOICES is to use technology to create more consistency and to lessen reliance on administrators’ judgement.

- Deb Krause asked for risk-adjusted data on HCBS.

- Representative Liebling noted that these are state and federally-funded services, so it is unclear why there would be variability in services provided by counties. Natasha Merz replied that the State gives a set budget to counties, and those counties have to develop services but maintain spending within their budget.

- Sheila Kiscaden said that some of the variation across counties is because all services may not be available within a given county. In addition, some counties may supplement services offered to individuals with disabilities because those counties have a broader tax base to support funding of additional services.

- Colin Stemper, a DHS fiscal policy supervisor, noted that the State is exploring approaches to reduce variability across counties in the provision of HCBS.

- Assistant Commissioner Doug Annett said that an individual’s needs fluctuate over a year, and some assessors are better than others in capturing that variation.

- Natasha Merz stated that DHS is evaluating proposals to build the next MnCHOICES platform, and a more streamlined assessment process. She acknowledged that no single tool will address the inconsistencies in services across counties, but that MnCHOICES will help eliminate disparities in access to services.
Natasha Merz reviewed the Waiver Reimagine effort, noting that it is intended to improve the disability HCBS waiver system so that it is more person-centered, easier to understand, and simpler to navigate.

Natasha Merz described Disability HUB MN, a free statewide resource for people with disabilities.

Natasha Merz described the rate setting methodologies for HCBS waivers. Beginning in January 2020, all rates are set by the Disability Waiver Rate System (DWRS) framework authorized in statute. Prior to implementation of the competitive workforce factor, DHS projected a statewide average rate increase of 14.1 percent, with 65 percent of providers experiencing a net rate increase. She noted that DHS will begin receiving cost-reporting data from providers in 2020, and that these data will inform the legislature and DHS about when DWRS framework modifications are needed to provider costs.

**Disability services strategy presentation**

Michael Bailit reminded the Commission that one of its charges is to identify strategies to reduce health and human services expenditures with net savings of $100 million in the next biennium.

Michael Bailit noted that the strategies already retained for further consideration by the Commission, as well as those presented at February 21 and March 6 meetings, sum to approximately $100 million in estimated savings. If not all strategies advance across the February 21 and March 6 meetings, the Commission will need to identify additional cost savings strategies.

Commissioner Malcolm acknowledged that the Commission may fall short in reaching the savings goal.

Julia Freeman asked whether the Commission is free to recommend strategies that the legislature is unlikely to pursue. Commissioner Malcolm acknowledged that the legislature may not support all the strategies recommended by the Commission.

Michael Bailit stated that final selection of strategies will take place after community engagement activities have concluded.

Michael Bailit reviewed the Discontinue Grant Programs strategy. He explained that DHS currently has two grants that no longer serve the purpose under which the legislature authorized them. Under the first grant, transitional payments are made to providers for whom a change in rate methodology reduced revenue by 10 percent or more; the legislation provided for continuation of these grant payments on an open-ended basis beyond the transition period. The strategy is to eliminate these transitional payments.

Michael Bailit said that the second grant provides payment to a single provider of HCBS services for people with HIV because this provider thought it would not be able to comply with a federal rule regarding home and community settings; a state appropriation ensured continued funding at the federal match level. The provider is now compliant with the federal rule, and the state grant is therefore no longer needed.

Sue Schettle said that state staff had received a letter from a provider who expressed strong concern about this strategy. Elyse Bailey of DHS explained that the letter referenced a separate grant, which helps transition providers who would receive a reduced payment for transferring patients from one waiver to another; she said that the Discontinue Grants Programs strategy does not include the grant referenced by the letter.

Sida Ly-Xiong asked if the concerns expressed by the letter writer were applicable to the two grants under discussion. Elyse Bailey said that the two grant programs under this strategy had introduced inequities in provider payments, and that the federal government urged a standardized approach.

Michael Bailit noted that there are no significant administrative or implementation costs associated with this strategy, and reviewed questions that were raised during the equity review. Elyse Bailey added that the two grants are not tied to individual services.

Decision: Commission members agreed to retain this strategy for continued consideration.

Michael Bailit reviewed the Absence Factor in Day Services strategy. Day services have rates determined by DWRS, a methodology that establishes rates through a formula comprised of cost components. The absence factor is intended to cover the costs incurred by the provider when a person has an unplanned absence and the provider cannot bill for services.

Michael Bailit explained that this strategy would reduce the absence factor for day services from 9.4 percent to 4.5 percent. This decrease would align with CMS’ expectation that the State’s rate method is
Disability services strategy presentation (Cont’d)

based on data and research related to provider costs. He shared supporting evidence that suggests an absence factor ranging from 3.1 percent to 4.5 percent.

- Michael Bailit said that new rates would be calculated during annual reassessments, so there are no implementation costs associated with this strategy. An anticipated challenge is that this strategy would reduce payment rates for day services, which could result in providers deciding to provide fewer services. However, this strategy would set the rate at the average cost incurred by providers, and this factor was previously set at 3.9 percent prior to January 2019.

- Debra Krause asked why the 9.4 percent rate increase was enacted. Michael Bailit noted that he understood that effective lobbying produced this rate increase.

- Lisa Weed asked why the Commission should consider this strategy when it was the legislature itself that enacted the increase.

- Elyse Bailey noted that at the time the legislature considered this issue, it also passed a provision asking DHS to study what an appropriate rate increase should be; DHS has completed this analysis, but the legislature has not yet made an adjustment based on the analysis.

- Representative Liebling stated that there is lobbying in this area, and rate setting is complex. She acknowledged that the legislature could accomplish this strategy on its own, and the legislature may not wish to wait for the Commission’s Action Plan to pursue this or other strategies.

- Sue Schettle referenced a comment letter from day service providers, who expressed concern at a possible rate reduction resulting from this strategy. Elyse Bailey said that the concerns expressed in the letter were not voiced at the time DHS conducted its analysis, and added that DHS’ calculation was conservative. DHS estimated that 80 percent of providers’ costs would still be incurred even if an individual did not show up.

- Gayle Kvenvold disclosed a conflict, as her organization has day service providers as members. She said that she has heard anecdotally that day service providers are struggling financially, and said that these providers play a unique role in bringing relief to families.

- In response to a request from the Commission, Elyse Bailey stated that she would examine changes in the number of adult service providers over time.

- Gayle Kvenvold asked that state staff provide additional information so that the Commission may be better informed on the potential impact of this strategy on day service providers.

- Elyse Bailey noted that day services are the only services that receive an absence factor; for example, home care providers do not receive an absence factor adjustment to their rates.

- Julia Freeman supported Gayle Kvenvold’s request for more information on the impact of this strategy on day service providers. Gayle Kvenvold also expressed concern that the State’s sample size of six months seemed small, and asked how state holidays were factored into the analysis. Elyse Bailey said that she believed the analysis addresses holidays, but she would double check.

- Lisa Weed asked if day service providers experience attendance variations over the course of a year. Elyse Bailey explained that DHS examined January thru June because there are fewer holidays.

- Jennifer DuPuis asked if providers shared information on why they needed the increase. Elyse Bailey responded that DHS did not receive such information and did not know the basis for 9.4 percent.

- Gayle Kvenvold noted that there are three types of services in this category, and asked state staff to identify differences in absence factor across three components of day services.

- Sue Schettle expressed concern, noting that with the workforce crisis, this strategy would be viewed as another “takeaway.” Providers are challenged and this strategy would be tough on them, she said.

- Representative Liebling agreed that providers are challenged, however the absence factor is one small component of the rate calculation and the State must strike a balance in order to afford these services.

- Sida Ly-Xiong asked staff to prepare an analysis that examines whether there are populations that would be disproportionately impacted by the strategies under consideration by the Commission.

- Gayle Kvenvold expressed reservations about the strategy and said she would like additional information – including the potential impact on providers, and the basis for the 9.4 percent rate increase – so as to inform
further consideration of this strategy by the Commission. She asked that the community events include a focus on this strategy.

- Sue Schettle also expressed reservations, and said that the Commission needs the input of organizations that submitted public comment letters. She clarified that her organization represents residential care providers, not day care providers.
- Joe Schomacker expressed ambivalence, noting that the data supports an adjustment, but that the rate may be helping to cover wages for staff, or it may be supporting a livable wage increase.
- Lisa Weed said that she shares concerns expressed by other Commission members.
- Commissioner Malcolm said that the policy merits of an individual strategy can coexist with the need for the Commission to take into account concerns from providers. She said that the Commission does not need to reach agreement and that the state staff have information requests that it can address.
- Jennifer DeCubellis submitted written comments related to day services, noting the concerns heard from the public and that the Commission should determine how to mitigate risks.
- Decision: The Commission will retain this strategy for continued consideration, and state staff will respond to the information requests made by Commission members.

Public comment

- Kevin Goodno introduced himself as representing a trade association for day service providers for adult foster services, adult day services, and day training and rehabilitation.
- Kevin Goodno said that while a 9.4 percent absence factor may not be accurate, it was based on the best available data from a provider survey. He stated that if the absence factor is reduced as proposed by the strategy, adult day service providers will experience a 5 percent revenue reduction. He noted that this is a tenuous time for the adult day service industry, and such a reduction would be significant and may disproportionately impact some providers.
- Kevin Goodno remarked that the 2018 six-month data sample was inadequate, and that a 2019 sample would have been better because 2019 had more winter storms than in 2018. He added that applying a 20 percent variable factor across all industries was also an incorrect assumption. He stated that the 3.9 percent factor that was in place before January 2019 was before banding took effect, and that the 9.4 percent absence factor had already been approved by CMS.
- Representative Liebling asked Kevin Goodno to supply information to DHS on how his organization conducted its analysis and the underlying methodology. Kevin Goodno agreed to do so and acknowledged that using claims data would have been better than the survey method used by the trade association.
- Debra Krause asked to see data that CMS has on this rate. Kevin Goodno said that he did not have access to CMS’ supporting data. Debra Krause clarified that she would like to see evidence of CMS’ approval. Kevin Goodno replied that the fact that the rate is in the system is such evidence.
- Joe Schomacker asked Kevin Goodno to explain his estimate that a revised absence factor would result in a 5 percent cut to day service providers. Kevin Goodno replied that his estimate was specific to day service providers, and that this would be the impact on average, i.e., 5 percent would be taken out of the revenue stream for day service providers. He noted that these programs are also experiencing a large turnover rate.
- Marcia Vandenberg encouraged the Commission to proceed carefully. She has two children whom she adopted out of the foster care program, and who are now adults. She shared her experience in waiting for services and noted that some service providers are extremely slow and difficult to work with. She said that it is a complicated, difficult system, and she did not want cuts to be made on the backs of disabled. She shared with the Commission her support of frugal and appropriate use of government funds.

Disability services strategy presentation (cont’d)

- Sheila Kiscaden said that once the Commission has identified the strategies that it will advance, it will need to seek county input. She asked that the Commission’s action plan discuss the pros and cons of each strategy as well as implementation issues.
- In reviewing the Family Foster Care Rate Reform Strategy, Michael Bailit explained that for foster care services, DWRS establishes rates through a cost-based shift staff method reflecting corporate residential
Disability services strategy presentation (cont’d)

settings. The formula applies provider costs to number of staff hours to calculate a daily rate. Beginning January 2020, the new methodology is estimated to result in an average rate increase of 20.4 percent.

- Michael Bailit explained that there are challenges to using a traditional cost-based approach because individuals are living within a family setting and care for that individual is part of the life of the family providing services. The recommended strategy is to replace the current rate methodology with a new tiered rate structure based on six tiers that reflect a person’s level of need. The estimated weighted average rate across all tiers would be $175.82 per day, or $64,174 per year per person supported (if all 365 days are billed). He said that the proposed strategy would also support implementation of a new “Life Sharing” model that would shift administrative tasks from the family to the administrative entity.
- Michael Bailit noted that estimated savings from this strategy would be between $10 and $20 million with a “best guess” estimate of $16 million. The strategy would simplify the rate system and rates would be more reflective of the services provided to a person. He said that the rate reform may increase access because the new model of contracting may be attractive to families put off by current administrative requirements.
- In terms of supporting evidence, Michael Bailit noted that several other states have a flat or tiered rate structure.
- Michael Bailit stated that CMS would need to approve the new method, and some systems work would need to occur. Because new rates would be calculated as annual reassessments occur, no additional administrative work would be needed. However, he noted one possible challenge, which is that family foster care providers could possibly choose to provide fewer services.
- Jennifer DuPuis disclosed a potential conflict in that her organization owns two foster care licensing entities. She then expressed concern with this proposed strategy, and described the challenge of finding family foster care homes, noting that decreased rates could further exacerbate this challenge.
- Elyse Bailey of DHS clarified that this strategy would only impact individuals on the family foster care waiver.
- Jennifer DuPuis requested that state staff determine the basis for the January 2020 rate increase.
- Elyse Bailey stated that this strategy addresses just one out of 15 services under the foster care waiver. She noted that counties spend a lot of time with families trying to determine the number of hours involved, which is difficult because the service is embedded into family life.
- Sheila Kiscaden asked state staff to provide information regarding the licensure of family foster care services, as there are multiple licensures required.
- Elyse Bailey noted that there is a limit of four individuals placed in a foster care home, and that a home serving four individuals would receive four times the amount of revenue. She said there are 1,700 individuals across the state receiving family foster care services.
- Debra Krause asked how the State calculated the components of the rate. Elyse Bailey explained the process by which the State proposes to determine the average rate for each tier.
- Deputy Commissioner Doug Annett commented that a one-size-fits-all solution is problematic, and emphasized the importance of a tiered rate structure as recommended by this strategy.
- Julia Freeman agreed that a tiered approach was important, and was encouraged that clients’ needs would be met on an individual basis. She asked if there were protections for special needs that are higher than normal.
- Elyse Bailey said that this strategy would not include an exceptions process, and that the strategy would not inhibit individuals from seeking supplemental services in addition to family foster care.
- Sheila Kiscaden noted that the work of the Commission is difficult because the highest costs are for individuals with disabilities and older adults. However, the legislature and county boards will proceed with making difficult choices regardless, she said.
- Lisa Weed commented that the work of foster families is undervalued, and that this service involves many unbillable hours. She questioned DHS’ method for calculating the tiered rates. Michael Bailit stated that he believed DHS made a mistake by including family foster care services in DWRS, and that this strategy would fix that mistake, which resulted in overpayment and a non-person centric rate.
• Elyse Bailey clarified that the assessment of hours results in a daily rate, and that the majority of families have stated that they provide services 24 hours a day, so the issue of unbillable hours is not as relevant for this program. Elyse Bailey explained that this program lacks a data-driven method for determining rates as exists for most other programs.
• Julia Freeman acknowledged that the Commission’s recommendation is important because the state budget is typically balanced on the backs of indigenous and low-income populations.
• Gayle Kvenvold noted the gravity of decisions that the Commission is making within a short timeframe. Given the interest in a tiered approach, but concern that such an approach would result in lower rates, she asked if DHS had considered a transition period or hold harmless to buffer a significant change. Elyse Bailey said that DHS could consider such options and noted they would reduce savings in biennium.
• Sida Xy-Liong asked how the impact of this strategy might vary by community, i.e., are we going to see increased access in certain communities? She expressed interest in an intermediate step as the strategy seems to be very cost-focused as opposed to contextually based.
• Natasha Merz commented on the shortage of options for people who cannot or do not want to live in their parents’ home. DHS conducted an analysis of the impact of this strategy on people of color and did not find that there was a disproportionate impact; she said she would provide a summary of this analysis to the Commission.
• Natasha Merz said that state staff hope that if they implement a tiered structure, such a structure could support piloting of additional innovative services. This strategy has the potential to promote alternatives to the family foster care program, and could bring in new service providers.
• Representative Liebling asked state staff for a better understanding of the providers offering these services. If there is a risk of losing providers, it would be helpful for Commission to understand the potential impact of such a loss. For example, if individuals lacked this option, what other options would they have?
• Natasha Merz said that this service is provided across the State, and that these are residential services provided to individuals who are not living in their own home.
• Commissioner Malcolm acknowledged that this strategy entails a rate reduction from a previous rate increase that is unsupportable.
• Elyse Bailey estimated that the impact in terms of reduction on rates will be slightly more than 20 percent on average.
• Sheila Kiscaden noted the transformational nature of this strategy and that the Department would like to offer new and innovative options.
• Debra Krause agreed it made sense to keep this option on the table.
• Decision: The Commission will retain this strategy for continued consideration.

Disability services strategy presentation (cont’d)

• Michael Bailit reviewed the strategy Curb the Growth and Use of Residential Services, which has four component sub-strategies to reduce use and curb the growth of residential services in the disability waiver programs. Cost savings estimates were available only for the first two sub-strategies.
• Michael Bailit noted that spending on the Developmental Disability (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) Waivers (collectively referred to as the “disability waivers programs”) had increased significantly in recent years and was anticipated to continue increasing. A primary cost driver in these programs has been spending on residential services. He noted that many in the disability community feel there is a need to transition away from the use of corporate foster care and customized living settings, also referred to as “group homes” or “assisted living,” and that there is strong interest in options in lieu of residential services.
• Sub-strategy: align corporate residential billing with rate framework. When providers bill for these services, the rate methodology includes an absence factor that increases the daily rate to account for absences; the factor amounts to about 14 days out of the home each year. This sub-strategy would place limits on the number of billable days for Corporate Foster Care and Supportive Living Services to align with absence factor, and would generate estimated savings of about $20 million.
Elyse Bailey noted that there is an exceptions process, for example, if a high needs individual is out of home frequently for services.

Sue Schettle asked about the State’s method for estimating savings. Elyse Bailey explained that DHS pulled claims for the last 12 months, determined what proportion of the population had absences that fell under this category, and then calculated what would happen if DHS did not pay those claims.

Lisa Weed asked if DHS would limit the number of non-emergency leave days for the provider. Elyse Bailey explained that the absence factor limits the number of billable absent days to 14.

Julia Freeman asked if this could lead to providers turning away individuals with high needs. Elyse Bailey said that providers can apply for an exception for an individual with high needs.

Sue Schettle said that applying for an exception is an administrative burden for providers.

Representative Liebling asked why DHS has an absence factor at all for these services. She noted that the absence factor yields a lower rate. Is DHS doing this because it is considered more simplified administratively? Why not have the providers simply bill one rate for when an individual is present and another for when individual is not present? Elyse Bailey responded that CMS does not allow for such a billing approach, and said that some states do not have an absence factor.

Lisa Weed asked DHS staff to identify which states do not have an absence factor.

Doug Annett clarified that this would not impact individuals in the home less than 351 days.

Commission members asked state staff to identify the number of individuals in the home between 351 and 362 days per year.

Sue Schettle expressed her opposition to further consideration of this strategy, and said she would share a letter that makes further requests.

Decision: The Commission will retain this strategy for continued consideration.

Sub-strategy: curb customized living services rate growth. Customized living services – available on the CADI and BI waivers – have rates that are determined using a “customized living tool” where the cost of discrete units of services are added together to determine a daily rate. There are no rules or limits regarding the number of appropriate units. Michael Bailit explained that this sub-strategy would place limits on how many discrete units would be allowed when determining rate for customized living services. This sub-strategy would generate estimated savings of between $1 and $10 million.

Sida Ly-Xiong asked for a definition of “units.” Elyse Bailey replied that the customized living services rate involves unique units, such as customized travel, behavior supports and these units compose the daily rate. This service is frequently described as “assisted living.” Elyse Bailey replied that savings for this strategy would be dependent on the types of limits the State would pursue.

Sue Schettle asked about growth of this service. Colin Stemper of DHS replied that it was difficult to ascertain overall trends because the units are variable; however, the latest data show an exponential growth in customized living services. He said that the State has experienced double digit percentage increases both for people receiving this service and for rates provided for these services. Hennepin County submitted a letter that expressed concern for growth in this service within its region. Sue Schettle said this strategy runs counter to the Commission’s charge to not curtail services. Lisa Weed echoed concern that this strategy could limit services.

Sheila Kiscaden commented the Commission needs to examine areas of rapid growth and to consider a reasonable range of services that can be provided for the budget available.

Debra Krause asked DHS if it could break out trends in the number of services and rates. Colin Stemper replied that growth over the past two years had been 10 percent, and that it was accelerating. He agreed to share the underlying data.

Gayle Kvenvold declared a conflict because her organization has a subset of members providing customized living services. She asked what happens to an individual whose needs exceed the ceiling.
Disability services strategy presentation (cont’d)

- Nona Ferguson disclosed a conflict because her organization provides customized living services. She raised the issue of homelessness, which was also flagged during the equity review. To what extent might this sub-strategy result in homelessness?
- Sue Schettle relayed that her providers expressed concern with current rates of reimbursement.
- Julia Freeman noted the challenge of determining the true costs associated with these services. Elyse Bailey replied that the rates for customized living services are the only services under the disability waiver that are not set based on cost.
- Gayle Kvenvold suggested a root cause analysis to determine the reasons for growth of these services. Sheila Kiscaden agreed that a root cause analysis would be helpful, and described this strategy as a high priority.
- Commissioner Malcolm agreed that further exploration would be helpful.
- Gayle Kvenvold said it would be difficult to advance this strategy in the cost savings strategy as presently defined. Elyse felt DHS could come up with cost savings.
- Tina Liebling noted that there may be a resource constraint for DHS to generate the additional information for this strategy, but that the strategy should stay on the table.
- Sida Xy-Liong suggested that the community engagement work should help to uncover who is using these services.
- Decision: The Commission will retain this strategy for further consideration, and will review it again later this spring when DHS has had time to conduct follow-up work to respond to Commission member requests.

- **Support planning for people who want to move.**
  - Michael Bailit explained this strategy, which would provide additional support planning assistance to people receiving disability waiver services who prefer to move out of foster care and customized living settings.
  - Elyse Bailey said this strategy could really support people and impact their lives. She said that while the strategy may not result in savings by 2023, it would move the State in a good direction. DHS has not yet conducted savings analysis because demonstrating savings would be challenging.
  - Julia Freeman expressed concern about DHS resources to develop the savings estimate.
  - Lisa Weed agreed with Julia Freeman, stating that since DHS cannot identify cost savings at this time, she would prefer for DHS to focus on the other strategies.
  - Decision: The Commission will retain this strategy for further consideration. Commission member are supportive of DHS continuing to develop this strategy as a second tier priority, if it has the resources to do so.

- **Bed closure targets and rate reform for corporate foster care.** Under current law, the rate methodology for corporate foster care considers the number of people in the home when determining the rate. Cost savings from reducing beds may only be achieved when an entire foster care home closes. Michael Bailit explained that this strategy would update the statute to derive cost savings from individual bed closures.
  - Sue Schettle, having disclosed a conflict of interest, said that her association members have expressed concern about this strategy and noted that many individuals like living in a group home. She said that consolidation could result in unsettling shifts in homes for individuals. In addition, many smaller providers are challenged and this would serve as a major disincentive for them.
  - Sheila Kiscaden said she would like to understand how this sub-strategy fits with workforce issues. She was not sure the four-bed group home model provides sustainable, high quality services. She acknowledged the cost savings of reducing beds, but was unsure how to assess this strategy. Michael Bailit acknowledged that the Commission’s savings target imperative has driven this specific, narrow strategy. Sheila Kiscaden said she would prefer it if this strategy constituted a step toward transformation.
  - Elyse Bailey said that under Waiver Reimagine, DHS tackles some of the broader transformative questions.
Deputy Commissioner Doug Annett commented on the bed closure strategy, noting that it is more expensive to close a four-bed home than it is to let the home operate at a loss. He noted that strategies that dismantle a four-bed approach may result in a short-term spike in cost.

Commissioner Malcolm stated that DHS had not yet calculated savings for this strategy and asked if Commission members would prefer additional exploration of this strategy.

Sue Schettle said that this strategy was indicative of a bigger problem, and wanted it removed from consideration. Lisa Weed and Julie Freedman also stated that they would prefer that this strategy be removed from consideration.

Representative Liebling said that she was not sure if resources were available for further investigation by DHS staff of this strategy. Elyse Bailey said she believed she could identify savings for this strategy, but that it would take time to do so.

Commissioner Malcolm said she would like the Commission to illuminate broader themes by identifying unanswered questions that need careful stakeholder engagement.

Julia Freedman suggested that the Commission place this strategy in an “honorable mention” category.

**Decision:** The Commission will no longer consider this sub-strategy.

Michael Bailit noted that one of the primary benefits of the four sub-strategies was a potential increase in access to alternative services. He said that in terms of the administrative implications, the required resources varied by sub-strategy. The first two sub-strategies required few administrative resources other than systems changes. The latter two sub-strategies would necessitate increased state technical assistance to lead agencies and providers, and associated administrative support.

Michael Bailit stated that the sub-strategies entail several possible challenges, including a reduction in revenue for residential service providers which could lead to concerns about provider sustainability and maintaining existing capacity.

**Public comment**

Gene Martinez, representing ARC Greater Twin Cities, expressed his strong support for the sub-strategy that provides support planning for people who want to move. He noted that ARC Greater Twin Cities has helped over 2,400 individuals – including individuals with disabilities – locate affordable housing and move into communities.

Gene Martinez added that another reason for the Commission to advance the sub-strategy that provides support planning for people who want to move is that there have been few housing options under the Olmstead Plan other than group homes. He believed that offering support planning for people who want to move will likely yield savings.

**Meeting wrap-up**

Commissioner Malcolm thanked state staff and adjourned the meeting.

Representative Tina Liebling said that both she and Representative Schomacker would be unable to attend the March 6th Commission meeting due to a conflict with the House Health and Human Services Policy Committee meeting.

Sheila Kiscaden and other Commission members thanked staff for sharing meeting materials in advance.

**Next meeting**

- **Date:** Friday, March 6, 2020
- **Time:** 9:00 a.m. – 3:00 p.m.
- **Location:** Elmer L Andersen Building, 540 Cedar Street, St. Paul
- **Focus:** Cost saving strategies related to services for older adults
Blue Ribbon Commission Meeting 9

Meeting Notes

- Date & time: March 6, 2020, 9:00 a.m. – 3:00 p.m.
- Location: 540 Cedar Street, St. Paul

Participation

Participating members: Commissioner Jodi Harpstead (DHS), Jennifer DeCubellis, Nona Ferguson, Representative Tina Liebling, Sheila Kiscaden, Debra Krause, Gayle Kvenvold, Shauna Reitmeier, Sue Schettle, Julia Freeman, Senator Matt Klein, Sida Ly-Xiong, Lisa Weed

Welcome and remarks

Commissioner Harpstead welcomed the Blue Ribbon Commission members and members of the public. She then provided an overview of the meeting agenda.

Follow-up topics from prior meetings

- Michael Bailit reviewed the status of work performed by state staff in response to requests made by Commission members during prior meetings.
- In follow up to the strategy Improve Compliance with Third Party Liability (TPL), Michael Bailit said that state staff have determined there may be an opportunity to have a weekly file exchange between DHS and the courts, which could help increase recovery of TPL. This idea needs to be further researched to determine potential operational processes.
- Michael Bailit noted that state staff are updating the strategy MCO Competitive Price Bidding to include more information about the quality and access assurance requirements that are part of DHS’ bidding process.
- In response to Representative Liebling’s prior request to discuss DHS’ managed care strategy, Michael Bailit stated that staff will discuss DHS’ purchasing strategies when the Commission reviews the transformation focus area.
- Michael Bailit noted that staff are working on follow-up actions on two additional strategies: additional services for potential volume purchasing, and the potential impact of extending DME strategies to MCOs.

Stakeholder engagement update

- DHS’ Krista O’Connor reported that the stakeholder toolkit draft has been completed and distributed to a small group of reviewers for feedback. The finalized toolkit will be distributed soon and will serve as a resource for Commission members to use with stakeholders and to standardize information collection.
- Krista O’Connor reported that an increasing volume of written public comments has been submitted recently. Commission staff are considering how best to organize that information for Commission members.
- Regarding community engagement, Krista O’Connor reported that there will be two events in Greater Minnesota. One will address services for persons with disabilities, and the other will address services for older adults. The Improve Group has recommended that the former be held in St. Louis County and the latter in Crow Wing County. She asked that if Commission members have recommendations on this approach, to please submit them by March 13th. The events are likely to occur in May, but dates have not yet been set.
Gayle Kvenvold asked staff to develop a contingency plan if COVID-19 inhibits future large gatherings.

Shauna Reitmeier asked how stakeholders can provide input if they don’t live in the area in which the two events will take place, but fall in the targeted groups.

Sue Schettle asked if the meetings in May would include strategies not yet discussed by the Commission. Krista O’Connor responded that early thinking is to focus on cost savings strategies at those meetings. She also reminded Commission members that there will be five public meetings in total.

Krista O’Connor invited Commission members to share any feedback they have been hearing.

Sheila Kiscaden said that county commissioners and staff are asking lots of questions about the Commission’s work. She suggested thought be given to directly communicating with county and local health department staff and soliciting their feedback. She noted that there will be a county meeting in September.

Shauna Reitmeier requested talking points for Commission members to use with stakeholders.

Commissioner Harpstead asked that information on when recommendations will be drafted and when public comment would be invited be included in the resources requested by Shauna Reitmeier.

**Background presentation: long-term services and supports for older adults**

- Dan Pollock, DHS’ Assistant Commissioner for Continuing Care for Older Adults, introduced his colleagues LaRhae Knatterud, Valerie Cooke, and Kari Benson. He also acknowledged Fred Andersen from the Department of Commerce.
- Dan Pollock provided an overview of long-term services and supports (LTSS) for older adults. Prior to the 1980s, most seniors in need of long-term care services were served in nursing homes. A significant shift has occurred, however; in 2018, 74 percent of those people receiving LTSS did so in the community. Nursing home capacity has been dropping and he anticipated that trend will continue.
- Dan Pollock reviewed LTSS innovations in Minnesota since the 1990s, including the Senior Linkage Line, long-term care consultation services, Minnesota Senior Health Options and Senior Care Plus, improved quality measurement, support for community transition, and MnCHOICES.
- Debra Krause asked how the delivery of LTSS in Minnesota compared to that in other States.
- Kari Benson of DHS responded that Minnesota and Washington are the States that provide the most LTSS community options for older adults and persons with disabilities, and provide the best decision-making support regardless of payer source. Despite this, DHS feels that there is still more work to be done in Minnesota, including through better integration of LTSS with social services.
- Julia Freeman asked if Kari’s recent national conference conversations focused on cost savings strategies.
- Kari Benson commented that recent conversations at a national conference focused on interventions to reduce risk for falls, manage chronic conditions, stabilize mental health, and reduce depression symptoms. Discussions also focused on reaching adults who are in their own home but need supports so they can stay in their home longer, including adults from tribal nations and ethnic communities.
- Dan Pollock described LTSS for older adults in Minnesota and provided context for the work of the Commission, including the ongoing “age wave.” Minnesota’s 65+ population will double by 2030, and most will need long-term care. Compounding this challenge is a shift toward smaller families and thus a reduction in informal caregivers. As a result of these trends, Minnesota’s long-term care spending has been expanding dramatically. There are now more older adults than children in Minnesota.
- Dan Pollock gave an overview of the spectrum of LTSS, from low-intensity, low-cost supports (essential community supports) to intensive supports (elderly waiver and nursing facilities).
- Val Cooke provided a presentation on the reduction of nursing home utilization and the corresponding increase in assisted living services. The nursing home industry is mostly non-profit but becoming more for-profit. The assisted living industry is for-profit.
- Jennifer DeCubellis asked if Minnesota could have a problem with insufficient nursing home capacity in the future.
- Val Cooke responded that she did not think that would be the case, adding that currently there are many inactive nursing home beds.
Gayle Kvenvold said that she believed that when the Baby Boom crests in the late 2020s/early 2030s, there will be more pressure on nursing home capacity.

Shauna Reitmeier said that unused capacity may be due to labor shortages, and not lack of need.

Gayle Kvenvold stated that the nursing home may not be where most people want to live, but it is the safety net for people who can’t be served elsewhere.

Val Cooke described the 2015 Value-Based Reimbursement (VBR) legislation and the upward impact that it had on nursing facility costs, specifically due to increased labor wages. She displayed average hourly wage data over time. Staff retention has slightly improved with the wage increases. Val Cooke explained that an evaluation found that VBR has not had its intended impact on quality improvement, although quality is improving for reasons unrelated to VBR (i.e., two unrelated quality incentive payment programs). She also described a new process in 2019 to support capital projects, since VBR previously did not support necessary facility investments in older buildings.

Debra Krause asked about the incentive programs. Val Cooke responded that Minnesota has one of the most robust quality measurement systems in the country, including looking at changes in 90-day assessments, quality-of-life measures, and family satisfaction surveys. The incentive program identified targets for improvement on selected measures and attainment of selected measure performance targets.

Representative Liebling asked how VBR works, and whether it was cost-based. She also asked how salaries in nursing facilities compared to salaries in other settings. Val Cooke replied that she could look at comparative wage information to answer Representative Liebling’s question. She also said that the idea behind VBR was to pay more for higher quality, but that hasn’t worked as desired.

Julia Freeman asked if workers in unionized homes make more money. Val Cooke responded by saying that such an analysis could be performed.

Gayle Kvenvold said that nursing homes often get new nursing graduates, who subsequently leave for higher wage positions.

Debra Krause asked how DHS knew that VBR hadn’t driven witnessed quality improvement. Val Cooke responded that DHS knows this because nursing facilities aren’t reaching the VBR budget limit available to them.

Gayle Kvenvold said that saving $10 in state dollars results in a larger reduction to providers due to the federal match, and because of rate equalization requirements of nursing facilities (e.g., private pay rates are the same as Medicaid rates).

Kari Benson described challenges facing the elderly waiver program, including workforce shortages for in-home services, growth in higher-cost/higher-income assisted living (“customized living”) services, increasing complexity of waiver participant needs (43 percent with mental illness), and 10 percent annual growth in spending.

Kari Benson explained that customized living is provided to 42 percent of elderly waiver beneficiaries. The service represents 62 percent of elderly waiver spending.

Sheila Kiscaden said she had heard that some group residential housing (group homes) had converted to customized living to get higher rates. Dan Pollock replied that he had recently heard of this trend as well, and was aware of some legislators’ concern.

Sheila Kiscaden asked if there was an equivalency or cap for receiving services at home or in a skilled care setting. Kari Benson replied that there is a person-based budget developed based on each person’s needs following an assessment. The individual can decide in which setting s/he wishes to receive services. The budget can move with the person across settings.

Gayle Kvenvold said that federal law requires that elderly waiver services be less expensive than nursing facility spending. She added that elderly waiver payments are only for services and not housing, whereas the two are integrated for nursing facilities.

Jennifer DeCubellis noted that some of the people served under the elderly waiver were previously served under the Community Access for Disability Inclusion (CADI) waiver which provided higher levels of
funding. She said for this reason Hennepin can’t get people out of nursing facilities, and described current policy as an arbitrary limitation based on age.

- Kari Benson shared data on who receives customized living stratified by case mix, and differences in home and community-based service enrollment and use by race. She noted DHS’ work with the Board on Aging to create an assisted living report card, the Senior Linkage Line, Alternative Care and Essential Community Supports Services, and Older American Act services delivered under the Board on Aging.
- Dan Pollock describe the Moving Home Minnesota program to assist individuals in moving out of institutional care and into community settings. Similarly, another program, Moving out of Institutions, provides assistance for individuals not eligible for Medicaid.
- Dan Pollock briefly described a new initiative, the Age-Friendly Minnesota Council, created by Executive Order 19-38.
- LaRhae Knatterud described a DHS initiative titled Own Your Future. Among its activities is the development of insurance products for middle income people to cover their future aging-related support costs.

Cost savings strategies related to long-term services and supports for older adults

- Beth Waldman introduced the strategy discussion, noting that if all of the strategies presented during the meeting were endorsed by the Commission, the Commission would be close to its $100 million savings charge. She clarified that the first strategy to be discussed was not projected to generate savings in the next biennium, but was being presented because it was thematically linked to the others.
- Gayle Kvenvold identified a conflict of interest for three of the four strategies to be discussed during the meeting.
- Beth Waldman described the first strategy, **Add an Enhanced Home Care Benefit in Medicare Supplement Plans**. She noted a problem with limited consumer access to insurance policies that cover LTSS, and few middle and lower income adults purchasing long-term care insurance. She said that lack of insurance leads to people spending down their assets and becoming eligible for Medicaid.
- Beth Waldman said that this strategy calls for requiring Medicare supplement products sold in Minnesota to include a non-medical enhanced benefit, and was projected to reach 120,000 Medicare beneficiaries in Minnesota. The benefit would entail a daily cap of $100 and a lifetime cap of $36,000. The benefit would have an associated cost of $8.49/month based on a 2017 actuarial study. The State could, if desired, cover some of all of that added cost.
- Beth Waldman said that the strategy would support an increase in individuals living independently in the community over the next decade, and would not include Medicare Advantage plans; it is currently optional for Medicare Advantage plans to add this benefit. Implementation would require a legislative requirement on insurers, and the Department of Commerce would need to review and approve benefit designs. DHS would track data and evaluate cost savings impact.
- Beth Waldman stated that challenges with this strategy could include reduced purchase of supplemental products due to added cost and adverse selection of the products.
- Representative Liebling asked for the reason why the policy excludes Medicare Advantage plans.
- Grace Arnold of the Department of Commerce explained that the State is unable to regulate Medicare Advantage Plans. These plans are subject to federal oversight and only licensed by the State, with no state influence on premiums or covered benefits.
- Representative Liebling asked how the proposed benefit design was created. LaRhae Knatterud said it was based on benefit designs already in the market, and that the proposed benefit design could be modified.
- Sheila Kiscaden asked why $100/day was selected as the benefit, as that seemed like a low amount.
- LaRhae Knatterud explained that this benefit would cover non-medical, in-home services that are lower cost than medical services. She explained that a $100 daily benefit for such services was not inconsequential.
- Sheila Kiscaden asked what are the premiums currently for Medicare supplemental benefits. LaRhae Knatterud explained that they range from $200 to $400/month.
• Debra Krause asked if this product would be sold on the individual market alone or also on the group market. Grace Arnold said that this was a good question to be further examined.
• Debra Krause asked if other states had undertaken a similar approach. LaRhae Knatterud said that she was not aware of any other states having done so.
• Grace Arnold said that there have been general discussions at National Association of Insurance Commissioners meetings about this idea and possible cost and adverse selection impacts, but all discussions have been qualitative, without actuarial analysis.
• Gayle Kvenvold endorsed this strategy, noting that it is part of a sustainability strategy. Jennifer DeCubellis agreed, but encouraged further analysis to make sure that the assumptions hold tight. She asked for consideration of equity in terms of people who might be “bumped” out of the market with the added cost.
• Sue Schettle agreed the strategy should be kept for future consideration.
• Representative Liebling supported the strategy and seeing how others, including AARP, respond to it.

Cost savings strategies related to long-term services and supports for older adults (Cont’d)

• Beth Waldman reviewed the strategy, Guidelines to Access Customized Living Services, explaining that customized living is essentially assisted living. This strategy addresses a population with low needs (Case Mix A: 0-3 activities of daily living needs) that receives 24-hour customized living.
• Nona Ferguson and Lisa Weed stated conflicts of interest with this strategy.
• Beth Waldman stated that the strategy is to maintain services available for customized living, but not 24-hour services. This change would generate savings through a rate cut for providers serving this population (approximately 400 individuals). She said that possible challenges included providers being unwilling to serve these individuals at the lower service level and rate. As a result, individuals might have to move to another setting, potentially a nursing facility if no other options exist.
• Jennifer DeCubellis suggested a market analysis to make sure that the strategy would not negatively impact individuals.
• Gayle Kvenvold reinforced Jennifer DeCubellis’ concern, and added that she felt that this could push people back to nursing homes after they were pulled out. She also voiced concern that this strategy reduced benefits, something that is counter to the Commission’s charge. Beth Waldman acknowledged Gayle Kvenvold’s concern, but said that the individuals are not actually having their benefits changed because they are not actually using 24-hour services - but the State is paying as if they were.
• Julia Freeman said that more analysis needs to be performed on the impact of this change and whether it could increase costs.
• Ashley Reisenauer of DHS said that the fiscal analysis of this strategy included the potential of using additional services in lieu of the 24-hour services.
• Beth Waldman said the net savings projected for this strategy were under $1M, in part because of the cost savings netting described by Ashley Reisenauer.
• Gayle Kvenvold said that the elderly waiver rates are already below the cost of care, suggesting that providers will leave the field.
• Nona Ferguson agreed with Gayle Kvenvold’s remark, and spoke to the importance of the equity review.
• Jennifer DeCubellis questioned the value of this strategy if savings are less than $1M. Dan Pollock responded that this strategy impacts people with the least need. Jennifer DeCubellis said that if people have been put in this service because of need, we should trust that the assessments were appropriate and services should continue.
• In response to a question, Beth Waldman explained that this strategy would impact about 400 of 15,000 people served in customized living.
• Representative Liebling and Sue Schettle also voiced concern that this strategy was not worthy of continued staff development.
• Shauna Reitmeier asked if this strategy reflected a problem in the assessment process. Elyse Bailey said that was not the case, and that it was a rate strategy. Beth Waldman observed that the consensus of the group was to not advance this strategy.
Jennifer DeCubellis asked that this strategy be kept for later consideration if savings are needed. Beth Waldman said this was possible.

Lisa Weed and Gayle Kvenvold recommended that the strategy not be adopted.

Commission members participated in an extended discussion of the process by which strategies will be reconsidered before final adoption. Michael Bailit explained that all strategies advanced during the initial review would be reconsidered in June. He also explained that if the Commission does not advance now, or approve in the future, sufficient strategies to reach the $100M savings, staff will bring alternative strategies.

Commissioner Harpstead and Elyse Bailey said staff will bring additional cost savings before June if it is clear that the Commission has not reached $100M in savings.

Representative Liebling said she did not view this strategy as producing a loss of benefits; rather, it addresses payment for a required level of benefits. She supported Jennifer DeCubellis’ suggestion to place the strategy in a “parking lot.”

Lisa Weed said if people will no longer receive a benefit, then this strategy constitutes a loss of benefits. She also stated that the Commission does not need to report strategies with $100M in savings if it is unable to do so.

Commissioner Harpstead said that the Commission was diligently working to fulfill its charge, including identifying $100M in savings, even if the strategies are not supported by all members of the Commission.

Beth Waldman reported that Sida Ly-Xiong was on the telephone and had voiced concern with the strategy.

Beth Waldman said that since nobody liked this strategy, whether it fits within the Commission’s charge or not, may not be a material question.

Commissioner Harpstead recommended that the strategy not move forward, but that it be recorded. There was no disagreement with the Commissioner’s recommendation.

Public comment

Ethan Vogel, Legislative Director for Minnesota AFSCME Council 5, spoke in support of the 2015 VBR legislation and voiced opposition to the Value-Based Reimbursement Strategy in Nursing Facilities (VBR) strategy that the Commission would be discussing. Minnesota AFSCME Council 5 represents 43,000 workers in Minnesota, including from some nursing home facilities. He said savings shouldn’t be found on the back of front-line workers who have experienced chronic underfunding. He noted that nursing facility rate increases had leveled off and predicted that quality improvement will come. He asked that the strategy not advance, and if it ever were to, that there be protections for the lowest cost workers.

Carrie Kranz from Augustana Health Care Center in Hastings asked for no cuts to long-term care facilities. She said that currently there was not sufficient staffing to meet the needs of the facility where she worked. In addition, she said it was hard to recruit new workers because of the stress of the work given the staffing level challenges. She said her facility was a five-star facility, but was struggling, and asked for no cuts.

Mike Dreyer from United Food and Commercial Workers International Union (UFCW), representing workers in Minnesota and Wisconsin, said that nursing facilities are suffering worse than he had ever seen in terms of staffing. He said that the VBR strategy was a good thing when it was launched. He worried what would happen if cuts were made.

Al Newman from the Midwest Association for Medical Equipment Services (MAMES) said that competitive bidding in the Medicare program has been a “train wreck,” especially in rural regions of the United States. He said that Medicare eventually recognized this and finally made rural rate adjustments. He said the CURES Act then implemented price caps. He asked why the State would want to go below the federal match, and explained that Medicare is completely different from Medicaid. Al Newman said most DME providers in Minnesota are not participating in Medicare and are instead doing cash business with Minnesotans who can pay, adding that 45 percent of DME providers nationally went out of business because of Medicare’s policies. He explained that health plans raise administrative costs to DME providers. He asked that the Commission look in areas other than DME for savings.
Cost savings strategies related to long-term services and supports for older adults (Cont’d)

- Beth Waldman reviewed the strategy, **Value-Based Reimbursement in Nursing Facilities**, reminding the Commission that in 2015 the legislature enacted Value-Based Reimbursement (VBR) aimed at nursing facilities and intended to increased worker pay. Under the model, direct care-related costs are actual costs, subject to a quality-linked limit. Beth Waldman stated that this strategy was developed because there is an opportunity to limit cost growth and strengthen the quality incentive.
- Lisa Weed disclosed a conflict of interest with this strategy.
- Gayle Kvenvold clarified that for DHS the term “other operating costs” includes some staff, e.g., nutritional, facility staff. Lisa Weed said these staff have not seen the same pay increases that have benefited direct care staff.
- Representative Liebling asked that public comment follow presentation of strategies and not precede it. She then asked for an understanding of the VBR rate methodology, which Val Cooke briefly provided, explaining that every facility receives 105 percent of the median costs in the State.
- Beth Waldman identified the six components to the strategy, as follows:
  1. Redesign rate-setting formula
  2. Establish a cap on annual growth in “other operating costs” to a published inflation factor
  3. Suspend the Critical Access Nursing Facility Program because it is no longer needed
  4. Suspend the Alternative Payment System automatic property inflation adjustment
  5. Eliminate a hold-harmless clause that no longer is relevant
  6. Add an assessment when therapy costs are discontinued so that rates are adjusted when care is no longer needed
- Beth Waldman said the benefits of these changes would include: a greater quality incentive; promotion of operational efficiency; removal of programs that were previously suspended and are no longer needed; and payment for services people are actually receiving. She also identified potential challenges with these strategies, the most significant being that nursing facilities will see this strategy as producing a rate cut.
- Senator Klein asked about the savings associated with this strategy. Beth Waldman responded that each component was worth $1-2M, and the group of them together about $10M.
- Senator Klein asked about suspension of the Alternative Payment System automatic property inflation adjustment. Val Cooke explained that previously there was something akin to a cost-of-living adjustment until it was suspended. The suspension ran out recently. This proposed strategy is to suspend it again.
- Representative Liebling asked about the underlying property rate. Val Cooke said the daily rate has five components, the property rate being one, and that it covers capital costs. The current property rate didn’t reflect the current value of the building, and reflected assessments that had been adjusted for 30+ years. She added that the property rate is a relatively small proportion of the overall nursing facility rate.
- Lisa Weed asked for evidence that operational efficiency would result from the recommended changes. Val Cooke replied that operating within a growth cap should lead to efficiency, but said there is no evidence that it will.
- Representative Liebling asked whether, and if so, how, the changes would impact hourly wages. Val Cooke said that the nursing facility would be able to increase wages up to the increase in the other operating cost growth cap, but there is no guarantee that the nursing facility will use those dollars to increase wages.
- Julia Freeman asked about property appraisal and who performs it. Val Cooke said DHS is just now resuming appraisals after 30 years of not performing them. She said the proposal is that the State would contract with an appraiser.
- Gayle Kvenvold said wages and benefits count for about 65 percent of nursing home expenses. She stated that, therefore, any payment change will impact wages and benefits.
- Shauna Reitmeier asked for a primer on VBR, including how nursing facilities are being paid currently, and an explanation of how the proposal differs from the status quo.
- Val Cooke described the VBR nursing facility rate components as follows:
  1. **Operating rate**: This is the largest component of the rate ($217 of the $270 per day rate, the later representing the average statewide rate as of January 2020), and includes the following services:
i. **Direct care-related**: nursing, over-the-counter drugs, training, consulting, food - all case mix-adjusted

ii. **Other care-related**: activity staff, social services - not case mix-adjusted

iii. **Other operating**: laundry, dietary, and plant staffing and facility operations - not case mix-adjusted

2. **External fixed rate**: For costs that the facility doesn’t have control over and that are treated as pass-through costs, e.g., taxes, health insurance.

3. **Property rate**
   - Gayle Kvenvold said that prior to 2015 the rates had no relationship to costs, and thus fell behind actual costs by about $35/day. She said VBR was developed cooperatively by providers and DHS. She said the system is still fairly new, but has brought a “fragile stability” to the nursing facility sector, bringing up wages and benefits. Gayle Kvenvold noted concern as to whether the quality incentive is structured in the right way, and said that rates have been going down the last few years. She also stated that there are already savings (i.e., a change in the fiscal year budget forecast) in this budget line of $84M for SFY20, which unfortunately can’t be counted by the Commission. Gayle said that while facility costs get covered, it takes 24 months for the reimbursement.
   - Representative Liebling asked for spending on nursing facilities. Val Cooke said it’s about $1B per year.
   - Commissioner Harpstead asked whether facilities wouldn’t put all available dollars into wages given the workforce shortage. Commissioner Liebling said that hasn’t happened in the overall economy, and so it might not be happening with nursing facilities. She noted that with an increasing number of for-profit facilities, owners must be taking money out of the facilities.
   - Gayle Kvenvold said that the median nursing facility margin in 2019 was 0.9 percent.
   - Val Cooke explained that VBR is a cost-based system, so taking out as profit will bring down a facility’s costs and its rates.
   - Jennifer DeCubellis said she saw this as a cost-based strategy with quality and guardrails. She thought that the recommendations could get to a “sweet spot” and generate savings if they address outliers.
   - Jennifer DeCubellis questioned whether an assessment when therapy costs are discontinued was necessary. Val Cooke explained that the assessment is not arduous and is needed to assign a person to the right case mix group.
   - Beth Waldman identified recommendations #1 and #2 as those for which concerns had been voiced.
   - Beth Waldman asked about strategy #3. Shauna Reitmeier said she would have concern only if strategies #1 and #2 proceeded without an adjustment for rural areas.
   - Beth Waldman asked about strategies #4 through #6. Commissioners did not voice concern with any of them.
   - Commission members focused their discussion on strategy #1. Val Cooke explained concerted efforts with the industry during the last legislature session on this strategy, and said that DHS is committed to working with this strategy again to strengthen quality and reward efficiency. Jennifer DeCubellis recommended viewing this as a quality investment (a fund) rather than an incentive. Val Cooke said that the current Performance Improvement Program (PIP) for nursing facilities operates just this way.
   - Gayle Kvenvold confirmed that her association, LeadingAge Minnesota, and Care Providers of Minnesota had pledged to work with DHS, but for transformation and not for cost savings. Her concern was that providers not have to incur costs and then wait two years for payment.
   - Val Cooke said it’s difficult to estimate savings for strategy #1. To generate maximum savings, the strategy would have to be implemented immediately. Savings would be $0 to $3.2M depending upon timing and form of implementation. Gayle Kvenvold said that care would be affected if it were implemented immediately.
   - Beth Waldman asked for discussion of strategy #2. Representative Liebling asked about the growth of the operating rate. Val Cooke said CPI is about 3 percent, and the operating rate has been growing about 3.5 percent. Val Cooke said this strategy could generate $4.7M savings for the next biennium.
   - Lisa Weed said she opposed strategy #2. She added that for-profit owners of nursing facilities aren’t giving pay increases to workers.
• Commissioner Harpstead asked for the savings associated with strategies #3, #4, #5 and #6. Val Cooke said they were estimated at $6.5M.
• Beth Waldman asked whether the Commission wanted to keep strategies #1 and #2 for continued consideration.
• Representative Liebling said she wanted to see an alternative approach to the cap on operating cost growth. Sheila Kiscaden said she did not see a big risk to carrying forward this strategy and asked Gayle Kvenvold to reconsider it with her members. Gayle Kvenvold said she could not support strategy #1 or #2.
• Julia Freeman said that she opposed the strategy as a long-term care worker and because the cuts would be on the back of black and brown and low-income people.
• Jennifer DeCubellis suggested that additional work be done with state staff to refine strategies #1 and #2.
• Debra Krause noted that the Commission already discussed a growth cap for spending on disability services. She expressed a belief that there was a means to implement a cap.
• Representative Liebling encouraged continued discussion of strategies #1 and #2.
• Michael Bailit proposed that Commission staff do additional work on these strategies and they be presented again at a future meeting. Commission members voiced support for the proposal.
• Commission members did not have sufficient time to discuss the final strategy on the agenda, Repeal Nursing Facilities’ First 30 Day Rate Adjustment. As a result, this strategy will be discussed at the March 20 Commission meeting.

Public comment

• Mike Marchant spoke for Villa Healthcare, which treats approximately 900 nursing facility residents in the Twin Cities. He said that 72 percent of his residents were served by Medicaid. He stated that the strategy, Repeal Nursing Facilities’ First 30 Days Rate Adjustment, would negatively affect his organization. He described the work that needs to be performed with new residents. He described one facility serving homeless and mentally ill residents. He said at one facility the financial operating margin was at or under zero, and stated that the proposed strategy would harm his organization’s margin. He said his organization serves disadvantaged individuals not served by other providers.
• Reverend Doctor Jean Lee spoke in favor of home repair, provision of medical and non-medical devices, First Alert-type systems, service plans involving families and friends, and delivery of the right type of services especially for people who are uninsured. She expressed concern with disparities, and with racism among service providers.
• Toby Pearson spoke on behalf of Care Providers of Minnesota. He asked the Commission to remember that nursing home services are an entitlement. He recalled that VBR passed the legislature and with Governor Dayton’s support in 2015. He noted that the VBR program in 2020 was just stabilizing. He said his organization was ready to work with the Commission and the Department.

Meeting wrap-up

• Michael Bailit presented a recommendation to remove from consideration at the next Commission meeting a strategy that had been previously prioritized through the staff review process. Strategy #145 addressed the problem of poor coordination between MDH and DHS for the state’s HIV prevention and care administration programs. That problem has been largely resolved. In addition, the two agencies and Hennepin County are near completion of system-wide change to centralize the eligibility process for Ryan White services.
• Commission members accepted the recommendation.
• Sheila Kiscaden encouraged a public health perspective be applied in future Commission conversations as the population ages to prevent disability. She asked that this be woven into the transformation strategy discussion.

Next meeting

• Date and time: Friday, March 20, 2020, 9:00 a.m. – 3:00 p.m.
• Location: Orville L Freeman Building, 625 Robert Street North, St. Paul
Focus: Waste, including fraud and program integrity
Blue Ribbon Commission Meeting 10

Meeting Notes

- Date: May 8, 2020, 10:00am – 1:30pm
- Location: Virtual - via WebEx

Participation

Participating members: Commissioner Jodi Harpstead, Jennifer DeCubellis, Senator Rich Draheim, Jennifer DuPuis, Julia Freeman, Sheila Kiscaden, Senator Matt Klein, Debra Krause, Gayle Kvenvold, Sida Ly-Xiong, Shauna Reitmeier, Representative Joe Schomacker, Lisa Weed

Welcome and remarks

Commissioner Harpstead welcomed Commission members and members of the public. Commissioner Harpstead stated that the Department of Health is occupied with COVID-19 response, and that she would lead the next several meetings of the Commission. Commissioner Harpstead expressed appreciation for the work of the Department of Health in response to the pandemic, and pledged to update Commissioner Jan Malcolm regarding the outcome of the meeting.

COVID-19 Discussion

- Commissioner Harpstead invited Commission members to share their experience with COVID-19 and its impact upon the organizations they represent.
- Deb Krause expressed her appreciation for the work of the Minnesota Department of Health, and reported that the Minnesota Health Care Action Group was focused on the impact of COVID-19 on mental health.
- Gayle Kvenvold reported that her member organizations had been hard hit by the pandemic, with 80 percent of the deaths that have occurred in the state taking place within nursing facilities. She acknowledged collaborations with the Department of Health and many other state departments, all of which have made the efforts of her member organizations across the state feasible. She noted that some of the BRC strategies reviewed previously will need to be revisited, especially the strategy that would impact critical access nursing homes.
- Julia Freeman reported that she was undertaking a lot of advocacy work. Some of her advocacy work has focused on the State’s response to incarcerated individuals and the threat of COVID-19 infections in correctional facilities. She reported she was also working on recommendations related to CARES Act funds and how best to allocate them.
- Lisa Weed said that the impact on staff in long-term care facilities has been overwhelming. She discussed the strain upon staff due to lack of personal protective equipment (PPE). She also described the impact on families when a family member is hospitalized, particularly due to prohibitions on hospital visitations.
- Senator Draheim said that it has been challenging to respond to constituents’ needs. He observed that while the lack of PPE was a primary concern early in the pandemic response, the supply of PPE has since improved. He reflected upon the difficult question of when to reopen the state.
- Shauna Reitmeier shared the experiences of the community mental health center that she leads. She reported that mental health providers moved to telehealth quickly, and were working to meet the needs of some of the most vulnerable mental health patients in the state. She noted that initially there was a decline in mental health services, particularly for young children, as it can be difficult to meet their needs.
via telehealth. She reported that her organization had started to observe an increase in domestic violence. Social service agencies have undergone layoffs, especially as they move out of rapid response and into recovery mode. She expressed concern over the long-term sustainability of these agencies as a result of the layoffs.

- Sheila Kiscaden reported that Olmsted County was observing more mental health issues and more disparities, particularly for distance learning for children. She expressed concern that educational impacts are falling disproportionately on underserved families. She reported that a number of not-for-profit organizations have formed a collaborative to share services, and to examine gaps in services for families (e.g., food distribution). She described the impact upon homeless populations, and noted that several shelters have shut down, adding that social distancing rules are difficult to enforce in shelter settings.

- Sida Ly-Xiong reported that her organization was working to provide technical assistance to small businesses, but the digital divide was becoming more apparent, particularly as it relates to access to technology. She observed that the digital divide is especially acute among Minnesota’s Native American populations.

- Jennifer DeCubellis reported that Hennepin County was working on lessening the disproportionate impacts of the pandemic. She said that organizations were collaborating in ways that the state has not seen heretofore. The implementation of testing in shelters was an example of organizations working quickly and collaboratively. She expressed concern that isolation has exacerbated the suffering of individuals with addiction and mental health issues.

- Senator Klein expressed concern that the pandemic will result in a second wave of demand on the health care system stemming from individuals who have delayed needed care.

- Commissioner Harpstead reported that state agencies are working at a fast pace and in an unprecedented manner in terms of collaboration and interagency efforts. She stated that DHS is examining disaggregated racial data in order to look at the impact of the pandemic through an equity lens.

**Background presentation – Aligning State and Federal Health Care Privacy Protections**

- Beth Waldman reviewed the Commission’s charge and the strategy review process. She reminded the Commission members that they did not need to reach agreement on the disposition of strategies during the May 8th meeting.

- Beth reviewed the presentation that DHS’ Jennifer Fritz prepared, noting that there are many Minnesota federal and state privacy laws, some of which work well together and some of which do not.

- Beth stated that the Minnesota Health Records Act is one of the primary pieces of legislation governing privacy, and requires a provider to obtain a patient’s consent before disclosing health records information – this is important because it is above and beyond what is required under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The Minnesota Government Data Practices Act regulates the collection, creation, storage, maintenance and dissemination and access to governmental data.

- At the federal level, HIPAA sets national standards for protection of individual identifiable health information for three types of covered entities (health plans, health care clearinghouses, and providers).

- Beth Waldman reviewed the HIPAA treatment and payment definitions, as well as the HIPAA operations definition. She noted that there are other purposes where consent is not required under HIPAA, for example sharing information with an individual, incidental use or disclosure, and public interest and benefit activities.

- In terms of interplay between federal and state law, Beth explained that there are differences in requirements regarding what permissions a health organization must obtain before it shares information with a third party for treatment, payment and health care operations purposes. Minnesota is one of the stricter states in terms of privacy.

- Sheila Kiscaden, being a former Minnesota State Senator, asked if there is still a strong philosophical bent in Minnesota for a stronger protection of personal health care information. She asked about the current political environment surrounding data privacy issues. Knowing this will help inform deliberations on this proposal, Sheila noted, adding that Commission members need to consider the political context.
**Strategy Discussion – Aligning State and Federal Health Care Privacy Protections**

- Michael Bailit described the Aligning State and Federal Health Care Privacy Protections strategy, which is intended to address misalignment between Minnesota privacy requirements and federal HIPAA privacy requirements. Michael noted that this misalignment has made it more difficult to coordinate care, has increased administrative burden, and has led to duplicate tests and wasteful spending.
- Michael Bailit explained that the strategy was intended to align the Minnesota privacy laws with HIPAA, and would include modifications to the Minnesota Health Records Act, the Minnesota Government Data Practices Act, and state statutes specific to insurance consent.
- Michael Bailit stated that while this strategy wouldn’t fully resolve the issue of lack of data interoperability across systems, the strategy was likely to improve care coordination, reduce duplicative testing, and reduce administrative burden.
- In terms of evidence supporting the strategy, Michael Bailit noted both national and state studies that offered recommendations in support of the strategy. He added that the State has previously studied this strategy extensively.
- Senator Klein commented that as the State works to address the pandemic, rapid exchange of information will become more valuable.
- Matt Anderson, Assistant Commissioner for the DHS Health Care Administration, commented that there is a large contingent of advocates working to address the State’s privacy protections. He noted that as the State addresses the challenges of the pandemic and the difficulties that providers have in addressing care needs in real time, the politics around this topic may shift.
- Shauna Reitmeier expressed her support for this strategy, while acknowledging that there are pockets of strong dissent. She added that Minnesota’s additional privacy protections have created some confusion.
- Sida Ly-Xiong also expressed her support for this strategy, and asked if there was evidence that Minnesota’s higher privacy standard has benefits. If not, that might help inform the Commission’s view of this strategy.
- Julia Freeman asked about the political issues surrounding this strategy, noting her preference for strategies that can be implemented and result in savings.
- Debra Krause commented that she supported the strategy as a path to reducing waste and also improving patient care and outcomes.
- Jennifer DuPuis expressed support for the strategy.
- Representative Schomacker noted his strong support for advancing the strategy.
- Sheila Kiscaden stated that she supported this strategy but wondered if it might cloud the political debate on other strategies that the Commission will be recommending.

**Background presentation – Low-Value Care**

- Michael Bailit shared background information that the Department of Health’s Stefan Gildemeister had prepared on the topic of low-value care. He shared a definition of low-value care as health care services that have been shown to “provide little benefit and in some cases have the potential to cause harm.” Michael shared statistics from a 2012 study, which found that waste accounts for a substantial amount of health care spending (25 percent or more).
- Michael Bailit described the ABIM Foundation’s Choosing Wisely initiative, which is an educational initiative focused on fostering conversations between clinicians and patients, particularly around low-value care. Michael stated that this initiative achieved support from an array of medical specialty societies, but appears to have had only modest impact on provision of low-value care. Michael said that even the ABIM Foundation has concluded that more aggressive steps need to be taken to reduce low-value care.
- Michael shared previous studies undertaken by Minnesota to examine low-value care. He noted that, in 2005, Bailit Health prepared a report on DHS’ behalf for the legislature that included consideration of low-value care. Michael stated that the Department of Health undertook a rigorous study of low-value care, which looked at claims data to examine and identify categories of outpatient low-value care in a few focused areas. The MDH study, published in 2012, found that in terms of spending by major select categories of low-value care, the largest category was for head imaging for uncomplicated headache, and...
the second was screening for carotid artery disease for asymptomatic adults. Michael noted that commercial payments for the low-value services examined by the study constituted the largest segment of spending for these services.

- Sida Ly-Xiong expressed interest in the definitions of “truly necessary” and “preventable harm.” She asked the Commission to consider what “preventable harm” means. Michael Bailit replied that this term addresses medical care that if delivered to a patient could cause harm to patient.

- Debra Krause recalled her experience with the rollout of Choosing Wisely in Minnesota several years ago. She found that sharing this information in employer settings did not result in provider behavior changes. She said that reducing low-value care would require dramatic changes in delivery care settings.

- Commissioner Harpstead asked if there is any evidence that the Choosing Wisely recommendations have had any impact on medical practices. Michael Bailit replied that while there has not been a formal evaluation of Choosing Wisely, there is a sense that it has not had a significant impact on medical practice. He further noted that there are a number of states looking more closely at low-value care.

**Strategy Presentation and Discussion – Reduce Overused, Misused and Low-Value Services**

- Michael Bailit reviewed the four key components of this strategy and its potential benefits, which are to improve patient safety and reduce spending for services that are not of value. The four components are:
  - Estimate the volume of provider-driven, low-value services for which there is broad consensus.
  - Work with a group of stakeholders and experts to identify areas of low-value services and publicize results of measurement.
  - Work with employers and providers to implement a statewide strategy to reduce provision of a defined set of low-value health care services.
  - Develop a coordinated approach to accountability of payers and providers for reduction or elimination of the provision of low-value services.

- For evidence supporting the strategy, Michael stated that numerous studies have found that a significant percentage of health care spending is associated with waste, including low-value services.

- In terms of administrative implications, Michael stated that MDH would need to lead an analytic effort to update estimates of low-value services in Minnesota. In addition, Michael noted that the legislature would need to authorize use of the state’s APCD beyond 2023 for this effort.

- Michael Bailit described the potential challenges of this strategy, noting that it can be difficult to bring together providers, employers and payers for collaboration purposes and also to sustain such an effort. He said that it will also be hard to change providers’ practices. Further, payers and providers may prove reluctant to adopt accountability measures to support such an initiative. Finally, Michael stated that such a strategy would need clinical champions to advance the change.

- Sheila Kiscaden commented that this appears to be a long-range strategy that will require cross sector collaboration and development to identify the low-value practices and gain compliance. She said that she would anticipate substantial upfront costs, and that the long-term benefits might not be visible to state government and state budget. She did not object to advancing this strategy, but noted it would not result in immediate savings. Sheila stated that this strategy was worthy of further development and consideration.

- Debra Krause commented that while this strategy would not deliver immediate savings, she strongly supported it. She believed there was good private sector support for the collaboration needed for this strategy.

- Senator Klein stated that he is a member of ABIM, and that he supported this strategy.

- Commissioner Harpstead asked if there are any proven tools that can help prompt changes in provider practices. Michael Bailit replied that so we do not have evidence to support any particular approaches for addressing low-value services.

- Debra Krause commented that this strategy requires more than education, and said that this strategy would also require process changes at the provider level.

- Jennifer DeCubellis commented that analytics show waste is not built into all systems, and enhanced awareness of low-value services does not drive improvements.
Shauna Reitmeier expressed her support for this strategy.

Matt Anderson said that if providers see their performance compared to peers, they will generally take action to improve. He described a Department initiative to lower the incidence of preventable C-sections before 39 weeks in non-emergency situations.

Commission members expressed general support for this strategy.

**Background presentation – Waste, Abuse and Fraud Prevention**

Kristine Preston from the DHS Office of the Inspector General (OIG) presented background information on waste, abuse and fraud within the Medicaid program.

Kristine Preston said that national estimates show that the majority of Medicaid improper payments result from errors, waste, abuse and fraud. Insufficient documentation accounts for 77 percent of improper payments. She provided an overview of the OIG’s provider and recipient investigation efforts, and explained the role of the Surveillance and Integrity Review Section (SIRS), which focuses on Medical Assistance providers, and the Fraud Prevention Investigation Grants Program (FPI), which provides support to county-level investigations. Kristine Preston noted that there is a provider investigations backlog.

Kristine Preston stated that generally counties are pleased with the support provided by the Department. In response to a question from Sheila Kiscaden, Kristine stated that not every county conducts its own fraud prevention activities, and while there are currently no fraud prevention grants for tribal communities, the State would like to be more engaged with tribal communities.

Debra Krause asked if the Department conducts reviews prior to disbursement of grants to counties. Kristine replied that the Department is limited in its ability to conduct such reviews, noting that there is a 270-day wait for cases to undergo investigation. Kristine added that the majority of the cases flagged as a result of data analytics received by the Department are post-payment fraud cases.

**Strategy Presentation and Discussion – Waste, Abuse and Fraud Prevention Enhancements**

Margaret Trinity of Bailit Health presented an overview of this strategy, which has three components: expand DHS’ investigatory capacity; enhance DHS’ statutory authority, and apply continuous improvement discipline to core operational functions.

Margaret stated that a key component of this strategy would be to add five FTEs to the Department’s Surveillance and Integrity Review Section, and additional funding of the Fraud Prevention Investigation grants program, which supports county-level investigations. This strategy would also reinforce a number of internal improvements to departmental functions such as better information sharing and data reporting, more effective decision making and workflow management, and improved data analytics.

Margaret Trinity noted that previous increases in the SIRS and FPI programs had yielded increased returns of investment of 3:1 for the SIRS program, and 4:1 for the FPI program.

Sheila Kiscaden commented that it was her understanding that the Department had increased funding for Fraud Prevention Investigation at the county level last year, and asked if this strategy was intended to provide additional funds.

Julia Freeman commented on the health equity review and the challenges faced by small provider groups. She noted that some provider groups may lack the resources to resend forms if the Department detects an error. Kristine Preston said that the Department communicates with provider groups on these topics and also provides training, but agreed that the education offered by the Department could be improved and should be more culturally sensitive.

Several Commission members expressed interest in the letter submitted by Nokomas Health, which proposed implementing a comprehensive payment integrity approach for the State.

Jennifer DuPuis questioned the relatively small scale of the strategy, noting that the opportunity seems much larger than what the strategy proposes to address.

Sheila Kiscaden noted that the strategy is heavily focused on investigations, and she encouraged consideration of what else the Department could undertake to support counties to reduce errors and fraud.

Commission members expressed general support for this strategy.
Next meeting

- Commissioner Harpstead announced the next meeting of the Commission, which will take place on May 21st, and would be conducted as a virtual meeting.
Blue Ribbon Commission Meeting 11

Meeting Notes

• Date: May 21, 2020
• Location: via WebEx (virtual)

Participation

Participating members: Commissioner Jodi Harpstead, Senator Rich Draheim, Jennifer DuPuis, Nona Ferguson, Sheila Kiscaden, Debra Krause, Gayle Kvenvold, Representative Tina Liebling, Sida Ly-Xiong, Shauna Reitmeier, Lisa Weed

Welcome and remarks

Commissioner Harpstead welcomed the members of the Commission. She relayed Commissioner Malcolm’s gratitude for the Commission’s work and noted that the Commission’s final report is due October 1.

Community and stakeholder engagement update

• The Improve Group’s Kylie Nicholas provided an update on the community and stakeholder engagement work of the Commission. Kylie said that as the engagement activities move forward, The Improve Group will be sensitive to the experiences of various communities during the pandemic.
• Kylie Nicholas stated that community engagement activities will be conducted by means of virtual events and interviews. She acknowledged that virtual platforms are not appropriate for all the audiences that the engagement activities would like to reach, and as a result The Improve Group will conduct supplemental interviews via telephone. She stated that the community engagement activities will focus on the cost saving strategies, and will also solicit feedback on the full draft report. Kylie stated that she expects findings from the community engagement activities to be available for the Commission’s review in August.
• Sheila Kiscaden asked about the number of strategies that will be addressed by the community engagement activities, and which subpopulations will be targeted by these activities. She also asked about the efficacy of using telephone interviews. Kylie Nicholas replied that The Improve Group will engage individuals who access the State’s Medical Assistance (MA) program, and will focus on the cost savings strategies that impact those groups of individuals. She said that some of the strategies have a narrower impact, whether regionally or by population, and the events will be tailored accordingly. Kylie stated that there are some strategies that impact a narrow group of people, for example those who access day services, and the interviews will be used to reach these individuals.
• Sheila Kiscaden expressed concern that the information collected will not be useful for the Commission’s deliberations because the impacts of the strategies are complex. Sheila suggested that state advisory groups, such as the Governor’s Council on Disabilities, might offer a means of supplementing the activities undertaken by The Improve Group. Commissioner Harpstead concurred, and suggested that Commission staff check the schedules of these advisory groups to see if there might be opportunities during June to collect feedback from these groups.
• Sida Ly-Xiong agreed with Sheila Kiscaden’s recommendation. She expressed concern that the activities undertaken by The Improve Group would generate only general and random feedback. She also encouraged use of the questions identified by the equity review process during the engagement activities.
• Debra Krause expressed her support for the Commissioner’s recommendation to work with the state’s advisory groups, and added that it might be helpful to have members of the Commission join those meetings to discuss the strategies.
• Sida Ly-Xiong asked what incentives were being provided to individuals to participate in the activities. Kylie replied that The Improve Group will use $50 incentives for individuals to participate in engagement activities. Sida Ly-Xiong asked if incentives would be available for outreach conducted by Commission members. Kylie Nicholas replied that there are not funds available for such purposes.
• Sida Ly-Xiong suggested that The Improve Group’s outreach communication undergo additional review. She volunteered to review the communication, and said that several MDH staff from the community engagement area might also serve as helpful reviewers.
• Gayle Kvenvold expressed support for engaging state advisory boards. She noted that members of LeadingAge convene weekly to confer, and offered the possibility that these meetings could be utilized for purposes of collecting feedback. She noted, however, that June meetings of this group would coincide with an expected surge in COVID-19 cases.
• Kylie Nicholas discussed the stakeholder engagement toolkit and said that it could be used by the Commission members in conversations they have with groups with which they are involved. She said the toolkit has a standardized form to facilitate submission of feedback to The Improve Group.
• Sheila Kiscaden asked for further guidance on use of stakeholder engagement toolkit.
• Kylie Nicholas stated that The Improve Group is responsible for compiling feedback collected by Commission members.

Background presentation: dental care

• Bailit Health’s Beth Waldman presented background information on dental care in Minnesota, noting the importance of oral health to overall health and wellbeing. She said that untreated dental disease can lead to both pain and infection, as well as lost schooldays for children and lost workdays for adults. She said untreated dental disease can also increase risk for exacerbating diabetes, and heart and lung disease.
• Beth Waldman said that the reasons for low utilization of dental care in Medicaid programs are similar across states and include low payment rates, administrative burden on participating providers, transportation issues for participants, and the fact that this has been an optional benefit that has come and gone over time for adults. She noted that under Minnesota’s Medicaid program, dental benefits are a mandatory benefit for children and an optional benefit for adults.
• Beth stated that Minnesota’s dental rates are based on 1989 charges that have been trended forward, and are among the lowest in the country (44th in 2015). She noted that the State’s rate setting methodology is complex and results in uneven payments to providers.
• Beth Waldman stated that nationally there are three ways states can offer dental services to Medicaid members: either through their FFS program, as part of their comprehensive managed care program, or as a managed dental benefit administered by an at-risk vendor or administrative service organization.
• Beth Waldman stated that the Centers for Medicare and Medicaid Services (CMS) has placed Minnesota on a corrective action plan due to substandard access to dental care; she said that based on mandated CMS reporting, only 40 percent of children have received dental care each year for the past three fiscal years despite a substantial incentive for managed care plans to improve their provision of dental services.
• DHS’ Diogo Reis commented that there are several reasons why access to dental care is limited for participants in the state’s Medicaid program, including: 1) inadequate provider reimbursement; and 2) a complex rate system. He reported that dentists perceive the rates as unfair across geographic areas.
• In response to a question from Representative Liebling, Beth Waldman said that access is defined as utilization of one dental service in a year. Representative Liebling also asked about costs associated with the state providing these services via multiple delivery systems (e.g., FFS and managed care).

Strategy presentation and discussion: improving access to dental care

• Beth Waldman provided an overview of the Improving Access to Dental Care strategy. She said that problems with dental care in Minnesota’s public programs have had cascading consequences, including that
Minnesota ranks near the bottom nationally in the percentage of children enrolled in the state’s Medicaid program who access dental services.

• Beth Waldman described the strategy, which is to establish a simpler and more efficient model for purchasing dental benefits through a common administrative structure. She said that the model would establish an updated and simplified payment method, with increased and equalized provider rates. She noted that the strategy proposes increases over the current MA fee schedule.

• Beth Waldman stated that there are several anticipated benefits of the strategy, including a simplified structure for administering dental services under the state’s public programs, an equitable rate structure that pays all dentists the same rates for providing the same services, and reduced inequities in access to dental services, as well as reduced distances that public program enrollees travel to receive dental care.

• Beth Waldman described the experiences of other states, including Connecticut, Tennessee and Virginia, which have moved to a single dental administrator and increased provider rates in response to historical issues with dental access. She conveyed that the strategy would require DHS to enter into a contract with a dental administrator, amend managed care contracts, complete systems work, and adjust rates.

• Beth Waldman shared the questions resulting from the equity review, including the question of possible unintended consequences, and the question of how this strategy will be impacted by COVID-19.

• Beth Waldman noted that as a result of this strategy some providers may have reduced reimbursement for some dental services; she said this would be true in those cases where providers were previously eligible for multiple rate add-ons. She emphasized that this strategy is aimed at paying a fair rate across the board.

• Debra Krause expressed support for the strategy, noting that improved outcomes are as important as access.

• Commissioner Harpstead asked whether the studies that Beth Waldman referenced reported any improved outcomes. Beth replied that the focus of the studies was on access, and relayed that while she was Medicaid director in Massachusetts, improved access to dental services did result in improved outcomes.

• Jennifer DuPuis expressed her support for this strategy, noting that dental staff struggle with referring patients who are in the MA program for specialty dental care. She said that concerns related to access to dental services are especially true for all tribes across Minnesota.

• Diogo Reis said that a dental administrator contract would include both primary and specialty dental care.

• Lisa Weed offered a disclaimer that SEIU MN represents workers in dental field, some of whom are under contract to HealthPartners and who receive add-on payments under the current dental system. She expressed concern that this strategy would complicate the delivery of dental care and potentially result in rate reductions for providers. Beth Waldman noted that HealthPartners would still have the ability to conduct coordination of care for these services. Diogo Reis added that he envisions that the contracted administrator would share data with health plans on individuals who are enrolled in the dental program. He said that the access issues described in the background presentation are as pertinent to MCO patients as they are to FFS patients. Lisa Weed stated that HealthPartners has a wide dental provider network, and asked if an administrative contract for dental services might reduce access for some. Diogo Reis replied that a single statewide network of dental providers for individuals in Medical Assistance and MinnesotaCare would improve access, and would make switching providers easier for patients who move from one area of the State to another.

• Representative Liebling stated her support for the strategy, and observed that HealthPartners has done well under the status quo. She said that many think that HealthPartners is being overpaid for dental services. She stated that some smaller providers have developed their business models around the status quo; she acknowledged that some providers will experience payment cuts, but observed that dental access rates are abysmal in Minnesota for children. She said that she has received complaints from constituents over the years about access to dental services.

• Debra Krause, Sheila Kiscaden, Gayle Kvenvold, Sida Ly-Xiong, and Nona Ferguson all expressed their support for this strategy. Lisa Weed stated that she did not support the strategy, but understood the group’s desire to advance it. The strategy was advanced for further consideration.
**Background presentation: targeted case management**

- DHS’ Jennifer Blanchard provided a brief overview of the case management redesign initiative, acknowledging that it is a complex topic and reflects work that has been ongoing for a number of years.
- Jennifer Blanchard said the initiative is designed to address all forms of Medicaid-funded case management services, and to determine how these services can best support families and improve equity.
- DHS’ Lisa Cariveau stated that a key component of the case management redesign is how the State can leverage case management to reduce disparities in access to medical, behavioral health, long-term supports and services, and other social services.
- DHS’ Leah Montgomery provided detail on the different types of case management available: 1) targeted case management, and 2) home and community-based waiver case management. She noted that in Minnesota, case management is a covered Medicaid service and builds on counties’ obligation to provide safety net services. She said that case management creates an opportunity to advance health equity because of its focus on access.
- DHS’ Leah Montgomery described Minnesota’s current case management system, which is complex due to its governing laws and funding structure. She said that case management eligibility requirements often result in services being available only to people with the highest needs. Leah stated that the current system is often unresponsive to the needs of people and families who are or who could be receiving preventative case management services.
- Leah Montgomery described the vision for case management services under the redesign as services that are simple, flexible, person-centered, culturally responsive, and universally available to those who qualify for them, and are effective in assisting people and families to access formal and informal supports. She said that the State needs a more prevention-focused model for targeted case management.
- Leah Montgomery said that the State must meet CMS expectations regarding financing, including a method for a single statewide subcontractor system. She said the State would also like to explore ways to expand populations eligible to receive targeted case management.
- Lisa Cariveau stated that the targeted case management redesign initiative was a joint effort between DHS leadership, and county and tribal partners.

**Strategy presentation and discussion: targeted case management**

- Beth Waldman provided an overview of the strategy, Targeted Case Management, noting that this strategy would advance a pre-existing redesign initiative that is being undertaken by DHS in partnership with counties and tribes. She said that the focus of the redesign is to expand the populations served, and also reconfigure services so that current populations served are better connected to the services that they need.
- In terms of anticipated benefits, Beth Waldman explained that the hope is that individuals will have support in accessing needed services, and also that rates across the State are consistent, transparent, and sustainable. Beth stated that there is a fair amount of evidence about the ability of targeted case management programs to improve outcomes. She noted that a number of other states have had good experience in using a prevention-based eligibility approach. She noted that redesigning the State’s targeted case management program is a big undertaking, and that it would entail significant systems work to implement changes in eligibility and case management rates. She also acknowledged potential administrative costs associated and the necessity of advancing a legislative proposal.
- Beth Waldman recapped the questions resulting from the equity review, including how would this strategy establish equity criteria in determining need, and how would an equitable rate methodology be established, as well as how might this strategy take into account the impact of COVID-19 on vulnerable populations.
- Beth Waldman described several of the anticipated challenges, including potentially higher costs to the State and counties from expanding the populations eligible to receive targeted case management services, and development of a uniform set of service delivery expectations and a statewide rate methodology. She also noted that this strategy would require a commitment from the legislature for funding both an expanded service model and statewide rate methodology.
• Debra Krause commented on the benefits, noting that this strategy will not only expand case management but also potentially improve outcomes.
• Sheila Kiscaden said that while it would expand access to targeted case management, this strategy is limited in scope because a lot of individuals served by counties are not MA eligible. She is interested in pursuing this strategy, but would like to explore further the downsides and tradeoffs.
• Lisa Cariveau noted that in many cases the intent is not necessarily to reach more individuals but to reach eligible individuals earlier.
• Sheila Kiscaden stated that counties are concerned about reducing federal commitment to the case management program, and asked if this strategy would build funding vulnerabilities by virtue of its expansion. She asked about balancing the potential benefits and risks. She noted that when the State has a shortfall, there is a tendency to assume that counties can pick up more of the costs, and if the State were to expand services that are funded by county dollars, this may force some ugly choices at the local level.
• Leah Montgomery noted that DHS is learning from other states that they have found ways to provide case management earlier without changing the populations they are serving. Sheila Kiscaden responded that the more the State spends on targeted case management, the less money it has for prevention. She noted that the State has greatly reduced spending on public health.
• Sida Ly-Xiong commented that case management services benefit those that are currently enrolled. She would like to examine who is currently enrolled versus those who are eligible but not enrolled, noting that there are many individuals in communities of color who are unable or afraid to enroll. Sida asked about the evidence for case management, and about the evidence for case management in family settings.
• Jennifer Blanchard stated that DHS has researched individuals who are eligible but do not seek services. She noted that in some cases it has been difficult for culturally specific providers to offer targeted case management services due to the complexity of the system. She said that DHS has been working diligently over past two years on these issues.
• Lisa Cariveau said that DHS is conducting research on the threshold requirement for persistent mental illness (PMI) targeted case management services, and the extent to which it serves as a barrier to care.
• Shauna Reitmeier disclosed a conflict of interest in that she represented a certified community behavioral health clinic and as such is required to provide targeted case management services. She noted that certified community behavioral health clinics offer a one-stop approach for a wide range of individuals who may be accessing care through this model. She noted that this is not necessarily a cost saving strategy.
• Sheila Kiscaden said that this strategy shifted from the transformative to the equity category. She was concerned that the strategy did not reflect the Commission’s broader goal of simplifying programs. She noted the need for a broader discussion of how partnerships between DHS, counties, tribes and providers could work better. She said that there is only so much time, attention and energy available to make transformational change, and asked if this strategy is the best way to direct DHS and legislative resources.
• Lisa Weed said she was inclined to support leaving this strategy on the list for Commission consideration. Gayle Kvenvold said the strategy was a step in the right direction, albeit with limitations, and she supported keeping it on the list for consideration. Debra Krause said she supported leaving this strategy on the list, noting that it is worthy of consideration but not transformational. Jennifer DuPuis supported keeping this strategy on the list, noting that she has found that case management has been effective in improving outcomes.
• Sida Ly-Xiong noted that this strategy had more to do with improving current services and questioned the return on administrative investment; she said that just expanding who can receive targeted case management without taking steps to ensure the quality of those services could result in increased costs and no reduction in disparities in access to care, services and supports.
• The strategy was advanced for further consideration.

**Background presentation: background studies eligibility**

• DHS’ Dawn Davis provided a background presentation related to the strategy, Background Studies Eligibility Task Force. She described the history of the background study system, noting that it was implemented in
1991. She stated that under Chapter 245C of the Minnesota Statutes, certain individuals are required to have a background study completed. She defined a background study as an analysis and review of an individual’s eligibility (or disqualifying offenses), and disqualifying offenses include arrests, convictions, maltreatment, and risk of harm. She noted that a study to assess the impact or whether disparities exist as a result of this policy has not been undertaken.

- Dawn Davis described the NETStudy 2.0 system, which processes 95 percent of the State’s background studies (5 percent are processed by DHS’ legacy system). Dawn noted that in 2019, 254,938 individuals completed a background study. DHS processed 381,040 study applications, of these 329,796 (87 percent) were cleared, and 7,460 individuals received disqualifications.

- Dawn Davis stated that the strategy represents an opportunity to examine more closely Chapter 245C of the Minnesota Statutes so that the State can better understand its impact.

**Strategy presentation and discussion: background studies eligibility task force**

- Beth Waldman reviewed the Background Studies Eligibility Task Force strategy, which proposes to form a new task force to review the background study disqualifying offenses and disqualifying time periods under Chapter 245C of the Minnesota Statutes. She explained that such a task force would assess the feasibility of decreasing the amount and duration of certain disqualifications for members of communities experiencing inequities. In addition, the Task Force would examine the impact of disqualifications on employment eligibility in DHS and other state agency programs serving vulnerable children and adults, for which a background study is required.

- Beth Waldman said that anticipated benefits of this strategy would be that the work of the Task Force would lead to changes in disqualifying offenses and time periods under Chapter 245C of the Minnesota Statutes. She said that these changes could potentially have a positive impact on workforce needs for the impacted programs, and could increase opportunities for communities experiencing inequities from disproportionate contact with the justice system.

- Beth Waldman noted that convening a task force can be an effective means for the State to examine potential policy changes. She said that administrative ramifications included the potential need for significant changes to the NETStudy 2.0, the system that processes background studies.

- Beth Waldman stated that the equity review raised several questions, and that these questions could help guide formulation of the proposed task force charge. She reviewed several anticipated challenges of the strategy, including that the Task Force would be limited in size and so not every viewpoint could be included in its membership.

- Representative Liebling asked if there were data available regarding disqualifications, and evidence of safety concerns surrounding individuals who receive disqualifications. She questioned whether the existing disqualification criteria are based on who we imagine is dangerous as opposed to evidence-supported safety concerns. Dawn Davis replied that she was not aware of the availability of such data.

- DHS’ Kulani Moti stated that the strategy was intended, in part, to do a better job of identifying which offenses should be disqualifying. She said that the State needed to do a better job, so that people who may have offenses but are quite capable of doing the job, remain eligible.

- Representative Liebling noted that the legislature had wrestled with this issue previously, and that the politics surrounding this strategy were difficult. She noted that there had been some changes in disqualifications over the years, and cited the example of recent legislation to change foster family qualifications. She said that legislators would like to do better on this topic, but they need help with explaining any potential changes to their constituents.

- Sida Ly-Xiong asked whether a study and task force was the best way to advance the goal of this strategy.

- Debra Krause indicated that she was less supportive of this strategy, because it recommended convening a task force with a 15-month timeline, on a topic with significant political issues.

- Sheila Kiscaden expressed her support for this strategy, as did Representative Liebling.
**Additional topics**

- Sheila Kiscaden discussed DHS’ COVID-19-related waivers for counties, and asked whether extending those waivers might be an additional strategy that the Commission would be willing to consider. Commissioner Harpstead noted that extension of those waivers will be considered during a June special session of the legislature, and also noted the problematic timing of waiting to include those waivers in the Commission’s action plan, which will not be final until October.

**Approach to action plan**

- Bailit Health’s Michael Bailit discussed the Commission’s approach to its final report, stating that because the meetings of the Commission were interrupted by the pandemic, there were a number of transformational strategies that the Commission has not had opportunity to consider. In addition, there would not be time for an anticipated second round review of each strategy previously advanced for consideration.

- Michael Bailit explained that in terms of inclusion of strategies in an action plan, he suggested a listing of all strategies prioritized, developed and presented to the Commission, and a separate listing of those not presented, including strategies that remain undeveloped. He said that the report could also identify potential state work groups and committees that might have the ability to follow up on some not-presented strategies, for example a new state health equity work group could continue development of the equity strategies, or the Governor’s health care subcabinet could continue development of some of the transformational strategies.

- Michael Bailit shared his suggestion that there be no voting on individual strategies, but that individual Commission members would have opportunity to provide a written response for inclusion in the report. He acknowledged that inclusion of a strategy in the report did not mean it received unanimous support, and said the report would serve as a comprehensive summary of the work undertaken by the Commission.

- Commissioner Harpstead emphasized the individual Commission members’ ability to comment on each strategy. She asked that Commission members consider the approaches outlined by Michael Bailit, and that Commission staff would follow up after the meeting to request their views on these approaches.

- Commissioner Harpstead also noted a prior request, which was for Commission members to identify stakeholder groups to which they would like to reach out; she indicated that Commission staff would follow up on this as well. Commission members responded with the following stakeholder group suggestions: Westside Community Health Services, Health Clinic Board, University of Minnesota Program in Health Disparities Research Community Academic Advisory Board, MDH Health Equity Advisory and Leadership Council, Minnesota Leadership Council on Aging, American Cancer Society Board, Minnesota Community Measurement Board, and Tribal Directors.

**Next meeting**

- The Commission’s next meeting will take place on June 4th, from 9:00am – 12:30pm.
Blue Ribbon Commission Meeting 12

Meeting Notes

- Date & time: June 4, 2020
- Location: Virtual via WebEx

Participation

Participating members: Commissioner Jodi Harpstead, Jennifer DeCubellis, Sheila Kiscaden, Deb Krause, Gayle Kvenvold, Representative Tina Liebling, Sida Ly-Xiong, Shauna Reitmeier, Sue Schettle, Representative Joe Schomacker, Lisa Weed

Welcome and remarks

Commissioner Harpstead welcomed members of the Commission. She acknowledged the difficult circumstances of the prior 10 days, and stated DHS’ commitment to equity review of strategies.

Approach to final report

- Michael Bailit of Bailit Health initiated discussion of the Commission’s final report (“action plan”), which is due October 1, 2020. He explained that COVID-19 and recent civil unrest have forced a different approach to the action plan. Michael noted that this was the first time that DHS conducted an intentional equity review process of this nature with public stakeholders. He said that the purpose of the health equity review was twofold: first, to raise questions during development of each strategy, and, second, to raise issues for consideration during implementation of the strategy.

- Michael Bailit explored with Commission members three potential complementary approaches for advancing the results of the equity review process. He said that one suggested approach was to recommend that strategy design details be developed with health equity in mind. A second approach was to refrain from strategy implementation until the outstanding equity considerations had been reviewed and an assessment completed. A third approach was to recommend that the Governor’s health subcabinet, and/or other appropriate executive branch bodies, be tasked with exploring the Commission’s identified but undeveloped transformation and health equity strategies, or to develop additional health equity strategies.

- Sheila Kiscaden said that while the Commission has not been able to maintain its schedule due to the pandemic, the time was ripe and the Commission was motivated to raise awareness of systemic racism and how that has created systemic health care disparities. She said that the Commission’s report should be a reflection of the current times, and stated that the local community demanded change. Deb Krause expressed her agreement.

- Sida Ly-Xiong said she did not have an objection to a modified approach. She said that Commission members expressed strong interest in the transformative strategies, but the Commission’s focus thus far had been narrow. She said the equity tool offered a set of questions, but lacked a means to assess the quality of responses to those questions.

- Representative Liebling remarked that this was a moment unlike any previous. She expressed agreement with Sida Ly-Xiong’s remarks, and stated that the relative primacy of achieving the Commission’s $100 million savings target had been diminished. She noted that Commissioner Malcolm was strongly supportive
of the transformative strategies and that her absence due to the pandemic had removed some of the spotlight on these strategies.

- Representative Liebling recommended that the Commission meet the moment and not go blindly forward with the charge as written. She said the Commission needed to pivot and refocus on transformational strategies. Representative Liebling urged the Commission to be bold and set out a vision.

- DHS’ Crystal Fairchild expressed her thanks for the work of the Commission. She stated that she would conduct a final health equity assessment for inclusion in the final report.

- Michael Bailit said that as staff start drafting the action plan, they will heed the Commission members’ urging to be bold. Michael addressed additional recommendations that the Commission members made at their last meeting, including the need to address the impact of COVID-19 and civil unrest on the Commission’s work. He acknowledged that these forces impacted the work of the Commission by reducing its ability to develop and review all identified strategies, and that the Commission lost its ability to reconsider each developed strategy after completing initial reviews of the presented strategies. Michael reviewed the suggested approach for strategy inclusion, including to rank support for each strategy on scale of 1 to 5 (1= no support; 5=full support). Michael said that the action plan would include a list of both undeveloped and developed strategies that were not presented, and suggestions for work groups or committees to address some of these. He said that members may also provide written comments for inclusion in the report.

- Sheila Kiscaden said it was a big disappointment not to have time to consider the transformative strategies. She asked for an update on transformational work being undertaken given the pandemic, citing as an example county-based waivers. Commissioner Harpstead suggested that an epilogue could discuss work such as this, as well as work that the Commission recommends continue beyond the Commission’s timeframe. She noted that there is an ongoing Governor’s health subcabinet to which the Commission may wish to bequeath some of the strategies, especially the transformative ones.

- Commissioner Harpstead asked that the action plan acknowledge the challenges of our current times.

- Representative Liebling recommended that the Commission develop a vision of transformation. She stated that this would be a good capstone for the work of the Commission.

- Commissioner Harpstead stated that the Commission could add a meeting for this purpose.

- Deb Krause commented on the vision statement requested by Representative Liebling. She expressed concern that it might be so vague as to not drive change, and asked how it would be used by the legislature. Representative Liebling said that in this time of tremendous change such a statement from the Commission would be helpful to her as a legislator. She urged the Commission not to waste this opportunity.

- Michael Bailit addressed comments about a proposed rating or ranking of the strategies. He noted that the suggestion of a means for rating the strategies derived from comments made by Commission members. He said that such ratings would be a means for the Commission to distinguish in communications to the legislature those strategies that the Commission would be most eager to have the legislature advance.

- Commissioner Harpstead stated that she had suggested the ranking so as to assess the level of Commission member support for each strategy.

- Sida Ly-Xiong noted that the strategies are not all comparable to one another in terms of their discreteness and clarity. She expressed support for prioritizing strategies, perhaps distinguishing those that were immediate from those that were long-term. Sue Schettle and Sheila Kiscaden expressed support for the original approach (i.e., no prioritization).

- Lisa Weed said that she did not support the original approach, but was not sure ranking the strategies would be helpful. Michael Bailit clarified that the 1 to 5 scale would be a rating and explained that the Commission would take an average of the ratings. Commissioner Harpstead noted that the Commission could decide to leave strategies with a very low rating out of the report.

- Lisa Weed expressed her support for a final report that lists the strategies that the Commission examined, not all of which were recommended.

- Shauna Reitmeier said the Commission needs a way to identify which strategies are more developed, and which are easier to achieve. She asked if the Commission could identify those strategies that garnered full support and those that did not; she said the Commission needed to be transparent about its deliberations.
• Commissioner Harpstead stated that the Commission’s timeline at present could not be extended. She added that the Commission could make an extension request of the Governor. She added that whether the Commission could continue to meet and work during the upcoming economic downturn was uncertain. She noted that the Lieutenant Governor had said that “we cannot go back to normal, we can only go to better.”
• Commissioner Harpstead suggested that the Commission discuss the transformative strategies in the preamble of the report. She said that DHS had learned a lot during its vetting of the cost savings strategies and noted that the State would need such strategies next year in order to navigate difficult budget times ahead. She remarked that while the Commission’s heart was in the transformative strategies, the cost savings strategies would be important also.
• Michael Bailit noted that based on the feedback of Commission members, there was not strong interest in rating the strategies on a 1 to 5 scale. He said that based on the feedback of the members, he could develop additional rating approaches for their consideration.
• Sheila Kiscaden encouraged the Commission members not to overthink the final report. She encouraged the members to advance a menu of options. She noted that the Commission could flag some issues needing attention such as health equity.
• Michael Bailit reviewed the last suggested modification to action plan, which would be a vote on the full action plan. He added that the action plan would make clear that the plan meets the Commission’s charge to the best of the Commission’s ability and the staff’s ability. There were no objections to this approach.

Public engagement update

• Krista O’Connor provided an update on the community and stakeholder engagement plan, and reviewed proposed engagement activities for three categories: the general public, targeted stakeholders, and the broader community. She reviewed those targeted stakeholders to whom Commission members had agreed to reach out, and invited Commission members to submit suggestions for additional stakeholder groups.
• Sue Schettle said she could take the lead in contacting ARRM and MORH in addition to Best Life Alliance.
• Krista reviewed engagement activities proposed by The Improve Group, including plans to reach out 35 individuals via two to three virtual events and 16-20 individual interviews.
• Krista O’Connor acknowledged that the original intent of Commission staff was to involve both interested Commission members and stakeholders in strategy development. She explained that this did not occur systematically due to the volume of work, overlap with the legislative session, and more recently due to the pandemic and civil unrest. She promised that follow-up requests made by Commission members for revisions to individual strategies would be made available to Commission members by June 25th.
• Sida Ly-Xiong asked if the number of individuals engaged by the community activities would be adequate. She stated that reaching out to such a small group by means of focus groups and interviews was inadequate. She questioned how much the outreach vendor was being paid to reach out to such a small number of individuals, and pointed out that 60 individuals was a high-end estimate of the outreach envisioned. Sida remarked that the vendor had had time and capacity to reach more, and said she was disappointed at this level of effort. Commissioner Harpstead acknowledged that DHS had struggled with its vendor and agreed that the outreach had been inadequate.
• Krista invited Commission members to review the timeline in slide deck, which noted the timeframe for posting the final report for public comment.
• Jennifer DeCubellis recommended that the Commission’s report include a disclaimer statement indicating that strategies considered by the legislature need to be further vetted with the community.
• Shauna Reitmeier expressed support for Jennifer DeCubellis’ recommendation of a disclaimer statement.

Background presentation: Ensuring equitable access to disability service programs

• DHS’ Maria Trueblood offered a background presentation on the disability service program. She noted that current research suggested the existence of disparities among people of color and American Indians enrolled in HCBS programs. Research found that new applicants of color were less likely to meet the threshold needed to obtain HCBS services.
• Maria Trueblood provided an overview of the strategy, stating that it was a multi-stage project that used both quantitative and qualitative methods to examine the assessment process and understand disparities resulting from the process. She stated that the project goals were to examine racial and ethnic disparities in the State’s HCBS programs, with a focus on the assessment process. She noted that the overall goal of this work was to inform policy and operational changes. Maria said that the Department was in phase 1 of implementation, which included a literature review and establishment of an external advisory group. She stated that phase 1 funding was provided by Moving Home Minnesota, with University of Minnesota and Purdue University as partners.

• Maria Trueblood said that the DHS was just entering phase II, which involved partnering with communities to better understand their use of HCBS services, and partnering with lead agencies to review the assessment process through an equity lens. She said that DHS anticipated issuing an RFP for a vendor to assist with community engagement. She noted that currently there was not secure funding for Phase II. Maria stated that Phase II would entail embedding the results from phases 1 and 2 into the work moving forward. She said that DHS will take a community-based participatory research approach and compensate for the time and subject matter expertise of community members.

• Sheila Kiscaden noted that this strategy represented a continuous improvement effort, and that it was a continuation of previous work and a request for funding. She asked whether such a strategy fit the Commission’s charge. Maria Trueblood stated that the strategy was originally proposed by a community organization, and the Department aligned it with current similar work underway, and also broadened it to include Native American and Latinx communities, as well as those identifying as multiracial.

• Commissioner Harpstead noted that a number of strategies considered by the Commission contained elements that had already been worked upon. She noted the suitability of using the Commission as a venue for advancing discussion of such strategies.

Strategy: Ensuring Equitable Access to Disability Service Programs

• Beth Waldman of Bailit Health reviewed the strategy Ensuring Equitable Access to Disability Service Programs. She reviewed the anticipated benefits of implementing the strategy, including the removal of barriers for African-American communities to access waiver services. She said that the strategy also addressed barriers for Latinx and multiracial individuals.

• Beth Waldman noted the lack of evidence in support of this strategy, but said that breaking down barriers would help the Department move forward. She said that there was a need for funding to continue this work, and that the strategy would require updates to MnCHOICES and other DHS systems. She added that the implementation costs were not significant, but that resources would be needed for this effort to continue.

• Beth reviewed the equity questions raised by this strategy, noting that they would require further exploration as the strategy details were worked out.

• In terms of challenges, Beth Waldman noted the need for funding to be secured in the next budgeting cycle. She also recognized that the change envisioned by the strategy may take time.

• DHS’ Elyse Bailey noted that resources were needed to undertake a thoughtful process, and asking the legislature to require DHS to undertake this strategy would enable the agency to engage with a wider community.

• Sue Schettle said she supported the strategy and that the disability community would be supportive of such changes.

• Sida Ly-Xiong stated that the strategy felt like a continuous improvement effort. She acknowledged that programmatic changes were needed, but that policy changes were more important. She asked if there was a way to connect policy changes to this strategy.

• Jennifer DeCubellis stated that she supported this strategy, and that the Commission needed to emphasize administrative simplification in order to move more money to care and allocate less money on administration of the program.

• Commissioner Harpstead stated that a work group recently examined demographic data for congregate settings, including many HCBS settings. The work group looked at disaggregated racial data of individuals
residing in these settings and those who worked in these settings. She noted that some of the better funded services were supporting white populations.

- Commissioner Harpstead remarked that this was a disruptive improvement strategy and felt that this work needed to continue. Jennifer DeCubellis stated her agreement, and noted that some of the most well-resourced services have well-funded advocates, and they insisted on modifications and flexibility. She stated that the services that tend to be accessed by populations of color lacked a voice in the public square. She noted that she had learned a lot about these inequities during the pandemic. She voiced her support for this strategy, as did Shauna Reitmeier.

- Deb Krause asked if the strategy should be broader than disability access.

- Commission members expressed their support for this strategy; there was consensus to advance this strategy.

Background Studies Eligibility Task Force

- Beth Waldman asked Commission members if they supported creating a task force for this strategy, as had been discussed with limited feedback during the prior Commission meeting. Commission members did not provide feedback on their level of support for this strategy.

Background presentation: MnCHOICES

- DHS’ Amy Alexander explained the need for assessments to connect people needing help with professionals in their local community to help them identify the publicly funded services available to them. She said that the MnCHOICES assessment is a part of a larger eligibility process for long-term services and supports. The process can be complicated because there are multiple staff from different departments that must complete work before eligibility can be determined.

- Amy Alexander stated that MnCHOICES assessments were completed by certified assessors from the county or tribal nation where the person lived. The assessment involved an interview and documentation of the person’s needs and preferences. She noted that MnCHOICES was part of a multiyear effort to transform and simplify the LTSS system. She said that MnCHOICES replaced three assessment processes that were designed for specific service programs: DD, LTCC and PCA.

- Amy Alexander said that assessors must become certified through the MnCHOICES Certified Assessor Training (MnCAT). MnCHOICES has the following components: a support plan application, calculation of rates to support the plan, and an LTSS improvement tool to evaluate a person’s satisfaction with services. Amy explained that the program is in a continuous improvement loop that has led to a range of program improvements.

Strategy presentation: MnCHOICES Improvements

- Beth Waldman reviewed the MnCHOICES Improvements strategy and said that the recommended strategy built on a 2019 LTSS process mapping that identified 34 process “pain points.” The strategy involved securing a qualified vendor to review these pain points and conduct a process improvement review. She stated that the strategy would entail working further with pilot counties and tribal nations to analyze processes.

- Beth Waldman noted that the strategy was intended to improve the experience of individuals and families requesting LTSS, and also to make the LTSS processes across the State more consistent and streamlined. She said that the strategy could reduce both federal and state costs, and also reduce administrative costs.

- In terms of equity review considerations, Beth Waldman noted that the equity review found that the strategy needed to consider the impact of COVID-19. She said that challenges with the strategy include time to implement the changes envisioned by the strategy, and that the strategy was dependent on interest from counties and tribal nations in changing their processes.

- Representative Liebling expressed concern that not just processes but also results vary across counties. Amy Alexander said her hope was that an in-depth business review would uncover variations in business practices and training opportunities that would address inconsistencies in results.
• Sue Schettle expressed curiosity as to the level of criticism that MnCHOICES had received. She asked whether those criticisms were addressed by this strategy.
• Shauna Reitmeier said that the MnCHOICES assessment tool was known to be insufficiently sensitive to the needs of people with mental illnesses. She said we would support not just process improvements but also improved assessment results.
• Amy Alexander stated that staff were undertaking refinements in the assessment to address these concerns.
• Mary Lenertz stated the shift to an electronic assessment tool involved a major effort, and that assessors had to broaden their expertise from a single program to three. She acknowledged the challenges and frustrations but stated that some of the improvements are not voiced.
• Lisa Weed asked if an individual is determined eligible in one county via MnCHOICES, are they then eligible in all counties? Mary Lenertz stated that while there was a process in place for such transitioning of services, it was awkward.
• Commissioner Harpstead said that the assessments shifted from in-person to telephonic as a result of the pandemic, and that this had been a popular change.
• Representative Liebling stated the strategy was good as far as it goes. She suggested that maybe it would make more sense to centralize this function if the assessments are no longer in person. Mary Lenertz said that the State released an RFP for vendor to ensure greater consistency across assessors. Tribal nations feel they know best the resources within their community.
• Sheila Kiscaden said there is a tradeoff between consistency and services in context of community. While we want equal access to service and equal consideration of needs, we also want individuals to get personalized services that connect them to services in their community.
• Sue Schettle asked about the cost of in-person administration of MnCHOICES assessment. Mary Lenertz said there was not a good mechanism for determining this cost. Mary noted the superior value of an in-person assessment over a virtual one.
• Commission members expressed support for this strategy.

Meeting wrap-up

• Commissioner Harpstead asked Commission members for their help in identifying stakeholder groups for outreach and engagement.
• Commissioner Harpstead said staff would follow up in order to ask for members’ input on the approach to the action plan. She asked that the action plan mention that the only area where the Commission felt it spent sufficient time was in its review of the cost savings strategies.
• Sheila Kiscaden stated that the Commission should provide a menu of strategy options for the legislature to consider. She noted that very little would happen without legislative approval except for the strategies for which work was already underway. She acknowledged that the work of the Commission had been frustrating, and that it had not been able to undertake the scope and level of analysis that Commission members had hoped for. She asked that the action plan provide a comprehensive listing of the work of the Commission, with a clarification that the Commission was not endorsing all the strategies.
• Representative Liebling expressed interest in participating in a broader discussion of some of the topics that the Commission had not been able to tackle fully.
• Commissioner Harpstead said she reserved the right to follow up with the Commission members to revisit some of issues surrounding conclusion of its work.
• Sida Ly-Xiong asked each Commission member to express in a single word how they felt about the work of the Commission. Commission members responded as follows:
  • Representative Liebling said she was a little disappointed.
  • Sida Ly-Xiong said she was conflicted and confused.
  • Deb Krause stated that she had hoped for something more transformational.
  • Shauna Reitmeier said she felt underwhelmed and noted that the Commission did not undertake transformational work.
Sheila Kiskaden said she was disappointed. She remarked that the Commission started with great anticipation but that the Commission’s scope had narrowed. She added that the work accomplished by the Commission was also realistic, and it had accomplished as much as it could.

Sue Schettle said she was frustrated due to the “new normal” and that the Commission could not do the things it had intended to.

Joe Schomacker remarked that the work of the Commission represented a start, even though Commission members had higher intentions at outset. He stated that the Commission opened some old conversations and started some new ones.

Commissioner Harpstead stated that she was wrestling over how to use the Commission’s report to spur transformational change.

**Next meeting**

- June 11th, 3:00pm – 5:00pm
Blue Ribbon Commission Meeting 13

Meeting Notes

- Date & time: June 11, 2020, 3:00pm – 5:00pm CT
- Location: Virtual

Participation

Participating members: Commissioner Harpstead, Jennifer DeCubellis, Jennifer DuPuis, Nona Ferguson, Julia Freeman, Sheila Kiscaden, Deb Krause, Sida Ly-Xiong, Shauna Reitmeier, Sue Schettle

Welcome and check in

- Commissioner Harpstead invited Commission members to share a word or phrase that described their current outlook.
- Jennifer DeCubellis said that she remained focused on the work of her constituency.
- Sheila Kiscaden stated that she felt the current times offered a moment of opportunity and hope, and that the culmination of many years of civil rights activism had now reached a tipping point.
- Deb Krause said she was determined to be part of moving things forward.
- Sida Ly-Xiong stated that she felt optimistic, and curious about how people would handle change.
- Shauna Reitmeier said she was experiencing an awakening and feeling hopeful.
- Sue Schettle said she felt optimistic, hopeful and thankful that people were speaking their truth.
- Julia Freeman stated that she had been on an emotional roller coaster due to unrest in the community over the death of George Floyd, and also due to the loss of both friends and family to COVID-19.
- Nona Ferguson stated that each day offers an opportunity for a better day than the last. She expressed her interest in recommitting and staying the course.
- Commissioner Harpstead expressed hope that the death of George Floyd and recent civil unrest would represent a turning point and lead to lasting change.

Draft statement on health equity and transformation

- Michael stated that the Commission’s 13th meeting was intended to allow for time to reflect and to respond to the demand of Commission members for greater action on transformation and equity. He said that while there was not opportunity to advance additional strategies beyond those already discussed, there was opportunity for the Commission to craft a statement that reflected its vision for health equity and transformation.
- Michael asked Commission members to review the draft statement on health equity and transformation found in their meeting materials and to provide their feedback. Michael explained that the words in the transformation statement were intended as a draft for the members to reflect upon and respond to. He stated that after receiving feedback Bailit Health would work with DHS staff to prepare the next version of the statement for inclusion in the final report.
- Sue Schettle said that she had no changes to propose to the draft language. She said that she appreciated the statement’s call to address the “longstanding, embedded practices in health care purchasing practices, payment and service delivery that lead to health disparities are identified and modified.”
• Shauna Reitmeier agreed with the wording of the statement and asked that a bullet be added that would address health care outcomes. She said that it may be difficult to recognize when transformational health equity strategies have achieved their desired outcome, and that including mention of health care outcomes would address this. She urged the Commission to use its charge to advance transformational change and to then measure that change. Shauna suggested that the State may wish to have a report card to measure progress, and to create accountability for change.

• Sida Ly-Xiong said she had no specific edits. She requested that the final report include a disclaimer to indicate that the Commission did not focus on transformational strategies. Sida asked for clarification of the three bulleted statements in the draft, and whether they represent the Commission’s vision for what it wished it had tackled with regard to transformational strategies.

• In response to Sida, Michael Bailit stated that he would revise the statement to distinguish between the completed work of the Commission and future work that the Commission proposed in its statement on health equity and transformation.

• Sida Ly-Xiong requested that the third bullet begin rather than end with mention of health care disparities.

• Michael Bailit said that the draft statement on health equity and transformation acknowledged that the Commission was not able to advance its work on transformation, but that Commission members feel there is urgent need to address transformation.

• Sida Ly-Xiong stated that the draft statement did not explain how the Commission ended up with a much narrower focus than it had originally envisioned.

• Deb Krause stated that advancing transformational strategies had always been a top priority of the Commission, and asked that a statement to this effect be added to the first paragraph. She agreed that people most affected by racism and health disparities should be involved in planning change, as stated in the first bullet of the draft statement. She asked that the third bullet be modified to indicate that practices that lead to health care disparities not just be “identified and modified” but also measured and publicly reported. She also expressed interest in including in the third bullet a list of practices that need to be identified (e.g. administrative practices).

• Sheila Kiscaden said the statement focused too narrowly on health care and needed to be broadened to address health, social and economic disparities. She said that the Commission could not state that it is proud of what it has accomplished. She noted that the circumstances of the last two months created an opportunity for change that we have never experienced before, and that the State was ready to address embedded racism in a way it had not been able to before. She said that public health systems need transformation and that she would prefer to have a separate statement on transformation and modernization. She said that the Commission needed to acknowledge that the time is right for change and to consider a more comprehensive approach.

• Julia Freeman expressed agreement with Sheila Kiscaden on the need to focus on racial and economic equity in the statement on health equity and transformation. She also expressed support for including peoples of color in the implementation of strategies, not just their planning and evaluation.

• Nona Ferguson expressed support for Julia Freeman’s suggestion that impacted communities be involved in implementation of the strategies. She suggested that the draft statement would be stronger if it included more discussion of social determinants of health.

• Jennifer DeCubellis agreed that the statement on health equity and transformation should be included in the report. She expressed interest in having the work of the Commission continue for another year, particularly given that transformational strategies needed by the entire community.

• Michael Bailit stated that he would incorporate the feedback provided by Commission members into the next draft of the health equity and transformation statement, which will appear in the draft final report.

• Julia Freeman asked that Sheila Kiscaden share some of her proposed language with the Bailit Health team.

**Opportunities and approaches for engagement**

• Michael Bailit recapped the Commission’s June 4th, 2020 meeting discussion during which members expressed concern that the community outreach proposed by The Improve Group would be insufficient. He
asked Commission members if they still felt that reaching out to 35 individuals as proposed by The Improve Group would be inadequate.

- Commissioner Harpstead stated that she was prepared to cancel the remainder of The Improve Group’s contract if the Commission did not support continuing it.
- Shauna Reitmeier stated that she supported Commissioner Harpstead’s offer to cancel the remaining contract with The Improve Group, noting that it was an opportunity for cost savings to the State. If The Improve Group was invited to conduct conversations with stakeholder groups, that would encourage her to continue The Improve Group contract.
- Sida Ly-Xiong expressed agreement with contract termination, stating that she did not believe that the approach suggested by The Improve Group would result in useful feedback. She said that if the stakeholder groups themselves could conduct some additional outreach that might be a better use of funds.
- Julia Freeman agreed with the proposal to cancel the remaining contract with The Improve Group, indicating that she had been skeptical about the ability of The Improve Group to engage with the most vulnerable and impacted groups, particularly since many individuals in these groups lack Internet access.
- Jennifer DeCubellis said that it will be important for the Commission members to solicit input from community members, and not just from the professional organizations that represent them.
- Michael Bailit said that Commission members who had offered to conduct stakeholder engagement would receive additional guidance on how to do so, including on how to use the template in the toolkit prepared by The Improve Group. He also invited Commission members to provide the names of any additional stakeholder groups that they wish to identify.
- Jennifer DeCubellis requested that the Minnesota Hospital Association and the This is Medicaid coalition be added to the list of stakeholder groups for outreach.
- Commissioner Harpstead stated that she would only be comfortable cancelling The Improve Group’s remaining contract if the list of stakeholder groups became more diverse, and she requested help from Commission members in achieving this.
- Julia Freedman suggested two additional stakeholder groups: ARC and Autism Speaks.
- Krista O’Connor invited Commission members to forward stakeholder group suggestions to her via email.

Final report

- Beth Waldman stated that the Commission would review a draft of the final report at its June 25th meeting. Beth provided an overview of the final report’s structure. Commission members did not provide feedback on the report structure.

Meeting wrap-up

- Commissioner Harpstead thanked Commission members for their input, and said that they would receive a draft of the final report on June 25th for their review. She said comments on the draft, including comments for inclusion in the final report, were due from Commission members on June 30th.
- Commissioner Harpstead requested that Commission members conduct stakeholder meetings in July.
- Sheila Kiscaden noted that a voluminous report might discourage individuals and organizations from reading it. Beth Waldman explained that the final report would include an executive summary.
- Commissioner Harpstead said that Commission members would need a slide deck for the stakeholder meetings in July.
- Sida Xy-Liong requested a pre-recorded presentation to accompany the report. Michael Bailit said staff could create a pre-recorded Webinar presentation with an index so that listeners could easily locate that section of the presentation of greatest interest to them.

Next meeting

- June 25th, 2020, 9:00am – 12:30pm
Welcome and remarks
Commissioner Harpstead welcomed members of the Commission and stated that the meeting would offer members the opportunity to review the Commission’s draft final report and the proposed process for completing the work of the Commission.

Review of draft report

- Beth Waldman provided an overview of the report structure, noting that the draft report was developed to communicate the strategies initially prioritized by the Commission, and then advanced by the Commission for further consideration. She stated that in preparing this draft, staff worked to ensure that the strategies were not presented as recommendations in acknowledgement of the fact that the Commission did not have opportunity to conclude its work and actually make recommendations.
- Beth said that because the Commission wished to be sensitive to the time constraints of legislators, staff prepared an executive summary that provides an overview of the Commission’s work. She also noted that an equity statement was included in the draft, recently modified to incorporate some of the latest comments from Sheila Kiscaden.
- Beth Waldman asked Commission members to provide their feedback on the draft report. She posed the following questions in order to guide the discussion: Was the report structure clear and easy to follow? Did the report present a balance of summary and detailed information? Did the report strike the right tone?
- Julia Freeman said that the report authors were careful to make sure the strategies were not conveyed as recommendations, however the word “recommendation” was still used several times in the draft report and she was not comfortable with such language. She requested that this wording be changed.
- Sida Ly-Xiong said that it felt to her that the report carried an underlying assumption that the strategies would be implemented and she would like this corrected. She noted that in a few spots, the report stated that the strategies had been fully considered, but that they had not. She asked when and how the Commission would address and incorporate comments from the public.
- Beth Waldman noted that links to the public comment submitted thus far had been included within each strategy summary in an appendix to the report. She said that during the Commission’s August 19th meeting, members would have opportunity to discuss the public comment received by the Commission, and that the Commission could discuss at that time how best to address the public comment in the report.
- Jennifer DeCubellis expressed her support for having the Commission review the public comment and then weave its response to the public comment into the final draft of report.
- Gayle Kvenvold remarked that the report structure was clear, and she had the same observation as Julia Freeman with regard to use of word “recommendation.” She also noted there were a few places in the
Gayle noted that the use of the first person was appropriate in some sections, but had been used inconsistently. She remarked that Commission members felt deeply informed by presentations made by state staff during Commission meetings. She expressed hope that members of public would have access to the background information that the Commission received as part of the strategy presentations at each Commission meeting.

- Beth Waldman noted that some of the strategies were revised in response to requests from Commission members, but not all of the conversation that took place at the Commission meetings was reflected in the strategy summaries found in the final report appendix. She invited Commission members to review the final report appendix, and to indicate if there were strategies for which they would like staff to provide more detail.

- Lisa Weed stated that the Commission was tasked with identifying the $100 million in savings, but that it was not required to do so. Lisa noted that there were several places in the draft where the word “required” was used. Beth Waldman agreed to check that the language in the report mirrored the wording in the legislation.

- Sida Ly-Xiong stated her agreement with Lisa Weed and noted that identifying $100 million in savings was one component of the Commission’s charge, and that safeguarding against the loss of benefits was another. She cautioned the Commission to consider unintended consequences of the strategies. Beth Waldman noted that each strategy summary includes a section on the populations impacted, and addressed both the potential benefits and challenges associated with each strategy.

- Sheila Kiscaden stated that she viewed the report as a menu of recommendations for the Legislature’s consideration in its upcoming session. She said that she appreciated the links to public comments in each strategy summary.

- Representative Liebling expressed agreement with Sheila Kiscaden’s description of the report as a menu of options for the Legislature. She said that the report needed to be as simple as possible with more detailed information available to readers via links. In terms of incorporating public comment, she said it would be helpful to include a summary of the types of concerns that were raised or positive comments that were made. She noted that the situation had completely changed since the Commission started its work, and that the Legislature will likely need to make more than $100 million in budget reductions. She noted that health and human services are typically the first area where such cuts are made. She said that having the detail of the public comments embedded in the report was not necessary and that a link to public comments would be sufficient.

Personal comment opportunity for Commission members

- Commission members discussed the option of submitting a thousand-word personal comment for inclusion in the final report. Members stated that they did not feel such an opportunity was needed as their comments related to each strategy could be found in the minutes of Commission meetings during which the strategies were discussed and which are available on the Commission’s website. Commission members also expressed their desire to speak with a unified voice, and agreed that the submission of individual member comments would undermine this goal.

- Commissioner Harpstead expressed her appreciation for the discussion, and noted that the Commission members appeared to agree that the final report should not include individual personal comments.

- Commissioner Harpstead requested that staff link to meeting minutes as appropriate in the final report. She noted the request of Commission members to remove references to “recommendation” in the final report.

Solicitation of community and stakeholder input

- Krista O’Connor noted that the Commission had previously discussed outreach by both DHS staff and Commission members for purposes of sharing information about the Commission’s work and to solicit feedback to convey back to the full Commission. Krista asked that Commission members collect stakeholder input between July 13th and July 31st, and stated that such input would be due to her by Noon on July 31st.
• Krista stated that a recorded webinar would be made available to Commission members for stakeholders to view prior to meeting with the Commission member(s) or during the meeting. She said that the webinar would provide an overview of the 22 strategies described in the final report. She noted that the webinar would be posted publicly.

• Krista said that she would share with Commission members suggested guidelines for soliciting feedback from stakeholders and a template to record their input.

• Krista invited suggestions on the process she outlined, as well as suggestions for additional support that Commission members might need during stakeholder outreach.

• Commissioner Harpstead stated that she was excited about the list of stakeholder groups that Commission members had identified for outreach, and the diversity of the list. She said that she planned to spend significant time in July joining these sessions.

• In response to a question posed by Sheila Kiscaden, Krista O’Connor clarified that Commission members were not required to conduct stakeholder outreach.

• Krista O’Connor reported that DHS is planning a virtual community WebEx meeting to provide an overview of the 22 strategies and provide instruction on how to submit input utilizing the public comment process. The WebEx meeting will be open to any interested entity and a broad range of community organizations from across the State will be invited. She said that this event will likely take place in July.

• Gayle Kvenvold said that it would be important to indicate during the community event how public comment would be considered by the Commission and included in its final report.

• Commissioner Harpstead asked that Commission members express their commitment regarding to which stakeholder groups they would reach.

• Krista O’Connor encouraged Commission members to begin scheduling meetings with stakeholder groups.

• Sheila Kiscaden urged DHS staff to meet with the Health Equity Advisory Leadership (HEAL) Council. Krista reported that she had joined HEAL’s most recent meeting, and that the group had been invited to provide feedback on the report during the July 13th through July 31st public input window.

• Krista O’Connor stated that the Bailit Health team will spend the first two weeks of August examining the public input received through the community and stakeholder engagement meetings and through written public comment. She said that the Commission would review public input at its August 19th meeting and determine then what additional modifications are needed to the report.

• Krista O’Connor stated that DHS staff are working on language around the public comment solicitation, and invited Commission members to review the language and process. Julia Freeman stated that she was willing to review the information and offer feedback.

• Krista O’Connor said that Commission staff will provide guidance surrounding stakeholder input solicitation to Commission members during the week of July 6th, adding that the updated draft final report will be posted on July 13th.

**Commission member strategy classification**

• Commission members discussed a possible classification or ranking of the 22 strategies in the final report. Members agreed that such a classification would not add value to the report.

**Final equity review assessment**

• There were no comments on the process for final equity review.

**Final report approval meeting**

• Michael Bailit noted that the Commission was scheduled to hold its final meeting on September 18, 2020, and that the Commission’s final report is due to the Legislature on October 1, 2020. Michael said that members will receive the final draft report in advance of the September 18th meeting for their review. He noted that at the September 18th meeting, Commission members will be asked to vote to confirm that the final report accurately reflects the work of the Commission. Michael stated that as staff prepare revisions to the report, they will be sensitive to the wording concerns expressed during the June 25th meeting of the Commission.
• Sheila Kiscaden stated that there is momentum for deep and wide-scale change. She observed that the Commission could be more forthcoming in its call for action. She noted that the Commission’s report will get a serious look from the Legislature, and encouraged the Commission to further detail its call for equity and transformation, and how the Legislature could build on the work of the Commission. She suggested adding a statement to this effect in a separate section of the final report’s executive summary, and several Commission members expressed their support for this suggestion. Michael Bailit promised to draft such a statement in the executive summary. Gayle Kvenvold expressed her support, and asked that this statement use the “we” voice; she said it could either be a separate section or a transmittal letter. Michael agreed it could be both.

Wrap-up

• Commissioner Harpstead commended the Commission members for their work and the unity of their voice. She stated that she was proud that the Commission was able to resume its work during the pandemic and complete its charge in a timely manner. She expressed her gratitude to Commissioner Malcolm for her work in responding to the pandemic, and her leadership of the Commission.
• Commissioner Harpstead invited each Commission member to share a word that described their sentiments.
• Deb Krause stated that she felt responsible, and that Commission members had worked to ensure the report reflects their common thinking.
• Gayle Kvenvold said she felt hopeful. She acknowledged that while hope is not a plan, she was hopeful that the Commission’s work will serve as a building block to a wider call to action.
• Jennifer Decubellis said she felt encouraged and ready. She said transformative work of the future will be important, and that the Commission’s work offers a foundation for that work.
• Commissioner Harpstead expressed her thanks to the Commission members.
• Lisa Weed stated that she felt ready for action.
• Sheila Kiscaden stated that she felt committed to the work of the Commission.
• Sida Ly-Xiong said she felt the Commission landed where we expected to land.
• Tina Liebling said she felt grateful to the Commission. She stated that she had learned a lot and gained a lot of insight from the Commission.
• Michael Bailit stated that he was impressed with the adaptiveness of the Commission.
• Krista O’Connor expressed gratitude for the commitment and work of the Commission.
• Beth Waldman expressed her appreciation for the work of the Commission.
• Karen Mickelson said she was honored to have worked with the Commission.
• Margaret Trinity stated that she was excited to help the Commission prepare its final report.

Next meeting

The next meeting of the Commission will take place on Wednesday August 19th from 9:00am to 12:30pm. The meeting will be held virtually.
Blue Ribbon Commission Meeting 15

Meeting Notes

- August 19, 2020
- Virtual

Participation

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

Welcome and remarks

Commissioner Harpstead noted the diversity and volume of comments received by the Commission. She thanked the Commission members who participated in listening sessions with stakeholder groups and welcomed back Commissioner Malcolm.

Overview of public input to Commission

- Krista O’Connor provided an overview of the public input received by the Commission. She noted that the Commission engaged in an unprecedented effort to reach out and collect public input. This effort included a comment collection tool on the Commission website that gathered nearly 100 submissions. Krista noted that a July 15 public webinar drew 142 participants, and that Commission members and community groups hosted 13 virtual town halls and listening sessions. Krista shared a tally of the number of comments received by each strategy.

Goal of meeting

- Michael Bailit explained the goal of the meeting, which included to share Crystal Fairchild’s final equity review assessment, to provide a recap of the public input received for each strategy, and to solicit the Commission’s feedback on how public input should be reflected in the report. He noted that the Commission would also review a proposed change to the dental strategy due to special circumstances. He added that the Commission would not otherwise be considering changes to the strategies; they would remain as-is per the discussion at the Commission’s late June meeting.

Health equity assessment

- Crystal Fairchild presented a final equity assessment of the Commission’s work, and noted that an equity assessment was incorporated into the final report. She shared DHS’ guiding principles on equity, which are to promote equitable considerations across programs to ensure Minnesotans achieve their full potential, and serving as an agency where barriers such as race, ethnicity, access and geographic locations do not predetermine opportunities in health and human service outcomes for those the agency serves. Crystal described the equity lens that was applied to the strategies considered by the Commission. She noted that the assessment process utilized seven steps for building a racial equity lens.
- Crystal Fairchild reviewed the equity assessment process that DHS staff used in reviewing individual strategies. She discussed the key takeaway findings from the public input and Commission report, and identified the needs and opportunities that emerged from the assessment phase of this process. She noted
that over half of the public input suggested the use of an equity lens and the need for further health equity evaluation, as well as desire for authentic engagement prior to further development of the strategies.

- Crystal shared an “intent vs. impact” analysis and remarked upon the absence of LGBQT people from the Commission’s charge, and the lack of community engagement in the equity review process (e.g., individuals who utilize services). Finally, she noted that she would have liked to have seen more health equity strategies considered by the Commission.

- Crystal reviewed her recommendations, including monitoring of strategies for equitable outcomes, tracking the impact of strategies on communities over time, ensuring ongoing conversations with the community in order to meet the goals of transparency and accountability, and prioritizing racial equity (dismantling racist barriers will lead to improved lives).

- Julia Freeman said that she agreed with Crystal’s remarks regarding equity and community engagement, noting that the Commission was not able to complete its charge. Julia also made note of the current moment and the heightened charge for racial equity, and urged the Commission to strongly say to the legislature that racial equity needs to continue to be a priority.

- Shauna Reitmeier commented that the Commission has only taken the first step with regard to the strategies, and to the extent any of them are advanced, an equity lens will need to be incorporated during implementation. Crystal Fairchild expressed her agreement.

- Sida Ly-Xiong said that while she appreciated the equity review, it focused on the Commission’s own processes and not on the potential impact of the strategies themselves. She emphasized the need for further equity review of the strategies. Julia Freeman expressed agreement and said that she was not comfortable with use of the word “recommendation” in the final report, nor was she comfortable with use of the words “consideration” and “priorities” in describing the strategies reviewed by the Commission.

- Commissioner Harpstead acknowledged the Commissioner member comments, and expressed gratitude for her introduction to groups such as Diverse Elders Coalition and Doctors for Health Equity. She heard from these groups that equity is in the details, and how the strategies are implemented will determine equity. She said that Doctors for Health Equity urged the Commission not just to evaluate equity, but to design a strategy that makes life better for people of color. Commissioner Harpstead noted that in the very beginning most of strategies were submitted by lobbyists and professional associations, and the Commission needs to be aware of this. She urged Commission members to review the call to action in the final report.

- Commissioner Malcolm said it will be important to be clear in the final report about what work the Commission was not able to address. She noted the time that the Commission lost, and expressed appreciation for the Commission’s work, stating that the critical work moving forward now will be to pursue transformative changes.

**Review of public comment**

- Michael Bailit noted that there were very few comments received from users of services. He explained that some comments did not indicate whether they supported or opposed a strategy and that Bailit Health staff did the best they could to categorize those comments. Michael reviewed public comments for the nine health care cost savings strategies.

- **Implement Uniform Administration of Non-emergency Medical Transportation.** Michael Bailit noted that most comments in support of this strategy applauded its potential for improved access for older adults. He said that three professional associations voiced opposition, expressing concern over potential payment shifts from providers to the vendor. In response to a question from Sheila Kiscaden, Michael clarified that the three professional associations were the health plan association, the hospital association, and a group of county associations.

- **Modify Certain Medical Assistance DME Equipment Payment Rates to Match Medicare Rates.** Michael noted that this strategy received no supportive comments, and that comments expressed concern that future reductions to DME reimbursement for the Medicaid population would have a devastating impact on providers serving the Medicaid population. Other commenters noted that individuals with disabilities would lose access to specialized medical equipment, and others expressed concern over the possible
impact on rural communities. Sida Ly-Xiong asked about the disposition of this strategy given that it did not receive any supportive comments. Michael replied that the Commission agreed previously to include all reviewed strategies in the report, and that the Commission would be asked to provide guidance on how to reflect this feedback in the final report. Shauna Reitmeier shared concerns that she heard during a listening session that this strategy could lead to a decline in the quality of the equipment. Michael replied that this concern was heard most often in response to the next strategy to be reviewed, the DME volume purchasing strategy.

- **Expand Volume Purchasing for DME.** Michael noted that the majority of comments expressed opposition to this strategy, with many expressing concern that it would limit access to specialized DME products for individuals with disabilities. He noted that several comments referenced DHS’ prior experience in trying to shift incontinence supplies to volume purchasing, and the opposition that followed. Commissioner Harpstead shared a public comment suggesting that it might make sense to include an exception process for individuals with complex needs who also need specialized equipment. Julia Freeman stated that the term “opposing comments” missed the mark based on the concerns that she heard. Michael acknowledged the challenges when trying earnestly to synthesize public comment and listening session comments. Julia Freeman requested a link to the full comments. Krista O’Connor stated that the results of the online public survey would be made available to the public. Commissioner Harpstead asked that the second bullet on slide 27 be reworded, changing “many expressed concern” to “many families expressed concern.”

- Representative Liebling acknowledged that lobbyists are adept at providing public comment, but that often they do share the input and voices of those who actually utilize the services. She said it is difficult because no one wants to make cuts, and the challenge is to identify which options have the least bad impact on people.

- **Expand Use of the Minnesota Encounter Alerting Service.** Michael said that this strategy received 31 comments, the majority of which expressed enthusiastic support. Comments in support noted that the strategy could improve care coordination across systems of care, and with social service agencies.

- **Improve Compliance with Third-Party Liability (TPL) Requirements.** Michael said that this strategy did not receive many comments, and that the Commission received a detailed response from a TPL vendor. Commissioner Harpstead asked that the term “TPL” be spelled out in the final report.

- **Require Managed Care Organization (MCO) Competitive Price Bidding.** Michael reported that just a handful of comments expressed support for this strategy. He said that most comments offered constructive feedback, and the overwhelming theme was for DHS to be cautious in proceeding with this strategy. In particular, comments expressed concern over the potential that this strategy could result in decreased provider reimbursement rates. He noted that not many comments expressed support or opposition. Rather, the majority offered feedback.
  - Sheila Kiscaden said she was not sure how this work dovetailed with the procurement process for county-based purchasing. She said that it would be helpful to clarify this in the report and note that there is a separate effort underway. Sheila stated that rural counties use county-based purchasing which gives them a lot of flexibility. Michael said that the final report could clarify the impact of this strategy on county-based purchasing.
  - Julia Freeman reiterated the importance of not describing strategies as recommendations in the final report.

- **Create Uniform Pharmacy Benefit.** Michael noted that the Commission received primarily supportive comments in response to this strategy, although it did receive several opposing comments that said the strategy lacked evidence and would undermine existing processes in place within MCOs.

- **Establish Prescription Drug Purchasing Council.** Michael said this strategy had many supporters, and that they lauded the strategy’s potential benefit to Minnesotans, especially for older individuals who have difficulty affording prescriptions.

- **Establish Prescription Drug Affordability Commission.** Michael noted that the majority of comments on this strategy offered strong support. Those opposing the strategy expressed concern that such a Council would cap or unilaterally set prices for certain prescription drugs.
- Beth Waldman reviewed public comment received in response to the cost savings strategies related to Long-Term Services and Supports (LTSS) for persons with disabilities and older adults.

- **Housing Opportunities for People with AIDS (HOPWA) Home and Community-Based Services Settings Rule Appropriations.** Beth Waldman noted that the Commission received relatively few comments on this strategy, with several expressions of support and acknowledgement that the goals of the grants have been achieved.

- **Update Absence Factor in Day Services.** Beth Waldman said that this strategy received the most comments, and not a single one was supportive. She said that most comments expressed opposition, noting it would create additional hardships for providers during a difficult time, strain the workforce, and diminish access and quality of care. She noted that one comment stated the data used by DHS to inform the strategy are flawed. Shauna Reitmeier said that she received feedback from providers in the northwest Minnesota area that this would have a large deleterious impact upon them. She shared concern that reducing staff would impact individuals receiving these services. Sue Schettle said it is an important consideration to understand the underlying data.

- **Change Disability Waiver Family Foster Care Rate Methodology.** Beth noted that this strategy did not receive many comments, and those that were submitted were a mix of supportive and opposing. She noted support for the Life Sharing services component of this strategy. Beth said that the opposing comments expressed concern about the impact on family foster care provider financial stability if there were rate cuts. Sue Schettle noted that children’s services are not included under the Disability Waiver Family Foster Care program. Julia Freeman commented that this is the kind of strategy where she regrets the Commission did not have opportunity to dig deeper to look at social determinants of health, and to speak to recipients of these services.

- **Curb Residential Costs in Disability Waivers.** Beth noted that there are three components to this strategy. Supportive components focused primarily on the first of these components, and opposing comments focused on concerns around rate reductions and lack of housing options. She said that overall the Commission received more opposing than supportive comments.

- **Require Medicare Enhanced Home Care Benefit.** Beth noted that this strategy received numerous comments, the majority of which expressed support and noting that the strategy would expand access to services and promote independence. The single opposing comment said the strategy offered an untested approach and could result in premium increases.

- **Update Value-Based Reimbursement in Nursing Facilities.** Beth noted that the majority of comments opposed this strategy and expressed concern about the financial stability of nursing facilities, especially now when they are experiencing financial hardships due to COVID-19. Commenters raised concerns also about the impact of such a strategy on the workforce given reduced nursing facility revenues from this strategy. Gayle Kvenvold expressed regret that there was not more opportunity to talk about transformative strategies. She noted that the physical environment greatly impacts infection control, and we need to reimagine what these congregate settings can and should be.

- Michael Bailit shared public comments in response to the three strategies in the fraud, waste and abuse prevention category.

- **Pursue Fraud, Waste, or Abuse Prevention Enhancements.** Michael noted that this strategy gathered a few supportive comments, and the remainder were constructive. He noted that 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.

- **Reduce Low-Value Services in Minnesota.** Michael reported that half a dozen comments supported this strategy and the balance were constructive. Constructive comments focused on the desire to define low-value services. Michael observed that a number of the organizations that submitted comments may not have been familiar with the concept of “low-value services”, which is a well-defined term in the health care field but likely not beyond it. Commissioner Harpstead said that one of the listening sessions she
attended expressed appreciation for the strategy and would also like to see a strategy to increase provision of high-value services.

- Julia Freeman asked for clarification of the term “constructive” in categorizing the public comments. Michael Bailit said that a significant number of commenters did not express support or opposition, and in cases where we could not detect a strong sentiment either way we categorized them as “constructive.” Julia Freeman and Sue Schettle asked staff to consider a different word choice. Tina Liebling suggested that maybe the word should be “neutral.” Michael promised to consider different nomenclature that did not create confusion. Jennifer DeCubellis suggested “actionable comments” or “detailed comments.”

- **Align State and Federal Health Care Privacy Protections.** Michael said that there was enthusiastic support for this strategy. Tina Liebling noted her opposition to this strategy, and commented that while big health systems like this idea, there is not legislative support for it. She said that in the past the legislature has tweaked the MN Health Records Act to respond to concerns, but there is not support for further change. Julia Freeman said that this strategy might raise fear for undocumented persons with its reference to sharing medical record with federal government. Michael clarified that the strategy’s intent is to align Minnesota’s law with the federal law, so that two providers caring for the same patient can share information more readily. It is not to share information with the federal government. Representative Liebling said that Minnesota provides an extra level of protection to individual in terms of sharing medical records, and many think the extra level of protection is appropriate.

- **Improve MnCHOICES and LTSS Processes.** Michael noted the Commission received strong supportive comments, with no opposing comments. He shared that one comment urged caution to avoid shifting costs to counties and tribes, and that some comments noted a guide would be helpful given complexity of program.

- Beth Waldman reviewed public comment received for the three health equity strategies.

- **Ensure Equitable Access to Aging and Disability Service Programs.** Beth Waldman noted that this strategy received many comments, all of which supported this strategy. Those commenting noted the disparities in access to services between white people and Black, indigenous and people of color (BIPOC) within the aging and disability service programs.

- **Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports.** Beth noted that two-thirds of the comments received by the Commission expressed support, and none opposed. Several applauded the goal of allowing individuals earlier access to targeted case management.

- **Improve Dental Access in Public Health Care Programs.** Beth noted that this strategy received the most comments of all. More than half of the comments supported this strategy, noting the importance of dental health to overall health. Others acknowledged the low reimbursement rates for dental providers in Minnesota, as well as access issues for children and older adults, especially in rural areas. Beth noted that several commenters expressed concern over funding loss to Critical Access Dental (CAD) providers. Jennifer DeCubellis expressed strong concern related to equitable access for individuals with disabilities provided by CAD; she noted the risk of losing capacity if rates are reduced. Jennifer disclosed that Hennepin Healthcare is one of those providers.

### Dental access strategy

- Commissioner Harpstead explained the history of the dental strategy expansion, explaining previous mistaken miscommunication that caused an overlook of MDH’s strategy. She noted that there was support when DHS met with the chair of a MDH committee and discussed blend of strategies. Commissioner Harpstead said it was not her intent to overlook MDH’s dental strategy, which is why she recommended adding the MDH dental strategy as a substrategy within the previously considered dental strategy.
Commissioner Malcolm expressed her thanks to the Commission for considering the expanded dental strategy, adding that MDH thought it was a highly consistent approach with that previously considered by the Commission.

Beth Waldman explained that the dental sub-strategy would increase children’s dental access through a coordinated statewide school-based oral health program. She explained that there were three components to this strategy:

1. Integrate, align, and implement oral health strategies developed by the Association of State and Territorial Dental Directors into the Whole School, Whole Community, Whole Child model.
2. Create state and regional reach and coordination. This component emphasizes leveraging existing school-based/school-linked oral health programs and partnership.
3. Eliminate administrative barriers for dental hygienists. This component would add oral health screening and risk assessments to the Minnesota Health Care Programs (MHCP) benefit, and would allow for direct reimbursement from MHCP to Collaborative Practice Dental Hygienists.

Beth described key implementation activities that would be required for this strategy, including engaging state and regional stakeholders and communities, establishing an advisory group, hiring collaborative practice dental hygienists, and conducting a needs assessment and an evaluation. Anticipated benefits include improved quality of life and education metrics, and lowered disparities. Beth shared several sources that offer evidence in support of this strategy.

Beth noted that there are challenges associated with this strategy, particularly given the COVID-19 pandemic. She said it would take some time to build trust with school districts and to build shared agenda towards improving oral health.

MDH’s Bilquis Khan added that the MDH oral health program was working on defining high-risk schools, and that children in these schools were the target population. She noted that the sub-strategy aimed to achieve equity in oral health for these children. Linda Maytan, Dental Policy Director for Medicaid, said that slide 61 should have said “hygienists should become the pay-to-provider” for Minnesota Health Care Programs specifically.

MDH’s Clare Larkin noted that the collaborative model is not new, and that it is underutilized.

Commissioner Harpstead said that DHS was dedicated to finding a way forward and to improving access to oral health for children.

Julia Freeman asked that family engagement and community involvement be moved up on the list of 10 components found on slide 54, as families are the experts in terms of these services.

Bilquis Khan stated that the needs assessment is a fundamental first step and will be key in better understanding the communities’ and families’ needs.

Commissioner Harpstead acknowledged that the Commission was not able to share the sub-strategy with the public for comment and noted that the Dental Services Advisory Committee, which had reviewed the strategy, has membership is reflective of people who understand community needs at a grass roots level.

Jeanne Anderson of the Minnesota Dental Hygienists’ Association noted that she worked for a school-based program, serving children in schools that received over half of school lunches on a subsidized basis. She said that in that environment, she learned firsthand about the lack of coordination with parents.

Commissioner Malcolm said that she would appreciate the Commission including the dental sub-strategy in its final report, but deferred to the Commission. She suggested adding a footnote to the report indicating that the sub-strategy was not available for public comment.

Representative Liebling said that she has no problem including the sub-strategy in the final report since the report describes possible strategies, not recommendations. Representative Liebling said that she very much supported the sub-strategy given that the lack of proper dental care for many children in Minnesota. She also noted the potential for downstream savings.

Several members raised questions as to why this sub-strategy was lost in the process, and Commissioner Harpstead said this was a unique oversight and due to the COVID-19 interruption.

Commissioner Harpstead noted general support in the WebEx chat box for the dental sub-strategy.
Reflecting public input in final report

- Beth Waldman suggested that the synthesis for each public comment be included in the report following the description of the strategy.
- Lisa Weed stated that the public comments need to be reflected more prominently in the report, showing that the Commission engaged the public. Representative Liebling said that she felt otherwise, noting that the Commission did not fully vet or review the comments. She expressed reluctance in giving the public comments prominence in the final report given that the Commission members have had little time to review them. Lisa Weed said she agreed and hoped that the comments would be included and not just a link. She said she would like the comments to be easy-to-find.
- Julia Freeman expressed regret that the Commission did not have the opportunity to hear directly from BIPOC communities. Commissioner Harpstead said she appreciated this input.

Meeting wrap-up

- Commissioner Malcolm expressed appreciation for the Commission members’ input, and noted the importance of the public comment that had been received by the Commission.
- Commissioner Harpstead invited Commission members to review the call to action contained in the draft final report.
- Sida Ly-Xiong asked about the voting process at the Commission’s final meeting in September. Michael Bailit suggested that agency staff confer on this topic and provide detail to the Commission members in a follow-up email communication. Commissioner Harpstead promised to share details related to voting procedures in advance of the final Commission meeting.
- Commissioner Malcolm noted that the Commission had captured the potential upsides and downsides of each strategy, and the extensive discussion had been helpful. She stated that she was eager to have conversations about transformative strategies. She expressed appreciation for the strategies found in the report, even though they lack the Commission’s endorsement.

Next meeting

- The Commission’s next and final meeting will take place on Friday September 18 at 9am CT.
Blue Ribbon Commission Meeting 16

Meeting notes

- September 18, 2020
- Virtual

Participation

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

Welcome and remarks

Commissioner Harpstead expressed her appreciation for the work of the Commission and staff over the past year. She expressed her gratitude for having worked with each of the Commission members. She stated that the insights that the members shared would guide her in her work moving forward at DHS. Commissioner Harpstead also expressed gratitude for the public comments received by the Commission and the public engagement opportunities initiated by the Commission. She expressed pride in having been a part of the Commission and the Commission’s efforts to complete its work despite challenging circumstances given the COVID-19 pandemic.

Commissioner Malcolm expressed appreciation for Commissioner Harpstead’s leadership of the Commission during the COVID-19 crisis. She stated that she shared the frustration of many members that the Commission lacked sufficient time to address health equity and transformation, but she added that the Commission aptly pointed out these deficiencies in its report. She acknowledged the uncertainty and anxiety surrounding the pandemic and recent social unrest, and stated that the best way to move forward would be in partnership with those most affected by the pandemic. Commissioner Malcolm acknowledged the painful work needed to address systemic racism and injustice in our society. She commended the Commission, noting that it had demonstrated the ability to engage in respectful dialogue. Commissioner Malcolm thanked the Commission members for their service.

Review of agenda

Commissioner Malcolm reviewed the agenda. She stated that the purpose of the Commission’s vote would be on whether the report accurately reflected the work of the Commission. She stated that the Commission would not invite public comment due to the virtual nature of the meeting. She noted that staff had not received any requests for revisions to the August meeting notes.

Commissioner Harpstead thanked the Bailit Health team for its contributions to the Commission’s work, and stated that they had been an invaluable asset.

Review of changes to final report

Beth Waldman recapped the changes made to the Commission’s draft final report since the Commission’s August meeting. She stated that staff had inserted a statement acknowledging that the COVID-19 pandemic and other constraints had impacted community engagement efforts and that these efforts had fallen short of the Commission’s expectations. In addition, she said that staff had inserted a sentence acknowledging insufficient engagement with BIPOC consumers. Staff also added to the draft report a description of the final health equity assessment. Beth explained that staff had added descriptions of the public comments received by the
Commission, including a new public comment that staff received in late August from the Tribal Nations. Beth stated that the dental strategy now included a second part in follow up to the Commission’s discussion at its August meeting. She noted several additional modifications to language throughout the draft report.

Beth Waldman stated that staff recently identified three additional public comment letters, which would be incorporated by reference to Appendix 5 and 6 of the report. The first letter was submitted by the Oral Health Alliance and expressed opposition to the strategy Improving Access to Dental Care. The second letter was received from the Biotechnology Innovation Organization and expressed opposition to both the Establish Prescription Drug Purchasing Council and Establish Prescription Drug Affordability Commission strategies; this letter also advocated that biopharmaceuticals be included in alternative payment models. Beth explained that a third public comment letter was received from Anne Jones, a retired registered nurse who supported an undeveloped strategy, State Healthcare Purchasing Strategy Reform.

Representative Liebling raised the issue of meeting minutes, noting that Appendix 5 included links to individual meeting minutes where a particular strategy was discussed. She expressed concern about the inclusion of links to meeting minutes, noting that while Commission members had received meeting minutes, they had never been asked to vote on their approval. She noted that the meeting minutes were actually not transcripts and that they paraphrase Commission discussions. Shauna Reitmeier expressed support for Representative Liebling’s comments. Sue Schettle suggested adding a disclaimer to the minutes. Representative Liebling expressed her preference that the minutes not be linked in the report. Commission members voiced their agreement. Michael Bailit stated that while he believed inclusion of the minutes was consistent with the transparency of the Commission’s process, he felt the minutes were not essential to the report because the report summarized the deliberations of the Commission.

Julia Freeman asked if it would be feasible to insert links to public comment letters in the report. Beth Waldman replied that staff could add link to the page where public comments are found on the Commission’s website.

Commission members agreed to include in the report a link to public comments received by the Commission, and also a single link to the website page where meeting minutes could be found -- accompanied by a disclaimer that the meeting minutes had not been approved by the Commission members.

**Roll call vote**

Julia Freeman made a motion, which was seconded by Jennifer DuPuis that the final report accurately reflected the work of the Commission. Commissioner Harpstead announced that the motion was passed by a roll call vote of the members with 14 members present and all voting affirmatively with an “aye” response. Commissioner Malcolm noted that per the Commission’s charter, a majority vote had approved the final report, subject to the changes agreed upon by members during the meeting.

**Learnings**

Krista O’Connor reviewed responses from seven Commission members to the following questions: What are lessons you have learned from participating in this Commission? What are you appreciative of? What would you most like to see happen as an outcome of the Commission’s work?

- Krista O’Connor reviewed responses from Commission members to the question “what are the lessons you have learned?”
  - Krista noted that the responses acknowledged that the Commission included members with various levels of understanding about DHS programs and policies, and this required significant time for level setting.
  - She noted that members stated that the Commission needed a deeper understanding on race, diversity, inclusion and systemic racism. She said that Commission members acknowledged the challenge of engaging those with lived experience in a meaningful way.
  - Krista stated that Commission members valued diverse perspectives, but sharing those perspectives took significant time.
  - She said that members were very committed to the charge of the Commission, and cared.
Members noted that the strategies were complex and detailed, and some felt that they should have been provided with a more realistic sense of the time commitment at outset. Others observed that member participation in the Commission dropped over time, perhaps due to the workload necessary to stay engaged.

Krista said that an additional lesson offered by those who responded to the survey was that the Commission’s scope was too broad to be completed even within the original timeline, and the interruption resulting from the COVID-19 pandemic made it impossible.

Krista shared an additional lesson from those responding to the survey, which was that perfect solutions do not exist, and there was no “low-hanging fruit” in terms of easy strategies to develop.

Finally, many of those responding to the survey acknowledged the need for transformational change, however the Commission did not achieve this.

Krista stated that Commission members learned that through a long and dedicated process, they were unified on the final report, and the vote reflected this.

Jennifer DeCubellis stated that this Commission was an enormous undertaking. She said that the Commission did the best it could. She noted that members said that while they were not aligned, they were able to listen to one another.

Julia Freeman expressed gratitude that the Commission members were unified and transparent in stating that they were not able to complete the Commission’s work.

Shauna Reitmeier reflected on her experience on a mental health task force under a previous administration. She stated that the Blue Ribbon Commission offered an example of how to achieve meaningful input on diversity and inclusivity.

Sue Schettle stated that she learned a lot from the Commission and the different perspectives shared by its members.

Sheila Kiscaden stated that she has been on many Commissions over the years and that she had gotten to know and understand the perspectives of the other Blue Ribbon Commission members in deeper ways than she had on other Commissions. She stated that the interpersonal listening of the Blue Ribbon Commission was unusual. She said that the scope of the Blue Ribbon Commission’s charge was enormous. She observed that the Commission had a lot of staff but that it would have needed more subgroups in order to accomplish its mission. She expressed gratitude to those legislators who attended and participated in the Commission’s meeting, notably Representative Liebling. She stated that Commission members had a new awareness of structural racism. She thanked members of the Commission, as well as state staff and Bailit Health.

Sida Ly-Xiong stated that she appreciated the amount of work accomplished by the Commission, noting that the Commission’s discussions were rich. She said that the Commission was largely reactive instead of proactive, and that the scope was narrowed too much at outset.

Krista O’Connor reviewed responses from Commission members to the question “what are you appreciative of?”

Krista stated that the responding Commission members appreciated one another’s hard work and commitment to the Commission’s charge. Commission members also appreciated the respectful, thoughtful commentary made by Commission members, as well as their passion and dedication.

Krista noted that Commission members expressed appreciation for state staff. In their survey responses, Commission members acknowledged the state staff who work “day in and day out,” and that state staff care about the programs. Commission members appreciated the work of the state’s vendor Bailit Health in organizing meetings, conducting research, and delivering the final report.

Krista also noted that Commission members expressed appreciation for input from stakeholders and the public.

Representative Liebling observed that the Commission was comprised mainly of women, which she speculated may have led to the Commission’s productive dynamic. She expressed her appreciation for
state staff and for Bailit Health. She also thanked staff and Commissioners for their work and service to the State.

- Krista O’Connor reviewed responses from Commission members to the question “what would you most like to see happen as an outcome of the Commission’s work?”
  - Krista stated that Commission members requested that the Commission’s unfinished work be completed. Members emphasized that the message to legislators should be clear that the Commission’s work was not finished and that the report is incomplete as a result. Commission members expressed desire to redirect the list of unfinished strategies to appropriate individuals. Commission members who responded to the survey also asked that the list of equity and impact considerations be examined further and that it be used to remove barriers and waste.

- Sheila Kiscaden asked if given budget shortfalls and challenges with COVID, there was still a path forward to address questions of transformation. She asked if there was a way to elevate the conversation on transformation so that it gets more attention.

- Commissioner Harpstead said that times of crisis often result in transformation. She added that the Commission had alerted the Governor’s subcabinet of the transformational changes desired by the Commission.

- Commissioner Malcolm remarked that transformational change requires time, and that she would like to build political will for changes that require a longer timeframe.

- Representative Liebling stated that she was hopeful, adding that crises create momentum for change, and that she felt this to be the case with regard to structural racism.

- Sheila Kiscaden stated that the COVID-19 crisis had revealed our interdependencies. She expressed optimism for future change as a result of current crises.

**Final remarks**

- Commissioner Harpstead stated that she appreciated the good government on display during the deliberations of the Commission. She observed that Minnesotans have the ability to come together to solve problems and she saw this trait in the Commission’s meetings and deliberations. She expressed gratitude to the Bailit Health team for developing each strategy and the process for gathering input on those strategies. She also expressed gratitude for the learnings provided by the Commission during her first year as DHS Commissioner. She remarked that she would never forget the Commission given the tough times during which it deliberated.

- Commissioner Malcolm thanked Commissioner Harpstead for her stewardship of the Commission, and stated that Minnesotans are fortunate to have her leadership at DHS. Commissioner Malcolm stated that she looked forward to future conversations on how best to pursue transformation.

- Michael Bailit expressed his gratitude for the good, thoughtful work of the Commission. He acknowledged that the Commission did not have time to fully address its equity and transformation charge. He suggested a follow-up commission to address these areas. Michael offered the following observations.
  - Michael noted that the Commission treated equity as an equal area of focus alongside traditional issues, and that he had not seen this previously in other states. At same time, he acknowledged that the equity strategies received by the Commission were not strong as they might have been. He observed that as a nation we are struggling with how to advance health equity. He noted the thoughtfulness of the equity review process, but added that this process was conducted retrospectively and missed the opportunity to consider equity during strategy development.
  - Michael commented that the Commission began its work with a real effort at authentic community engagement, and while this was not achieved the intent was impressive nonetheless.
  - Michael stated that the composition of the Commission was unusual, and included a mix of both policy veterans and others who in the past would not have had a seat at the table. He said that this mix of representation on the Commission provided both an opportunity and a challenge, as the Commission members lacked a common language but they brought a fresh and new perspective. He stated future such commissions would benefit from extra time to achieve equal level of understanding among participants.
Finally, Michael stated that Minnesota is fortunate to have health and human services agencies with such a deep pool of smart and dedicated staff, noting that all other states do not share this resource.

- Commissioner Harpstead adjourned the Blue Ribbon Commission on Health and Human Services.