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June 24, 2020

Dear members of the Blue Ribbon Commission,

We write as the Minnesota Consortium for Citizens with Disabilities, a coalition of over thirty disability advocacy organizations and providers that work together to advance independence, equity, and quality of life for people with disabilities through policy advocacy. We have been following the work of the Blue Ribbon Commission for Health and Human Services and are grateful for each of your time and commitment to finding ways to fulfill your legislative mandate on behalf of the state of Minnesota.

As you are narrowing your work to a list of specific strategies, we write to offer feedback on various strategies that impact people with disabilities in Minnesota.

**Strategies We Support**

Many of the strategies you’ve considered would bring great improvements to Minnesota’s disability service system and the lives of people with disabilities. We strongly support these strategies, many of which were submitted by MNCCD members:

**Ensuring Equitable Access to Disability Service Programs (Strategy #43)**

Racial disparities across Minnesota’s disability service programs have long resulted in Black, Indigenous, and people of color with disabilities accessing fewer and less services than their White counterparts. We applaud DHS for establishing the HCBS Disparities Advisory Group and urge the Commission to push for the legislature and DHS to implement the plans outlined in this strategy. This strategy was submitted by MNCCD member Mid-Minnesota Legal Aid/Minnesota Disability Law Center.

**Curb the Growth and Use of Residential Services (Strategy #425 and others)**

The goal of this strategy, to increase waiver participants’ access to independent housing, is one MNCCD strongly supports (we submitted a strategy along these lines!). We applaud DHS for submitting this specific strategy and urge the Commission to advance this strategy and sub-strategies. Specifically, support planning for people who want to move should be a key driver of this strategy overall. Any bed closures and rate reform should be done in a way that does not decrease access to group residential settings for people who want them. In sum, we urge the state to take swift and transformative action to ensure that all people who want to live on their own have access to the opportunity to do so. Not only will this save money, but it will afford people with disabilities the independence and choice they deserve.

**Family Foster Care Rate Reform (Strategy #424)**

This strategy includes a new service that we strongly support: Life Sharing. Life sharing is a relationship-based living arrangement that carefully matches an adult 18 years or older who has a disability with an individual or family who will share their life and experiences, as well as support the person using person-centered practices. This service will lead to better community-
based living and person-centered services for adults with disabilities. We urge you to advance this strategy.

Finally, we write in support of a strategy that was not selected for development: Increasing Access of Home & Community Based Services for Older Adults (Strategy #105). We urge you to advance these strategies and push for them to be incorporated into state policy, practice, and law, as applicable.

Strategies with Concerns
Several strategies raise significant concerns for people with disabilities and access to needed services and supplies. Our members may have shared some of these concerns with you as you considered these strategies. We write now on behalf of MNCCD and urge you to reconsider advancing following strategies:

Durable Medical Equipment and Supplies Rate Reform (Strategy #420)
This proposal changes the reimbursement for Medicaid Durable Medical Equipment (DME) to the Medicare rate. This strategy is likely to result in people with disabilities losing access to needed specialized medical equipment and is not necessarily likely to offer savings. The vast majority of the fee schedule is reimbursed at the Medicare rate currently. The remaining items reimbursed above the Medicare rate are specialized supplies that are medically necessary for certain people, but that tend to be very costly. Reducing the reimbursement for these specialized DME and supplies will not allow suppliers to be reimbursed for these items at cost. When suppliers must take a loss on a certain item, they typically are unable to continue carrying it and the people who need those items will not be able to access them.

The supporting evidence for cost savings with this proposal is based on "evaluation evidence that suggests maintained Medicare beneficiary access to services and satisfaction for DME and supplies paid at the Medicare rates." But Minnesota’s Medicare population is different from our state’s Medicaid population and they are not readily comparable in terms of DME needs. Our Medicare population is primarily elderly and stable adults, whereas our Medicaid population includes children, pregnant women, people with disabilities, and a small portion of the Medicare population. The Medicaid population likely has far more need for the highly specialized DME products targeted by this proposal and will decrease access to them. Reducing reimbursement for specialized DME and supplies will have a disproportionate impact on the families that need it to live safely at home.

Volume Purchasing (Strategy #419)
This proposal is to expand volume purchasing for durable medical equipment beyond the current items subject to volume purchasing (eyeglasses, hearing aids, oxygen and diabetic test strips) to other DME products such as enteral nutrition, incontinence supplies, wheelchairs, walkers, and wound care supplies. Expanding volume purchasing to these items will make it difficult for people with disabilities to access the supplies they need. Volume purchasing has historically reduced the quality and variety of products available, which means that many people cannot access products that work for them. If a person with a disability does not fit into
the "floor model" item because of sensitivities or specialized needs, that person will likely not have access to get specialized supplies even if it is ordered by the doctor. Patients that cannot afford to pay out of pocket will not have access. The supporting evidence for this strategy is the same as for DME rate reform, that "Medicare beneficiary access and satisfaction have not been affected by competitive bidding." But again, Medicare and Medicaid serve different populations, and people with disabilities have a diverse set of needs that cannot be met with a "one size fits all" program.

**Absence Factor in Day Services (Strategy #383)**

This strategy is also a proposal of concern to the disability community. People with disabilities and advocacy groups are working hard to improve outcomes for adults with disabilities in their employment and day enrichment goal and this proposed reduction in the Absence and Utilization factor within the Disability Waiver Rate System formula will hinder our state’s progress in this area. Disability employment and day enrichment services are experiencing a workforce crisis, and service providers are using all available administrative time and resources to attract and retain quality employees to perform these vital services. Reductions in the factors in the rate setting formulas, including the Absence and Utilization factor, will make reimbursement rates even tighter and it will be hard for providers to pay adequate wages and benefits to people doing good and innovative work supporting people with disabilities to reach their employment and day enrichment goals. Previous public comments outlining concerns regarding this proposal have been shared with the Blue Ribbon Commission, and providers of these services continue to welcome the opportunity to collaborate with DHS for further discussions on this specific issue and broader reforms for the disability waiver rate setting system.

Thank you for your work on behalf of Minnesota’s health and human services systems. You have received and absorbed a tremendous amount of information in a short period of time. We hope that you will consider our views on these strategies that would impact people with disabilities in Minnesota.

Sincerely,

Marnie Falk  
MNCCD Board Chair

Maren Hulden  
MNCCD Policy Co-Chair

Melissa Haley  
MNCCD Policy Co-Chair
Member of the Blue Ribbon Commission,

I am a part of a group of parents who share the bond of being mom’s to children with medical complexities in the state of Minnesota. These children rely on Durable Medical Equipment (DME) and home care to lead their best lives and participate in their communities. The cost cutting measures that are being proposed by the Minnesota Blue Ribbon Commission, particularly those focused on Durable Medical Equipment rate reform and volume purchasing, will limit access to vital resources needed for our children.

First, I will share a bit about my journey with Leo

Leo was born in May of 2016 and was diagnosed with infantile Pompe disease, a rare genetic disorder. His body stores up glycogen in the muscles and the heart causing deterioration, muscle weakness, respiratory failure, cardiomyopathy, and the list goes on.

Throughout his life, Leo has received support from quite a few different home care services. Weekly enzyme replacement infusion therapies, monthly respiratory therapy visits to check his trach and ventilator, and even enteral nutrition support.

That’s not even the full list. Needless to say, he is a very complex patient, but at the end of the day he is still a kid. And he wants to play, to run, to keep up with his older brother, just like any other kid. For that to continue, he needs access to care through an organization that understands the unique needs of a child and who has the supplies and the specialists to care for his growing and changing needs. The ability to be nimble and adjust the supplies to fit his needs is one of the many reasons he is succeeding at home today, and why we have been able to avoid hospital admissions despite his complex diagnosis and care needs.

Now that you know a little more about Leo, I’d like to share some of our concerns around the suggested changes to DME.

‘Rate Reform’ moves all DME rates to the Medicare fee schedule and will reduce access to the medically necessary equipment and supplies that are specific to caring for children with medical complexity. It could also have the impact of sending complex pediatric children, like Leo, to live in the hospital due to lack of available equipment that meets his unique needs at home.

It’s important to call out that Medicare is designed for stable aging Americans, not children with complex disabilities. The overwhelming majority of DME products on the Medicaid fee schedule are currently reimbursed at the Medicare level. The Medicaid program has worked hard to create as much efficiency as possible to find the lowest cost solutions where possible. The products that do not align with the Medicare fee schedule are highly specialized, medically necessary items designed for the complex pediatric population. I’m talking about items such as custom trach tubes for smaller airways,
gastrostomy tubes, and specialized enteral nutrition, all supplies that we have relied on at some point for Leo. I want to highlight the importance of these specialized eternal formulas and supplements because they reach far beyond just the patients with Pompe, into other diseases like MS, ALS, MPS, and Alzheimer to name a few. Each of these diagnoses have approved dietary treatments that help extend life and keep patients out of the hospital. Maintaining coverage and reimbursement for the specialized nutrition options results in patients will needing fewer medications and even possibly, less durable medical equipment.

I am asking for protection on the reimbursement for these specialized DME products. They are essential to allowing our children the freedom to live life at home and participate within our communities. If these products were reduced to Medicare reimbursement levels, suppliers would not be able to afford to provide them at such a significant loss. As a result, our children would be forced to use products designed for a completely different population. This would result in risks to their health and negative impact to our whole family's quality of life.

‘Volume purchasing’ for an expanded list of Durable Medical Equipment will reduce the quality of care that Medicaid beneficiaries have access to by inviting the lowest cost, lowest quality products to be provided by the supplier who wins the bid. Where the quality of product is not sacrificed, the quality of service is. Similar to the negative impact that would be experienced by patients through rate reform, volume purchasing will also reduce access to supplies required by our complex kids as it limits the number of providers who can support our families. Additionally, not all providers carry these specialized products in the first place. So, restricting further would guarantee access issues. Many of us family advocates did not support the preferred incontinence volume purchasing program that passed without stakeholder engagement and helped to get it repealed. I have learned about other states that have tried to volume purchase incontinence products and how that lead to issues such as leakage, skin break down, and other complications that result in lower quality of life and readmissions. A program like this was overridden in the state of Texas due to beneficiary and provider concerns that proved valid.

As parents and citizens, we would like to see you work with the Blue Ribbon Commission to withdraw these two strategies from your list of cost cutting recommendations. Both options will limit access to care, increase costs by sending patients into the hospital due to lack of access to supplies necessary for their unique needs. I am available to meet with you virtually along with Leo and further explain why these recommendations will hurt the access to healthcare and the quality of life for children like Leo.

Thank you for your time and attention to this matter.

Sincerely,

Anne St. Martin | 630-670-6569
Concerned Parents of Children with Medical Complexities
Blue Ribbon Commission Written Public Comment

Date: 05/06/2020

To: Health and Human Services Blue Ribbon Commission

From: Unite Us

Comment

Suggested Strategy Title:

Paving the Way for Healthier Communities with Public Health Infrastructure

Rationale and Background:

Across the country, health and human service organizations lose visibility on a patient the moment they walk out of that facility. At that point, there is no way of understanding the impact of another organization, or if that patient made it to another facility. The system does not understand if they have made an impact on this person’s life, or if that person fell through the “cracks”. With the ability to track referrals and outcomes, health and human organizations will have better insight into the full patient journey, and the patient would receive better, more holistic care.

Short description of the proposed change:

Unite Us is changing the traditional care delivery model to one that holds providers accountable and goes beyond the referral. Our intuitive technology platform supports meaningful collaboration, community-wide care coordination, and secure, bidirectional data-sharing. Our comprehensive network-building and change management process creates value for network partners with a focus on increasing public access to services and empowering people in the community to take ownership of their own health. Our platform is the only proven platform that tracks the entire lifecycle of every referral, but also every interaction, outcome, and overall health indicator around every patient and has the sophisticated ability to report on it. Embedding our public health infrastructure within the communities to enable the flow of data across these historically siloed organizations will allow outcome-level data, both positive and negative, to be shared across the communities and understood at the state level. By having an understanding of a baseline of outcome-level data, the state can now make policy decisions to impact or improve upon the health of the population.

This strategy addresses the following aspect(s) of the Commission's charge:

Transform the health and human services system.

Suggested Strategy:

Work with Unite Us to stand up and implement the public health infrastructure to connect these disparate groups. Our team will work with the state to develop a network deployment strategy to span across the state in a series of incremental steps with a goal of covering the entire state.

***For reference check out the work we are doing in North Carolina (simple Google search of NCCARE360).
Dear Co-Chairs Harpstead and Malcolm,

Minnesota is on the cusp of unprecedented shifts in demographics to an older, more diverse state. This shift allows us opportunity to think creatively about our health and human services policies and programs. It is vital that we continue proactive, future-oriented thinking to ensure that our state remains economically productive.

The Blue Ribbon Commission’s charge to find $100 million in cuts in the near-term HHS budget is deeply concerning, particularly within the context of the demographic shift. We are in many ways not prepared.

**Supporting Low-Income, At-Risk Older Adults**

As reported by the Department of Human Services, Elderly Waiver rates need modernization, including filling a nearly $400 million gap in investment. Providers across the state are subsidizing the cost of care and many are transitioning to discontinue service or limit the number of Elderly Waiver clients. These forced economic choices decrease choice and access for individuals. Further cuts or adverse changes to eligibility are short-sighted and would limit access to and increase costs of services in the future. Investments in the home and community-based service infrastructure through Elderly Waiver are common-sense and helpful in keeping individuals out of the more costly Skilled Nursing Facility setting, which results in bending the cost curve.

**Living Well with Chronic Conditions**

Older adults are living longer, and for many that means managing chronic conditions that can threaten independence and quality of life. Significant spending in health care occurs at the end of life, a curve that can be mitigated with early intervention and supports. The Blue Ribbon Commission should pay particular attention to supporting older adults living with chronic conditions such as Alzheimer’s Disease and related dementias. All Minnesotans should have access to early screening, diagnosis and competent long-term services and supports including the best in evidence-based health promotion and chronic disease management strategies.

The Commission should support proven models such as palliative care and innovate new models of integrative services across community-based, acute and long-term care settings. This work must include considerations for friend and family caregivers who are key to ensuring high quality of life and cost containment strategies.
Eliminating Social, Economic, and Health Disparities
For many, Minnesota is a great place to age. The state is consistently ranked the healthiest and most senior-friendly in national polls. However, this is not true for all groups. Minnesota ranks as one of the highest in disparities between communities of color and the LGBT community and their peers. Healthy aging is both a public health and health disparities issue. Differences in education, income, and wealth, along with the impact of chronic stress and social exclusion associated with race and language barriers negatively impact the health of older adults. The lack of equity (social, health, environmental) impacts the health and well-being of all older Minnesotans and their families and creates health disparities. The Blue Ribbon Commission must continue to place focus on eliminating health, economic and social disparities if our state is to thrive for all older Minnesotans.

Own Your Future
It is well documented that a significant cohort of the Baby Boom Generation will not have enough retirement income to support their rising health and long-term care costs. We need to take immediate action to bolster the retirement outlook for future older adults. This immediate action should include adding a rider to Medicare Supplemental Insurance plans to include essential community supports and PCA services. It should also include building on the important work of the Own Your Future initiative to develop new private-market products to increase individual investments in health and long-term care. These personal investments will save money in the long-term.

Age-Friendly Minnesota
Purposeful involvement of older adults, their families, and the aging services workforce in systems design, programs and policies is critical. The Blue Ribbon Commission must inform and support the work of the Governor’s Council on an Age-Friendly Minnesota. This Council is charged with recommending to the Governor initiatives to ensure we continue to thrive into the future as we become older and more diverse. This work recognizes the diversity of communities across the state and further recognizes that these communities are uniquely positioned to be their own best problem-solvers and innovators. The recommendations you make will have far reaching implications across all communities in the state. Using a community-based framework to make decisions can help ensure strong communities now and in the future.

Thank you for your commitment to ensuring older Minnesotans have access to the needed supports to live well and age well. Please do not hesitate to contact me at adam@mnlcoa.org or (651) 271-3116 for further clarification or to answer any questions.

Respectfully submitted,

Adam Suomala
Executive Director
Mollie O’Brien
Chief Strategy Officer
Alzheimer’s Association Minnesota-North Dakota

Maureen Kenney
Director of Aging Services
Amherst H. Wilder Foundation

Patti Cullen
President and CEO
Care Providers of Minnesota

Patricia McArdle
Director of Aging and Disability Services
Catholic Charities

Roxana Linares
Executive Director
Centro Tyrone Guzman

Ann Bailey
President and CEO
DARTS

Beth Wiggins
Director of Caregiver Support and Aging Services
Family Means

Phil Duran
Director of Advocacy and Research
JustUs Health

Mary McKeown
President and CEO
Keystone Community Services

Gayle Kvenvold
President and CEO
LeadingAge Minnesota

Mary Quirk
Executive Director
Living at Home Network

Jeri Schoonover
Chief Services Officer – Community Services
Lutheran Social Services of Minnesota

Terri McCarthy
Geriatrician
Minnesota Association of Geriatrics Inspired Clinicians

Amanda Vickstrom
Executive Director
Minnesota Elder Justice Center

Kathy Messerli
Executive Director
Minnesota HomeCare Association

Jessica Hausauer
Executive Director
Minnesota Network of Hospice and Palliative Care

Deb Taylor
Chief Executive Officer
Senior Community Services

Jarrod Peterson
Vice President and Public Policy Committee Chair
St. Paul Senior Workers Association

Kate Grathwol
President and CEO
Vision Loss Resources
Email Correspondence

Date: 03/14/2020

To: Health and Human Services Blue Ribbon Commission

From: Rachel Spaulding

RE: Strategy Input

I’m Rachel Spaulding and I am very grieved by the abuse to children that the system continues to turn a blind eye to, failing our children, every single day allowing children to remain in abusive living situations that are inflicting malicious physical, emotional, mental and sexual pain on our children everyday potentially leading up to irreparable and irreversible consequences such as death. The system takes children away from the fit people and keeps them with unfit people. People being parents, relatives, foster care, etc. Being in the system for 8 years and having a place called “The Family Justice Center” is a crime against children and family in an of itself! It is a crime against humanity. There is no justice and the Family Justice Center and should be renamed to Satan’s Sanctuary for how they have destroyed families and children by the dozens every single day and get it so obnoxiously wrong every single day, by the dozens. This is pure evil. Family court prompted suicide is real and it is a problem. Why does this continue to happen? Because, the judges, the social workers, the guardian ad litems, child protection services, magistrates have heard the same cases every single day. Do you know, I got sanctioned in court because of a motion I filed and the judge responded and denied my whole motion that had absolutely nothing to do with my motion. It was a copy and paste from a different case I can only conclude because it was not a grammatical error because it was a whole response and at no time was it stated, “sorry, wrong case”... it was cleared up on Christmas Eve and the sanctioned was lifted.

What could potentially resolve this pandemic of failing our children and families every single day?

We need workers who are of sound mind working for our children who don’t have voices and to be their voice. We need workers who aren’t burnt out. We need workers who pay attention to detail and can do the math when things aren’t adding up. Just like parents get burnt out, doctors, nurses, primary caregivers to their adult parents, so do these workers. They need support. They need to undergo routine psychological testing to see if they still have their head in the game. Mandatory Therapy sessions quarterly by therapists to observe these workers and if they need to engage in more sessions, probationary period by having their work diligently double and triple checked so nothing gets missed, audits, if a coworker is concerned by how another coworker is presented they need to speak up so that worker can get help if they are overworked or sidetracked by life’s problems or simply lost interest in their job. These workers are humans too and to be a part of the department of human services, your workers should be included. If things get missed, mistakes are made and it happens far too much than it should be happening. Our future generation will continue to be compromised if these workers are mentally spent and compromised themselves! They need to get random drug tests. Are you aware of the cases when child protection workers meet their new dealers checking on the welfare of a child who’s parents are drug dealers and get child protections to go way with a quick fix. This is corruption and crimes against children and these workers are humans. They have problems too, they are addicts too, alcoholics, suffer from mental illness and they need to have repeat screenings just like health care workers, law enforcement workers, prison guards, etc. When people are making daily decisions that will be impacting a child and/or family, they need be mentally sound and if not they will continue to destroy our children’s worlds.

Sincerely,

Rachel Spaulding
Strategy title
Implementing a Comprehensive Payment Integrity Solution for the State of Minnesota

Rationale and background
A comprehensive payment integrity program is an essential component of a well-managed health plan. An effective payment integrity initiative includes two primary areas of focus:

1. Each claim is reviewed prior to payment to ensure that only correct claims are paid, and that all claims are paid accurately.
2. All components of the claim adjudication cycle are audited to ensure correct configuration.

Establishing a robust payment integrity plan is critical to the achievement of the Commission’s goals of cost savings and improved program efficiencies.

Although Medicaid plans are required to employ a recovery audit contractor (RAC), the RAC’s success is limited due to the retrospective nature of its reviews. By reviewing post-paid claims, any recoveries must be achieved either on a pay-and-chase method or by offsetting future claim payments. A better method is to review 100% of claims prior to payment. Savings are achieved immediately, and errors are corrected prior to payment being made.

Short description of proposed change – 1000 characters
Nokomis Health, a Minneapolis-based leader of payment integrity services, will implement a comprehensive, sustainable payment integrity program. This program will include two areas of focus:

Initiative #1: Implement daily review of all post-adjudicated, prepaid claims to ensure that payments are accurate, that only correct claims are paid, that each claim is free of coding defects, is not a duplicate payment, is not a fraudulent claim, and the charges are supported by accurate and correct documentation.

Initiative #2: Full audit of the claim adjudication system, focusing specifically on each component’s configuration. The goal is to identify systemic errors, resulting in increased accuracy, reduced rework, and increased savings. Nokomis will lead the effort to correct any deficiencies noted as part of the audit. Nokomis will then periodically repeat the audit to ensure that there is no slippage over time.

Populations impacted
All members whose claims are adjudicated by the State of Minnesota or its contracted vendors.
Change proposed

A comprehensive payment integrity program is an essential component of a well-managed health plan. An effective payment integrity initiative includes two primary areas of focus:

1. Each claim is reviewed prior to payment to ensure that only correct claims are paid, and that all claims are paid accurately.
2. All components of the claim adjudication cycle are routinely audited to ensure correct configuration.

Establishing a robust payment integrity plan is critical to the achievement of the Commission’s goals of cost savings and improved program efficiencies.

Paying healthcare claims is an incredibly complex feat. Many components must work correctly for the claim to be paid accurately, including:

- Enrollment data must be accurately compiled, processed, and maintained; retrospective adds, changes and terminations must be managed correctly;
- Provider data must reflect the correct practitioner ID and tax ID, credentials, location, specialty, and participation status;
- Fee schedules and contracts must be configured correctly and attached to the appropriate provider record;
- Benefits must be set up correctly, including coding of covered services; benefit limitations; network restrictions, and other benefit components must be accurate;
- Authorizations must work properly so that services requiring approval do have a valid authorization on file;
- Claims need to be reviewed for possible third-party liability and coordination of benefits;
- Banking information, provider pay-to addresses, explanations of benefits and payment remittances all must be accurate;
- Claims should be flagged for clinical review when appropriate, such as when services are excessive, possibly investigational or experimental, or when treatment patterns deviate from the expected norm;
- The entire claim flow must work efficiently such that claims are taken in, routed appropriately, reviewed for errors and possible duplicate submissions, and paid within a prescribed time frame.

Managing each of these elements can be an arduous task, balancing accuracy with prompt payment requirements. Inevitably, one piece or another will break down or deteriorate which allows claims to be paid incorrectly.

Compounding the errors generated in the adjudication process are errors generated by providers. Various studies show the high rate of claim errors, both on the part of the provider and on the part of the health plan. Actual estimates vary widely, with error rates ranging from 7% to 50% or more, but regardless of the actual error rate, it is clear that errors are abundant throughout the entire claim life cycle.

Although Medicaid plans are required to employ a recovery audit contractor (RAC), the RAC’s success is limited due to the retrospective nature of its reviews. By reviewing post-paid claims, any recoveries must be achieved on a pay-and-chase method or by offsetting future claim payments, both of which have limited results. In addition, identifying fraudulent providers at this late stage essentially guarantees that any recoveries will be non-existent.

Payors have increasingly turned towards payment integrity programs as a way to manage costs and improve profits; however, without a holistic view of payment integrity, “a variety of problems persists, which for many plans, leads to a continued focus on claims recovery at the expense of cost avoidance” (Healthcare Finance blog post, Apr. 9, 2015). The
Nokomis Health

author advocates for an enterprise view to payment integrity such that all key departments participate in achieving the goal. As he concluded in the post, "... the best strategy is to take the enterprise view and put in place the organizational structure to own it."

The solution

Nokomis Health, a Minneapolis-based leader of claim review, audit and consulting services, will implement a comprehensive, sustainable payment integrity program for the State of Minnesota. This program will include two areas of focus:

- Initiative #1 - Review 100% of post-adjudicated, pre-paid claims to ensure that payments are accurate and correct prior to payment
- Initiative #2 - Full audit of each component of the claim adjudication system

Initiative #1 – Post-adjudicated, pre-payment claim review

We will review 100% of post-adjudicated, pre-paid claims to ensure that they are accurate and correct prior to payment being made. We will receive a daily file of claims that are ready to be released for payment, and we will review and return 99.8% of claims to the payor within one business day (100% within three business days), so we do not substantially increase claim processing times. By reviewing prepaid claims, we identify and correct errors prior to payment being made, which eliminates pay-and-chase retrospective reviews. We typically save plans 5% to 9% (or more) of their claim spend, and our appeal rate is less than 1%, which means that most savings are not overturned on appeal. All of our reviews and edits are based on industry-standard coding and billing requirements and standards.

We distinguish ourselves from our competitors through the following features:

- We are highly efficient at requesting and reviewing medical records, which means that our dollar threshold for reviewing records is much lower than our competitors. We are able to ascertain whether charges are supported, and if they are not, we use that information to build a provider profile which informs future claim reviews.
- We are experts at finding fraud. We saved a New York Medicaid plan over $2.5 million in one year by uncovering a ring of fraudulent, fictitious providers. We did this by identifying the aberrant practice pattern that they used, and then requested records on every claim. Had we not reviewed these claims, the plan would have paid the fictitious claims and only after the fact would the plan have realized that the providers were fraudulent, and they would never have recovered any of the payments that would have been made.
- We do the "heavy lifting" wherever possible so that it is easy for our clients to work with us. This means that we will configure our claim file layouts to our clients' layouts wherever possible; we support our clients through all aspects of implementation and when the program is operational; and we provide support to both plan employees and providers in responding to questions, concerns, appeals, etc.
- Our fees are contingent on our findings, which means that the plan only pays fees to Nokomis if we find savings. Our program is a no-risk solution.
Our claim review services include five main areas of focus:

- Code edits
- Clinical reviews
- Fraud/waste/abuse
- Medical record reviews
- Administrative reviews

**Code edits**

We review all claims for coding accuracy. Although claims should already have been reviewed for pricing edits (NCCI, MUE, assistant surgeon, multiple procedure reduction, etc.), we apply those edits again as well as other investigational edits to ensure that nothing has been missed in prior reviews.

A key differentiator for us is that we apply our edits across claims. We find additional savings by looking at the entire encounter rather than only looking at one claim. Certain rules also look at the member’s claim history.

Certified coders and/or claim analysts review claims and make recommendations for denials and adjustments based on industry coding and billing standards. They rely on guidance published by the American Medical Association, the Centers for Medicare and Medicaid Services (CMS), state regulatory agencies, medical societies and associations, state and national coding guidance, other payors, and other applicable sources. All code edits are supported by an external source.

Examples of code edit rules include:

- Bundling/unbundling issues
- Code mismatches (place of service, procedure, diagnosis, age, sex, etc.)
- Level of service review
- New/established patient coding errors
- Incorrect modifiers for code
- NCCI and MUE edits
- Hundreds of proprietary edits based on guidance from AMA, CPT, LCDs, other payors, medical societies, as well as our own data mining

**Case study:** We review claims for appropriateness of “new patient” charges. The standard rule for using a “new patient” code is that the member did not receive services from the same specialty in the same practice in the prior three years. All “new patient” claims are reviewed to ensure that there is no prior claim from the same specialty in the prior three years and if so, we deny the claim for having an inaccurate code.

**Case study:** We often find errors due to incorrect CPT code for the place of service. For example, providers bill inpatient consultation charges for outpatient observation claims, or they bill observation charges for a consult that occurs in the ER. We review claims to ensure that the code is appropriate for the place of service.
Clinical reviews
We review and identify claims that are inconsistent with expected care delivery patterns. We bring these claims, along with recommendations, to the client’s clinical team for review and discussion. Examples include:

- Overutilization of services
- Length of stay not supported by documentation
- Services which may not be medically necessary
- Level of service assignment for NICU claims
- Emerging and experimental procedures and services
- Excessive drug usage
- Potentially cosmetic procedures
- Questionable services based on diagnosis

Case study: We identified an ENT group that had a pattern of seeing a patient for a consultation which also included a laryngoscopy on most patients. The patients were then brought back 7 to 10 days later for a follow-up visit. We brought these data to the plan’s medical director who then reached out to the clinic for discussion of their practice patterns.

Fraud, waste and abuse
We monitor all available sanctioned provider lists to identify claims from sanctioned providers. Claims from sanctioned providers are either denied or undergo a deeper review. We also continuously monitor provider practice patterns to identify suspicious claims. Once a suspicious provider or member is identified, we investigate them and will prepare a written referral to Bind, which can be forwarded to the applicable authorities.

Case study: We saved a New York Medicaid client $2.5 million that otherwise would have been paid had we not monitored their claims. We identified a fraud ring that included payment to members in exchange for copies of their ID cards. The fraudulent providers then submitted fictitious claims under these valid member IDs. We stopped payment on the claims and requested records on all claims once the issue was identified. Fictitious records were submitted and once the perpetrators knew that the health plan was aware of their deception, they stopped submitting claims. The fraudulent providers were recently sentenced which included a large fine and prison time.

Medical record review
When we determine that records are needed in order to validate the charges, we return the claim to the client for denial and we request records on behalf of the client. We make multiple attempts to obtain records. Once records are received, certified coders and/or analysts review the claim and records and write an investigative case summary. The summary includes a discussion of our findings and recommendations on whether to deny or pay charges. All denials are supported by a written discussion which supports our findings.

These reviews allow us to profile providers and further investigate providers who have demonstrated a pattern of submitting incorrect claims.

Examples of the types of claims that often yield savings from record review include:

- Evaluation and management (E&M) level of service
- Incorrect procedure codes based on operative report
- E&M with procedure – abuse of 25 and 59 modifiers
- Assistant surgeon, team surgeon incorrectly billed
- Emergency anesthesia, other anesthesia charges not supported by documentation
• Time-based charges to ensure rounding and time calculations are correct
• Chemotherapy, other drug infusion/administration charges – to ensure accuracy of drug units, infusion codes, and charges
• Radiation therapy charges, often incorrect code assignment
• Emergency level of care, critical care, trauma activation, related charges
• Home health, interpreter, transportation charges
• Allergy testing not supported by diagnosis
• Diagnostic testing not supported by diagnosis
• Drug screens not supported, not correctly billed, excessive
• Behavioral health claims not documented correctly, time not documented, wrong code assigned
• Hospital charges not separately payable
• Incorrect place of service for procedure

Case study: We often find errors related to improper use of the 25 and 59 modifiers. Providers often append these modifiers to E&M and other procedure codes in order to bypass an NCCI edit. We obtain records to ensure that the code with the modifier is indeed a “separate and distinct procedure or service” per the modifier definition. Dermatology claims in particular are prone to these types of errors. We deny the claim line if the documentation does not support a separate and distinct service.

Case study: Providers often do not apply correct rounding logic to time-based charges. Hospitals often charge OR time in 15-minute units. The rule is that providers can only round up to the next chargeable time unit if more than 50% of the time has been used. We recently reviewed a hospital claim in which the hospital charged for five 15-minute units of operating room time. The anesthesia record showed that the time from “wheels in” to “wheels out” was 62 minutes. Since 2 of 15 minutes is less than 50%, the hospital should have only charged for four units. We denied one unit, resulting in savings of $3,540.

Administrative edits
We review claims for administrative issues that may have arisen from the primary payor’s adjudication. Examples include:

• Identification of duplicate claims/claim lines
• Provider network status incorrectly applied, typically due to faulty provider pick logic
• Incorrect fee schedule applied resulting in incorrect allowed amount
• Other edits that ensure that claims are accurate prior to payment

Case study: We routinely identify incorrect fee schedule applications. We recently identified an overpayment of $27,000 on one claim due to a fault in the plan’s provider contract setup. It is unlikely that the provider would have notified the plan of the overpayment.

Case study: We identified an issue with a client’s provider pick logic. Anesthesia claims from a provider were to be paid in-network, but we discovered that the claims were suddenly all being adjudicated as out of network. The provider changed their billing name on the claim from “Long Island Anesthesiology” to “LI Anesthesiology” and therefore the pick logic failed, since the plan was matching on TIN, NPI, and the first several characters of the billing name.
Initiative #2 – Full audit of the claim adjudication system

Nokomis will audit all aspects of the claim adjudication cycle, focusing specifically on each component’s configuration. The overall goal is to identify systemic errors and thereby increase compliance, reduce rework, and generate claim savings. Nokomis will lead the effort to correct any deficiencies noted as part of the audit. Nokomis will then periodically repeat the audit to ensure that there is no slippage over time.

In particular, the audit will focus on these key claim adjudication components:

- Enrollment, disenrollment, retro adds/changes/deletes
- Provider setup – provider demographic data accuracy
- Fee schedules – accuracy of setup, maintenance, assignment to providers
- Provider pick logic – ensure correct provider record is chosen for a claim
- Benefit setup – accumulators, covered services, benefit limits, etc.
- Authorizations – ensure process works correctly
- Claim intake – accuracy of scanned claims, ensure claims are received
- Repricing – ensure correct rates are applied
- Identification of third-party liability claims and coordination of benefits processes
- Payment – ensure payments are made to correct providers via appropriate pay method
- Member EOBs (if applicable) and provider remittance advice – ensure accuracy
- Adjustments and corrected claims – ensure accuracy of process

We typically find errors across many of these functions, which lead to processing errors, provider frustration, and the need for rework. By identifying and correcting these issues prospectively, the plan is able to increase accuracy and reduce the amount of rework needed to fix problems.

Impact of the change

The State of Minnesota will reduce healthcare costs, increase claim processing efficiency, reduce errors and related reworking of claims, and increase compliance with related billing and payment regulations. Potentially fraudulent services will be identified, and waste will be reduced. Many of these impacts will be realized with no downside risk to the State, because Nokomis’ fees for claim review services are contingency-based and the State only pays fees if Nokomis finds savings.

Other

About Nokomis Health

Nokomis Health is a national leader in payment integrity and claim support services. We offer a comprehensive suite of services to payors including claim review, fraud/waste/abuse detection, repricing, consulting, and reinsurance claim adjudication and management. Nokomis specializes in serving Medicaid plans and has a deep understanding of the nuances of state public programs.

We are industry experts providing small firm attention and quality service with big firm expertise. Our certified coders, analysts, and clinical staff have a detailed understanding of claim complexity and risk areas. Together with the power of our ClaimWise™ system, we have mastered the art and the science of claim management and strive to provide services that ensure accuracy, integrity and long-term savings.
Blue Ribbon Commission Written Public Comment

Please use this form to provide written comment for the Blue Ribbon Commission. All information submitted to the Blue Ribbon Commission is considered public and will be provided to Commission members and posted on the public website located at: https://mn.gov/dhs/hhsbrc/

Comment:

- Competitive bid process MCO requirement.
- Minimum $200 million contracting commitment to FQHCs who are at the forefront of impacting health equity.
- FQHC center of excellence.
- Primary Care Access Program.
- Relieved restrictions on bonus program.
- Access programs that impact SDOH.

Name (optional): Rubber Moore

Address (optional): 

Email (optional): rmoore@gmail.com

Phone (optional): 612-275-1071

This information is available in other forms to individuals with disabilities. For individuals with a disability who need a reasonable accommodation to access this document, please contact Krista O’Connor at 651-431-7297. TTY users can call the Minnesota Relay Service, 711 or 1-800-627-3529. For the Speech-to-Speech Relay, please call 1-877-627-3848
To: Members of the Minnesota Health and Human Services Blue Ribbon Commission

I represent the Transitional Rehab Program (TRP) at Courage Kenny Rehabilitation Institute, a nonprofit entity that is part of the Allina Health System. The TRP is a 56-bed skilled nursing facility located in Golden Valley. We specialize in neurological rehabilitation, e.g., from brain and spinal cord injuries. The intensity of therapy the TRP provides greatly exceeds that of a typical nursing home: the average client receives 2-3 or more hours of daily therapy, clients have access to adaptive technology, and therapists have advanced certification in treating traumatic brain injury, stroke, and spinal cord injuries. In 2019, the average age of the persons we served was 58, average length of stay was 67 days, and 88% of clients discharged to community settings. The care we provide this uniquely challenging population is key to maximizing their function and independence and preventing future health and social welfare costs.

I am writing to express our opposition to the proposal to eliminate the rate enhancement for the first 30 days of a nursing home stay. The impact of this proposal is not evenly distributed across all nursing homes. It takes the most revenue away from those who have a high number of Medicaid admissions, and clients who are on Medicaid at admission are some of the most challenging to serve—under 65, with significant disabilities and/or behavioral health issues. These clients are already difficult to place and eliminating this rate enhancement will make that problem worse.

The rate enhancement compensates nursing homes like ours, who take a disproportionate share of highly complicated clients on Medicaid, for the cost of work related to admitting and assessing those clients. Eliminating the rate enhancement would have a devastating impact on our ability to accept and serve those clients who most need the services of our nursing home.

Thank you so much for your time and consideration.

Sincerely,

Marcia Lindig
Administrator
Transitional Rehab Program

allinahealth.org
March 6, 2020

Dear Commissioners Harpstead and Malcolm and Members of the Blue Ribbon Commission,

We are writing to you today on behalf of LeadingAge Minnesota and Care Providers of Minnesota (collectively the Long-Term Care Imperative) to express deep concerns regarding proposals before this Commission to modify funding for older adult services.

In terms of demographic change, Minnesota is at a historic time. Sixty thousand people turn 65 every year in our state and will do so every year for the next decade. This year our state reached a demographic tipping point where there are now more seniors than school children. Most seniors will require some form of long-term care services, especially those fortunate enough to reach age 85+.

Minnesota can be proud of its efforts to increase the availability of home-based services for older adults and to more effectively target nursing home services to those who can’t be cared for in other settings. As stakeholders working together, we have dramatically reduced nursing home utilization, prevented unnecessary hospitalizations and helped elders live longer in the setting and community they call home.

We are mindful of the need to address the drivers of future costs; it is important that we continue to ensure that our continuum of care for seniors is strong and choice is available to seniors no matter where they live in the state. There are three strategies before the Commission we believe will jeopardize this goal.

First, we are deeply troubled with the strategy regarding Value-Based Reimbursement (VBR) in Nursing Facilities. This strategy was advanced by the Administration in the 2019 legislative session, fiercely debated and ultimately rejected. Proponents of the proposal pointed to significant forecasted growth in Medicaid expenditures for nursing homes after years of a stable or decreasing year over year growth. Opponents argued that the growth in nursing home expenditures were not only significantly overstated in the budget forecast but also that growth in expenditures was expected and intended in order to correct for years of underfunding and to encourage investment in staff wages and benefits. Opponents also decried changes to the complex formula that would produce disparities for rural providers, cuts in reimbursement for dollars already spent and ultimately impact staff wages.

In fact, the November 2019 forecast, revised the growth of nursing home expenditures downward by $84 million state dollars for the 2020 to 2023 state fiscal years. This is due in large measure to the fact that providers who invest additional dollars in their operations must wait approximately two years for those costs to be reimbursed for those costs – a design feature that has a chilling and self-limiting effect on future growth.

We would ask Commissioners to be mindful of the following in their deliberations:

- **We are in the midst of unprecedented staffing challenges.** Even with the investments we have been able to make in raising wages and benefits for our staff, for example Certified Nursing Assistant wages have grown by 26.3%, from $12 in 2014 to nearly $16 in 2018, on any given day we have approximately 3,000 open positions in our settings across the state. Within the VBR reduction proposal are provisions that would impact our staff wages and benefits and we urge the utmost caution. The reality of daily challenge is brought home by the work we are doing right now to address the possibility of a COVID-19 epidemic.

- **Nursing homes are unique in that they are the only area of Medicaid expenditures you are addressing where the rates set for the Medicaid population also dictate the rates that are charged...**

The Long-Term Care Imperative 3-6-2020
to individuals paying privately – which means that when cuts are enacted to save state Medicaid dollars, those cuts also result not just in the loss of a federal match but also of private pay dollars.

- We agree that more can be done to further strengthen the quality incentive in the reimbursement methodology but because of the complexity of how best to incent quality – which measures, how weighted, how best to improve performance of poor performers – and the importance of giving providers time to adapt to a new approach, we believe this change should be done collaboratively and based on research and impact analysis. We are working with the Department on this even now and have a member task force helping to guide our discussions. This is the reason we submitted a strategy to the Commission under the category of Transformation.

- Finally, the VBR strategy as presented to the Commission is a bundle of individual proposals, some having system-wide impact and others impacting more targeted groups of providers. It will be important to understand and evaluate the impact of each.

Secondly, we are concerned with the strategy called “Guidelines to Access Customized Living Services.” This strategy proposes to limit the services that will be covered by Elderly Waiver for those individuals who are assessed by an independent care manager as falling into the lowest need category. This means that even though an elder’s care needs will not have changed, the rate providers will receive for their care will be reduced. By the state’s own report to the 2019 Legislature, Elderly Waiver rates are currently 30 percent below actual costs. Again we urge caution in that this proposal will likely have the unintended consequence of forcing some individuals into more expensive nursing home settings where their care needs can be met, particularly in rural parts of the state where there are fewer overall care options. As a reminder, individuals go through person centered assessments to arrive at their payment rates, and unlike disability waivers, the individuals have a cap on rates.

Finally, we are concerned with the strategy “Repeal Nursing Facilities' First 30 Days Rate Adjustment.” This strategy will repeal the increased rate to nursing facilities in the first 30 days of admission. Under current law, the total payment rate paid to a nursing facility is increased by 20 percent for the first 30 calendar days after a resident is admitted in order to account for increased costs associated with a new admission. Based on an analysis of the care settings most likely to impacted by this strategy, we believe this change would disproportionately impact persons under the age of 65 who are seeking nursing home placement care due to complex care needs, behavioral and mental health needs and/or substance abuse disorder. Reductions to this payment rate may make it more difficult to find appropriate post-acute care options for these complex, difficult to serve patients.

We appreciate that you have been given a difficult task and we are grateful for the time and attention that you have given to this work. We stand ready and willing to continue to partner with you and the state agencies as you work towards your final recommendations.

Sincerely,

Paula K. Rocheleau
Chair, Board of Directors
Care Providers of Minnesota

Nancy Stratman
Chair, Board of Directors
LeadingAge Minnesota
Value Based Reimbursement (VBR) System for Nursing Facilities: Transforming the Quality Incentives

2015 GOALS of Value Based Reimbursement
- Preserve Access to the Continuum of Care
- Invest in Recruitment and Retention of Caregivers
- **Reward Quality Care**
  - Preserve Dignity and Quality of Life Regardless of How and Where Services are Delivered
  - Institute a Payment System that Fully Funds the True Cost of Care

We all agree that rewarding quality care and promoting mechanisms for quality improvement are a crucial component of VBR. After evaluating the first few years of VBR implementation, the Minnesota Department of Human Services January 2019 Legislative Report: Nursing Facility Payment Reform Recommendations included a future recommendation:

> DHS will continue to evaluate the impact of VBR and will consider future recommendations to VBR ... to ensure its intended focus on improving the quality of long-term care.

VBR is achieving its goal of addressing workforce challenges, as significant improvement in caregiver wages and benefits illustrate. The impact of the payment system on quality is more complicated to determine. Provider organizations and the Department of Human Services (DHS) have spent the past months researching the current VBR quality incentives, as well as re-examining all of the quality measures available for consideration, asking key questions such as:
- Are we using the “right measures“? the right incentives?
- How can we both ensure rewards for high quality and incentives for quality improvement?
- Can the quality incentives factor in the backdrop of our significant labor shortage?
- Can we simplify the measures to ensure that providers and consumers both understand the goals, and actions needed to improve quality?
- How do we design the payment system so that all facilities have a financial incentive to invest in and improve their quality performance?

To date, our discussions have led us to a few conclusions, with much more work to come:
- Changing the metrics and the means for rewarding quality is complex and transformational and should be done in a planful, research-based manner.
- Improving the quality in long term care isn’t a budget savings exercise, rather, at best there would be a redistribution of funds over time.
- Many of the quality measures have relationships with provider, workforce and patient characteristics and are intertwined other measures themselves. The tight labor market and change in patient needs, requires research to better understand these relationships.
Enhanced Medicaid Rate for the First 30 Days of a Nursing Home Stay

The rate enhancement for the first 30 days of a Medicaid stay has been in place since 2001, and was designed to increase revenue for nursing homes while targeting that increase at homes with the highest number of admissions, which are a costly time due to the assessment work required when taking on new clients.

**Purpose of the Rate Enhancement:**
- Address the cost of processing nursing home admissions
- Invest in nursing home workforce at a time of shortage
- Reduce any disincentive to take complicated Medicaid clients

Eliminating this rate enhancement is problematic for several reasons including:
- The impact is not evenly distributed - 10 nursing homes make up 15% of the savings from this proposal
- The type of clients most likely to qualify for this enhancement - On Medicaid, under 65, behavioral health issues - are already very difficult to place and this will make that problem dramatically worse
- Admissions are increasing while length of stay is decreasing, so the cost burden of bringing in new clients is growing
- The state’s assessment process is in flux due to upcoming federal changes that will make the admission process more complex, so this is not the type to eliminate resources to deal with these issues
- Any reduction in revenue to nursing homes comes at a time when they are trying to make investments in their workforce to improve recruitment and retention and this policy change would make that more difficult

To summarize, the rate enhancement policy has a solid justification and serves an important purpose in compensating nursing homes for the costs related to admitting new clients. It plays an especially important role in allowing nursing homes to take admissions of Medicaid clients with complex needs and the elimination of the enhanced rate would create more access issues for those already hard to serve clients.
Conceived through collaboration between provider associations and the Minnesota Department of Human Services, Value Based Reimbursement (VBR) for Minnesota’s nursing facilities was introduced and adopted with bi-partisan legislative support in 2015.

This important rate reform replaced a system under which rates had not kept pace with the cost of meeting consumer needs and which did not allow providers to make crucial investments in employee wages and benefits.

2015 Stated Goals of Value Based Reimbursement (VBR)
- Preserve Access to the Continuum of Care
- Invest in Recruitment and Retention of Caregivers
- Reward Quality Care (e.g. Incentivize quality by rewarding improved quality of care)
- Preserve Dignity and Quality of Life, Regardless of How and Where Services Are Delivered
- Institute a Payment System That Fully Funds the True Cost of Care - Today and Tomorrow

Why VBR was Essential for Nursing Facility Stabilization
Prior to the implementation of VBR, the Medicaid rates paid under the previous rate system were significantly below the actual cost of providing care to clients on Medicaid. Due to the unique nature of Minnesota’s rate equalization law, the impact of spending gaps in state Medicaid payments is threefold--including federal matching Medicaid funds and all private pay funds where their rates must be equal to the underfunded Medicaid rates.

While legislators attempted over the course of the past 15 years to provide meaningful increases to nursing facility payments (see below chart), the increases, when provided, did not match the cost of living adjustments nor did they reflect the need to significantly increases wages and benefits in a challenging workforce environment. As a result of this long-term underfunding, nursing facilities were struggling to offer competitive wages and benefits to attract the employees necessary to provide quality care.
Prior to VBR, DHS data showed that more than half of nursing facilities were operating at a loss due to low rates and increasing costs.

An annual national study has shown that the implementation of VBR means that Medicaid rates now cover almost all of the cost of providing care, instead of falling more than $30 per person per day short for all Medicaid and private pay residents. This dramatic funding improvement under VBR has allowed providers to make much needed investments in wages and benefits for employees.
Since its passage in 2015 and implementation starting on January 1, 2016, VBR has succeeded in funding significant investment in the wages of direct care employees. According to data compiled by the Minnesota Department of Human Services for all nursing facilities in the Medicaid program, hourly wages of direct care staff have increased substantially:

<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>$27.93</td>
<td>$28.90</td>
<td>$31.61</td>
<td>$33.01</td>
<td>3.5%</td>
<td>9.4%</td>
<td>4.4%</td>
<td>14.2%</td>
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<tr>
<td>LPN</td>
<td>$20.73</td>
<td>$21.54</td>
<td>$24.16</td>
<td>$24.79</td>
<td>3.9%</td>
<td>12.2%</td>
<td>2.6%</td>
<td>15.1%</td>
</tr>
<tr>
<td>C.N.A.</td>
<td>$13.62</td>
<td>$14.15</td>
<td>$15.84</td>
<td>$16.58</td>
<td>3.9%</td>
<td>11.9%</td>
<td>4.7%</td>
<td>17.2%</td>
</tr>
<tr>
<td>TMA</td>
<td>$15.23</td>
<td>$15.84</td>
<td>$17.59</td>
<td>$18.23</td>
<td>4.0%</td>
<td>11.0%</td>
<td>3.7%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$14.36</td>
<td>$16.85</td>
<td>$19.48</td>
<td>$21.79</td>
<td>17.3%</td>
<td>15.6%</td>
<td>11.9%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>$21.79</td>
<td>$22.10</td>
<td>$23.30</td>
<td>$24.29</td>
<td>1.4%</td>
<td>5.4%</td>
<td>4.3%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Activities</td>
<td>$15.04</td>
<td>$14.98</td>
<td>$16.34</td>
<td>$16.75</td>
<td>-0.4%</td>
<td>9.1%</td>
<td>2.5%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Nursing Administration</td>
<td>$31.89</td>
<td>$33.10</td>
<td>$35.14</td>
<td>$36.35</td>
<td>3.8%</td>
<td>6.2%</td>
<td>3.4%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

Source: Minnesota Department of Human Services
The LTC Imperative also conducts and annual compensation survey, and the results of that survey since the passage of VBR show similar findings to the DHS data.

Our survey also collects data on additional positions not covered by the DHS data, and that shows that other nursing home employees in dietary and housekeeping roles have also benefitted under VBR:

<table>
<thead>
<tr>
<th>Percent Change from 2015 to 2018 to the Weighted Average Hourly Wage</th>
<th>Registered Nurse</th>
<th>Licensed Practical Nurse</th>
<th>Nursing Assistant, Registered</th>
<th>Food Service/Dietary Aide</th>
<th>Housekeeping and Laundry Aide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>15.3%</td>
<td>15.9%</td>
<td>21.3%</td>
<td>15.0%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

Source: Long Term Care Imperative Wage and Benefits Survey

In addition to addressing the need to improve caregiver wages, VBR also provides incentives to improve employee benefits offered by nursing facilities. According to the data compiled by DHS, employee benefit spending per resident day (PRD) increased by almost 40% from 2015 to 2017. Much of this new funding has been used to improve and expand health insurance plans offered by nursing facilities and to reduce employee costs for health care.
The Elderly Waiver Program and Nursing Facility Reform

The state’s elderly waiver program services nursing facility eligible clients at a fraction of the cost of a nursing facility stay. Growth in this program is saving the state money as the number of LTC Medicaid recipients residing in nursing facilities declines annually.
Nursing Facility Costs Go Primarily to Support Workers

Well over half of operating costs for nursing facilities, according to cost reports audited by DHS, go to staff wages and benefits. VBR has allowed for providers to make investments in this important area to respond to the highly challenging work force environment.

Salaries, Benefits and Payroll Taxes Comprise 64.6% of Nursing Facility Costs

March 5, 2020

DHS Commissioner Jodi Harpstead
MDH Commissioner Jan Malcolm

Dear Blue Ribbon Commission Co-Chairs:

As unions representing over 10,000 Minnesota nursing home workers, we encourage the Minnesota HHS Blue Ribbon Commission to drop consideration of the cuts to nursing home reimbursement rates as proposed in the Value-Based Reimbursement in Nursing Facilities priority strategy.

In 2015, the Minnesota Legislature made a historic bi-partisan investment in our nursing homes. This investment reversed decades of underfunding and inequitable rates. Before the new value-based reimbursement system (VBR) passed, the workforce shortage was chronic and there were huge funding disparities between Greater Minnesota and the Metro. Since VBR passed, workers have made real wage gains, but low unemployment means we continue to see serious staffing shortages. Since VBR has passed, regional disparities have narrowed little, if at all, because many rural homes are unable to find the cash to fund upfront wage increases, while waiting around 18 months for their reimbursement rate to increase. We oppose rolling back the current VBR system until we reach the original goal of well-staffed nursing homes funded equitably across the state.

While this strategy is labeled under “evidence-based strategies”, most of the savings likely come, not from targeted efficiencies, but from simply capping the growth of the other operating price and the property rate. We share concerns that recent increases may be excessive and funding unnecessary administrative costs, but we think this calls for better transparency and regulation before we implement a flat cap. A flat cap does not by itself promote greater efficiency and ignores the fact that we need to make up for decades of under-investment.

An effective value-based reimbursement system could be an evidenced based way to save money through better, more efficient, care, but we don’t think this strategy meets that goal. First, we prefer an adequately funded system to an inadequately funded system with an effective value-based component. Instead of intentionally making current funding inadequate in order to make
the value-based limit effective, we prefer to let homes continue growing towards the current limit. Again, Minnesota nursing home workers are making up for years of under-investment, so, instead of halting that progress, we should wait to see if the growth over the next few years starts to bring the quality limit into play. Second, the evidence so far is mixed, at best, whether this proposed change will improve quality and efficiency. Simply changing the quality system after just a few years is likely to deter operators from relying on any reward for quality. More importantly, there is little academic study of the current system and results from other systems in Minnesota and other states are mixed, at best.

Finally, further work on this strategy is not an effective use of the Commission’s time. This issue was fully thrashed out by the Legislature and the Executive. This Commission is unlikely to add to those debates. If these proposals were not included in last year’s budget, they are almost certainly not going to be adopted by the legislature. Instead we should focus on proposals that have some chance of getting enacted.

Sincerely yours,

Ethan Vogel, AFSCME Council 5
Rick Varco, SEIU Healthcare Minnesota
Bernie Hesse, UFCW Local 1189
Bob Ryan, USW District 11
March 4, 2020

Commissioner Jan Malcolm
Chair, Blue Ribbon Commission
Minnesota Department of Health
625 Robert Street North
St. Paul, MN 55164

Re: Blue Ribbon Commission Day Services Absence & Utilization Factor Follow-up

Dear Commissioner Malcolm:

Thank you for the opportunity to testify before the Commission on February 21, 2020 about the Department of Human Services ("DHS") proposal to cut day service reimbursement rates by about 5% for individuals with intellectual and developmental disabilities. This cut would result from reducing a component, the Absence and Utilization Factor, of the formula that sets reimbursement rates for day services from 9.4% to 4.5%. As I stated during my testimony, I represent the Minnesota Organization for Habilitation & Rehabilitation ("MOHR"), the trade association representing 105 of the 130 day service providers in the state of Minnesota.

MOHR is strongly opposed to the DHS proposal to reduce the Day Service Absence and Utilization Factor as it will result in a rate cut for day services of about 5%. With the current workforce shortage and high staff turnover rates this cut would be destabilizing to the day service component of community-based services for individuals with disabilities.

The Absence & Utilization Factor is a combination of two cost factors that are similar, but distinct. "Absence" refers to when an individual planned to receive a certain service but does not accept or is unable to accept that service. "Utilization" refers to when a provider has capacity to provide services but does not have enough demand for the services. MOHR is not aware of any way to reliably measure either of these factors for day services with the data DHS collects, or with the information that day service providers currently maintain. This has led to the application of various methodologies with questionable success.

At the Commission meeting, I was asked to provide data that supports the current Day Service Absence & Utilization factor of 9.4% factor. The 9.4% is based on data collected in March of 2016 by MOHR from its membership. MOHR conducted two surveys concerning absence. The first survey was conducted in March 2015 with a 60% response rate (78 respondents). The raw data from that survey is enclosed. The unweighted average of absence for that survey was 9.1%.
The second MOHR survey was conducted shortly after the survey that was performed for DHS by Truven Health Analytics in March 2016. The intent was to have MOHR members send the same data to MOHR that they sent to Truven. MOHR had 36 respondents or a 27% response rate to that survey. This second survey showed a 9.4% average absence percentage. MOHR does not have access to the raw data for this survey as the individual who did the work for MOHR is no longer under contract.

In defense of its proposed cut, DHS offers three studies that it states provide support for its position. The studies are the January 31, 2012, study prepared by Navigant Consulting, Inc. ("Navigant Study"); the May 31, 2016, study prepared by Truven Health Analytics ("Truven Study"); and the November 15, 2017, Absence Factor Study prepared by DHS ("DHS Study"). MOHR believes that its March 2016 survey is as valid and more reliable than the studies cited by DHS.

**Navigant Study**

Navigant Consulting, Inc. ("Navigant") collected data from 211 providers of home and community based providers across all services including day services. The number of respondents was not broken down by service type, so there is no information on how many day service providers were included in the study. However, day service providers represent just over 5% of the total number of unique HCBS providers. From this it can be extrapolated that the number of day service providers surveyed was 11. This is far fewer than the numbers of day service respondents in either MOHR survey.

Absence and utilization varies by service type, but in its report, Navigant did not show an analysis specifically related to the day service absence & utilization data. Rather Navigant applied the residential service data to day services without explanation. The Residential Absence Factor used was 1.7% and the Utilization Factor was 2.2% (see Navigant Study, page 16). In the calculation of the Residential Absence Factor, Navigant did not use the survey data, but used DHS data from its case management system. The calculation was based on the number of units authorized by the county compared with the units billed. However, the subsequent DHS Study states that the number of days an individual planned to attend could not be determined through service authorizations "due to the common practice of over authorizing or authorizing a standard number of units." (see DHS Study page 11). This statement from DHS calls into question the Navigant’s methodology of determining the Absence Factor for all services.

In the calculation of the Residential Utilization Factor, Navigant used the survey data and compared the Median percentage of the Average Daily Census as a Percentage of Licensed Capacity. Although this approach may work for residential services, it does not work for day services as day services licensed capacity only applies to the number of recipients in a licensed facility at any one time. Although many day service recipients receive services throughout the day, many also receive services in the facility for only a portion of the day or do not receive any services at the facility. As a result, day service providers can serve more individuals each day than its licensed capacity. Accordingly, licensed capacity undercounts the denominator for the day service utilization factor which in turn will overstate actual day service utilization.
Finally, the Navigant Study clearly states that the 20% discount for fixed costs was based on DHS Disability Services Division policy (see Navigant Study page 12) and was not supported by data collected by or an analysis done by Navigant.

In conclusion, the 3.1% Day Service Absence & Utilization Factor included in the Navigant Study is not supported by applicable or reliable data. Too few day service providers were surveyed, the data used was based on residential service data, the methodology used was flawed and the decision to discount the factor by 20% is not supported by data. Accordingly, the Navigant Study should not be relied upon to support the DHS position on the Day Service Absence & Utilization Factor.

**Truven Study**

Truven Health Analytics ("Truven") collected data from 193 providers of home and community based providers across all services including day services. Like Navigant, the number of respondents was not broken down by service type, so there is no information on how many day service providers were included in the study. However, day service providers represent just over 5% of the total number of unique HCBS providers. From this it can be extrapolated that the number of day service providers surveyed was 10. This is far fewer than the number of day service respondents in either MOHR survey.

Truven only asked one question of providers related to the Absence & Utilization for day services. This is the identical question asked by MOHR in its 2016 Survey:

For Unit-Based and Day Services Only: How many of your scheduled HCBS units were not provided because of recipient refusal or cancellation?

Truven did not ask any Absence & Utilization questions of providers with under $250,000 in revenues. Additionally, Truven did not ask any questions to address the “Utilization” costs of day service providers, thus ignoring a factor component that represented 70% of the initial 3.1% Day Service Absence & Utilization Factor (2.2% of 3.1%).

The Truven Study used both survey data from providers and studies from other states. The “other state” studies were used by Truven to verify the reasonableness of the survey data collected. Four states served as sources for Utilization and Absence: Georgia, Oregon, Virginia, and Arizona. The study found the range of absences for these four states to be from 2 percent to 6 percent but noted that these factors were only for absence and not utilization. Based on these studies Truven found that the 2% to 6% range was reasonable but felt the survey results “provide better results due to inclusion of utilization in the results” (see Truven Study at page 19).

Unfortunately, this is untrue for day services. Truven did not collect utilization data for day services through the survey but only absence data. Accordingly, the 3.9% rate promoted by Truven could not include a utilization component.

For the studies from other states, Truven did not use comparable data. Truven used data for services other than day services, “primarily behavioral health” (see Truven Study at page 6). Additionally, the four comparison states are not similar to Minnesota concerning a substantial cause of absences—weather. Finally, In the subsequent DHS Study, DHS undermines both the range
provided by Truven and the use of the data from other states. The DHS Study cites a range of 0% to 15% for absence from other states and added that the absence factor is not applied consistently nationwide. DHS concluded that the “complexity of interaction with other cost components and limits such as billing caps make it difficult to draw from national data” (see DHS Study page 6).

Without providing any analysis or raw data, Truven stated that the Utilization & Absence was 3.1% for day services, 2.2% for residential, 7.5% for unit based with programming, 3.9% unit based without programming and 3.9% for all service categories. The Truven Study did not provide a breakdown of how these numbers were determined for each service category, the total respondents from each service category, or how the cumulative number, 3.9%, was determined. This is especially perplexing when only one question was asked of day service providers about absence and none about utilization. Unit based services was asked two different questions to determine absence, but none for utilization and residential services had one question for absence and one for utilization. It is apparent that the utilization factor was only applied to residential and not any other services.

The MOHR March 2016 study collected data from 36 day service providers, a 27% response rate of all licensed day service providers, and shows a weighted average absence rate of 9.4% using the identical question asked by Truven.

The Truven Study was also silent about whether it applied the 20% DHS discount for fixed costs in its calculation or whether there was any analysis of the validity of this DHS policy.

In conclusion, the 3.9% Day Service Absence & Utilization Factor included in the Truven Study is not supported by applicable or reliable data. Too few day service providers were surveyed, the analysis did not provide for an utilization factor for day services, the data and use of studies from other states was undermined by the DHS Study, no information on the analysis of the data collected or the methodology used to determine the factor was provided, the 3.9% was not supported by the 2015 MOHR study or the 2016 MOHR study, and the study was silent on a major point of contention—the 20% fixed cost discount factor established by DHS policy. Accordingly, the Truven Study should not be relied upon to support the DHS position on the Day Service Absence & Utilization Factor.

**DHS Study**

The DHS Study took a completely different approach to calculating the Day Service Absence & Utilization Factor by analyzing the data by recipient rather than by provider. The analysis estimated the days an individual planned to attend day services by using the number of days that the individual attended services in the past and comparing that to the days actually attended.

The DHS Study only analyzes the Absence Factor and not the Utilization Factor, thus ignoring that factor.

The DHS Study does not analyze the validity of the 20% fixed cost discount applied to the Day Service Absence & Utilization Factor.
The use of past attendance as a determinant for planned days does not account for individuals with a history of absence from services. With day services absence can be the result of many things ranging from illness to deciding in the morning not to attend. Some individuals are more likely to do this than others and these types of absences are not predictable. This approach ignores the challenge of unpredictable but expected absences in serving this population. Although it could be argued that the methodology used generous assumptions that err on the side of assumed attendance, unfortunately there is no way to test the validity of that assumption. I believe this approach to calculating the Absence Factor is unique to Minnesota and has not been tested in other states.

In addition to the methodology, the data used to do the DHS Study was from a six month period from January to June 2016. The weather and other factors during such a short period distorts both the data used to determine the Planned Days and also the Days Attended. The first half of 2016 had fewer weather-related absences (these are not always from provider closures—individuals are less likely to choose to attend services if the weather is bad) than the first half of 2019 for example.

Unique to January to June 2016, because of changes to the rate setting system, many counties were delayed in issuing new service agreements which likely impacted the validity of the data used in the DHS Study.

In conclusion, the 4.5% Day Service Absence & Utilization Factor included in the DHS Study, although a novel approach, uses incorrect assumptions in determining Planned Days, failed to consider the impact from utilization, did not provide data or analysis to support the 20% fixed cost discount, and used data from a limited and unrepresentative time period. Accordingly, although a bona fide attempt to calculate the Day Service Absence & Utilization Factor, the DHS Study is still flawed and should not be relied upon to support the DHS position on the Day Service Absence & Utilization Factor.

I would ask that the Commission not support the DHS proposal to reduce the Day Service Absence & Utilization Factor from 9.4% to 4.5%. The 9.4% rate is supported by data and was set by the 2017 Minnesota Legislature, was approved by CMS, and was considered and retained by the 2019 Minnesota Legislature. The DHS proposed cut would ultimately negatively impact Minnesotans with intellectual and developmental disabilities and the services they receive in the community.

Again, thank you for the opportunity to share our concerns with you and the Commission. Feel free to contact me with any questions that you may have about our position on this issue.

Yours sincerely,

Kevin P. Goodno
Direct Dial: 612.492.7348
Email: kgoodno@fredlaw.com

Enclosure
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To the Blue Ribbon Commission,

The Midwest Association for Medical Equipment Services & Supplies (MAMES) is an 8-state regional association that represents the durable medical equipment (DME) and medical supply providers in Minnesota, and 7 others states in the Midwest: Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota and Wisconsin.

MAMES is writing in response to the Blue Ribbon Commission’s two strategies, #419 and #420, impacting Durable Medical Equipment (DME) and medical supplies.

I. Strategy #419: Volume Purchasing Durable Medical Equipment

This strategy requires DHS to expand the use of volume purchasing to additional types of DME products, including enteral nutrition, wound care supplies, and standard wheelchairs and walkers. DHS anticipates costs savings of $1M to $9,999,999.

MAMES opposes this strategy for the following reasons.

Spending on DME and supplies is not a cost driver, as the total spend on fee-for-service DME and supplies is estimated to be only $87 million in SFY 2020-21 (per the BRC January 14, 2020 handout, slide 48). Total spending on fee-for-service health care by DHS is projected to be in excess of $12.3 billion in FY 2019 (per the BRC October 10, 2019 handout, slide 47). Fee-for-service represents 25% of this total (per BRC January 14, 2020 handout, slide 19), so fee for service spending exceeded $3 billion in 2019. This means that spending on DME and supplies constitutes less than 3 percent of fee-for-service budget.

DHS states it is currently volume purchasing, oxygen, hearing aids and diabetic test strips. These items are very different from the other equipment and supplies they are proposing to volume purchase.

Most of the items listed, like wheelchairs and walkers, are already set by a volume purchase program -- Medicare’s competitive bid program (CBP). That pricing established the upper payment limit for Medicaid federal cost sharing for those items addressed by the 21st Century Cures Act. As a result of legislation in 2019, Minnesota Medicaid has reduced payment rates on those items to Medicare rates, including walkers, wheelchairs, hospital beds and other common DME items. DME providers would not go below what is already the lowest fee schedule for those items included in the Medicare CBP.

Enteral nutrition, which had been included in the initial rounds of Medicare competitive bidding, was specifically excluded for the 21st Century Cures Act upper payment limit, presumably because the enteral food prices that had resulted from the competitive bid process, caused significant access issues for Medicare patients who needed enteral nutrition.

The statement included in the Strategy #419, “Individuals who access health care services through Medical Assistance and MinnesotaCare fee-for-service and utilize the DME products that are volume purchased will be minimally impacted. These individuals may have different brand options covered but similar products will be available” is simply not true. This is evidenced by the issues stated below with the fundamentally flawed Medicare CBP as acknowledged in recent rule changes by the Centers for Medicare and Medicaid Services (CMS):
- CMS implemented a 2-year gap between January 1, 2019 to December 31, 2020 in the Medicare CBP to address the rule changes.
- CMS specifically recognized that the access issues created by the Medicare CBP rates were especially damaging to rural areas, so it created a separate fee schedule for rural areas that has much higher reimbursement for CBP items.
- Despite the rural relief, and as documented in the GAO report released December 2018, the number of suppliers of DME is continuing to decline. According to our national Association’s ongoing study on the estimate of number of DMEPOS suppliers and locations, there was a -37% loss in the number of Unique Supplier Companies in the US between 2010 (when the CB program began) to October 2019, which included the loss of the second largest supplier in Minnesota back in 2018.

In addition, the Medicare CBP and its pricing expansion nationwide has had a tremendous impact on DME providers and access to DME and medical supplies. Below are two studies on the Medicare CBP from Dobson|DaVanzo, a leading consulting group focused on healthcare economics and policy:

- **DME Cost Study**: the study was done to determine the real impact Medicare’s competitive bidding program is having on quality of care, reimbursements and overall costs. One of the key findings shows that Medicare reimbursement rates for home medical equipment cover just 88% of overall costs for companies providing the service.
- **DME Access Study**: it was discovered that competitive bidding “negatively affected beneficiaries’ access to DME services and supplies, adversely impacted case managers’ ability to coordinate DME for their patients and placed additional strain on providers to deliver quality products without delay.”

The unsustainable price reductions have severely damaged the DME infrastructure upon which patients rely, including business closures, reduced service areas, restricted products offered, paying for items out of pocket and extensive delays in getting DME and supplies. *The low-income Medicaid population is at an even greater risk if further reductions result from the proposed volume purchase expansion, for they likely do not have any additional financial resources to bypass the Medicaid system when it fails them.*

Finally, in 2017, DHS conducted a volume purchase program for adult incontinence products. There was an exhibit presented on the unsustainability of the volume purchasing program for incontinence products. The exhibit showed the costs of doing business and the losses providers would experience if the program was implemented. DHS was sued during implementation of the program, and subsequently, in 2019, the Minnesota Legislature passed a law prohibiting DHS from volume purchasing incontinence supplies.

MAMES requests the Blue Ribbon Commission recognize that DME is already at the lowest fee schedule due to Medicaid using the Medicare CBP fee schedule for a majority of items. Any attempt to do further volume purchasing would not save any money because providers would not go below the rates already being reimbursed by Medicaid. MAMES requests the Blue Ribbon Commission reject Strategy #419.

**II. Strategy Healthcare #420: Modify certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates.**

This strategy modifies Medical Assistance fee-for-service payment rates for select DME and supplies. DHS states that currently, the rates are based on a methodology outlined in administrative rule and are calculated in a complex manner that is based on a percentage of billed charges. DHS indicated a projected savings for this strategy between $1M to $9,999,999M.

MAMES opposes this strategy for the following reasons.

Outside of a few categories within DME and medical supplies, Medicaid is currently paying Medicare rates due to legislation passed in 2019. The language directs DHS to set the Medicaid payment rate equal to the Medicare payment rate for all DME items that are subject to the Medicare DME upper payment limit (UPL), which CMS established under the 21st Century Cures Act. DHS began implementing this requirement effective for dates of service on or after July 1, 2019.

In Minnesota and throughout all states, Medicare has three payment rates:
1. a rate for certain large metropolitan areas where CMS’s competitive bid program was used to establish rates;
Strength Through Advocacy, Education & Collaboration

(2) a rate for non-rural areas outside of the competitive bid zones; and
(3) a higher rate for zip codes deemed rural by CMS.

DHS applies each of these rates, depending on the zip code of the Medicaid client which designates the rate. Currently DHS is only reimbursing at non-rural and competitive bid rates and is working to have its system reprogrammed to accommodate the rural rates.

Further reductions to DME reimbursement for the Medicaid population to the items not already reduced to the Medicare fee schedule will devastate all providers who care for the Medicaid population. Providers would no longer be able to provide the same products and services where the reimbursement does not cover their costs. In addition, it will eliminate any estimated Medicaid program savings by shifting those savings to long-term care expenses.

The Minnesota Legislature has repeatedly recognized that Medicare and Medicaid programs are drastically different. Medicare beneficiaries tend to be older, disabled, or both. Medicaid covers infants and mothers, low-income and dually eligible individuals. Medicare also restricts DME access for “in home use” only, whereas Medicaid covers for use in the home and community, recognizing the need for this more active population to participate in the community.

MAMES requests the Blue Ribbon Commission recognize that Medicaid is already paying Medicare rates and that no further savings could possibly be obtained. MAMES requests the Blue Ribbon Commission to reject Strategy #420.

IN CLOSING
The Blue Ribbon Commission was directed by the legislature to “not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.”

MAMES believes if the Commission proceeds with Strategies #419 and #420, it would negatively impact access to DME and medical supplies for a vulnerable population. If DME and medical supplies are not available through the Medicaid program because no provider can carry the items due to reimbursement that is less than costs, it would result in significantly reduced access to care for thousands of Minnesotans, including many of its most vulnerable citizens.

DME and medical supplies, like wheelchairs, oxygen, enteral formula, feeding tubes, and incontinence products, etc., enable millions of Americans with disabilities and chronic illnesses to remain safe and independent at home and in their communities. Providing these products is an essential cost benefit tool for keeping the overall costs of health care down. The more that people receive quality medical equipment, supplies and services at home, the less that is spent on hospital stays, emergency room visits, and nursing home admissions.

Thank you for your consideration.

Respectfully,

Rose Schafhauser, MAMES Executive Director
email: info@mames.com  ph. 651-351-5395
February 18, 2020

Dear Blue Ribbon Commission:

I am writing in response to the Blue-Ribbon Commission’s Consideration of Strategy #383: Reduce Absence and Utilization Factor in Day Services. We believe that this strategy would have a detrimental effect on day services providers, like Rise, and the final impact will be lower quality services and won’t result in overall cost reductions across the disability services system.

Today, Absence and Utilization is a major factor in the expenses and rates in day and employment services. Unfortunately, our ability to influence absences and utilization is minimal. Many of the people Rise supports have complex medical needs and are absent from services in ways that are unpredictable. Rise also needs to close when the weather is bad, which sometimes happens multiple times per year. The current Absence and Utilization factor was calculated based on data collected by day services providers across the state.

Rise’s services support people in meeting their goals for community employment, integration and participation. To do so, we need to be able to attract and retain quality staff to provide these services. This is challenging in this job market, even with our current rates. Rise’s turnover rate for Direct Support Professionals is approaching 45%. Other employers can simply raise the prices of their goods or services if they need to raise wages. Rise must work within the rate framework to cover staff wages. If the Absence and Utilization factor is reduced the current workforce crisis will be made even worse because we will struggle to maintain wages that are competitive in the marketplace.

Rise’s services must meet many state and federal mandates like the Minnesota Olmstead Plan, Employment First, and the HCBS Final Rule. Cutting Rise’s rates makes it harder for us to meet these mandates because we rely on quality staff who have experience in their positions to do so. We also need a pool of experienced people to promote into more specialized positions. For example, it’s difficult to fill job placement positions with people who have disability services experience when people leave entry level positions quickly for better wages outside the field. Experienced job placement professionals are needed to help people reach their competitive employment goals.

If fewer people pursue competitive employment, this actually increases expenses to the State as people opt for higher-cost center-based services instead of employment in the community. Also, when people are competitively employed, there is research to show that their overall healthcare costs decrease, it supports their mental health, and they pay back into the system like typical citizens through taxes and economic participation. We need qualified, experienced staff members to support good employment outcomes and have a positive impact on people’s lives.
DHS performed a study in order to determine the average rates of attendance and utilization across Minnesota. The Commission is proposing to use this data to decrease the attendance and utilization factor. We believe the current attendance and utilization factor is accurate based on data collected by the Minnesota Organization for Habilitation and Rehabilitation (MOHR) and is accurate based on our experiences at Rise. We believe the way the DHS study was conducted had some flaws resulting in inaccurate data. We have concerns with the data collection methods and believe there were incorrect assumptions made about the similarities between different services. It also does not reflect the true costs that Rise experiences when there are absences or closures. For example, fixed costs are not accurately reflected in this latest study by DHS.

If this change to the absence and utilization factor is implemented, Rise will have to pursue additional requests for rate exceptions for people who are absent at rates higher than this factor. Paying higher rates will increase costs, but also increases the staff time required at DHS to evaluate the increased volume of exception requests. This will increase administrative costs across the system.

Strategy #383 (below) states that a reduction in the Absence and Utilization factor will not impact eligibility or supports for beneficiaries. Rise disagrees. We are experiencing a workforce crisis, and Rise is using all available administrative time and resources to attract and retain quality employees to perform these vital services. We have spent everything that we can from our existing budget to have an impact on our workforce. Reductions in any of the factors in the rate setting formulas, including the absence and utilization factor, will make our finances even tighter, and we will struggle with wages and benefits for our employees. A staffing shortage will have a negative impact on the people we support and will harm their ability to pursue their goals.

The Blue Ribbon Commission was directed by the legislature to NOT include recommendations that “may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to healthcare and human services”, and we believe reductions to this factor will have an impact on Minnesotans with disabilities accessing day and employment services.

We urge you to reconsider Strategy #383.

Thank you for your consideration,

Lynn Noren
President & CEO
Strategy #383: Reduce Absence and Utilization Factor in Day Services

TITLE: Reduce the Absence and Utilization Factor in DWRS for Day Services

Short Description: The change would be implemented on a rolling basis during the first year to align with service agreement renewals. Savings in the first year of implementation are lower than in year 2 due to the phased-in service agreement renewals. Savings would roughly double in year 2 and remain approximately at the year 2 level ongoing with small saving increases each year due to forecast increases.

Long Description: Change the absence and utilization factor currently in law governing DWRS to one supported by recent DHS analysis.

Impact of the changes: A reduction in the forecasted state and federal cost of HCBS day services.

Populations impacted: Impact would be a reduction of rates paid providers for day services. No beneficiary impact (eligibility or support reductions) should occur due to this change.

Rationale and background: The absence and utilization factor for day services is identified in state law and has a higher value than DHS analyses have identified. Day services providers under the disability waivers are paid at the rate required by state law. This recommendation will require a change in state law to reduce the absence and utilization factor to a level supported by data analysis.

Other:
Submitted by DHS Community Support Administration
February 17, 2020

hhs.blue.ribbon.commission@state.mn.us

To Whom It May Concern:

I am writing in response to the Blue-Ribbon Commission’s Consideration of Strategy #383: Reduce Absence and Utilization Factor in Day Services. I believe this strategy will not result in the desired effect of reducing health and human services budgetary costs to the level it intends. Further, this strategy will hinder the efforts of disability service providers like MSS to improve the workforce crisis and make it more difficult for them to provide disability services that meet state and federal mandates and initiatives such as the HCBS Final Rule, The Minnesota Olmstead Plan, and Employment First.

Absence and Utilization is a major cost driver for day and employment services, and it is one that providers have little to no control over. The individuals MSS serves are frequently absent due to illness, hospitalizations or other concerns, and MSS is forced to close, sometimes multiple times in the winter due to extreme cold and dangerous conditions. The current absence and utilization factor ensures that the rates MSS are reimbursed take these factors into consideration. DHS conducted an analysis that aimed to determine the average rates of attendance and utilization across the state. This analysis is what the Commission is proposing to use to decrease the current absence and utilization factor. I have long felt that the data in DHS’ analysis is flawed and does not match the reality for service providers. This is due to considerations such as how the data was collected, differing attendance levels among the various services, and the true costs associated with persons served not attending MSS.

If this change to the absence and utilization factor is implemented, MSS will have to pursue additional requests for rate exceptions for the individuals we service with absences higher than this factor. This will decrease the cost savings associated with this proposal and will lead to additional administrative costs for providers, lead agencies, and DHS to process these rate exception requests. MSS supports 370 individuals funded by a waiver, and we anticipate requesting rate exceptions in 2020 for 35% of these individuals whose rates do not cover the cost of our services when attendance and utilization is factored. If the absence and utilization factor is reduced to match the data from DHS’ analysis, we would file rate exceptions on 50% of these individuals.

Strategy #383 (included for reference below) states that a reduction in the Absence and Utilization factor will not impact eligibility or supports for beneficiaries. I disagree with that assertion. There are many different factors included in the rate setting formulas that produce a final rate for supporting Minnesotans with disabilities in their employment and day services. We are in the midst of a crisis-level workforce, and MSS
is putting a significant amount of time and resources into using every last dollar we have to increase wages and benefits to attract and retain the staff providing these services. Reductions in any of the factors in the rate setting formulas, including the absence and utilization factor, will make the overall finances for MSS even tighter, making it even harder to improve our staff recruitment and retention. Staffing shortages directly impact the people we serve by limiting the resources available to support them in increasing job opportunities and making community connections.

The Blue Ribbon Commission was directed by the legislature NOT to include recommendations that “may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to healthcare and human services”, and I believe reductions to this factor will have an impact on Minnesotans with disabilities accessing day and employment services as they pursue their goals.

I urge you to reconsider Strategy #383.

Thank you for your consideration,

Julie Johnson
President, CEO

Strategy #383: Reduce Absence and Utilization Factor in Day Services
TITLE: Reduce the Absence and Utilization Factor in DWRS for Day Services
Short Description: The change would be implemented on a rolling basis during the first year to align with service agreement renewals. Savings in the first year of implementation are lower than in year 2 due to the phased-in service agreement renewals. Savings would roughly double in year 2 and remain approximately at the year 2 level ongoing with small saving increases each year due to forecast increases.
Long Description: Change the absence and utilization factor currently in law governing DWRS to one supported by recent DHS analysis.
Impact of the changes: A reduction in the forecasted state and federal cost of HCBS day services.
Populations impacted: Impact would be a reduction of rates paid providers for day services. No beneficiary impact (eligibility or support reductions) should occur due to this change.
Rationale and background: The absence and utilization factor for day services is identified in state law and has a higher value than DHS analyses have identified. Day services providers under the disability waivers are paid at the rate required by state law. This recommendation will require a change in state law to reduce the absence and utilization factor to a level supported by data analysis.
Other:
Submitted by: DHS Community Support Administration
E-MAIL CORRESPONDENCE

February 17, 2020

hhs.blue.ribbon.commission@state.mn.us

To Whom It May Concern:

I am writing on behalf of the Minnesota Organization for Habilitation and Rehabilitation (MOHR) in response to the Blue-Ribbon Commission’s Consideration of Strategy #383: Reduce Absence and Utilization Factor in Day Services. MOHR is comprised of more than 105 day and employment services provider members serving in excess of 26,000 Minnesotans with disabilities. I believe Strategy #383 will not result in the desired effect of reducing health and human services budgetary costs to the level intended. Further, this strategy will hinder the efforts of disability service providers to improve the workforce crisis and make it more difficult for them to provide services that meet state and federal mandates and initiatives such as the HCBS Final Rule, The Minnesota Olmstead Plan, and Employment First.

Absence and Utilization is a major cost driver for day and employment services, and it is one that providers have little to no control over. The individuals MOHR members serve are frequently absent due to illness, hospitalizations or other concerns, and providers are often forced to close in the winter due to extreme cold and dangerous conditions. The current absence and utilization factor ensures that the rates providers are reimbursed take these factors into consideration. DHS conducted an analysis that aimed to determine the average rates of attendance and utilization across the state. This analysis is what the Commission is proposing to use to decrease the current absence and utilization factor. MOHR members have long felt that the data in DHS’ analysis is flawed and does not match the reality for service providers. The analysis uses information from only six months of 2016 and relies on an assumptive formula that we do not feel generates accurate representative data.

If this change to the absence and utilization factor is implemented, MOHR members will have to pursue additional requests for rate exceptions for the individuals we service with absences higher than this factor. This will decrease the cost savings associated with this proposal and will lead to additional administrative costs for providers, lead agencies, and DHS to process these rate exception requests. This additional administrative burden for providers will diminish their already strained resources that need to be spent improving staffing stability and each ensuring each individual in our programs has options to pursue the highest quality of life possible.

Strategy #383 (included for reference below) states that a reduction in the Absence and Utilization factor will not impact eligibility or supports for beneficiaries. I and the members of MOHR disagree with that assertion. There are many different factors included in the rate setting formulas that produce a final rate for supporting Minnesotans with disabilities in their employment and day services.
We are in the midst of a crisis-level workforce, and MOHR members are putting a significant amount of time and resources into using every last dollar we have to increase wages and benefits to attract and retain the staff providing these services. Reductions in *any* of the factors in the rate setting formulas, including the absence and utilization factor, will make the overall finances for providers even tighter, making it even harder to improve our staff recruitment and retention. Staffing shortages directly impact the people we serve by limiting the resources available to support them in increasing job opportunities and making community connections.

The Blue Ribbon Commission was directed by the legislature **NOT** to include recommendations that “may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to healthcare and human services”, and I believe reductions to this factor will have an impact on Minnesotans with disabilities accessing day and employment services as they pursue their goals.

On behalf of MOHR’s more than 105 service providers, I urge you to reconsider Strategy #383. MOHR plans to continue our current ongoing discussions with DHS to identify a long-term solution that all stakeholders are comfortable with aimed at making the absence and utilization adjustment process data driven and more reliant.

Thank you for your consideration,

Julie Johnson
MOHR President

**Strategy #383: Reduce Absence and Utilization Factor in Day Services**

**TITLE:** Reduce the Absence and Utilization Factor in DWRS for Day Services

**Short Description:** The change would be implemented on a rolling basis during the first year to align with service agreement renewals. Savings in the first year of implementation are lower than in year 2 due to the phased-in service agreement renewals. Savings would roughly double in year 2 and remain approximately at the year 2 level ongoing with small saving increases each year due to forecast increases.

**Long Description:** Change the absence and utilization factor currently in law governing DWRS to one supported by recent DHS analysis.

**Impact of the changes:** A reduction in the forecasted state and federal cost of HCBS day services.

**Populations impacted:** Impact would be a reduction of rates paid providers for day services. No beneficiary impact (eligibility or support reductions) should occur due to this change.

**Rationale and background:** The absence and utilization factor for day services is identified in state law and has a higher value than DHS analyses have identified. Day services providers under the disability waivers are paid at the rate required by state law. This recommendation will require a change in state law to reduce the absence and utilization factor to a level supported by data analysis.

**Other:** Submitted by: DHS Community Support Administration
Email Correspondence

Date:  02/17/2020

To:  Health and Human Services Blue Ribbon Commission

From:  Thomas H. Weaver

RE: Public Comment:  DWRS Transition Grants

Blue Ribbon Commission,

Thank you for the opportunity to comment on the proposed Cost Savings Strategies you have identified. Specifically, I would like to comment on Strategy No. 10: “Discontinue Grant Programs.”

Strategy 10 proposes to end two grant programs that the Commission describes as “no longer needed.” One of those grant programs is the Disability Waiver Rate System (DWRS) Transition Grant, and I would like to assure the Commission that the DWRS Transition Grants are still very much needed.

Achieve Services is one of just a few programs that are eligible for the DWRS Transition Grants. The grants are targeted to helping those programs being hit the hardest by the DWRS. To be eligible, a program must be losing at least 15% and at least $300,000 of its rate revenue when the DWRS rates are fully implemented – which is happening in 2020. Eligible programs must also be serving at least 100 waivered service recipients.

Achieve Services serves 195 adults with I/DD, and we have more than 100 on our waiting lists. Moreover, as the DWRS rates are fully implemented in 2020, Achieve is projected to lose more than $560,000 in revenue compared to 2019. 2020 is the year of “rolling implementation” as service agreements are renewed, so 2021 we be the first full year with the new rates, and our revenue loss in that year is projected to exceed $800,000.

Over the past several years, Achieve has taken a number of steps to reduce this anticipated funding gap, including:

• We increased our fundraising from $95,000 in 2013 to more than $400,000 in 2019, and we reduced our reliance on waiver funding from 90% to 79% during that time;
• We’ve created an endowment and a transition reserve;
• We’ve increased our grant revenue;
• We launched Achieve Clean, and laundry detergent company creating jobs and revenue for the people we serve; and
• We’ve achieved significant reductions in transportation and other overhead costs.

Despite the steps we’ve taken to close the funding gap, the magnitude of the shortfall required the creation of this short-term Transition Grant program, and it remains an essential component of our transition to a long-term sustainable business model. And, in addition to the grant dollars, the Transition Grant program also includes technical assistance from DHS to help programs like Achieve develop sustainable business models that do not require additional assistance beyond the life of this 2-year grant program.
Clearly the legislature and Governor saw a need for this legislation last spring when the Transition Grants were enacted, and in the meantime, nothing has changed to mitigate the need for the Grants. The Grants are still very much necessary. Accordingly, on behalf of Achieve and the 195 people we are privileged to serve, I respectfully request that the Commission remove the DWRS Transition Grant from it’s list of proposed Cost Savings Strategies.

Best Regards,

Thomas H. Weaver

CEO, Achieve Services, Inc.

1201 89th NE

Blaine, MN 55434

763 783-4910

tweaver@achieveservices.org
February 13, 2020

Jan Malcolm, Commissioner
Minnesota Department of Health
625 Robert St. N
PO Box 64975
St. Paul, MN 55164-0975

Jodi Harpstead, Commissioner
Minnesota Department of Human Services
444 Lafayette Rd.
St. Paul, MN 55155

Dear Commissioners Malcolm and Harpstead:

As you will recall, in the 2019 session, the Minnesota Legislature extended the health care provider tax, while directing that a “Blue Ribbon Commission” be empaneled to review the operations of the Minnesota Departments of Health and Human Services to find efficiencies. I understand that a commission has been established and has begun to undertake this work, and I thank you and your respective staffs for helping make that happen. We can easily appreciate that given the extensive programs and services both Departments offer, this will be a significant project.

I recently received from a constituent a copy of an 11-page document entitled “Commission member interest for prioritized strategies,” resulting from a meeting in December. It is a thoughtful and ambitious description of the work facing the commission, and I appreciate the effort which went into its drafting. I write, however, to express concern regarding item #35 on page 9 of the document, related to developing health-care curricula which “enhances understanding and engagement with communities of color, tribal and immigrant communities.” My concern, of course, is not that these discussions should not occur; rather, my concern is that there are marginalized communities which experience health-care
disparities and inequities whose needs may not be included within this framework. I am thinking, in particular, of the lesbian, gay, bisexual, and transgender (LGBT) communities in Minnesota. As I understand it, MDH’s own data, drawn from the Minnesota Student Survey, show that LGBT youth are at greater risk for mental-health, substance-misuse, and other challenges. Transgender individuals of all ages frequently experience barriers in accessing care specific to transgender people, or even basic care in circumstances which respect their identities. LGBT older adults report deep hesitation to access care for fear of discrimination. These experiences, and more, contribute to the reports of disparities affecting these communities.

Considering this, it seems extremely appropriate to find ways to assure that LGBT communities are specifically identified as among the priority populations the commission is considering in the context of promoting equity in general, and in developing equity-enhancing educational efforts in particular. I am writing, therefore, to raise this question with you both and hope to explore ways to accomplish this end. I believe there are various individuals and organizations in Minnesota who could assist in informing a discussion.

Thank you for your consideration of this request.

Very truly yours,

D. Scott Dibble
Minnesota State Senator, District 61
February 3, 2020

Members of the Blue Ribbon Commission

Dear Commissioners:

AARP is writing to express our thanks to the commission for including efforts to lower the cost of prescription drugs in your Priority Strategies (Proposals 192, 205, and 407). As the nation’s largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age, we work on policies designed to enhance health security, financial stability, and the overall health of Minnesota older adults and their families.

Prescription drug prices are a high priority for AARP. AARP members are fifty years of age and older – and many of them, just like everybody else, struggle every day to afford needed and life-saving medications. High drug costs hurt everyone, not only those who rely on prescription drugs for their health and chronic conditions, but all of us who are paying higher premiums and out-of-pocket costs for health insurance as well as the taxpayers who help fund our public programs.

AARP appreciates the Commission’s inclusion of the proposal to develop an affordability commission and purchasing council that will develop a strategy related to pharmacy costs. We strongly support efforts in the legislature, brought forward by Sens. Scott Jensen and Matt Klein, to create an Rx Affordability Commission that sets an upper payment limit on how much payers, providers, and patients can be required to pay for certain drugs. As the Commission continues development of strategies 192 and 205, we hope you will model the strategy after the legislation proposed by Sens. Jensen and Klein.

AARP also urges the Commission to include a Uniform Pharmacy Benefit strategy that would allow the state to negotiate the cost of prescription drugs for enrollees on all public programs; and further expanding the State’s authority to negotiate drug prices for all state agencies (Proposal 407).

Americans have seen their prescription drug prices skyrocket. About 30 years ago, the public was outraged over a drug that cost less than $10,000 per year. We now have drugs approaching $1 million per year. And a 2015 study noted that the average annual retail cost of prescription drug therapy for a specialty drug was more than $52,000 per year – a number just
below the median U.S. household income and more than twice the median income for Medicare beneficiaries.

Our research shows drug prices are rising faster than inflation & quickly out of reach for many of our members. Moreover, older Minnesotans tend to take more drugs on average – typically 2 to 4 prescriptions to manage chronic conditions – so any increase can make the cost of these drugs unaffordable.

So, it’s hardly surprising that our members consistently tell us they cannot afford the medications they need and are forced to make difficult choices as a result. Take for example the story of Claire Henn who lives in St. Paul. Claire should be taking the prescription Remicaid for her rheumatoid arthritis. A prescription that once cost $60 for a treatment now costs $1400. Due to these outrageous costs she went three years without the drug until she began to find it difficult to grasp a knife and fork. She’s only able to afford the drug with assistance from a charitable institution. The reality for Claire is that without charitable assistance, to afford this drug would force her out of her home and her community. So she is forced into a harsh tradeoff that is all too common - sacrificing her health and quality of life so that she can keep her home.

Or take the story of Sue and Tom Counters form La Crescent. Sue Counters has breast cancer and has a prescription costing more than $240,000 a year. They feel lucky because they have insurance. But even with insurance their cost is $12,000 a year. They worry if they had just their social security and pension alone, it would be impossible to afford even the $12,000.

Every day we hear stories such as these from our members who are facing serious health and financial consequences as a result of high prescription drugs. And the reality of many of these stories is that we’re often talking about costs that patients will face every year for the rest of their lives. High and growing drug prices are affecting all Minnesotans in some way. The cost is passed along to everyone with health coverage through increase health premiums, deductibles and other forms of cost-sharing. Minnesota is not exempt from these increasing costs. The escalating costs of prescription drugs will affect all of us in the form of higher taxes, cuts to public programs, or both.

AARP, with nearly 670,000 Minnesota members, and hundreds of volunteers stands ready to work with the Commission to work toward implementing these proposals. Already, many of these proposals have been passed in other states with success in achieving the intended outcomes. While no one proposal is a silver bullet, AARP urges the Commission to adopt these common sense proposals that can improve the overall health of Minnesotans and save the state money over both the short and long term.

Thank you in advance for your consideration to our proposals.

Sincerely,

Will Phillips
State Director
Blue Ribbon Commission Written Public Comment:

Please use this form to provide written comment for the Blue Ribbon Commission. All information submitted to the Blue Ribbon Commission is considered public and will be provided to Commission members and posted on the public website located at: https://mn.gov/dhs/hhsbrc/

Please submit form at the Blue Ribbon Commission meeting or to hhs.blue.ribbon.commission@state.mn.us

Date: November 7, 2019

Comment:

The "low hanging fruit" of cost savings is usually tracking down waste and fraud.

Those efforts will be stymied by the stifling and retaliation that DHS employees encounter when they report. Solve that and waste and fraud can be reported.

Name (optional): Faye K. Bernstein

Address (optional): ________________________________________________

Email (optional): ________________________________________________

Phone (optional): 651-431-2230
Blue Ribbon Commission Written Public Comment:

Please use this form to provide written comment for the Blue Ribbon Commission. All information submitted to the Blue Ribbon Commission is considered public and will be provided to Commission members and posted on the public website located at: https://mn.gov/dhs/hhsbrc/

Please submit form at the Blue Ribbon Commission meeting or to hhs.blue.ribbon.commission@state.mn.us

Date: Nov. 7, 2019

Comment: A group that could easily & quickly provide cost saving info would be DNS employees who 1) have dedicated their career to this field, and 2) have these conversations on a day to day basis. The unions could gather this info for you.

Name (optional): Faye K. Bernstein

Address (optional): [Redacted]

Email (optional): [Redacted]

Phone (optional): 651-431-2230

This information is available in other forms to individuals with disabilities. For individuals with a disability who need a reasonable accommodation to access this document, please contact Krista O’Connor at 651-431-7297. TTY users can call the Minnesota Relay Service, 711 or 1-800-627-3529. For the Speech-to-Speech Relay, please call 1-877-627-3848
July 30, 2019

Governor Tim Walz  
130 State Capitol  
75 Rev. Dr. Martin Luther King Jr. Blvd.  
St. Paul, MN 55155

Cc: Lt. Governor Peggy Flanagan, Commissioner Jan Malcolm, Acting Commissioner Pam Wheelock

Dear Governor Walz:

This Is Medicaid writes today regarding the Blue Ribbon Commission on Health and Human Services (the Commission) created during the final negotiations of the 2019 legislative session. This Is Medicaid is a coalition of more than 50 nonpartisan organizations, including hospitals, advocacy organizations, services for seniors and people with disabilities and other health care providers, representing the 1.2 million Minnesotans who access Medical Assistance (MA) for their healthcare.

Our coalition does not oppose the general idea of a Commission looking into the Health and Human Services Budget, but we do have questions about the Commission’s stated purpose, and some of the rhetoric surrounding health and human services in our state. The fact that Medicaid represents a large and growing part of the HHS budget gives us great concern about the potential cost savings the Commission might pursue and the impacts of those savings on Minnesotans who rely on MA for their care. We also have apprehensions about the claims of waste, fraud, and abuse that continue to be directed at HHS, and whether those claims will be exploited in this venue to the detriment of our neighbors who legitimately count on MA for support. While rooting out inefficiencies in the system is essential, we hope that these claims will not be overstated and distract from other avenues toward improvement and savings.

Your administration has been a strong advocate for protecting essential funding for MA, this Commission will be yet another venue where your leadership on this issue will be essential. This Is Medicaid agrees that HHS spending growth is an important consideration as we develop plans to ensure that Minnesotans continue to receive the coverage and care they need. However, we also recognize that spending growth is due in large part to growth in need for services, especially as it relates to populations with higher average costs such as older adults.
and people with disabilities. The Commission will need to take great care to ensure that its work does not cause harm at a time when demand for core services is on the rise.

We need a thoughtful, deliberative, and sustained process if we are to identify strategies to handle the growing cost of care. *This Is Medicaid* implores you to ensure that this process is as open and transparent as possible. The Commission must be accountable to the millions of Minnesotans who rely on HHS services, who can understand where and why the Committee is recommending any changes at the end of their tenure.

*This Is Medicaid* believes that the Commission has the potential to be a highly productive and beneficial pursuit. We look forward to the appointment of Committee members who will work collaboratively and openly with the public to deliver ambitious and constructive proposals not only for the good of Minnesota's bottom line, but for the good of our communities and our most vulnerable neighbors.

Sincerely,

*This Is Medicaid*
Dear Governor Walz,

We are writing to you about the Blue Ribbon Commission established as part of the final negotiations of the 2019 legislative session. Our organizations represent Minnesotans impacted by the Department of Health and Human Services spending and programs, many of which are in need of further investments, not cuts.

Like many items in the final HHS omnibus bill, the commission was developed behind closed doors with no public input on its duties or the budget reduction allocated to its work.

We are requesting a meeting with Governor Walz to discuss appointments, the work of the commission and how its purpose is communicated to the public, and the priorities of the Administration regarding the commission’s duties. Going forward, we wish to ensure there is input from those directly impacted and their communities.

Further, we are concerned that the framing of the Blue Ribbon Commission could unwittingly further a problematic and mostly false narrative of government programs as being wasteful and inefficient, and that certain communities, usually poor, immigrant, and communities of color, are undeserving.

In the context of those fundamental concerns, we especially want to address the following weaknesses in the convening statute:

- **Public input and engagement**: The statute does not preclude people served by DHS programs being a part of commission make-up or being part of the process, but neither does it require their engagement. The broad charge of the commission to “transform health and human services” will require a diversity of expertise. We strongly believe that appointed members should include community, patients, and advocacy voices. It is very disappointing that the statute does not specify any seats, much less a majority, for those representatives, and that the “public and stakeholder engagement” provision specifically indicates that a literature review alone may fulfill that duty. We believe understanding people’s experience must be a critical focus of the appointments and the process so that the commission is rooted in the experience of Minnesotans needing and attempting to access affordable healthcare.

- **Equity in representation and analysis**: Minnesota’s systemic racism and equity issues are consistently reflected in data across the Health and Human Services system and programs. In addition, the state struggles with equitable access in rural and Greater Minnesota. Appointments of the 11 appointed members (legislators and commissioners excluded) should prioritize direct representation of individuals that represent the breadth of communities being served by the programs, and organizations led by and serving those communities. The
commission should also conduct an equity analysis of any proposed changes and reject those that would exacerbate disparities.

- **Improving health and outcomes**: While the duties of the commission include “promote better outcomes for Minnesotans” this is not highlighted in the action plan. Improving health and outcomes should be central to the work of the commission, and therefore reflected in appointments, structure, and future public discussion of the commission. This is the area with the greatest potential to discuss how to advance the health and well-being of Minnesotans through our public services and to deliver long term savings, rather than a harmful focus on limiting Minnesotans’ access to health care, economic assistance, and other essential services.

- **Educating the public**: The work of the commission may be one of the more visible through-lines covered by the press in the Health and Human Services space over the next year and a half, and will be concluded at a highly politicized time in our state and nation. We see the above concerns as critical to the outcomes of the commission, and also to the project of bringing Minnesotans to a deeper understanding of how our collective needs and values relate to the programs and infrastructure of HHS. Advocates want to work with the Administration and departments as partners in promoting an honest and productive message about this work, one that corrects rather than perpetuates myths of scarcity and mistrust.

While we have many concerns, we also hope the Administration sees this commission as an opportunity to work to improve the programs and services for the people who are directly served, providers, counties, tribes and the state. We would like to meet to discuss our concerns so we can determine how our organizations can promote better outcomes for the people we represent and serve.

Sincerely,

AARP
AFSCME Council 5
CDF-MN
ISAIAH
Land Stewardship Project
Minnesota Budget Project
Minnesota Nurses Association
SEIU Healthcare Minnesota
TakeAction Minnesota
Voices for Racial Justice