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Final Report of the Blue Ribbon Commission on Health and Human Services

07/10/2020

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Executive Summary

The Blue Ribbon Commission on Health and Human Services (the Commission) was created by the Minnesota Legislature and Governor Tim Walz in 2019 to develop an action plan “to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans.” The Commission members sought public and stakeholder input on ideas to consider as part of its work, and culled through over 200 submissions to identify priority strategies to develop for inclusion in this Final Report.

The Commission organized its work by five aims defined in the legislative charge: health and human services expenditures (cost savings), health equity, administrative efficiencies and simplification, waste (including fraud and program integrity), and system transformation.

Given the emphasis of the requirement within the legislation to identify \$100 million to be saved within the next biennium¹, the Commission focused its early discussion of strategy proposals on ideas that would result in those savings without negatively impacting eligibility or access. In addition to strategies focused on cost savings, the Commission also reviewed strategies focused on administrative simplification, reducing waste, and addressing health equity.

The Commission did indeed complete the development and review of enough cost-savings strategies from September 2019 through March 2020 to identify nearly \$100 million in savings. These strategies were advanced for further consideration.

Immediately after, the COVID-19 pandemic disrupted the work of the Commission, resulting in the cancellation of numerous meetings. This had substantial impact upon the Commission’s work. First, the Commission was unable to review developed proposals for all of its prioritized strategies. The health equity and system transformation aims were most greatly affected – only some of the health equity strategies and none of the prioritized transformation strategies were developed for presentation to the Commission. Second, a final review of those strategies that were developed, presented, discussed, and advanced for further consideration never occurred, meaning the Commission was unable to render final judgement on those strategies. Third, community engagement activity as part of strategy review was not nearly as comprehensive as envisioned.

Because of the COVID-19 interruption of the Commission’s work, the Commission recommends that additional analysis be undertaken of the Commission’s prioritized strategies and that additional strategies be identified and assessed to advance the health equity and transformation aims which the Commission was unable to address. We recommend the following:

1. The Governor's Health Sub-Cabinet, or a subsequent commission or task force, explore undeveloped and/or additional health equity and system transformation strategies.

¹ The Commission was charged with identifying strategies that reduce health and human services (HHS) spending by \$100,000,000 for the biennium beginning July 1, 2021. In order for strategies to achieve savings towards this goal, they were required to directly impact the state’s HHS budget (rather than the federal government, counties, providers, or other external entities) and have implementation timelines that facilitate changes in spending in the FY22-23 biennium.

2. Any Commission strategies selected for implementation should first 1) have design details have been developed with health equity in mind and 2) have the health equity considerations identified by the Commission reviewed and addressed.
3. A concerted effort be initiated to truly transform DHS and MDH programs to address a real opportunity for better outcomes for residents and better use of funding. While the strategies included in this report provide some relief, they should not be misconstrued as true reform. Minnesota can and must reimagine these programs from the ground up, to get at root causes and to create pathways out of poverty. Our current systems often trap people in poverty and create unnecessary bureaucracy to get help at high cost to individuals and systems with limited positive outcomes.

In this Final Report, the Commission presents the Minnesota Legislature with the following 22 strategies that were considered by the Commission but not reviewed a second time to make recommendations. It is the hope of the Commission that this work will serve as a foundation for further study and action, providing value in terms of the areas for consideration, the potential for satisfying the Charter of the Commission, and a framework for collaboratively assessing viable solutions.

1. Cost Savings Strategies: Health Care

Based on its initial discussion, the Commission agreed to advance the following nine cost savings strategies focused on health care for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Implement Uniform Administration of Non-Emergency Medical Transportation (NEMT)	This strategy recommends implementation of a uniform NEMT program. Through a uniform NEMT program, a single administrator pays a per member, per month fee and contracts with the drivers, negotiates the rates, and coordinates the rides for the members. This administrative oversight would lower costs and improve program integrity.	Greater than \$10 million
b. Modify Certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates	This strategy proposes capping payment rates for durable medical equipment and supplies at the Medicare rate in the instance where a Medicare rate exists.	\$1 million to \$9,999,999
c. Expand Volume Purchasing for Durable Medical Equipment	This strategy proposes expanding DHS' use of volume purchasing of durable medical equipment and supplies to include additional items.	\$1 million to \$9,999,999

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
d. Expand Use of the MN Encounter Alerting Service	The DHS Encounter Alerting Service (EAS) provides real-time notification of emergency room visits, hospital admissions, transfers, and discharges to primary care and/or care coordinators. This strategy expands the use of the service to more providers, allowing for improved care coordination and reduced incidences of readmission.	\$1 million to \$9,999,999
e. Improve Compliance with Third Party Liability (TPL) Requirements	Third parties are individuals, entities, or programs that are, or may be, liable to pay all or part of the medical costs provided to Minnesota Health Care Programs enrollees. This strategy would authorize and fund the development of additional resources that will improve compliance with current TPL requirements.	Up to \$1 million
f. Require Managed Care Organization (MCO) Competitive Price Bidding	This strategy would require competitive price bidding for procuring managed care contracts in public health care programs.	\$1 million to \$9,999,999
g. Create Uniform Pharmacy Benefit	This strategy would create a uniform pharmacy benefit for public health care programs.	\$1 million to \$9,999,999
h. Establish Prescription Drug Purchasing Council	This strategy would create a commission appointed by the Legislature and Governor on pharmaceutical costs would develop a strategy related to pharmacy pricing, focused on reducing skyrocketing Rx prices. If implemented, more Minnesotans may experience lower-than-projected increases in their premiums or cost-sharing for prescription drugs.	This strategy has the potential for savings based on solutions from the proposed commission
i. Establish Prescription Drug Affordability Commission	This strategy would create a commission appointed by the legislature and Governor on pharmaceutical costs would develop a strategy related to pharmacy pricing, focused on regulating pharmaceutical prices. It is anticipated that with this commission, spending on prescription drugs by individuals and health plan payers will decline or stabilize over time.	This strategy has the potential for savings based on future solutions identified by the proposed commission

2. Cost Savings Strategies: Long-Term Services and Supports (LTSS) for Persons with Disabilities and Older Adults

Based on its initial discussion, the Commission agreed to advance the following six cost savings strategies focused on services for persons with disabilities and older adults in need of long-term services and supports for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Discontinue Grant Programs	This strategy combines two strategies that end appropriations for two grant programs that are no longer needed: 1) Disability Waiver Rate System Transition Grant and 2) Clare Housing Settings Rule Appropriation.	Up to \$1 million
b. Update Absence Factor in Day Services	This strategy changes rate formulas for day services under the disability waivers to reduce the absence and utilization factor to a level supported by data analysis.	\$1 million to \$9,999,999
c. Change Disability Waiver Family Foster Care Rate Methodology	This strategy changes the rate methodology for family foster care services to reflect the service setting and promotes Life Sharing services under the disability waivers.	Greater than \$10 million
d. Curb Residential Costs in Disability Waivers	<p>This strategy is comprised of multiple strategies to reduce utilization of high-cost services in the Medicaid disability waivers. Strategies include:</p> <ul style="list-style-type: none"> • Development of a new initiative that would assist people who indicate that they want to move. This process would help facilitate the moving/service planning process and then reduce statewide capacity available after people move. • Implementation of a more robust process with more stringent guidelines for people not yet in corporate foster care or customized living services to ensure that the level of care is appropriate for the person’s needs. • Changes to billing requirements for corporate foster care and/or unit limitations in customized living services. 	Greater than \$10 million

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
e. Require Medicare Enhanced Home Care Benefit	This strategy would mandate that all Medicare health plans sold in Minnesota provide a set of non-medical services that could assist seniors in remaining in their homes and communities.	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium but there are potential for savings in future years.
f. Update Value-Based Reimbursement in Nursing Facilities	<p>This strategy proposes a significant revision to value-based reimbursement in nursing facilities to reflect appropriate rates over time and incentivize quality care, including:</p> <ul style="list-style-type: none"> • Suspend the Critical Access Nursing Facility Program (CANF) funding as it has no value under VBR. • Suspend the Alternative Payment System automatic property inflation adjustment. • Eliminate a hold harmless clause which states that facilities at least receive the rate they had for the year prior to the implementation of VBR. • Add an assessment when therapy services are discontinued which, will result in a decrease in the resident’s daily payment rate because the assessment will reflect that the service is no longer needed and no longer being provided. 	\$1 million to \$9,999,999

3. Strategies focused on Waste, Including Fraud and Program Integrity

Based on its initial discussion, the Commission agreed to advance the following three strategies focused on program integrity and waste reduction for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Pursue Fraud, Waste, or Abuse Prevention Enhancements	This strategy would expand investigatory capacity, strengthen policy framework, and improve internal processes in order to achieve a higher return on investment in identifying fraud, waste, and abuse.	Up to \$1 million
b. Reduce Low- Value Services in Minnesota	<p>This strategy includes the following four areas of activity:</p> <ul style="list-style-type: none"> • Estimate the volume of provider-driven, low-value services for which there is broad consensus. • Work with a group of stakeholders and experts to identify additional areas of low-value services and publicize results of measurement. • Work with employers and providers to implement a statewide strategy to reduce provision of a defined set of low-value health care services. • Develop a coordinated approach to accountability of payers and providers for reduction/elimination of provision of low-value services. 	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium, but there are potential for savings in future years.
c. Align State and Federal Health Care Privacy Protections	This strategy would align the Minnesota Health Records Act with federal HIPAA patient privacy protections. These changes would maintain patient privacy protections while eliminating burdensome requirements for clinicians.	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium but there are potential for savings in future years.

4. Strategies focused on Administrative Efficiencies and Simplification

Based on its initial discussion, the Commission agreed to advance the following strategy categorized as administrative efficiency for further consideration.

Strategy	Strategy Summary
a. Improve MnCHOICES and LTSS Processes	Through this strategy, DHS would create and implement a process improvement plan with counties and tribal nations across the state, building on the LTSS process mapping done in 2019. Using these findings, DHS would work with pilot counties to implement changes and streamline the LTSS process across the state. As part of this work, DHS would incorporate feedback from people who have had a MnCHOICES assessment, and work with counties and tribal nations on specific changes to their organizational structure while identifying best practices that can be implemented across similar agencies. The work would also include producing a guide for families and people requesting assessment that provides a clear explanation of the process and spans the assessment and eligibility process.

5. Strategies focused on Health Equity

Based on its initial discussion, the Commission agreed to advance the following three strategies focused on reducing disparities and addressing health equity for further consideration.

Strategy Title	Strategy Summary
a. Improve Dental Access in Public Health Care Programs	This strategy recommends contracting with a third-party administrator to manage dental services for all Medical Assistance and MinnesotaCare enrollees, while updating the rate structure to be more equitable.
b. Ensure Equitable Access to Aging and Disability Service Programs	This strategy seeks to ensure that aging and disability services are accessed equitably regardless of race or ethnicity. This strategy includes developing a community engagement strategy to better assess service access for racial and ethnic minorities with disabilities and older adults. The strategic goal would be to ensure that all people make informed choices about their services.
c. Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports	This strategy would expand targeted case management eligibility and establish a statewide targeted case management rates methodology.

2020 Crises Create a Portal for Transformation

Finally, the Commission notes that life in Minnesota has shifted dramatically since the Blue Ribbon Commission began its work in September 2019. Today, we are experiencing a time unlike any that we have seen. The COVID-19 pandemic highlighted significant health disparities in Minnesota and nationally, and paralyzed our economy. George Floyd's murder, and the subsequent civil unrest, dramatically brought us face-to-face with the deep-rooted racism that persists within our society. With these twin tragedies, it is clear to the Commission that there is an urgent and compelling need for Minnesota to take action now to address inequity and health disparities through health and human services system transformation. The Commission members implore the Legislature to take bold and decisive action now to address these needs and consider opportunities which this Commission was not sufficiently able to address.

The Commission sets forth the following vision of a transformed Minnesota health and human services system that provides a fair and just opportunity for health and well-being and where race no longer determines health outcome:

- People most affected by structural racism contributing to health and social disparities have a substantive role in the planning and decision-making process when planning system changes, as well as in implementation of the changes.
- Prioritized attention is placed on the roles of public health and social infrastructure to foster resilience and reduce the social determinants that greatly contribute to health and social disparities.
- Longstanding, embedded practices in health and social services purchasing, administration, payment, and service delivery that lead to health and social disparities are identified and modified.
- The partnerships between the Department of Human Services and the Department of Health, are strengthened and there is clarity about the roles and responsibilities for delivery and coordination of services at the local, regional and state level.
- Outcomes are measured on an ongoing basis to ensure transparency and accountability for real change.

The Commission completed valuable work on behalf of Minnesotans. To its disappointment, however, the Commission was unable to fulfill its entire charge due to the impact of COVID-19. There is, however, now a portal for transformational change of Minnesota's health and human services systems due to the COVID-19 pandemic and the awakening to the reality of structural racism have created. The Commission urges the Legislature to take bold steps towards the Commission's vision, for this moment calls for such action and for transformative change.

Introduction

The Blue Ribbon Commission on Health and Human Services (the Commission) was created by the Minnesota Legislature and Governor Tim Walz in 2019 to develop an action plan “to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans.”² The legislation designated the Commissioner of the Department of Human Services and the Commissioner of the Department of Health as its co-chairs and included two members of the House appointed by the Speaker of the House, two members of the Senate appointed by Senate Majority Leader, and the 11 additional members appointed by the Governor.³ Commission members were appointed by August 2019.

The Commission was charged with developing an action plan by October 1, 2020 for transforming the health and human services system to improve program efficiencies, produce savings, and promote better outcomes for Minnesotans. Specifically, the legislation included language that required the Commission to identify strategies to reduce health and human services expenditures by \$100,000,000 for the biennium beginning July 1, 2021. Pursuant to the legislation, the action plan was required to include, but was not limited to, the following:

1. *strategies to increase administrative efficiencies and improve program simplification within health and human services public programs*, including examining the roles and experience of counties and tribes in delivering services and identifying any conflicting and duplicative roles and responsibilities among health and human services agencies, counties, and tribes;
2. *approaches to reducing health and human services expenditures*, including identifying evidence-based strategies for addressing the significant cost drivers of state spending on health and human services, including the medical assistance program;
3. *opportunities for reducing fraud and improving program integrity* in health and human services; and
4. statewide strategies for improving access to health and human services with a focus on *addressing geographic, racial, and ethnic disparities*.

In addition to addressing these charges, the Commission members also expressed an early desire to address the legislation’s call for “transforming the health and human services system” to a) improve program efficiencies, b) produce savings, and c) promote better outcomes for all Minnesotans.

The legislation placed limitations on strategies that could be entertained by the Commission, specifying that “the Commission shall not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.” Further limitations required the Commission to take into consideration capacity of state staff, as well as county and tribal partners.

The Commission began meeting in September 2019 with the goal of developing its Final Report by July 2020 for public comment. In its first four meetings, the Commission received an orientation to Minnesota health and

² The Blue Ribbon Commission enacting legislation: Laws of Minnesota 2019, 1st Special Session, Chapter 9, Article 7, Section 46)

³ A listing of the Blue Ribbon Commission members and their biographies is found in Appendix 1.

human services programs, discussed its charge and developed a charter and principles.⁴ The Commission continued meeting on a bi-weekly basis through March 6, 2020, identifying and considering strategies to meet its charge. When the COVID-19 pandemic resulted in the issuance of a peacetime state of emergency in Minnesota, the Commission paused its activity, resuming with shorter, virtual meetings between April and June 2020. However, the context within which the Commission started its work has changed dramatically given the twin tragedies of COVID-19 and George Floyd's murder.

The Department of Human Services (DHS) contracted with Bailit Health Purchasing, LLC (Bailit Health) to work with DHS and Department of Health staff to support the Commission and facilitate the Commission meetings beginning in October 2019. The Department also set up the Blue Ribbon Commission [website](#) to provide Minnesotans with transparency of the Commission process.⁵

Priority Strategy Identification and Development

The Blue Ribbon Commission solicited ideas from the public in order to identify strategies for the Commission to consider to meet its charge. The Commission co-chairs also requested strategy proposals from Commission members, state staff, and Bailit Health. In offering policy proposals, submitters were asked to submit ideas that:

1. possessed a high probability of achieving the aim of the defined focus area that the proposal addressed;
2. were subject to the influence of government action;
3. were feasible to implement, both administratively and politically;
4. would not contribute to health inequities or disparities, nor negatively impact individual and community health status, consumers in private marketplaces, quality of care, or access to necessary care, and
5. would not result in benefit reductions.

In total, the Commission received over 200 unique strategy submissions. The strategies came from a variety of stakeholders and members of the public. Based on the following criteria and questions, state staff and Bailit Health reviewed each submission and recommended a subset of submissions or ideas stemming from the submissions for additional analysis in order to assess whether they merited presentation to the Commission for further consideration. In assessing each strategy, the team considered the following questions:

1. How will the proposal concept achieve its identified aim?
2. Is there reason to believe that the strategy will be effective? (e.g., has it been applied successfully in Minnesota or in another state? Is there research documenting its effectiveness?)
3. Will the impact be one-time or sustained?
4. How difficult will it be to implement the change given state resources and stakeholder support/opposition and capacity?
5. How long will it take to implement?
6. Does it create an administrative burden or additional staff costs?

⁴ The Commission's Charter is found in Appendix 2.

⁵ The Blue Ribbon Commission website can be accessed at <https://mn.gov/dhs/hhsbrc/>

7. What steps are required?

Strategies were organized by five aims defined in the legislative charge: health and human services expenditures (cost savings), administrative efficiencies and simplification, waste (including fraud and program integrity), health equity, and system transformation. In addition to the staff review, the Commission members ranked those strategies that were of greatest interest to them individually. Ultimately, the Commission agreed to have Commission staff develop 47 strategies for its close consideration.⁶ In some cases, proposed strategy concepts were combined together and/or modified from their original submissions.

The Commission developed a schedule in which to review the 47 strategies. Given the emphasis in the legislation in identifying \$100 million in cost savings in health and human services in the next biennium, the Commission first focused on strategies to reduce health and human services expenditures, improve administrative efficiencies, and reduce waste. Before the delays due to COVID-19, the Commission had reviewed 16 strategies, focused mainly on cost savings. The Commission reconvened virtually in early May and discussed eight additional strategies, focused on addressing waste, administrative efficiencies, and health equity.

State staff developed strategies for the Commission's consideration. The selection of strategies for development does not indicate state agency advocacy, endorsement, or support. Instead state staff developed strategies as technical assistance, similar to what they customarily provide for legislator-initiated proposals. Prior to review by the Commission members, each strategy underwent an equity review. There were two intended purposes to the equity review⁷ – 1) raise questions through an equity lens to help guide the development of strategies; and 2) raise questions that should be considered in implementation of strategies. The equity review process is described in the next section.

Beginning in January 2020, state staff developed and Bailit Health presented 24 strategies during the course of the Commission's meetings.⁸ At each meeting, Commission members received a background presentation from state staff or Bailit Health to provide context to each specific strategy, as well as a presentation of the proposed strategy by Bailit Health. Commission members were then given the opportunity to ask questions, discuss each strategy and debate the merits of each strategy relative to the Commission's charge. Each meeting was open to the public; the audience represented an extensive list of providers, interest groups, and advocates. Public comment was invited either orally or in writing for each of the strategies. Commission members were asked to indicate their initial degree of support for each strategy. In some cases, Commission members requested that the State conduct further research into a strategy.⁹ Prior to the shift in timeline due to COVID-19, the Commission had intended to revisit each of the strategies. Given the meeting cancellations, revisiting the strategies for further discussion as a Commission became no longer possible. In addition, two strategies were

⁶ A full list of the 43 strategies selected for development by the Commission, and the order in which Commission planned to review them is found in Appendix 3.

⁷ The equity review template is found in Appendix 4.

⁸ Summaries of the 22 strategies developed and considered by the Commission are found in Appendix 5.

⁹ Some of this additional research was completed and incorporated into the strategy descriptions, but not all of the work was able to be completed.

developed but not presented to the Commission due to timing at meetings, and an additional 18 prioritized strategies remain undeveloped.

The Commission was required to identify strategies that reduce health and human services spending by \$100,000,000 for the biennium beginning July 1, 2021. In order for strategies to achieve savings towards this goal, they were required to directly impact the State's health and human services budget (rather than the federal government, counties, providers, or other external entities) and have implementation timelines that facilitate changes in spending in the FY22-23 biennium. Given this charge, some strategies that would save money over time (beyond the biennium, or requiring an investment) were excluded from consideration. However, they may have merit and could be considered if the scope of future work allows for more transformational strategies not subject to these constraints. Initial estimates of the savings strategies-reviewed by the Commission totaled up to \$106 million and those that the Commission advanced for further consideration totaled up to \$98 million. These fiscal estimates were developed for informational purposes for the Commission. The final fiscal impact of each strategy will depend on the following:

- **Updated Forecasts and the Fiscal Impact of COVID-19:** These initial estimates did not consider the fiscal impact of the COVID-19 pandemic on the state's health and human services budget. The final fiscal estimates of enacted strategies will be determined based on future updated state forecasts;
- **Impact of COVID-19 on HHS policy and technical systems:** These initial estimates assumed effective dates and implementation deemed feasible prior to the incidence of COVID-19. Effective dates and implementation timelines may need modifications due to the demands required of the HHS system to respond to the COVID-19 pandemic.
- **Interactive Impacts:** Interactive effects between proposals were not considered in these initial estimates due to uncertainty as to which strategies the Legislature would subsequently pursue.

As the Legislature considers these strategies in the future, all strategies will require new estimates based on updated forecasts and the legislative language accompanying them.

Equity Review Process

Early in its deliberations, the Blue Ribbon Commission determined the importance of applying an equity lens to its strategy development process and tasked the DHS Health Care Administration's Equity Director with implementing an equity review process for strategies under consideration by the Commission. Commission members agreed that applying an equity lens to each strategy would be important in order to understand the impact of the strategies on under-served and marginalized individuals and groups.

The following underrepresented individuals or population groups were included in the scope of the equity lens review: individuals and groups that are under-served or marginalized based on their ethnicity, race, age, socio-economic status, veteran status, or geographic location; people with both apparent and non-apparent disabilities, people of various gender and sexual identities and expressions, people of color, and American Indians/Indigenous populations.

Each strategy presented to the Commission underwent a comprehensive equity review, which was led by agency staff in consultation with outside experts as needed. The equity review team met at least one week prior to the scheduled Commission meetings to assess proposed strategies and identify any potential equity implications on one or more individuals or population groups listed above. Questions raised by the equity review process were

included in the presentation of each strategy during Commission meetings; in addition, these presentations discussed implementation considerations identified by the health equity review team.

Common themes found during the equity review process include those listed in the following table; these themes and issues were flagged so that agency staff could revise the strategy if feasible.

Common Themes Emerging from Equity Review of Strategies

1. Unintended consequences of strategies
2. Establish accountability provisions and transparency within strategies
3. Geographic access and impact of strategies
4. Determine equity impact of strategies to those receiving Medical Assistance
5. Evaluate population impacts of strategies
6. Ensure that strategies are implemented in cultural competent way
7. Consider Intent vs. Impact (benefit or burden) of strategies
8. Ensure equitable access to providers
9. Define service delivery impact of strategy
10. Conduct needs assessment and gap analysis related to strategies
11. Impact to racial/ethnic individuals and populations by strategies
12. Equity implications among tribal governments of strategies
13. Consider racial and ethnic disparities as a result of barriers
14. Consider impact of social determinants of health
15. Utilize Equity Framework and analysis tools
16. Establish equitable mechanisms
17. Assess community and stakeholder impact of strategies
18. Embed equitable standards within performance measures
19. Conduct unconscious bias and cultural sensitivity training
20. Consider whether strategies reduce poor health outcomes and advance equity
21. Consider how strategies reduce institutional and structural barriers
22. Consider disproportionate impacts of strategies on most vulnerable populations

The equity review criteria focused on four levels of analysis to inform the equity lens of each proposed strategies: the individual, the interpersonal, the institutional, and the structural. By applying an equity lens at each of these levels, the Commission began to identify opportunities in each strategy to promote equitable change.

The metaphor of a lens describes the possibility of seeing the strategies in new and revealing ways that will lead to actionable change. Our health and human service systems make many decisions each day that impact those served. State agencies grapple with how to reach out to communities and serve them in culturally responsive ways that don't perpetuate the current health inequities they face. In order to advance and promote health outcomes that will reduce health disparities, public servants must analyze the culture and conditions that impact the people served in order to guide our decision-making.

Part of the Commission's charge was to evaluate those rules that serve, either implicitly or explicitly, to perpetuate health and human service gaps for Minnesotans who are most vulnerable and most impacted with the purpose to apply an equity lens, which shifts the vantage point to uncover the unseen.

The potential for equity implications and actions taken in the strategy development are included in the strategy summaries found in Appendix 5.

Community Engagement

The Commission recognized the importance of and need for community engagement and public input as the Commission reviewed strategies. The Commission envisioned a multi-pronged approach to engaging the community beginning with soliciting input on potential strategies for Commission consideration. While the Commission has collected some feedback on strategies from the community and stakeholders, the Commission acknowledges that given COVID-19 and other constraints our engagement efforts have fallen short and the strategies considered by the Legislature should be further vetted with the community.

Through its public website, the Commission aimed to be transparent and open with its approach to meeting its legislative charge and strategies being considered by the Commission. As required by state law, all of the meetings were open to the public and public comment was accepted. The State also developed a listserv to provide email notification of information to the public, including meeting notices and Commission updates. 250 individuals signed up to receive these messages.

In addition to the general approach to informing the public described above, state staff reported on Commission activities and received input from the Cultural & Ethnic Communities Leadership Council (CECLC) and included the Health Equity Advisory & Leadership Council (HEAL) participation in the equity review process on each developed strategy. To further solicit input, DHS contractor The Improve Group developed a Stakeholder Toolkit for Commission members to use with their constituencies to obtain feedback on the Commission's work. Finally, DHS staff and individual Commission members met with a number of community groups in July and August 2020. A list of stakeholder groups with which meetings occurred appears below.

Blue Ribbon Commission: Stakeholder Group Outreach

1. American Cancer Society Board/Stakeholders
2. Area Agencies on Aging
3. ARRM
4. Association of Minnesota Counties
5. Best Life Alliance
6. CECLC (Cultural and Ethnic Communities Leadership Council), DHS
7. Community Partners
8. Diverse Elders Coalition
9. Doctors for Health Equity
10. Employers
11. Health Equity and Leadership Council, MDH
12. Local PH Association (LPH)
13. MACSAA (MN Assoc of Social Services Administrators)
14. Medicaid Services Advisory Committee, DHS
15. Minnesota Alliance for Patient Safety (MAPS)
16. Minnesota Community Measurement Board/Committees
17. Minnesota Home Care Association

- 18. Minnesota Leadership Council on Aging
- 19. MOHR (MN Organization for Habilitation & Rehabilitation)
- 20. This is Medicaid
- 21. Tribal Health Directors

Stakeholder input was requested on the draft version of this Final Report and was shared with and discussed by Commission members during their meeting on August 19, 2020. Stakeholder input is included throughout the report.

Strategies for Consideration

Of the 24 strategies the Commission fully considered, the Commission advanced the following 22 strategies for further consideration. Full details for each of these strategies is included in Appendix 5. There was not full agreement on all of the strategies, and the concerns identified, by Commission members and the public, should be carefully weighed before adopting any of the strategies. These concerns were documented in the minutes of the Commission meetings and in public comments, and are included as part of Appendix 5. The Commission recommends that prior to implementation of any strategy 1) design details are developed *with equity in mind* and 2) the outstanding equity considerations are reviewed and addressed.

1. Cost Savings Strategies: Health Care

Based on its initial discussion, the Commission agreed to advance the following nine cost savings strategies focused on health care for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Implement Uniform Administration of Non-Emergency Medical Transportation (NEMT)	This strategy recommends implementation of a uniform NEMT program. Through a uniform NEMT program, a single administrator pays a per member, per month fee and contracts with the drivers, negotiates the rates, and coordinates the rides for the members. This administrative oversight would lower costs and improve program integrity.	Greater than \$10 million
b. Modify Certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates	This strategy proposes capping payment rates for durable medical equipment and supplies at the Medicare rate in the instance where a Medicare rate exists.	\$1 million to \$9,999,999
c. Expand Volume Purchasing for Durable Medical Equipment	This strategy proposes expanding DHS' use of volume purchasing of durable medical equipment and supplies to include additional items.	\$1 million to \$9,999,999

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
d. Expand Use of the MN Encounter Alerting Service	The DHS Encounter Alerting Service (EAS) provides real-time notification of emergency room visits, hospital admissions, transfers, and discharges to primary care and/or care coordinators. This strategy expands the use of the service to more providers, allowing for improved care coordination and reduced incidences of readmission.	\$1 million to \$9,999,999
e. Improve Compliance with Third Party Liability (TPL) Requirements	Third parties are individuals, entities, or programs that are, or may be, liable to pay all or part of the medical costs provided to Minnesota Health Care Programs enrollees. This strategy would authorize and fund the development of additional resources that will improve compliance with current TPL requirements.	Up to \$1 million
f. Require Managed Care Organization (MCO) Competitive Price Bidding	This strategy would require competitive price bidding for procuring managed care contracts in public health care programs.	\$1 million to \$9,999,999
g. Create Uniform Pharmacy Benefit	This strategy would create a uniform pharmacy benefit for public health care programs.	\$1 million to \$9,999,999
h. Establish Prescription Drug Purchasing Council	This strategy would create a commission appointed by the legislature and Governor on pharmaceutical costs would develop a strategy related to pharmacy pricing, focused on reducing skyrocketing Rx prices. If implemented, more Minnesotans may experience lower-than-projected increases in their premiums or cost-sharing for prescription drugs.	This strategy has the potential for savings based on future solutions from the proposed commission
i. Establish Prescription Drug Affordability Commission	This strategy would create a commission appointed by the legislature and Governor on pharmaceutical costs would develop a strategy related to pharmacy pricing, focused on regulating pharmaceutical prices. It is anticipated that with this commission, spending on prescription drugs by individuals and health plan payers will decline or stabilize over time.	This strategy has the potential for savings based on future solutions identified in the proposed commission

2. Cost Savings Strategies: Long-Term Services and Supports (LTSS) for Persons with Disabilities and Older Adults

Based on its initial discussion, the Commission agreed to advance the following six cost savings strategies focused on services for persons with disabilities and older adults in need of long-term services and supports for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Discontinue Grant Programs	This strategy combines two strategies that end appropriations for two grant programs that are no longer needed: 1) Disability Waiver Rate System Transition Grant and 2) Clare Housing Settings Rule Appropriation	Up to \$1 million
b. Update Absence Factor in Day Services	This strategy changes rate formulas for day services under the disability waivers to reduce the absence and utilization factor to a level supported by data analysis.	\$1 million to \$9,999,999
c. Change Disability Waiver Family Foster Care Rate Methodology	This strategy changes the rate methodology for family foster care services to reflect the service setting and promotes Life Sharing services under the disability waivers.	Greater than \$10 million
d. Curb Residential Costs in Disability Waivers	<p>This strategy is comprised of multiple strategies to reduce utilization of high-cost services in the Medicaid disability waivers. Strategies include:</p> <ul style="list-style-type: none"> • Development of a new initiative that would assist people who indicate that they want to move. This process would help facilitate the moving/service planning process and then reduce statewide capacity available after people move. • Implementation of a more robust process with more stringent guidelines for people not yet in corporate foster care or customized living services to ensure that the level of care is appropriate for the person’s needs. • Changes to billing requirements for corporate foster care and/or unit limitations in customized living services. 	Greater than \$10 million

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
e. Require Medicare Enhanced Home Care Benefit	This strategy would mandate that all Medicare health plans sold in Minnesota provide a set of non-medical services that could assist seniors in remaining in their homes and communities.	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium but there are potential for savings in future years.
f. Update Value-Based Reimbursement in Nursing Facilities	<p>This strategy proposes a significant revision to value-based reimbursement in nursing facilities to reflect appropriate rates over time and incentivize quality care, including:</p> <ul style="list-style-type: none"> • Suspend the Critical Access Nursing Facility Program (CANF) funding as it has no value under VBR. • Suspend the Alternative Payment System automatic property inflation adjustment. • Eliminate a hold harmless clause which states that facilities at least receive the rate they had for the year prior to the implementation of VBR. • Add an assessment when therapy services are discontinued, which will result in a decrease in the resident’s daily payment rate because the assessment will reflect that the service is no longer needed and no longer being provided. 	\$1 million to \$9,999,999

3. Strategies focused on Waste, Including Fraud and Program Integrity

Based on its initial discussion, the Commission agreed to advance the following three strategies focused on program integrity and waste reduction for further consideration.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
a. Pursue Fraud, Waste, or Abuse Prevention Enhancements	Expand investigatory capacity, strengthen policy framework, and improve internal processes in order to achieve a higher return on investment in identifying fraud, waste, and abuse.	Up to \$1 million
b. Reduce Low- Value Services in Minnesota	<p>This strategy includes the following four areas of activity:</p> <ul style="list-style-type: none"> • Estimate the volume of provider-driven, low-value services for which there is broad consensus. • Work with a group of stakeholders and experts to identify additional areas of low-value services and publicize results of measurement. • Work with employers and providers to implement a statewide strategy to reduce provision of a defined set of low-value health care services. • Develop a coordinated approach to accountability of payers and providers for reduction/elimination of provision of low-value services. 	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium but there are potential savings in future years.
c. Align State and Federal Health Care Privacy Protections	Align the Minnesota Health Records Act with federal HIPAA patient privacy protections. These changes would maintain patient privacy protections while eliminating burdensome requirements for clinicians.	This strategy was determined to not result in savings to the state budget in the FY22-23 biennium. But there are potential savings in future years.

4. Strategies focused on Administrative Efficiencies and Simplification

Based on its initial discussion, the Commission agreed to advance the following strategy categorized as administrative efficiency for further consideration.

Strategy	Strategy Summary
a. Improve MnCHOICES and LTSS Processes	Through this strategy, DHS would create and implement a process improvement plan with counties and tribal nations across the state building on the LTSS process mapping done in 2019. Using these findings, DHS would work with pilot counties to implement changes and streamline the LTSS process across the state. As part of this work, DHS would incorporate feedback from people who have had a MnCHOICES assessment, and work with counties and tribal nations on specific changes to their organizational structure while identifying best practices that can be implemented across similar agencies. The work would also include producing a guide for families and people requesting assessment that provides a clear explanation of the process and spans the assessment and eligibility process.

5. Strategies focused on Health Equity

Based on its initial discussion, the Commission agreed to advance the following three strategies focused on reducing disparities and addressing health equity for further consideration.

Strategy Title	Strategy Summary
a. Improve Dental Access in Public Health Care Programs	This strategy recommends contracting with a third-party administrator to manage dental services for all Medical Assistance and MinnesotaCare enrollees, while updating the rate structure to be more equitable.
b. Ensure Equitable Access to Aging and Disability Service Programs	This strategy seeks to ensure that aging and disability services are accessed equitably regardless of race or ethnicity. This strategy includes the development of a community engagement strategy for better assessing service access for racial and ethnic minorities with disabilities and older adults and ensuring that all people are being offered an informed choice of appropriate services.
c. Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports	Expand targeted case management eligibility and establish a statewide targeted case management rates methodology.

Priority Strategies Not Reviewed

The following strategies were initially identified for development, but due to time constraints, were not fully developed and/or not presented to the Commission:

1. Repeal Nursing Home Rate Adjustment in the First 30 Days
2. Improve Access to Minnesota IT Services
3. Improve Health Care Delivery for Individuals Transitioning out of Jail or Prison
4. Technology Upgrades to Increase Efficiency and User Experience
5. Process Improvements¹⁰
6. Pilot Project Focused on Intensive Care Coordination for High Cost High Need Members
7. Develop a Single, Inter-Operable, Secure, Low-Cost Telepresence Network
8. Default Native American Medical Assistance Enrollees into Fee for Service
9. Health Care Curricula that Enhances Understanding and Engagement with Communities of Color, Tribal and Immigrant Communities
10. Pilot Hospital Global Payments & Rural Hospital Global Budgets
11. Invest More in Primary Care
12. State Healthcare Purchasing Strategy Reform
13. State Healthcare Rate Reform Study
14. Establish Targets on Health Care Spending
15. Expansion and Sustainable Funding of Medical Respite for Homeless Adults in Minnesota
16. Optimize Use of the All Payer Claims Database (APCD)
17. Implement Structured & Coordinated Health Information Exchange (HIE)
18. Define and Measure “Wellbeing”
19. Waiver Reimagine
20. Increase Access of Home & Community Based Services for Older Adults

¹⁰ The proposed process improvements focused on eligibility assessments and other program processes.

Conclusion

Life in Minnesota has shifted dramatically since the Blue Ribbon Commission began its work in September 2019. Today, we are experiencing a time unlike any that we have seen. The COVID-19 pandemic highlighted significant health disparities in Minnesota and nationally and paralyzed our economy. George Floyd's murder dramatically brought us face-to-face with the deep-rooted racism that persists within our society. With these twin tragedies, it is clear to the Commission that there is an urgent and compelling need for Minnesota to take action now to address inequity and health disparities through health and human services system transformation. The Commission members implore the Legislature to take bold and decisive action now to address these needs and consider opportunities which this Commission was not sufficiently able to address.

The Commission sets forth the following vision of a transformed Minnesota health and human services system that provides a fair and just opportunity for health and well-being and where race no longer determines health outcome:

- People most affected by structural racism contributing to health and social disparities have a substantive role in the planning and decision-making process when planning system changes, as well as in implementation of the changes.
- Prioritized attention is placed on the roles of public health and social infrastructure to foster resilience and reduce the social determinants that greatly contribute to health and social disparities.
- Longstanding, embedded practices in health and social services purchasing, administration, payment, and service delivery that lead to health disparities are identified and modified.
- The partnerships between the Department of Human Services and the Department of Health, are strengthened and there is clarity about the roles and responsibilities for delivery and coordination of services at the local, regional and state level.
- Outcomes are measured on an ongoing basis to ensure transparency and accountability for real change.

The Commission completed valuable work on behalf of Minnesotans. To its disappointment, however, the Commission was unable to fulfill its entire charge due to the impact of COVID-19. There is, however, now a portal for transformational change of Minnesota's health and human services systems due to the COVID-19 pandemic and the awakening to the reality of structural racism have created. A concerted effort to truly transform DHS and MDH programs presents a real opportunity for better outcomes for residents and better use of funding. While the strategies included in this report provide some relief they should not be misconstrued as true reform. Minnesota can and must reimagine these programs from the ground up, to get at root causes and to create pathways out of poverty. Our current systems often trap people in poverty and create unnecessary bureaucracy to get help at high cost to individuals and systems with limited positive outcomes. The Commission urges the Legislature to take bold steps towards the Commission's vision, for this moment calls for such action and for transformative change.

Appendices

Appendix 1: Blue Ribbon Commission Members

Commission Co-Chairs

Jodi Harpstead, co-chair | Commissioner, Minnesota Department of Human Services

Governor Tim Walz named Jodi Harpstead commissioner of the Minnesota Department of Human Services in August 2019.

Prior to her appointment, Commissioner Harpstead was the president and CEO of Lutheran Social Service of Minnesota (LSS) since September 2011. She also was the executive vice president and chief operating officer for LSS and spent 23 years in a variety of positions with Medtronic, Inc.

Commissioner Harpstead has volunteered in leadership capacities for a variety of other organizations including Augsburg University, Lutheran Services in America and ARRM – the statewide association of community-based service providers for people with disabilities.

She received her Master of Business Administration in finance and bachelor's degree in business administration from Michigan State University.

Jan Malcolm, co-chair | Commissioner, Minnesota Department of Health

Commissioner Malcolm was appointed in January 2018 as commissioner for the Minnesota Department of Health.

Prior to being appointed commissioner, Commissioner Malcolm was an adjunct faculty member at the University of Minnesota, School of Public Health, where she co-directed a national research and leadership development program funded by the Robert Wood Johnson Foundation. Earlier she also helped develop initiatives to strengthen the nation's public health system as a senior program officer at the Robert Wood Johnson Foundation.

A graduate of Dartmouth College, Commissioner Malcolm previously served as CEO of the Courage Center and as President of the Courage Kenny Foundation following the merger of Courage Center and the Sister Kenny Rehabilitation Institute. She has also worked as Vice President of Public Affairs and Philanthropy at Allina Health. From 1999 to 2003, Commissioner Malcolm served as Commissioner of the Minnesota Department of Health.

Throughout her career, she has been active in state and national health care, public health associations, and government commissions on health care access and quality.

Minnesota House of Representatives

Tina Liebling (DFL) | District: 26A

Tina Liebling was born and raised in Minneapolis. She earned her B.A. from the University of Minnesota, her M.P.H. from the University of Massachusetts, and her J.D. from Boston University. She was elected to the Minnesota House of Representatives in 2004 from a Rochester district and is now serving her 8th term in the Minnesota House of Representatives, where she has served on the House Health and Human Services Committees since her second term. She was chair of the House Health and Human Services Policy Committee 2013-15, minority lead of that committee 2015-17, minority lead for health on the House Health and Human Services Finance Committee 2017-19, and now is chair of the House Health and Human Services Finance Division.

Joe Schomacker (R) | District: 22A

State Representative Joe Schomacker (R-Luverne) is the Republican Lead of the Minnesota House Health and Human Services Finance Division. He has previously served as Chairman of the Minnesota House Health and Human Services Reform Committee, and the Aging and Long Term Care Policy Committee. Schomacker was first elected to the Minnesota House in 2010. He represents Minnesota House District 22A, which includes all or parts of Lincoln, Lyon, Pipestone, Murray, Nobles, and Rock counties in southwestern Minnesota.

Minnesota Senate

Rich Draheim (R) | District: 20

Rich Draheim is a small business owner and Washington Township resident serving his first term in the Minnesota State Senate representing District 20. A graduate of Minnesota State University, Mankato, Draheim has nearly three decades of business management experience. He currently owns and manages the highly successful Weichert Realtors, Community Group of Mankato and the New Ulm Event Center. Draheim's legislative priorities include job creation and growth of main street economies, reduced regulatory burden on farmers and small business owners, equitable education funding, government reform and accountability, term-limits, reducing the cost of health care through price transparency, and an overall emphasis on effective and efficient government.

Matt Klein (DFL) | District: 52

Matt Klein attended Mayo Medical School ('89) and completed an Internal Medicine residency and chief residency at Hennepin County Medical Center. During his years of practice, he spearheaded a hospitalist program at St. Mary's Hospital in Madison, Wisconsin, and served on the board of directors for Dean Medical Systems, a large provider network and health insurer in Southeast Wisconsin. He was elected to the West St Paul School Board in 2013 and to the state senate in 2016. During his time at the legislature he has championed regulation of the pharmaceutical industry, prudent gun safety legislation, and a public health insurance option for all Minnesotans.

Community Members and Stakeholder Representatives

Jennifer DeCubellis | Chief Executive Officer, Hennepin HealthCare

Jennifer DeCubellis is the Chief Executive Officer of Hennepin HealthCare. Formerly the Hennepin County Deputy Administrator responsible for the health and human services divisions of the county, Jennifer was a leader in developing Hennepin Health, the nationally recognized partnership between the county and the healthcare system that integrates medical and behavioral care with social services for patients on Medicaid. Hennepin is Minnesota's largest county and is home to over 1.2 million residents.

Jennifer has a Master's degree in Clinical Psychology from the Illinois School of Clinical Psychology and a Bachelor's degree in Special Education (Emotional and Behavioral Disorders) from the University of Wisconsin, Madison. Jennifer has spent the last 20 plus years in public program administration with an emphasis on program redesign, system efficiencies, and quality improvements to ensure positive resident outcomes for lower cost.

Jennifer DuPuis | Associate Director, Fond du Lac Nation Human Services

Jennifer DuPuis is an enrolled member of the Fond du Lac Band of Lake Superior Chippewa. She has served as an Associate Director for the Fond du Lac Human Services Division since 2012. In her role she is responsible for

oversight of the business office including program budgets and third party billing, as well as the behavioral health, substance abuse disorder, and social services departments. Jennifer served as a technical advisor to the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare and Medicaid Services (CMS) and was a member of the Medicare and Medicaid Policy Committee (MMPC) for CMS. She also sits on the Healthy Nations Advisory Board for Mayo Clinic.

Nona Ferguson | Vice President, Economic Stability and Aging Services

Nona Ferguson has been with the Wilder Foundation since 1995, providing a wealth of experience and expertise in health and human services work, program design, employment services and housing. She oversees Wilder's housing support services, early childhood and parent education, aging services, and basic needs programs. She focuses on creating integrated service models that meet the needs of whole families and multiple generations. Nona holds a B.A. in Psychology from Tougaloo College, Mississippi, and a Master's in Rehabilitation Counseling from Minnesota State University-Mankato.

When she's not working, Nona enjoys spending time with family and friends, and learning about the capacity of human beings to be resilient and rebound from life circumstances. Her favorite quote comes from author Paulo Coelho's book The Alchemist, and in summary says that once you commit and determine what you want, the whole universe conspires to support you in achieving that goal.

Julia Freeman | Director of Community Engagement, Voices for Racial Justice

Julia Freeman is Director of Community Engagement at the Voices for Racial Justice. Since 2007 she has led the Education Equity work using a healing and racial justice lens. Julia has helped Districts and Schools use co-created tools that put students and parents in the center of equity solutions. The narratives that come out of this work are very powerful. She is a racial justice trainer and coach. Julia is a grandmother of ten and education is her passion, which she brings to her work coordinating shared learning opportunities for the Education Equity Parent Fellowship.

Sheila Kiscaden | Commissioner, Olmsted County

Sheila Kiscaden, an Olmsted County Commissioner (2012- present) who previously served in the Minnesota Senate representing Rochester/Olmsted County (1992-2006). She is currently the Vice Chair of the State Community Health Advisory Council and is the Vice Chair of the Association of Minnesota Counties Human Services Policy Committee. Her long career in health and human services includes managing small non-profit organizations, serving as Olmsted County's human services planner and legislative liaison, and being a consultant in private practice specializing in the organizational development needs of public and non-profit health and human services organizations. Sheila holds a Master's Degree in Public Administration from the University of Southern California and a Master's in Participation, Development and Social Change from the Institute of Development Studies at the University of Sussex.

Debra Krause | Vice President, Minnesota Health Action Group

Ms. Krause is Vice President of the Minnesota Health Action Group, a nonprofit coalition of public and private purchasers whose sole purpose is to represent the collective voice of those who write the checks for health care in Minnesota. In this role, she is directly involved in major Action Group initiatives, including the organization's Mental Health Learning Network, annual employer benefits survey, annual employer leadership summit, community dialogues, and member meetings. She collaborates with other purchasers nationally by representing The Action Group on work groups led by the National Alliance of Healthcare Purchaser Coalitions. Deb also represents employers/purchasers on Minnesota Community Measurement's Board of Directors and several

committees/work groups. Deb has a B.S. in Business Administration from Valparaiso University and an M.B.A. in Finance from the University of Wisconsin—Madison.

Gayle M. Kvenvold | President and Chief Executive Officer, LeadingAge Minnesota

Gayle M. Kvenvold is the President and Chief Executive Officer of LeadingAge Minnesota and has held this post since 1989. With a membership encompassing nearly 1,000 organizations engaged in the delivery of services and supports to older adults in more than 700 Minnesota cities and towns, LeadingAge Minnesota is one of the largest associations of its type in the nation. Under Kvenvold's leadership, LeadingAge Minnesota has broadened the base of its members from care centers to an ever-evolving spectrum of residential and home-based services for older adults and has focused the organization on advancing change in service delivery and financing models. Collaborative work in Minnesota's aging and health care services network includes the Minnesota Leadership Council on Aging, the Minnesota Alliance for Patient Safety, the Department of Human Services' Own Your Future Initiative, Act on Alzheimer's, Silos to Circles, the Minnesota Gerontological Society, Robert L. Kane LTC Chair Advisory Committee, and the University of Minnesota Duluth Health Care Management Advisory Council. Kvenvold holds a master's degree in Social Work from the University of Minnesota, Duluth.

Sida Ly-Xiong | National Program Manager, Nexus Community Partners

Sida Ly-Xiong has spent over 18 years serving and learning from communities in order to change systems. At Nexus Community Partners, Sida manages a national initiative in partnership with Robert Wood Johnson Foundation. She is responsible for developing community and civic engagement processes strategies for collective impact. In a previous role at the Minnesota Dept. of Health, Sida worked with public health teams and health policy. Sida supported community health initiatives to apply a racial equity lens in their work and build authentic relationships in and with communities they serve. Sida also serves as Chair of the Program in Health Disparities Research community-academic advisory board at the University of Minnesota Medical School and is the Chair of the Ramsey County Libraries Board. Sida holds a Master's of Science degree in Science, Technology and Environment Policy from the Humphrey School for Public Affairs.

Shauna Reitmeier | Chief Executive Officer, Northwestern Mental Health Center

Shauna Reitmeier serves as the Chief Executive Officer of the Northwestern Mental Health Center, Inc. for a six-county rural and frontier Community Mental Health Center in NW Minnesota and has over 20 years of administrative and clinical experience. She holds a Master of Social Work degree from the University of Michigan at Ann Arbor. Prior to her current endeavor, she worked with the National Council for Behavioral Healthcare providing technical assistance for demonstrating the integration of primary and behavioral healthcare. She has extensive experience in Quality and Process Improvement, Strategic Planning and integration of systems. She serves as the past President of the Minnesota Association of Community Mental Health Programs and a newly elected board member for the National Association of Rural Mental Health. Most recently through the Excellence in Mental Healthcare Act the NWMHC became a Certified Community Behavioral Health Clinic, implementing a new integrated service delivery and payment model of care for impacting overall health outcomes of individuals with behavioral health conditions.

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

Sue Schettle serves as the Chief Executive Officer of ARRM, a trade association representing nearly 200 home and community based service providers in Minnesota. Sue joined ARRM in late 2017 after working nearly 30 years in the healthcare sector. Prior to joining ARRM, she was the CEO of the Twin Cities Medical Society, a membership association representing more than 4,000 physicians from the 7-County Metropolitan Area, leading several ground-breaking public health initiatives on behalf of members. Sue provides the strategic vision and

organizational management for ARRM, working collaboratively with the Board of Directors, staff and members to ensure the association is a leading voice in the advocacy for community-based providers and the people they support.

Lisa Weed | Executive Vice President, SEIU Healthcare Minnesota

Lisa Weed joined the labor movement in 2003 by organizing a union where she worked as a Licensed Practical Nurse at Infinia Owatonna Nursing Home. Lisa was actively involved with SEIU HCMN as a member organizer and in October 2004 moved into a position as an external organizer. In 2007, she was an Internal Organizer, and in 2012, became the Long Term Care Director. Lisa has been an Executive Vice President since January 2013. She was appointed by the Executive Board in 2013 and elected by the membership the following year. In 2014, Lisa became the Southeast Sector Director. She currently serves on the Department of Labor's Rehabilitation and Review Panel, as a Labor Member, and sits on the Health Professionals Services Program Advisory Committee.

Appendix 2: Minnesota Health and Human Services, Blue Ribbon Commission, Charter

1. Commission Charge

The 2019 Minnesota legislature and Governor Tim Walz created the Blue Ribbon Commission on Health and Human Services to develop an action plan for transforming the health and human services system. The action plan must be submitted to the legislature by October 1, 2020.

The Laws of Minnesota 2019, 1st Special Session, Chapter 9, Article 7, Section 46 specify the duties of the Commission as follows.

The Commissioners of health and human services shall review available research to determine Minnesotans' values, preferences, opinions, and perceptions related to human services and health care benefits and other issues that may be before the commission and shall present the findings to the commission.

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

- strategies to increase administrative efficiencies and improve program simplification within health and human services public programs, including examining the roles and experience of counties and tribes in delivering services and identifying any conflicting and duplicative roles and responsibilities among health and human services agencies, counties, and tribes;
- approaches to reducing health and human services expenditures, including identifying evidence-based strategies for addressing the significant cost drivers of state spending on health and human services, including the medical assistance program;
- opportunities for reducing fraud and improving program integrity in health and human services; and
- statewide strategies for improving access to health and human services with a focus on addressing geographic, racial, and ethnic disparities.

Limitations. In developing the action plan, the Commission shall take into consideration the impact of its recommendations on:

- the existing capacity of state agencies, including staffing needs, technology resources, and existing agency responsibilities; and
- the capacity of county and tribal partners and of providers.

The Commission shall not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.

2. Commission Principles

The Commission's principles are as follows.

- The Commission recognizes that change to the status quo is a likely outcome.

- In its deliberations, the Commission will be honest about who will be impacted by any cost containment or system reform strategies, and how, and give attention to such parties.
- The Commission will recommend a balance of nearer-term and longer-term initiatives.
- The Commission will be transparent with respect to the criteria for strategy selection, design and proposed implementation of recommended strategies.
- Commission Members
- The enabling legislation specified a 17-member Commission with composition as follows:
 - four members are appointed by legislature
 - one Commissioner of DHS, Blue Ribbon Commission Co-Chair
 - one Commissioner of MDH, Blue Ribbon Commission Co-Chair
 - four experts/leaders in health care, social services, long-term care and health and human services technology/systems
 - two leadership in employer and group purchaser activities (not a health plan)
 - five public or private leadership, cultural responsiveness, and innovation in the area of health and human services

3. Term

- Commission members will serve a term that concludes on October 1, 2020 with submission of the action plan to the legislature. At his sole discretion, Governor Walz may extend the term of Commissioners by up to three months in any increment of time.
- If the individual representing an organization leaves the organization or for any other reason can no longer serve on the Commission, the organization must promptly notify DHS and may propose a replacement with equivalent background to the Co-Chairs of the Commission.
- Vacancies for any cause will be filled by an appointment made by the Governor's Office and will be immediately effective.

4. Commission Member Responsibilities

- Commission members must participate in good faith and act consistently with the Commission's charge.
- Unless told otherwise by the Co-Chairs, Commission members represent their organization and are expected to coordinate with their organizational colleagues so that they speak for their organizations when engaging in Commission discussion.
- Commission members must be available to devote the time needed to perform the roles and responsibilities of the Commission, review all meeting materials in advance of meetings, complete pre-meeting and follow-up tasks as requested by the Commission or its staff, participate in the development and review of work plan deliverables, and provide advice and guidance to staff as requested.
- Commission members may not send a representative to a meeting in their place.
- Members must be respectful at all time of other Commission members, staff, and audience members. They must listen to each other to seek to understand the other's perspectives, even if they disagree.
- The Co-Chairs may remove members who are not meeting these obligations, including regular meeting attendance, or who are not qualified, and may appoint new members, as needed.

5. Operating Procedures

• Commission Meetings

- The Commission will meet at times and places as stipulated in the meeting schedule. Changes may occur based on the needs of the Commission, the availability of meeting space, and/or other factors, such as weather.
- Work groups, subcommittees or other advisory processes may be established by the Co-Chairs. Meetings of these groups will be conducted in accordance with these operating procedures.
- A majority of voting members constitutes a quorum for the transaction of Commission business. A Commission member may participate by telephone for purposes of a quorum, but only if the Co-Chairs determine that telephonic participation will be operationally feasible for a given meeting.
- Meetings will be conducted in a manner deemed appropriate by the Co-Chairs to foster collaborative decision-making and consensus building. Robert's Rules of Order will be applied when deemed appropriate.
- Meetings are public and therefore are subject to the Open Meeting Law.
- Supports, including accommodations for Commission members with disabilities, will be available for members who need them.
- The Co-Chairs may, in their sole discretion, require a Commission member to recuse him or herself from review of specific matters in the event of a perceived or actual conflict of interest.

• Consensus Process and Voting

- A consensus decision-making model will be used to facilitate the Commission's deliberations and to ensure that the Commission receives the collective benefit of the individual views, experience, background, training and expertise of its members. Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.
- Members agree that consensus has a high value and that the Commission should strive to achieve it. As such, decisions on Commission recommendations will be made by consensus of all present members unless voting is requested by a Commission member. Voting shall be by roll call.
- Final action on Commission recommendations for the action plan will require an affirmative vote of the majority of the Commission members.
- If no consensus is reached on an issue for proposed Commission recommendation, minority positions will be documented. Those with minority opinions are responsible for proposing alternative solutions or approaches to resolve differences.
- Members will honor decisions made and avoid re-opening issues once resolved unless pertinent and substantive new information becomes available after the decision has been made.

• Written Communications

- Members agree that transparency is essential to the Commission's deliberations. In that regard, members are expected to include both the Co-Chairs and Commission staff in written communications commenting on the Commission's deliberations from/to interest groups (other than a group specifically represented by a member); these communications will be included in the public record as detailed below and copied to the full Commission as appropriate.
- Written comments to the Commission, from both individual Commission members and from agency representatives and the public, should be directed to Commission staff. Written

comments will be distributed by Commission staff to the full Commission in conjunction with distribution of meeting materials or at other times at the Co-Chairs' discretion. Written comments will be posted to the Commission public site, if appropriate, and made publicly available if requested.

- **Media**
 - While not precluded from communicating with the media, Commission members agree to generally defer to the Co-Chairs for all media communications related to the Commission process and its recommendations.
- **Documentation**
 - Commission meeting presentations will be distributed to Commission members, via email, in advance of meetings when possible, and will be documented on the Commission website at <https://mn.gov/dhs/hhsbrc/>.

6. Amendment of Operating Procedures

- These procedures may be changed by the Co-Chairs, with at least one day's notice of any proposed change given in writing to each member of the Commission.

Appendix 3: Strategies Prioritized for Development

*(If in italics, not developed and/or discussed by the Commission; if *not moved forward for continued consideration by the Commission)*

Health and Human Services Expenditures - Cost Savings Strategies

1. Implement Uniform Administration of Non-Emergency Medical Transportation (NEMT)
2. Modify Certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates
3. Expand Volume Purchasing for Durable Medical Equipment
4. Expand Use of the MN Encounter Alerting Service
5. Improve Compliance with Third Party Liability Requirements
6. Require Managed Care Organization (MCO) Competitive Price Bidding
7. Create Uniform Pharmacy Benefit
8. Establish Prescription Drug Purchasing Council
9. Establish Prescription Drug Affordability Commission
10. Discontinue Grants Program
11. Update Absence Factor in Day Services
12. Change Disability Waiver Family Foster Care Rate Methodology
13. Curb Residential Costs in Disability Waivers
14. Require Medicare Enhanced Home Care Benefit
15. Guidelines to Access Customized Living Services*
16. Update Value-Based Reimbursement in Nursing Facilities
17. *Repeal Nursing Facilities' First 30 Days Rate Adjustment*

Waste, Including Fraud and Program Integrity

1. Pursue Fraud, Waste, or Abuse Prevention Enhancements
2. Reduce Low-Value Services in Minnesota
3. Align State and Federal Health Care Privacy Protections

Administrative Efficiencies and Simplification

1. *Improve Access to MN-IT*
2. *Improve Health Care Delivery for Individuals Transitioning out of Jail or Prison*
3. *Technology Upgrades to Increase Efficiency and User Experience*
4. Improve MnCHOICES and LTSS Processes
5. *Process Improvements¹¹*
6. *Pilot Project Focused on Intensive Care Coordination for High Cost High Need Members*

¹¹ The process improvement in this strategy proposal focused on eligibility assessments and other program processes.

Health Equity

1. Improve Dental Access in Public Health Care Programs
2. Ensure Equitable Access to Disability Service Programs
3. *Develop a Single, Inter-Operable, Secure, Low-Cost Telepresence Network*
4. *Default Native American Medical Assistance Enrollees into Fee for Service*
5. Background Studies Eligibility Task Force*
6. *Health Care Curricula that Enhances Understanding and Engagement with Communities of Color, Tribal and Immigrant Communities*

Transformation

1. *Pilot Hospital Global Payments & Rural Hospital Global Budgets*
2. *Invest More in Primary Care*
3. *State Healthcare Purchasing Strategy Reform*
4. *State Healthcare Rate Reform Study*
5. *Establish Targets on Health Care Spending*
6. Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports
7. *Expansion and Sustainable Funding of Medical Respite for Homeless Adults in Minnesota*
8. *Optimize Use of the All Payer Claims Database (APCD)*
9. *Implement Structured & Coordinated HIE*
10. *Define and Measure "Wellbeing"*
11. *Waiver Reimagine*
12. *Increase Access of Home & Community Based Services for Older Adults*

Appendix 4: Equity Review Process and Template

Blue Ribbon Commission Equity Review Process

The 2019 legislature and Governor Tim Waltz created the Blue Ribbon Commission on Health and Human Services to develop an action plan for transforming the health and human services system. The action plan will include strategies which will: transform the health and human services system, increase administrative efficiencies and improve program simplification, reduce health and human services expenditures with a net savings of \$100M in the next biennium, reduce waste, and advance health equity. The administration is committed to conducting an equity review on each strategy to provide commission members equity perspectives as they thoughtfully review each strategy for consideration of inclusion into the final action plan. The information below outlines the equity review process.

Step 1

- Policy team develops and completes strategy template
- Policy team notifies Healthcare Administration's Equity Director of completion

Step 2

- Healthcare Administration's Equity Director conducts and embeds initial equity review results into strategy template
- Policy team is notified of initial equity review completion

Step 3

- External equity review team is notified of initial equity review completion and provided strategy summary

Step 4

- External equity review team conducts a final evaluation of the initial equity review
- Evaluation of the Equity Review is performed by:
 - Commission representatives
 - Department of Human Service Equity Directors
 - State policy and subject matter experts
 - Health Equity Advisory and Leadership (HEAL) Council
 - Cultural Ethnic Cultural Leadership Council (CECLC)
 - Department of Human Service Policy Leads
 - Department of Health
 - Department of Human Service External Relations

Step 5

- Communicate final equity review results to policy leads
- Finalize strategy template; provide finalized strategies to Commission members, and provide publicly via posting to public website

Equity Review Template

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

We Agree:

- Accountability for implementation and use within our own administration and to our respective communities will be essential.
- To approach the equity review from an evaluative / continuous improvement perspective, as opposed to a check list. We will seek to strengthen programs, policies and procedures to promote equitable outcomes.
- That if the proposal works for our most vulnerable communities, it works for everyone. The reverse, however, is not true.
- That we will not let the perceived barriers prevent us from interrupting patterns of inequity.
- That use of the review may not be linear. For example, users may want to start with question 2 in order to ensure they have a clear understanding of the community conditions that may be impacted by the implementation of this strategy. All 5 questions may not be answered.
- That after the use of the equity review, changes in a particular strategy may not be needed. However, the procedures associated with that strategy may need to be created or enhanced to ensure equitable outcomes can be achieved.

Proposal Title: _____

Reviewer/Reviewers: _____

1. How does the strategy promote inclusive collaboration and engagement?

BEST PRACTICES

- Which community does this strategy impact?
- How will you identify the geographic, racial/ethnic groups potentially affected by this proposal?
- What process will you undertake to collaborate and engage in a dialogue with communities (internally and/or externally) who have traditionally not been involved in the development, implementation and evaluation of this strategy?

ADDITIONAL INSIGHT

- What insight can the community provide as to how this policy might contribute to inequities?
 - Does the policy have an unintended consequence to people of color?
 - Decide how you will share, collect information from the community in a culturally competent manner.
 - Ensure the community voice guides the policy work. Keep them informed of progress and stay accountable to the community. Collaborate and maintain two-way communication from start to finish

2. How does the strategy reflect a consideration of community conditions and set goals for advancing equity?

BEST PRACTICES

- Are the community conditions and/or agency inequities clearly documented? If not, what is your plan for assessing the community conditions?
- Are there goals and measures for eliminating inequity, if so what are they?
- How will goals be adjusted regularly to keep pace with changing community needs and racial demographics?
- What additional information could be added to strengthen the strategy?

ADDITIONAL INSIGHT

- Strategy includes language about how the agency recognizes the current realities of racial/ethnic and geographic disparities and seeks to create or strengthen the strategy to align with the BRC charge.
- Include any definitions that might be helpful.
- What information do we have about the community conditions that contribute to inequities internally/externally?
- State how you will continue to collect data on community conditions/racial/ethnic/geographic inequities so that adjustments can be made. This would mean that you meet with communities of color on a regular basis.

3. How will the strategy expand opportunity and access in health and human services?

BEST PRACTICES

- How does the strategy increase opportunity and/or access for those who historically have been excluded? This means, more explicitly, who benefits from and/or who is harmed by the strategy?
- What are the strategies to improve access for ethnically diverse communities, including immigrants and refugees?
- What additional information could be added to strengthen the strategy?

ADDITIONAL INSIGHT

- How does the strategy increase opportunity? If the data you have collected or gathered from your stakeholders indicates racial inequity that could be addressed through implementing/revising this policy, then state how you see the policy contributing to more opportunity and access.
- Other strategies: These strategies would come from the group you have convened.
- Additional information: If language is a concern then how will we gather information on languages spoken? Resources for translation?

4. How will the strategy affect systemic change?

BEST PRACTICES

- How does the strategy make changes to eliminate institutional racism?
- Does the strategy make provisions for accountability? If so, what are they?
- How does the strategy work to address and eliminate structural racism?

ADDITIONAL INSIGHT

- Eliminate institutional racism: include language about how this ties back to the identified racial inequities in the community (internal/external). This is closely related to Question #2.
- Provisions for accountability: How will this strategy ensure communities of color remain ongoing essential partners with power in collaborative decision making?
- Eliminating Structural Racism: Have you identified any other community agencies/institutions connected to this strategy that could be invited to the table?

5. What activities for advancing equitable outcomes does the strategy suggest?

BEST PRACTICES

- How does the strategy make changes to eliminate institutional barriers?
- Does the strategy make provisions for accountability? If so, what are they?
- How does the strategy work to address and eliminate structural racism?

ADDITIONAL INSIGHT

- Overall goals and outcomes: Include any strategies, from the community, that will reduce disparities as it relates to the policy (NOTE: may be repeat of information cited in #4)

- Any strategy adjustments: Continue meeting with communities to ensure you have access to current data regarding community conditions mentioned in #2.

Equity Review Evaluation:

Click or tap here to enter text.

Appendix 5: Strategies Developed and Considered by the Commission

Implement Uniform Administration of Non-Emergency Medical Transportation (NEMT)

Problem Statement: NEMT expenditures can be reduced.

Strategy: Contract with a uniform NEMT vendor

1. Problem Statement

Currently NEMT providers provide transportation to Medical Assistance and MinnesotaCare clients to and from covered medical service appointments. Depending on the level of services needed NEMT may be administered by either a local county or tribal agency, through DHS or a managed care organization.

In September 2017, the federal Office of Inspector General finalized an audit of Minnesota's NEMT program that showed over 75 percent of NEMT rides that were audited did not comply with either state or federal requirements. Of the rides that did not meet the requirements, the ride either lacked sufficient documentation, lacked any documentation, or did not have a corresponding medical service to warrant the trip.

These findings were consistent with an evaluation the Minnesota Office of Inspector General conducted of the NEMT program in 2014. As a result of the federal 2017 audit, the state had to pay \$1.9 million dollars, the federal share of the improper reimbursement, to the Centers for Medicare and Medicaid Services.

While DHS is currently instituting reoccurring audits of the NEMT program and will be requiring enrollment of NEMT drivers, a uniform approach to NEMT would further enhance program integrity. There is risk to federal funding if federal payment error audits identify high rates of payment errors. NEMT claims that do not have sufficient documentation to support the payment contribute to that risk.

2. Strategy Proposal

This is a cost-saving strategy which will also increase administrative efficiencies. This strategy authorizes DHS to contract with a third party administrator to facilitate NEMT services and implement a uniform NEMT program across all members. The uniform administrator model pays a per-member-per-month fee rather than a fee-for-service system reimbursement. A uniform administrator model offers efficiency because the administrator would contract with the drivers, negotiate the rates, and coordinate the rides for members. This administrative oversight would lower costs, improve program integrity, and create a consistent user experience across the state.

A uniform administrative structure would also make it easier for recipients to access the benefit. Today, individuals contact various entities to potentially schedule a ride. A uniform administrator would essentially serve as a one stop shop for NEMT.

Lastly, a uniform administrator allows for economies of scale in the administration of the program.

It is expected that this strategy will decrease the cost of NEMT services by more than \$10 million in the biennium, improve program integrity, and standardize consumer's experience across the state.

3. Supporting Evidence

Other states have successfully implemented this model for NEMT services and have realized savings in their programs. Additionally, program integrity reviews have showed that when an administrator is involved there is higher likelihood that the ride was appropriate.

4. Populations Impacted

Individuals who access health care through Medical Assistance and MinnesotaCare and utilize Non-Emergency Medical Transportation (NEMT) services. A reduction in the current cost of NEMT services in Medical Assistance and MinnesotaCare program is anticipated since a uniform administrator will be able to leverage efficiencies that are not available under the current model. This change should streamline consumer's experience when they use NEMT services and make the NEMT service experience uniform across the state.

5. Implementation Steps

DHS would need to conduct a RFP to contract with an administrator. The RFP process could start as soon as legislative language is passed (presumably May 2021) and services could be transferred by July 2022. Transitioning enrollees to a new administrative structure will be the biggest challenge and will require outreach and education.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Incorporate cultural competency training that includes language considerations.
- The strategy indicates that the development of a more standardized approach to NEMT services is needed to enhance program integrity, how will the strategy promote equitable outcomes to those who receive Minnesota Care and Medical Assistance who utilize NEMT? Will those who receive rides be impacted by the change and if so how?
- Will the changes promote geographic access?
- What are the possible unintended consequences?
- Does this strategy make provisions for accountability?

7. Public Comment

At the January 16, 2020 Commission meeting, Reverend Dr. Jean Lee commented that with regard to transportation, tweaking the use of bus cards could help transportation use. She suggested that bus cards would allow for greater flexibility if they could be used like a credit card and the State had a method to keep track.

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-011620-minutes_tcm1053-418401.pdf

Modify Certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates

Problem Statement: Minnesota pays more than Medicare for certain DME products.

Strategy: Reduce Minnesota's reimbursement to pay Medicare rate.

1. Problem Statement

The Centers for Medicare and Medicaid Services has provided guidance to states on opportunities for cost savings within the durable medical equipment spend. One strategy was CMS limitation on federal financial participation for certain DME products and supplies. Medicare is a very large payer of DME supplies and equipment and currently Minnesota is paying between 3% and 13% higher than Medicare for certain products.

Currently, the rates are based on a methodology outlined in state law and administrative rule and are calculated in a complex manner that is based on a percentage of billed charges. As billed charges have limited correlation to a provider's acquisition cost, this methodology is inefficient, unpredictable, and administratively complex. Matching the Medicare rate will increase transparency to providers, reduce administrative burden for providers and the state and provide cost savings to the program.

2. Strategy Proposal

This is a cost savings strategy which would change the Medical Assistance reimbursement formula for durable medical equipment that is also covered by Medicare to pay equivalent to the Medicare rate.

This would reduce payment for durable medical equipment starting in FY2022. Projected fee for service Medical Assistance state expenditures for durable medical equipment are expected to reach nearly \$86.5 million in FY20-21. This strategy is estimated to have savings between \$1 million and \$9,999,999 in the biennium.

3. Supporting Evidence

Medicare has been successful at reducing costs related to DME products while providing needed access to those they serve.

4. Population Impacted

There are no anticipated impacts to access to services. This strategy modifies payment rates for select durable medical equipment (DME) and supplies in Medical Assistance fee-for-service. These changes do not impact coverage of DME and supplies for consumers so the same equipment and supplies will be available. Providers would see a reduction in their payments for some equipment and supplies.

5. Implementation Steps

Following legislation allowing the change in rates, changes would need to be made in the MMIS to reflect the rate methodology change. Limited implementation challenges would be expected since this reduces

administrative work related to claims submission and adjudication for providers and DHS. Providers have raised concerns about access related to some Medicare rates set through competitive bidding methods, however, CMS has monitored access and continues to indicate that Medicare beneficiaries have access to DME and supplies.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- The strategy indicates that matching the Medicare rate increases transparency to providers, reduces administrative burden, and provide cost savings to program, what is the impact to those who receive Medical Assistance? Further evaluation of strategy suggests the need to incorporate an itemized list of the cost for durable medical equipment.
- What are the possible unintended consequences?
- What are the potential population impacts?
- With the demographic shifts specifically what are the impacts to the elderly and older adult population?

7. Public Comment

The Commission received a letter in June 2020 from Anne St. Martin who is part of a group of whose children live with medical complexities in the state of Minnesota. Ms. St. Martin stated that these children rely on Durable Medical Equipment (DME) and home care to lead their best lives and participate in their communities. A link to the letter is provided below

[Written public comment: Anne St. Martin, June 2020](#)

The Commission received a March 2, 2020 public comment letter from the Midwest Association for Medical Equipment Services and Supplies expressing its opposition to this strategy. A link to the letter is provided below.

[Written public comment: Midwest Association for Medical Equipment Services & Supplies, March 2, 2020 \(PDF\)](#)

The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced concerns regarding this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:

https://mn.gov/dhs/assets/BRC-011620-minutes_tcm1053-418401.pdf

Expand Volume Purchasing for Durable Medical Equipment

Problem Statement: The state may be overspending on DME products.

Strategy: Add new products to DHS' current volume purchasing strategy.

1. Problem Statement

The Department of Human Services (DHS) spent \$75M on Durable Medical Equipment and Supplies in the fee-for-service program in SFY 2018. National research and Minnesota's experience has indicated additional savings can be achieved in this area through the use of alternative purchasing strategies. DHS currently volume purchases eyeglasses, hearing aids and oxygen.

2. Strategy Proposal

This is a cost savings strategy which requires DHS to expand the use of volume purchasing to additional types of DME products. Multiple DME product types could move to this purchasing methodology, including enteral nutrition, wound care supplies, and standard wheelchairs and walkers. These product types can be acquired at reduced prices when purchased in bulk.

The Department currently volume purchases other supplies that have led to cost savings including oxygen, hearing aids and eyeglasses. DHS also implemented a diabetic test strips program several years ago that leveraged volume purchasing aspects that also generated cost savings.

This strategy aligns with the Center's for Medicare and Medicaid Services (CMS) Office of Inspector General (OIG) recommendation that states volume purchase select types of DME products. The CMS OIG recommendation was specific to adult incontinence products. The state previously attempted to implement volume purchasing for adult incontinence products but was not successful due to a lawsuit which ultimately prohibited implementation.

This strategy is expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

CMS OIG recommends this purchasing strategy for adult incontinence products. Additionally, DHS has already effectively utilized this strategy for some DME product types.

4. Populations Impacted

Individuals who receive health care coverage through Medical Assistance and MinnesotaCare fee-for-service and use select types of durable medical equipment (DME) will be required to obtain such services through specified vendor(s). These individuals may have different brand options covered but similar products will be available.

5. Implementation Steps

To implement this proposal DHS would have a request for proposals (RFP) to gather bids for vendors to contract with for each product type. Depending on the products selected, there could be one or several contracts. We anticipate it will take six to nine months to implement following legislative enactment. Assuming legislation directing DHS to implement this strategy is passed in the 2021 legislative session, DHS could operationalize this strategy in early 2022.

In 2017, the legislature directed DHS to volume purchase adult incontinence products. During implementation DHS was sued and subsequently in 2019 the legislature prohibited DHS from volume purchasing adult incontinence products. It is possible a similar lawsuit will be filed again.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Embed an Equity Analysis in the RFP process specifically in rating and scoring
- What is the impact to individuals who access health care services through Medical Assistance and Minnesota Care fee-for-service and utilize Durable Medical Equipment, specifically to those who have varying abilities? Further evaluation of strategy suggests partnering with diverse vendors could advance equitable outcomes.
- Community and Stakeholder Engagement is important
- What are the benefits and burdens?
- What are the unintended consequences?

7. Public Comment

The Commission received the following public comment related to this strategy.

- At the January 16, 2020 meeting of the Commission, Reverend Dr. Jean Lee noted the purchasing power of the counties, and said it would help to have them undertake volume purchasing. In terms of volume purchasing, Reverend Dr. Lee suggested that upgrades can be required within service contracts; she also commented on the need for people to have the ability to return items that do not work properly.
- The Commission received a letter in June 2020 from Anne St. Martin who is part of a group of whose children live with medical complexities in the state of Minnesota. Ms. St. Martin stated that these children rely on Durable Medical Equipment (DME) and home care to lead their best lives and participate in their communities. A link to the letter is provided below

[Written public comment: Anne St. Martin, June 2020](#)

- The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced concerns regarding this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

- The Commission received a March 2, 2020 public comment letter from the Midwest Association for Medical Equipment Services and Supplies expressing its opposition to this strategy. A link to the letter is provided below.

[Written public comment: Midwest Association for Medical Equipment Services & Supplies, March 2, 2020 \(PDF\)](#)

- At the March 6, 2020 Commission meeting, Al Newman from the Midwest Association for Medical Equipment Services (MAMES) said that competitive bidding in the Medicare program has been a “train wreck,” especially in rural regions of the United States. He said that Medicare eventually recognized this and finally made rural rate adjustments. He said the CURES Act then implemented price caps. He asked why the State would want to go below the federal match, and explained that Medicare is completely different from Medicaid. Al Newman said most DME providers in Minnesota are not participating in Medicare and are instead doing cash business with Minnesotans who can pay, adding that 45 percent of DME providers nationally went out of business because of Medicare’s policies. He explained that health plans raise administrative costs to DME providers. He asked that the Commission look in areas other than DME for savings.

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-011620-minutes_tcm1053-418401.pdf

Expand Use of the MN Encounter Alerting Service

Problem Statement: Because care can be fragmented, communication and coordination of a person’s care at the time of a health event may not happen as quickly as needed to provide support to the individual.

Strategy: Expanding provider participation in the Minnesota Encounter Alert System would increase the number of health event alerts, leading to greater communication and coordination of care.

1. Problem Statement

Fragmented care is expensive; the sooner a provider who is accountable for coordinating a person’s care can be informed of a health event, the more effectively they can support recovery, transitions between care settings, and avoid re-hospitalization. This strategy continues efforts to implement more timely communication from an emergency room, hospital or LTC facility to a person’s care team.

There is an administrative cost to provider systems in communicating key information to all necessary, permitted, responsible parties. Establishing a standards-based, consistent approach for exchanging critical information for Minnesotans helps reduce administrative cost and complexity.

2. Strategy Proposal

This is a cost savings strategy which would expand participation in the Minnesota Encounter Alert System (MN EAS)¹² so that more Medical Assistance and enrollees dually eligible for Medicare and Medicaid benefit. Currently providers voluntarily participate, and notifications from 77 sources enable delivery of over 20,000 alerts per month. DHS contributes attributed patient panels for Integrated Health Partnerships (IHPs), and providers who perform care coordination can upload additional consenting panels. On average, one quarter (25%) of the notices generated can be matched and delivered to a subscribing participant’s care coordination panel. Expanding to add remaining sources and additional care coordination panels would allow more of the alerts to be delivered. Having a critical mass of the providers contributing to and benefiting from the alerting service in an area accelerates the value gained and in turn encourages participation. Two ways to accelerate participation include: introducing additional use cases for home and community based services providers, county or Medicaid payer participation; and enhancing alerts to include discharge summary info so that the alerts have even greater value to receiving providers.

Greater provider participation allows the service to deliver a higher rate of alerts to the appropriate care provider. For example, currently alerts might be received by the service, but if the patient’s care coordinator is not subscribed, the alert cannot be delivered. Likewise, a care coordinator may be subscribed, but if the patient is seen at one of the ERs/hospitals that is not yet participating, they will not receive the alert.

¹² Additional information about the MN EAS system can be found here: www.mneas.org.

The implementation of this strategy may also have positive unintended consequences, including:

- Interest in use of the service for populations beyond Medicaid.
- Deeper community discussion about data sharing hurdles including need to review patient consent notices.
- Greater identification of care coordination needs.

This strategy is expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

Medicare beneficiaries who had transitional case management following a discharge had a significantly lower overall mean cost (\$3,358 vs. \$3,033). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6583218/> MN has relatively low rates of using that service (<https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Provider-Utilization-and-Payment-Data-Phy/fs4p-t5eq/data>) and a functioning ADT system would aid/enable this.

Studies indicate that if the necessary follow-up is not provided after an ER or hospitalization, recovering patients are more susceptible to complications and illness, resulting in worse health outcomes and costly readmissions (Kirsch, Kothari, Ausloos, Gundrum & Kallies, 2015). Also, people who are not seen by their primary provider within 30 days of an ER or hospital admission have a 10x greater risk of readmission. (Moran, Davis, Moran, Newman, & Mauldin, 2012).

In addition, CMS will be requiring the sharing of hospital alerts: CMS Interoperability and Patient Fact Sheet

<https://mneas.org/wp-content/uploads/2018/12/jhcp-ens-case-study-1.pdf>

4. Populations Impacted

The strategy applies to persons covered by Medical Assistance or MinnesotaCare who receive treatment in an Emergency Room, Hospital, or Long Term Care (LTC) facility and the providers who serve them.

For a consumer, health care is more cohesive and support needed during a care setting transition can be arranged sooner. This impact can be experienced immediately as evidenced by family and patient stories shared by participants who describe a sense of relief or re-assurance that their care team was on the same page and knew about an event so they could help with follow-up.

For health care providers in hospital or ER setting, the service reduces administrative burden (phoning/faxing) and allows for critical health event information to be communicated seamlessly to a patient's primary provider. The service ensures that the provider can receive the information securely even if they are not on the same electronic health record (EHR) system or part of the same health system.

For primary care providers or other care coordination staff, less time is spent searching and seeking updated clinical information and there are improved health outcomes because the critical information was pushed to them right away when there was still time to intervene.

For providers who have traditionally not been able to participate in e-health exchange – this service provides a low cost, high value way to receive necessary notifications.

5. Implementation Steps

The Center for Medicare and Medicaid Services (CMS) finalized interoperability rule will require hospitals to share alerts as a condition of participation in Medicare and Medicaid by July 2021. DHS will continue reaching out to and onboarding providers in anticipation of this deadline. Providers are electing to add dually-eligible panels and Medicare panels that are part of a value-based payment arrangement. This helps accelerate participation because providers can use consistent workflows and the alerts for Medicaid and Medicare consumers can be matched at a higher rate to the appropriate care team. DHS has added participation in the MN EAS or a similar health information service as part of the quality framework for IHP contracts.

To enhance the alerts so that additional information such as discharge summary notes can be pushed to the appropriate care teams, DHS would need to work with Audacious Inquiry, and the Minnesota Department of Health (MDH) to connect the MN EAS to the National e-health exchange. When an alert is received, the MN EAS could then leverage existing e-health exchange network to obtain discharge summary info and include it when pushing the alert to the receiving organization. DHS needs to update HITECH documentation and obtain approval from CMS annually. Ongoing collaboration with MDH and the E-Health Advisory community will be required to ensure alignment with the direction and recommendations of the Health Information Exchange (HIE) task force. This strategy could complement and help lay groundwork for other transformational HIE activity proposed by MDH. Enhancing alerts could be done anytime following an update to CMS, but is ideally initiated prior to July 2021 in order to maximize federal HITECH matching funds.

Basic onboarding of new providers typically takes three weeks, but may take longer for more extensive workflow or system integration. Introducing and obtaining approval for additional use cases from MN EAS participants takes approximately 6 months. Remaining work to enhance alerts is estimated to take approximately 6-12 months.

Implementation does require staff and IT resources of provider systems. For provider organizations receiving information, this includes time of staff for onboarding/training and workflow discussions. For organizations sending information, required resources also include information technology resources to establish connection information from electronic health records (E.H.R.). For systems desiring deeper integration into existing infrastructure and workflow tools, resources required may be higher. Implementation could be supported by the existing DHS FTEs and the Audacious Inquiry contract, which are currently funded through the federal Health Information Technology for Economic and Clinical Health (HITECH) Act (90%) and state Medicaid dollars (10%).

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- The strategy promotes cohesive and supportive health care for the consumer, while promoting a reduction in cost, administrative burden, and time for individuals covered by Medical Assistance or Medicare receiving treatment in an emergency room, hospital, or long term care facility. Populations that benefit most from this strategy are those who experience high use of the emergency room as their main source of care – homeless, persons with mental illness, etc. Additionally, provider systems who disproportionately serve these populations were previously unable to take advantage of e-health opportunities due to cost.

- How will this strategy allow for the communication of key events if an individual does not have a primary provider?
- How is cultural competency being considered?
- Does the strategy have unintended consequences?
- Does the strategy make provisions for accountability?

7. **Public Comment**

The Commission did not receive public comment specific to this strategy.

8. **Commission Discussion**

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:

https://mn.gov/dhs/assets/BRC-011620-minutes_tcm1053-418401.pdf

Improve Compliance with Third Party Liability (TPL) Requirements

Problem Statement: Estate recovery and subrogation relies on actions of attorneys outside of DHS who may not fully understand the requirements to enforce TPL statutes.

Strategy: Create educational resources and trainings for County attorneys and other attorneys to improve compliance with TPL requirements.

1. Problem Statement

DHS undertakes a variety of activities to ensure Medical Assistance is the payer of last resort. In certain cases, relating to estate recovery and subrogation, DHS relies on attorneys outside the agency to enforce or pursue recovery. In estate recovery, it is up to the county based prosecutors to enforce these statutes in the various counties. While DHS provides litigation support to counties when requested, it is clear that there could be better training and education to ensure consistent, equitable and legally sound application of statutes across the many counties.

Similarly, in the area of recovery in personal injury or casualty cases, DHS relies on personal injury/trial attorneys to litigate these cases on behalf of our members. Statute requires that these attorneys notify DHS and resolve the Medicaid payments related to the accident/injury. It is not clear that trial attorneys are aware of these requirements, nor do they adhere to all the notification requirements laid out in statute.

2. Strategy Proposal

This is a cost savings strategy which would authorize and fund DHS to work with the county-based prosecutors, the Minnesota County Attorney Association (MCAA), the elder/estate planning bar and the trial attorney group, Minnesota Association for Justice. Through this strategy, DHS will create educational resources related to the Medicaid program, recovery from probate and non-probate assets, DHS's process for seeking recovery or subrogation and DHS's approach to resolution of these cases on behalf of the Medicaid program. This proposal will:

- Establish a web content/resource
- Produce and publish training materials – i.e. trust guide, Medicaid Tort Recovery materials – and provide trainings to relevant stakeholders.
- Complete and publish litigation support materials/forms for county attorneys to utilize to defend and initiate lawsuits involving health care.
- Complete and record trainings for attorneys to access.

The resources developed will be utilized in ongoing trainings of stakeholders and will assist with TPL work at the county level and improved understanding of Medicaid requirements for private attorneys resulting in more equitable application of the Minnesota Medicaid estate recovery program and personal injury subrogation recovery efforts.

Implementing this strategy will result in better supervision and advice for local Medical Assistance agencies and increased and consistent enforcement of Medicaid laws. It will culminate in a higher rate of proper payment and recovery. DHS will also build a stronger partnership with trial and public attorneys and better educate them about their clients who receive public benefits.

Implementing this strategy will assist counties and personal injury attorneys in complying with current TPL requirements. Increased compliance by stakeholders will ensure consistent enforcement of Medicaid laws, higher rates of proper payments, and increased cost avoidance accountability. We should begin feeling the effects within the year, as attorneys reach out to us as a resource and continue to verify information on a case by case basis. We will be able to track increases in recoveries and cases, although cases are generated based upon injury and death, which is not necessarily a predictor of success.

This strategy is expected to save up to \$1 million in the next biennium.

3. Supporting Evidence

County based survey conducted in the estate recovery program identified an opportunity for education and more consistency, which would result in more equitable administration of the program. The Minnesota Association for Justice and attorneys in the personal injury and workers' compensation bar have expressed an interest in and opportunity to understand Medicaid programs and benefits and the unique role DHS plays in recovering benefits from an injured recipient's cause of action.

4. Populations Impacted

This strategy does not have a direct impact on individuals who access health care through Medical Assistance or MinnesotaCare. Implementing this strategy will result in increased compliance, recoveries, and accountability with Medicaid laws requiring Medicaid to be the payer of last resort.

5. Implementation Steps

DHS staff will create new resources to assist stakeholders through the TPL process. These resources will be created in consultation with county attorneys and other stakeholders (such as elder/estate planning attorneys and personal injury attorneys) to ensure they address the highest areas of need. The development of new resources will likely take six to nine months. The longer timeline is in part to ensure adequate time to engage with stakeholders to ensure that the resources are responsive to stakeholders' needs. Once created, DHS staff will provide trainings to improve understanding and compliance with TPL requirements.

Once the materials are developed they will be available online, distributed to the attorneys we interact with, and our attorneys will present at Continuing Legal Education classes (CLEs) and make materials available at other professional training events. We will rely on the timelines of DHS communications and web developers. It will also depend on our ability to be added to agendas for CLEs and other educational opportunities and attorney gatherings.

DHS will require some additional administrative resources to develop the training materials. These costs should be approximately \$20,000 in one time spending. The most significant barrier to implementation will be time and resources of the attorneys to attend or consume trainings. County attorneys, in particular, pose a geographic and resource challenge, but once they confirm that this will make their work easier and increase revenue for their county, there should be less resistance.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- The strategy considers equity implications by addressing opportunities for counties and personal injury attorneys to ensure a consistent practice across Medicaid programs.
- Embed cultural awareness into training
- Establish an equity lens into the training that focus on intent vs. impact (benefit and burden).
- Embed awareness around nuances pertaining to sovereign nations who are not subject to recovery.

7. Public Comment

The Commission did not receive public comment specific to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:
https://mn.gov/dhs/assets/BRC-020620-minutes_tcm1053-420203.pdf

Require Managed Care Organization (MCO) Competitive Price Bidding

Problem Statement: MCO's administrative cost increases remain high year over year.

Strategy: As part of the planned MCO re-procurement, include a competitive price bid to lower administrative costs associated with the program.

1. Problem Statement

State Medicaid programs are allowed to contract with managed care organizations (MCO) to provide health care services to enrollees. The State has utilized this option for more than 25 years to provide services to certain populations specified by the legislature. In addition, states that have approval to operate a Basic Health Program (BHP) must contract with MCOs to provide services to enrollees covered under that program. MinnesotaCare is operated under this authority. All contracts must be approved by the Centers for Medicare & Medicaid Services (CMS) in order for states to receive their federal matching funds.

Federal regulations governing managed care contracting for Medicaid programs require that states select their MCO vendors through an open, competitive process. That competitive process can, but is not required to, include a competitive price bid. In addition to responding to questions regarding technical proficiency, quality, innovation, and network adequacy, MCOs can also compete based on the price for which they can perform those functions and achieve the objectives they have laid out in their responses. In order to curb steadily increasing capitation rates, Minnesota incorporated price bids in three previous procurements as part of the procurement process for the Families and Children contract. These procurements were for selected counties in 2012 and 2014 and as part of a statewide procurement required under law for 2016. In each case, these procurements generated savings to the state's budget while maintaining access to services and quality care.

Concurrently, DHS has made great strides in the annual MCO rate setting process which has contributed to reducing the annual cost trend associated with the managed care contracts, particularly the Families and Children contract. Current rates remain relatively low and closer to the lower boundary of actuarial soundness. Actuarial soundness means a health plan could reasonably be expected to be able to provide services to enrollees at that rate. An actuary must certify, subject to CMS actuarial review and approval, that the state's rates paid to MCOs are actuarially sound.

There still remains concern that year-over-year cost increases are still too high to sustain the program over time. There is also the belief that MCOs could employ additional administrative and cost efficiencies as well as strategies around care management, improving quality of care, and reduction of waste that may lead to lower cost.

2. Strategy Proposal

This is a cost savings strategy that requires the state to incorporate a limit on the base rates that will be paid to MCOs selected to contract with the state to serve the Families and Children populations. The base rate limit would reflect a projected decrease in the base rates from the previous year. This strategy would be reflected in the procurements for the Families and Children contract will be divided between Greater Minnesota and Metro

Minnesota for contract year 2022 and 2023. This strategy is expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

The state has successfully utilized price bids on three previous occasions, each time helping to reduce the overall costs.

4. Populations Impacted

Managed care organizations that respond to a request for proposals (RFP) to contract with the Department of Human Services (DHS) to provide services to non-disabled adults, parents, and children enrolled in the Pre-Paid Medical Assistance Program (PMAP) and enrollees in the MinnesotaCare program. These groups are managed under a single contract referred to as the “Families and Children” contract. Depending on which bidders are successful, enrollees may have to transition their care to a different MCO.

5. Implementation Steps

Under the current procurement schedule, the development of the RFP for Greater Minnesota for the 2022 contract year will begin at the end of 2020. The price bid component is developed further along in that development process, but would likely need to be completed by the end of 2020 or early 2021. The RFP for the 7-county Metro area for the 2023 contract year will undergo the same process, but the dates associated with that development would be one year later than greater Minnesota.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish equitable contractual mechanisms that concentrate on social determinants as a risk factor to coverage
- Implement a framework of equitable metrics that address concerns of those who disproportionately rely on managed care for their coverage
- Further equity considerations:
- How will this strategy advance equitable health outcomes related to care management and quality of care?
- Does the strategy make provisions for accountability?
- How will the strategy assess community and stakeholder impact?
- Embed equitable standards in the contract design, RFP, and selection process
- Evaluate best practices across health plans considering access across geographic locations.
- Establish a transparent and accountable process.
- Establish requirements for procurement with training focused on unconscious bias and cultural sensitivity.
- Create an equitable evaluation over time and implement recommendations

7. Public Comment

- At the Commission's February 6, 2020 meeting, commentary was voiced by Reuben Moore, CEO, Minnesota Community Care, the State's largest Federally Qualified Health Center. Mr. Moore noted a fundamental flaw in health care funding in terms of its lack of support for primary care. He stated that there should be a requirement for minimum dollars invested in primary care by MCOs, and that these investments should be aimed at at-risk communities. He recommended that the State place a requirement on MCOs to allow for an innovative billing model that would account for services that have greater impact on social determinants of health (SDOH). He urged the State to undertake innovative efforts to reduce SDOH, and suggested regulating such efforts through the competitive bidding process.
- At the Commission's February 6, 2020 meeting, commentary was voiced by George Klauser, Executive Director, the ALTAIR Accountable Care Organization, commented on the MCO competitive price bidding strategy. The Altair ACO is a collaborative of community service providers and a health care practice serving 19,000 individuals with intellectual, developmental and mental health disabilities, primarily offering Home and Community Based Services (HCBS). He noted the lack of discussion on how to incorporate value-based designs or payments into the competitive price bidding strategy. His vision of value-based design incorporates person-centered outcomes, and entails engaging all stakeholders. Mr. Klauser urged the Commission to consider new emerging ideas, particularly those with direct impact on individuals and at-risk communities.

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:
https://mn.gov/dhs/assets/BRC-020620-minutes_tcm1053-420203.pdf

Create a Uniform Pharmacy Benefit

Problem Statement: Prescription drug prices continue to grow more rapidly within the Managed Care Organization (MCO) program as compared to the fee-for-service (FFS) program.

Strategy: Carve out all outpatient pharmacy coverage from the MCOs and provide coverage through DHS' FFS program.

1. Problem Statement

According to Minnesota's All Payer Claims Database (APCD), spending on prescription drugs in Minnesota is rising at a rate much higher than growth in the number of prescriptions. Between 2009 and 2013, prescription drug spending rose 20.6 percent. In Medical Assistance these increases have been substantial, with pharmacy service spending per enrollee increasing by 56.6 percent between 2012 and 2016. These increases have been significantly more rapid in the managed care pharmacy benefit than the fee-for-service benefit.

This strategy will also improve transparency in pharmacy related spending in Medical Assistance. Recent Office of the Legislative Auditor (OLA) findings have documented concerns with Managed Care Organizations' (MCOs) compliance with reporting requirements. Moving these responsibilities to DHS will improve visibility into costs.

2. Strategy Proposal

This strategy is aimed at increasing administrative efficiencies and improving program simplification, as well as address significant cost drivers of state spending on health and human services. Under this strategy, DHS will administer the outpatient pharmacy benefit for Medical Assistance beginning January 2022. Currently, pharmacy benefits are either administered by DHS or the MCOs through their Pharmacy Benefit Managers (PBM). By moving management of the outpatient pharmacy benefit to DHS, the state will reduce the cost of providing the outpatient pharmacy benefit to individuals on Medical Assistance and improve visibility and transparency into pricing and operations. The uniform pharmacy benefit will rely on the state's preferred drug list process, which is established and maintained transparently with consumer and provider input.

This strategy will address the problem of rising pharmacy services cost by leveraging additional drug rebates, reducing profits seen between MCOs and PBMs, and increasing transparency into pricing related to pharmacy services.

This strategy is expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

West Virginia recently implemented this strategy and experienced significant savings. Additional states have recently implemented or are in the process of implementing in order to support cost savings for their programs; these states include California and North Dakota.

4. Populations Impacted

Individuals who access outpatient pharmacy services through Medical Assistance Managed Care Organizations (MCOs). Implementation of this strategy will result in reduced cost and increased transparency for Medical Assistance without significant impact on consumers.

Some enrollees will have to change from drugs they currently take to therapeutically equivalent alternatives that may be less costly. Changing medications can be unnerving for some people, even if the change generates an equivalent therapeutic result. However, state law allows patients who are taking anti-psychotic medications to remain on the same drugs they have been taking, even if they switch between certain coverages.

5. Implementation Steps

If legislative direction is provided, DHS will need to modify MCO and prior authorization services contracts, undertake systems changes in the Medicaid Management Information System (MMIS), create new policies for the administration of the uniform pharmacy benefit (such as how and when additional pharmacies would need to enroll in the Minnesota Medicaid program). Assuming the uniform benefit starts in January 2022, work would need to begin six months prior to the effective date. Additional DHS funding will be necessary to account for increased prior authorization volume that would have been handled by MCOs but will shift to DHS.

Ensuring continuity of experience for consumers where an existing prior authorization exists will be essential. This will require close collaboration with MCOs, DHS, and DHS's vendor for prior authorization services. Additionally, creating policy to effectively address instances where claims come from out of state providers will require additional consideration to ensure appropriate program integrity is maintained without impacting access to medication for consumers.

The MCO withhold implemented in state statutes creates financial complications in extricating benefits from MCOs. This requirement results in delayed payments to MCOs for 8 percent of their payments in a calendar year. The delayed payments typically are made in the July following the completion of the calendar year for which the payments were delayed. This results in spreading payments to a MCO across multiple fiscal years and delaying the full impact of removing a benefit from MCOs. Furthermore, if additional MCO payment delays are implemented prior to or during the implementation of this strategy additional fiscal interactions and a delay in accruing savings will have to be considered.

While the net cost to the state is expected to decrease, the actual net cost of any drug is not made transparent. This lack of insight has been an ongoing frustration for many, and because states are prohibited under federal law from disclosing the federal rebates they receive, this strategy may seem to some to not fully address a core concern.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- How does the strategy impact Medicaid beneficiaries?
- How will the strategy assess community conditions and geographic impact?
- How will this strategy reduce poor health outcomes?
- Does the strategy pose a potential impact in access to pharmacy service benefits?

- Embed an equitable process utilization management
- What are the potential burdens based on geographic locations?
- What are the additional cost drivers associated with this strategy?

7. **Public Comment**

In a February 6, 2020 letter, AARP Minnesota expressed its support for this strategy.

[Written public comment: AARP Minnesota, Feb. 3, 2020](#)

8. **Commission Discussion**

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:

https://mn.gov/dhs/assets/BRC-020620-minutes_tcm1053-420203.pdf

Establish Prescription Drug Purchasing Council

Problem Statement: Prescription drug costs continue to rise across all payers of health care benefits.

Strategy: Establish a legislatively chartered group of state and local officials to coordinate and collaborate on strategies to reduce prescription drug spending.

1. Problem Statement

All payers of health care benefits have experienced increasing pressure in their budgets from the high and rising cost of prescription drugs. This has been aided by a market for pharmaceutical products – both in the retail setting and delivered in office-based environments – that fails to operate effectively and transparently. Intermediaries benefit from the opaqueness in establishing formularies or preferred drug lists, negotiating rebates and other financial components in contracts, and payers operating in isolation.

2. Strategy Proposal

This is a cost savings strategy. A legislatively chartered group comprised of officials from across applicable state agencies, counties, cities, and other public entities will work to:

- Conduct a comprehensive inventory of prescription drug spending among public entities within Minnesota;
- Identify opportunities, as well as statutory barriers, to greater collaboration on purchasing of prescription drug benefits and data-sharing;
- Support the development and implementation of strategies to increase leverage of prescription drug benefit purchasing within existing statutory authorities, as well as the development of legislative proposals to address statutory barriers. Such strategies may include changes in procurement to enable greater aggregation of covered lives across public payers, participation in multi-state purchasing agreements, or the establishment of a market accessible to a broader cross-section of individuals seeking prescription drug coverage.¹³

The goal of the Public Prescription Drug Purchasing Council is to leverage purchasing power of the state and other public payers in the purchase of prescription drug benefits across Minnesota, initially focused on employees and clients of public payers. By bringing economies of scale to the negotiations with manufacturers, benefit managers, and other entities in the prescription drug supply chain, as well grounding this in coordinated benefit designs across organizations, payers would benefit from more advantageous contract terms, greater

¹³ Horvath, J. "State Initiatives Using Purchasing Power to Achieve Drug Cost Containment." National Academy for State Health Policy. April 2019. https://nashp.org/wp-content/uploads/2019/04/Rx-Purchasing-Paper-Jane-Horvath-FINAL-4_9_2019.pdf

transparency, and increased likelihood of slower prescription drug spending growth. For individuals, this is expected to translate into lower-than-expected premiums and cost-sharing.

Collaboration in the process of contracting for prescription drug benefits can contribute to collaboration around best practices of maximizing prescription drug therapies, enhancing such therapies with non-drug options, optimizing cost-sharing strategies, and otherwise bringing critical mass to improving health outcomes.

In addition, the ability to collaborate in purchasing decisions, contract negotiations and other aspects of acquiring prescription drug benefits may result in better balance of power between purchasers vis-à-vis manufacturers and PBMs. It may also provide the ability to more quickly and consistently “counter-steer” against evolving newly emerging industry practices that are disadvantageous to purchasers of prescription drugs.

3. Supporting Evidence

Delaware and New Mexico each passed legislation to create an interagency group tasked with identifying steps to increase the leverage of state purchasing of prescription drugs.^{14,15} At this point there is no data available from these states about their results.

4. Populations Impacted

Depending on the aim of the Public Purchasing Council’s activities – only public payers or public and private purchasers, including individuals – this strategy could reach a range of Minnesotans:

- Persons who work for state agencies, counties, and cities, as well as employees or clients of other public entities (e.g., correction department), or
- Persons with private market coverage or uninsured who seek prescription drug benefits (e.g., Minnesotans with individual market or employer coverage).

By pursuing collaborative strategies for prescription drug data sharing and purchasing, more Minnesotans may experience lower-than-projected increases in their premiums or cost-sharing related to inflation in prescription drug prices.

Potential unintended consequences include more narrow pharmacy benefit offerings or formulary designs that may not be well suited to populations with certain conditions and needs for specific drug therapies. Similarly, the existence of preferred drug lists, step therapy or other forms of utilization management aimed at assuring appropriate use of drug benefits might create time and administrative barriers to access to high-cost drugs.

¹⁴ Delaware General Assembly. Interagency Pharmaceuticals Purchasing Study Group. <http://legis.delaware.gov/TaskForceDetail?taskForcelid=410>

¹⁵ Riley, T. “New law enables New Mexico to leverage state purchasing power to lower Rx spending.” National Academy for State Health Policy. April 22, 2019. <https://nashp.org/new-law-enables-new-mexico-to-leverage-state-purchasing-power-to-lower-rx-spending/>

5. Implementation Steps

Enact legislation to establish a Public Prescription Drug Purchasing Council and authorize the Council to:

- Collect data from participating agencies on prescription drug spending, contract provisions, and other details;
- Consult with public payers on needs for support in purchasing prescription drug benefits;
- Conduct analysis and business simulations to assess impact of leveraging public purchasing power;
- Consult with other states on group procurement strategies;
- Implement necessary administrative changes to achieve goals related to more efficient, effective purchasing; and
- Make recommendations to the Legislature concerning any needed statutory changes.

An existing informal interagency work group can do some initial planning to identify possible avenues for more effective purchasing, and potential statutory or administrative barriers. Initial development of a prescription drug benefit inventory, review of opportunities for and statutory barriers to increased leverage of public purchasing, and the development of potential legislative proposals to address known statutory barriers to more efficient purchasing can occur through 2020 via the existing informal interagency group. More formal planning and implementation of proposed strategies likely cannot happen until the Legislature enacts legislation to establish a Public Prescription Drug Purchasing Council.

Resource requirements for this strategy are likely related to project planning, acquiring technical expertise through vendors, financial modelling to assess the impact from different strategies for group purchasing.

Implementation challenges may exist in the form of:

- Statutes that prevent collaboration in purchasing (e.g., concerning sharing data, collective negotiation, structuring formularies);
- Existing contract provisions that constrain collaboration or shared purchasing decisions;
- Limited legal, business, and operational expertise;
- Risk aversion among partners to substantial change, reinforced by labor contracts; and
- Reliable data to model procurement alternatives.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- How will this strategy ensure cross collaboration among public entities in the establishment of the council?
- How will applicable public entities be determined?
- Will this strategy impact existing programs? i.e., Minnesota Health Care Programs and SEGIP
- Which specific populations could experience unintended consequences?
- How will the strategy make provisions to reduce administrative challenges, specifically to existing utilization management tools?
- What could be the equity implications when adapting this strategy to the Minnesota health and human service structure?

- Establish an equitable mechanism in the development of the council, considering racial/ethnicity, tribal and geographic access that is representative of Minnesota.
- Considerations for tribal facilities that go through the purchasing process.
- Take reimbursement structures into consideration.

7. Public Comment

In a February 6, 2020 letter, AARP Minnesota expressed its support for this strategy.

[Written public comment: AARP Minnesota, Feb. 3, 2020](#)

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:

https://mn.gov/dhs/assets/BRC-020620-minutes_tcm1053-420203.pdf

Establish Prescription Drug Affordability Commission¹⁶

Problem Statement: High prescription drug costs can result in high out-of-pocket costs and premiums, as well as foregone care and worsened health outcomes.

Strategy: Develop a Prescription Drug Affordability Commission to set upper payment limits.

1. Problem Statement

Amidst high and increasing prescription drug prices, a sizeable group of Minnesotans face high costs associated with prescription drug treatment, which can result in high out of pocket costs for those individuals, increased premiums for all beneficiaries on affected health plans, as well as foregone care and worsened health outcomes. For those that filled prescriptions, approximately 135,000 Minnesotans paid more than \$1,000 out of pocket in prescription drug pharmacy costs in 2013; and 1,075 commercially insured Minnesotans paid over \$5,000 or more out of pocket.¹⁷ Yet, some Minnesotans find they must forego filling a prescription due to cost, which is now at levels observed during the economic recession from ten years ago (9.1 percent in 2017); not filling a prescription is associated with worse health and wellbeing. For example, Minnesotans with a chronic condition who did not fill a prescription due to cost reported an average of 4.4 additional mentally unhealthy days per month and 3.9 additional physically unhealthy days than their counterparts who did not report challenges with filling a prescription.¹⁸

Because of the high and increasing cost of prescription drugs, the share of Minnesotans reporting forgoing a prescription therapy because of cost is substantial. This can have an impact on the health of individuals and the well-being of individuals and families, especially if the foregone care results in the worsening of an underlying condition, lost work and wages, or reduced quality of life.

2. Strategy Proposal

This is a cost savings strategy. The strategy would establish a Prescription Drug Affordability Commission to:

- Assess, for certain drugs, whether the wholesale acquisition cost (WAC) would lead to affordability challenges for the state health care system or high out-of-pocket costs for patients.
- Establish an upper reimbursement limit to apply, as permitted, to all purchases and payer reimbursement for drugs dispensed or administered to individuals in the state through a range of means.
- Through analysis, identify potential instances of price gouging for referral to the Minnesota Attorney General.

¹⁶ Modeled after Senator Jensen's proposed SF353, the Prescription Drug Affordability Act.

¹⁷ MDH Health Economics Program Analysis of the All Payer Claims Database; updated data is not currently available.

¹⁸ MDH Health Economics Program analysis of 2013 and 2017 Minnesota Health Access Survey data.

- Perform certain activities related to ensuring compliance with requirements for upper reimbursement limits.

Establishing upper reimbursement limits for select prescription drugs has the potential to generate savings (over the long term) to individuals using prescription drugs, as well as individuals and employers contributing to health insurance premiums.

3. Supporting Evidence

Nationally, it remains too early to assess the impact of state-level action to set upper price limits on selected, high cost prescription drugs. Prescription drug affordability review legislation was passed in Maryland¹⁹ and Maine²⁰ in 2019. Internationally, there is substantial evidence that the use of centralized, national reimbursement limits, or centralized negotiation with drug manufacturers, results in lower pharmaceutical prices.²¹

4. Populations Impacted

This strategy is intended to benefit all Minnesota commercial purchasers of prescription drugs, including individuals, by establishing upper limits for reimbursements paid to pharmacies for selected drugs, and ultimately across the prescription supply chain serving Minnesota residents.

Depending on the number of drugs considered under this strategy, it has the potential to indirectly affect premiums in Minnesota's fully insured market and costs faced by self-insured employers.

By reducing reimbursement levels for select drugs consistent with the therapeutic value of a drug, spending by individuals and payers on the drugs subject to these levels will, over time, decline or stabilize. Moreover, recognizing state-level initiatives, manufacturers might have incentives to establish reimbursement levels more consistent with likely outcomes of a review and produce useful public information for cost- and therapeutic effectiveness considerations. The impact will be experienced with the first establishment of an upper reimbursement level; to be felt in substantial ways across prescription drug spending, upper reimbursement levels for a number of drugs would have to be in force.

This strategy is not designed to directly affect Minnesota's Medical Assistance reimbursements, given that they are regulated by federal law and benefit from existing rebate arrangements. Employer plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Part D plans will not be bound by the upper reimbursement limits.

¹⁹ An Act Concerning Health – Prescription Drug Affordability Board. HB 768. 2019. http://mgaleg.maryland.gov/2019RS/chapters_noln/Ch_692_hb0768E.pdf

²⁰ An Act to Establish the Main Prescription Drug Affordability Board. SP 461/LD 1499. 2019. <https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0461&item=3&snum=129>

²¹ Sarnak, DO, Squires D, Bishop S. "Paying for Prescription Drugs Around the World: Why is the U.S. an Outlier?" The Commonwealth Fund. October 5, 2017. <https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/paying-prescription-drugs-around-world-why-us-outlier>

5. Implementation Steps

The following implementation steps are needed:

Establishing infrastructure including:

- Enact enabling legislation;
- Appoint members of the affordability review commission;
- Appoint members of a technical advisory council that would support the technical and analytic activities of the commission;
- Hire staff to support the commission and the operation of its activities, including to work with the technical advisory council;
- Enter into contractual arrangements to access pricing information, establish needed data systems, and acquire needed technical expertise;
- Establish a process for reporting by manufacturers, including timelines, content and data submission requirements, and enforcement; and
- Enact legislation giving the Attorney General authority to pursue suspected cases of price gouging.

Conduct affordability review process

- Analyze available data on WAC, including data submitted by manufacturers to identify drugs meeting the review criteria;
- As authorized, select potentially a subset of all drugs meeting the requirement that the commission believes it is able to conduct a review on with available resources and in a reasonable length of time;
- Conduct public meetings during the review and otherwise seek feedback from the interested public, including patient advocacy organizations;
- Conduct review of selected drugs selected and, as appropriate, establish upper reimbursement limits; and
- Publish findings accessible to all affected entities across the supply chain and interested stakeholders.

Compliance, Enforcement and Ongoing Operations

- Conduct compliance activities related to reporting by manufacturers and adherence to payment limits;
- Report incidents of suspected price gouging to the Attorney General; and
- Report annually to the Legislature and the public on prescription drug price trends, statistics on drug price notifications submitted by manufacturers to the review commission, and any affordability reviews findings.

Activities by the commission could be performed by a broad set of actors, depending on factors related to costs, independence, access to price data, and available expertise, including:

- Commission chair, staff, and members;
- Technical advisory council members;
- State agency staff;
- Vendors such as the Institute for Clinical and Economic Review (ICER) with expertise in cost-effectiveness analysis;
- The Minnesota Attorney General (related to enforcement and pursuing price gouging incidents); and

- The Minnesota Legislature.

Similar legislation being debated across the country assumed the establishment of reimbursement limits within approximately two years after the passage of legislation. Resource needs for implementation would be highly dependent on the structure of the commission's work, how it chooses to execute it (e.g., contracts vs. staff research), how many drugs meet the criteria for review and are selected for review, how many reviews will result in the establishment of upper reimbursement limits, and how rigorous the enforcement of reimbursement limits will be.

There are some potential challenges to a Commission's work:

- **Scope and Capacity** – We estimate that possibly 1,000 drugs per year would fall within the purview of the prescription drug affordability commission. Thus, the time and resources needed to perform the evaluation charged to the commission would be substantial, limiting the commission to taking action on only a handful of drugs per year based on clearly defined criteria that would need to be developed by the commission.
- **Litigation** – Evidence from states that have pursued similar or related legislation suggests manufacturers and representatives of their trade group will take vigorous legal actions to challenge any legislation and potentially aspects of implementation. This will require legal support, including from the Attorney General.
- **Compliance and Enforcement** – Although the commission may articulate a reimbursement limit, it is possible that entities in the supply chain may assume they are not bound by it. This presents operational challenges around how the State will assess and be aware of compliance, as well as how the State will approach enforcement.
- **Assignment of Responsibilities** – There is limited public information concerning cost-effectiveness analysis of prescription drugs, which makes it challenging for payers to assess the value of a drug relative to alternative drug therapies or non-drug therapies. While certain third-party entities are beginning to produce cost- and therapeutic effectiveness analyses that could be of use to implementation of this strategy, the commission would need to find ways to conduct this highly complex, technically demanding work, including by assessing the rigor of industry-produced analyses and studies, and considering patient testimony on access, affordability and preferences.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Does the strategy consider the impact on populations that experience high costs associated with prescription drugs?
- How does the strategy reduce institutional and structural barriers?
- Establish an equitable mechanism in the development of the commission and in the implementation process
- How will the commission reduce inequities and disproportionality that impact populations experiencing poor health outcomes?
- Establish equity criteria in the selection of prescription drugs

- What could be the equity implications when adapting this strategy to Minnesota’s health and human service system?
- Make decisions to prioritize drugs based on usage and necessity for each population group.

7. Public Comment

In a February 6, 2020 letter, AARP Minnesota expressed its support for this strategy.

[Written public comment: AARP Minnesota, Feb. 3, 2020](#)

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:

https://mn.gov/dhs/assets/BRC-020620-minutes_tcm1053-420203.pdf

Discontinue Grant Programs – DWRS Transition Grants and Clare House Settings Rule

Problem Statement: There are two grants required by statute that are no longer necessary.

Strategy: This strategy would repeal the legislation providing for these grants going forward.

1. Problem Statement

This strategy eliminates ongoing provider grants that no longer serve the purpose under which the legislature authorized them. The first grant was intended to support providers of disability waiver services that would be most negatively affected by a transition between rate methodologies. In 2013, the Minnesota Legislature enacted a new rate methodology for disability waiver services called the Disability Waiver Rate System (DWRS). The new rate methodology, required by the federal government, transitioned the state from having variable rates based on county and provider negotiations to a statewide rate methodology based on provider costs. Implementation of the new rate structure began gradually in 2014, with full implementation occurring in 2020. As of December 2018, the aggregate impact of the transition was projected to increase rates by 14 percent. In addition, the 2019 legislature increased rates through implementation of a Competitive Workforce Factor. The purpose of the DWRS Transition Grants enacted in 2017 was to ensure ongoing service access as the transition occurred and to provide stability to providers as they transitioned to new service delivery models. A total of 364 providers meet the threshold for eligibility of this grant. Distributed evenly among those providers, each organization would receive a grant of about \$769 annually. The grant is not tied to services provided to individual people with disabilities, but rather intended to support providers in the transition.

The second grant proposed to be repealed in this strategy was created out of concerns that a single provider of services to persons with HIV would not be able to comply with a federal rule related to home and community-based settings. Since this grant's passage, the provider has complied with the federal rule, eliminating the need for the additional appropriation.

2. Strategy Proposal

This is a cost savings strategy which eliminates two grants that no longer serve their intended purpose. This strategy proposes to eliminate the DWRS Transition Grants effective July 1, 2021, as the transition to the cost-based rate methodology for services would have already occurred through a seven-year process. Further, the strategy proposes to eliminate the Clare House Settings Rule effective July 1, 2021 as the provider is able to comply with the relevant federal rule related to home and community based settings.

The second grant proposed to be repealed in this strategy was created out of concerns that a single provider of services to persons with HIV would not be able to comply with a federal rule related to home and community-based settings. Since this grant's passage, the provider has complied with the federal rule, eliminating the need for the additional appropriation.

This strategy is expected to save up to \$1 million in the next biennium.

3. Supporting Evidence

For the DWRS grant, the December 2018 DWRS Impact Study determined that the average rate change following the banding period was a 14.1 percent increase. Since this report's publishing, the legislature has made additional investments in DWRS rates. Furthermore, the transition period, which the grant is intended to address, will conclude by January 2021.

4. Populations Impacted

This proposal would affect the subset of providers administering services paid for under the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) waivers (collectively referred to as the "disability waivers") that experienced revenue reductions due to a transition to the Disability Waiver Rate System rate methodology in 2020.

5. Implementation Steps

The laws appropriating the funds for each grant would have to be repealed by the Legislature.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Does the strategy consider reporting from grant recipients?
- How will the strategy assess community and stakeholder impact?
- What would be the impact to providers if either grant were eliminated?
- How will the strategy assess community conditions and geographic impact (rural v. urban)?
- Ensure that providers have equitable access to technical support during the transition process.

7. Public Comment

Achieve Services submitted a public comment letter on February 17, 2020 expressing its opposition to this strategy, and specifically to discontinuation of the Disability Waiver Rate System (DWRS) Transition Grant program. The submitted public comment letter is linked below.

[Written public comment: Achieve Services, Feb. 17, 2020 \(PDF\)](#)

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-022120-minutes_tcm1053-422173.pdf

Update Absence Factor in Day Services

Problem Statement: The state’s current absence factor for day services is significantly higher than provider costs and unnecessarily increases state expenditures.

Strategy: This strategy changes rate formulas for day services under the disability waivers to reflect research on provider costs.

1. Problem Statement

People who receive services through the four disability waiver programs have access to day services, which include day training and habilitation, structured day program, prevocational services, and adult day services.

During fiscal year 2019, day services were used by the following number of people:

- Adult day services: 2,931 people
- Day training and habilitation and structured day program: 10,286 people
- Prevocational services: 2,847 people

Day services have rates determined by the Disability Waiver Rate System (DWRS). DWRS establishes service rates through a formula comprised of cost components. The values of the cost components are set in statute and are based on data and research on the average costs incurred by providers across the state. Cost components in the formulas consist of provider costs, such as staff wages, employee benefits, program costs and administrative costs. The absence and utilization factor (referred to as “absence factor”) is a cost component in the DWRS frameworks intended to cover the costs incurred by the provider when the person has an unplanned absence from services and the provider cannot bill for services as planned.

The rate methodology set in state law and approved by the federal government is based on average provider costs. The current absence factor of 9.4% in the Disability Waiver Rate System (DWRS) day service rate framework is not supported by evidence. This strategy would replace this factor with a revised figure that is more reflective of real-world provider costs.

Previously, the absence factor was set at 3.9%. The legislature amended this value effective January 1, 2019 to 9.4% and required the state to complete an additional analysis and recommend an adjustment according to updated data. This strategy aligns with those findings, published in the [2018 DWRS Absence Factor Legislative Report](#).

2. Strategy Proposal

This is a cost savings strategy which aligns cost components within DWRS to evaluations of provider costs of delivering services. Specifically, this strategy would reduce the absence and utilization component value for day services from 9.4% to 4.5%. The recommended component value is based on a 2018 legislative report that determined that this component value was not supported by provider claims data.

This strategy will result in decreased costs, ensures that rates are set based on data, and ensures that all services across the disability waiver service menu have standardized rate setting methods.

This strategy addresses federal and state concerns regarding ensuring the DWRS rate frameworks align with the cost of providing services. The current absence and utilization factor is out of sync with this federal expectation. Currently, day services have a higher factor than what the data shows while other services, such as unit-based services supporting people in their own home or in their workplace, do not have the inflated factor. This strategy ensures that the rate for all services is based on provider costs, resulting in a level playing field across all services.

This strategy is expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

This strategy is supported by data. The following research has been completed on the absence factor in day services:

- Research conducted by Navigant Consulting in 2010 recommended a value of 3.9 percent.
- Research conducted by Truven Health Analytics in 2016 assessing provider cost data recommended a value of 3.1 percent. Their findings were published in the [2017 DWRS Legislative Report](#).
- Research conducted by DHS in 2017 assessing provider claims data recommended a value of 4.5 percent. This recommendation, published in the [2018 DWRS Absence Factor in Day Services Study](#), was made after the 2017 Legislature increased this factor from 3.9 percent to 9.4 percent, with the requirement that DHS would research and make recommendations for adjustment.

4. Populations Impacted

Providers delivering day services paid for through the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) waiver programs would be affected by this strategy. Because this strategy will reduce payment rates for day services, which could have the unintended consequence of creating barriers to services if day service providers choose to provide fewer services.

5. Implementation Steps

The legislature and the federal Centers for Medicare and Medicaid Services (CMS) must both approve this change. Following approval, DHS and MNIT must program the MnCHOICES Support Plan to calculate updated rates. We anticipate it will take one year to implement these changes.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish a plan to continue to assess equitable outcomes.
- Define the impact on similar programs and services between DHS and other agencies.
- Ensure rate exception process is equitable.
- Establish an equitable mechanism for tracking and reporting
- How will this strategy consider other cost components and limitations (for example; billing caps)?

- What is the impact on service delivery among counties and tribes?
- What are the provisions for accountability among providers and DHS?
- What has been the impact on service delivery under the 9.4% increase?
- How are recipients who have exceptional needs impacted by this proposed strategy?
- What is the total cost associated with this strategy?

7. Public Comment

- The Minnesota Organization for Habilitation & Rehabilitation (MOHR) submitted a public comment letter on March 2, 2020 in follow up to its February 21, 2020 meeting testimony. MOHR's letter expresses strong opposition to the strategy, Update Absence Factor in Day Services. A link to the letter appears below, as well as link to a February 17, 2020 public comment letter from MOHR, also expressing opposition to this strategy.

[Written public comment: Minnesota Organization for Habilitation & Rehabilitation, March 4, 2020 \(PDF\)](#)

[Written public comment: MOHR, Feb. 17, 2020 \(PDF\)](#) - 383

- Rise submitted a public comment letter on February 18, 2020 expressing its opposition to this strategy. A link to the letter appears below.

[Written public comment: Rise, Feb. 18, 2020 \(PDF\)](#) - 383

- MSS submitted a public comment letter on February 17, 2020 expressing its opposition to this strategy. A link to the letter appears below.

[Written public comment: MSS, Feb. 17, 2020 \(PDF\)](#) – 383

- The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced concerns regarding this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:
https://mn.gov/dhs/assets/BRC-022120-minutes_tcm1053-422173.pdf

Change Disability Waiver Family Foster Care Rate Reform

Problem Statement: The state’s rate methodology is resulting in family foster care rates that are growing at an unsustainable rate.

Strategy: This strategy changes rate formulas for family foster care to reflect a tiered rate based on an individual’s service need.

1. Problem Statement

In 2013, the Minnesota legislature enacted a new rate methodology for disability waiver services called the Disability Waiver Rate System (DWRS). At the time, service rates were determined through individual county and provider negotiations, and the federal government required the state to adopt a consistent statewide methodology in order to maintain federal participation. Implementation of the new rate structure began gradually in 2014, with full implementation occurring in 2020.

While previous rates were set through individual negotiations, the new rate methodology for family foster care services is a cost-based, shift-staff methodology reflecting corporate residential settings. The methodology applies provider costs like staff wages and administrative costs to the number of staff hours to calculate a daily rate.

This methodology results in an average rate increase of 20.4 percent compared to past rates for family foster care services. While the new methodology provides a standardized approach for setting rates, these higher rates do not relate to the costs or type of services provided in a family foster care setting. This methodology does not appropriately reflect the nature of a service for the following reasons:

- Hours: The current daily rate applies cost factors to an estimated number of hours to determine a daily rate. Because this service is provided within the provider’s home and is imbedded within their daily life, establishing direct service hours is difficult;
- Costs: Determining a methodology based on costs is difficult when the service is provided within a person’s own home. Many costs are not applicable. Additionally, external staff may not be used to provide supports in many instances; and
- Tax Status: Income received from providing family foster care is not subject to state or federal income tax, making it different than other DWRS services.

2. Strategy Proposal

Family foster care and family supported living services (collectively referred to as “family foster care”) are residential services available under the disability waivers that are administered within a provider’s own home. This cost savings strategy changes the rate methodology for family foster care services and promotes new services under the disability waivers in order to 1) ensure that rates appropriately reflect the nature of the service; and 2) promote access to a wider array of services to match the needs of people. People who receive services through the four disability waiver programs have access to day services, which include day training and

habilitation, structured day program, prevocational services, and adult day services. As directed by the legislature, DHS studied family foster care rates and published findings in a [January 2020 legislative report](#). This proposal reflects those findings and proposes a rate structure that better reflects the nature of the service.

Specifically, this strategy proposes a tiered rate structure based on a person's needs that would replace the current DWRS, hours-based rate calculation method for family foster care and supported living services. It will simplify family foster care reimbursement by automatically assigning a rate from one of the six tiers according to a person's assessed support need. If a person's support needs change in subsequent assessments, they would move to a different tier and have a different rate according to their updated level of need.

The analysis used to determine this proposed methodology is outlined in the January 2020 legislative report. The methodology determined the tiered rate structure by first defining 6 tier levels and then it set a rate for each tier by estimating the average pre-DWRS rate within each tier (adjusted for cost of living adjustments). The average daily rate proposed in this strategy ranges from \$133.56 in the lowest tier to \$262.79 in the highest tier. The estimated weighted average rate across all tiers is \$175.82 per day, or \$64,174 per year per person supported if 365 days were billed. Moving forward, the strategy would include an ongoing inflationary adjustment to the tiered rates to ensure the rate structure is sustainable over time.

This strategy also supports the continued development of a life sharing model by unbundling the multiple supports included in this model. 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. Presently, the family foster care rate includes payments to support the matching, oversight, and family support components of this model. This rate strategy would support unbundling these components into individual services and payments that would increase the program integrity of this model.

This strategy will also result in administrative simplification. The current DWRS rate calculation requires the provider and county/tribal nation staff to work together to determine and agree upon the number of hours a person receives services in a family foster care setting. This can be a difficult and time-consuming process because the service provider lives in the service setting, making it harder to define what actions are considered part of the family foster care service versus part of everyday living in one's own home. This strategy would eliminate the discussion of service hours as part of the rate determination process.

This strategy is expected to save more than \$10 million in the next biennium.

3. Supporting Evidence

This strategy aligns with how other states set rates for family foster care services. In identifying the methodology to pursue in the [January 2020 legislative report](#), DHS assessed how other states determine rates for family foster care services. They found that many states utilize tiered rates or flat rates for this service given the challenges of determining a cost-based or hours-based rate formula.

The recommended rate tiers is also consistent with the support ranges recommended by the [2019 Waiver Reimagine legislative report](#). This research determined the appropriate data-based foundation to determine support ranges.

4. Populations Impacted

The populations that are affected by this strategy are providers of family foster care and supported living services paid for through the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) waivers (collectively referred to as the “disability waivers”).

1,725 people received family foster care and supported living services, in a daily unit, during fiscal year 2019. Prior to the cost-based DWRS rate methodology that was fully implemented beginning in January 2020, rates were set between counties and providers. Moving to DWRS rates is estimated to result in an average rate increase of 20.4 percent compared to past rates. This impact is variable across providers and people receiving services.

The rates proposed in this strategy are based on average rates prior to the implementation of DWRS, adjusted for cost of living increases. Compared to the newly implemented DWRS rates, the tiered rate methodology proposed in this strategy is expected to result in the following: 35% of service rates will have rate increases over 10%; 17% will change within 10%, and 48% will experience a decrease of over 10%.

5. Implementation Steps

Legislative approval, federal approval, policy development, systems modification, and public engagement are required to implement this strategy. We anticipate that the effective date could be January 2022, with full implementation taking a year as service agreements would need to be renewed and rates recalculated

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish training for at home providers.
- Establish an equitable person centered/whole family approach to assess rates
- Embed an equitable rate selection process
- Establish an equitable needs assessment
- How will the strategy assess community conditions and geographic impact?
- How will this strategy use equitable mechanisms to pre-determine reimbursement rates?
- How will this strategy impact family foster care and supportive living program recipients?
- How will this strategy impact MNIT, MnCHOICES, and individuals receiving services?
- Does the strategy make provisions for accountability?

7. Public Comment

The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced support for this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

8. Commission Discussion

Minutes of the Commission meeting during which this strategy was discussed may be found at the following link:
https://mn.gov/dhs/assets/BRC-022120-minutes_tcm1053-422173.pdf

Curb Residential Costs in Disability Waivers

1. Align Corporate Residential Billing with Rate Framework
2. Curb Customized Living Services Rate Growth (Revised)
3. Support Planning for People who Want to Move (Revised)

Problem Statement: Residential services comprise a large portion of spending under the Medicaid disability waiver programs.

Strategy: This is a three-part strategy: 1) align corporate residential billing with rate framework, 2) limit an individual to receiving no more than 24 hours of services each day in customized living services, and 3) support planning for people who want to move. Together these strategies are expected to save more than \$10 million in the next biennium.

Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-022120-minutes_tcm1053-422173.pdf

Align Corporate Residential Billing with Rate Framework

1. Problem Statement

Spending on the DD, CADI, CAC, and BI waivers (collectively “disability waivers”) has increased significantly in recent years and is anticipated to continue increasing in the foreseeable future. One of the primary cost drivers in these programs is spending on residential services, specifically supports provided to people with disabilities in a corporate foster care and customized living setting.

In Fiscal Year 2021, the total projected spending on the disability waivers is \$3.4 billion (both state and federal share). Of that amount, 43% or about \$1.4 billion is expected to be spent on corporate foster care and corporate supportive living services.

In addition to residential services, the disability waivers offer services provided to people in their own home, workplace, and the community. There are differences in costs between people who receive residential services and those who do not. The following table illustrates the cost differences found in FY2019:

Waiver	Average daily cost for people receiving residential services	Average daily cost for people not receiving residential services
CADI	\$228.49	\$48.71
DD	\$304.35	\$116.07

While these numbers are not adjusted for level of need, this table illustrates the average current cost differences between the two groups. This strategy seeks to reduce spending on corporate residential services and facilitate the use of other support options available on the disability waivers.

2. Strategy Proposal

This is one piece of a four part strategy to address the significant cost of customized living. This sub-strategy would place limits on the number of billable days for Corporate Foster Care and Supportive Living Services to align with the absence factor in the rate methodology.

Corporate foster care and supportive living services have rates determined by the Disability Waiver Rate System (DWRS). DWRS establishes service rates through a formula comprised of cost components such as staff wages, employee benefits, program costs and administrative costs. The absence and utilization factor (referred to as the “absence factor”) is a cost component in the DWRS frameworks intended to cover the costs incurred by the provider when the person is gone from the home and the provider cannot bill for services as planned. This factor accounts for approximately 14 absence days per year.

While the rate methodology increases the daily rate to account for these absent days, a provider is able to bill the increased rate regardless of how many absent days actually occur. If a person is in the home 365 days a year, the provider can bill every day even though they receive compensation for assumed absences. This sub-strategy would ensure that if a person was in the home for more than 351 days in a year, the provider could only bill 351 days to be consistent with the rate methodology.

Fiscal Impact: This sub-strategy would reduce spending within one year by reducing the amount of units paid.

3. Supporting Evidence

Reducing the number of units billed and/or reducing the total daily rate will result in reduced costs on the disability waivers.

The effectiveness of the foster care moratorium and other strategies to reduce the use of corporate foster care are documented in the [Corporate Foster Care Needs Determination Report](#). The alignment of billing limitations with absence assumptions in rate methodologies is a strategy used by other states' waiver programs to support program integrity.

4. Populations Impacted

This strategy affects people who receive, and providers that render, residential services through the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) waivers.

5. Implementation Steps

This strategy requires legislative approval and federal approval to implement. It also will require system changes.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- How does this strategy meet current and growing demand for care and services and support for low-income residents in facilities that receive disability waiver programs?
- How will cost savings be defined?
- Embed equitable process to curb residential costs
- Does the strategy make provisions for accountability?
- Does the strategy pose a potential impact in access to disability waiver program recipients?
- What is the impact to the state for individuals that become homeless when a residential service facility closes?
- How are data sets for various underrepresented groups being integrated in the assessment process?

7. Public Comment

The Commission did not receive public comment specific to this strategy.

Curb the Growth and Use of Residential Services (Customized Living)

1. Problem Statement

Customized living rates use a similar rate calculation method between the disability and aging waiver programs. However, unlike aging rate calculations, there are no individual cost control mechanisms for customized living rates calculated under the Community Access for Disability Inclusion (CADI) and Brain Injury (BI) waiver programs. The customized living rate tool relies on an entry of the number of support hours that will be provided to a person each day.

In recent years, CADI and BI waiver payments for customized living services have increased dramatically. Between fiscal years 2017 and 2019, the average rate for CADI and BI customized living increased from \$133.61 per day to \$170.03 per day (a 27% increase). The number of people receiving this service also increased over the same time period by 24%, creating an overall spending increase of 51% for this service. DHS analysis has found that this rate increase was driven by an increasing number of support hours entered into the customized living rate tool, especially in the mental health category. By limiting the number of support hours per day to 24 hours, this strategy will help control service spending and align rate entries with supports provided to service recipients.

2. Strategy Proposal

This strategy is focused on reducing waste in administrative and service spending in health and human services. It creates a daily limit of 24 hours of support for customized living rates calculated under the CADI and BI waiver programs. Beginning on January 1, 2022 lead agencies would be unable to authorize a rate for customized living under these programs that included support inputs in excess of 24 hours. This limit would be programmed into the MnCHOICES Support Plan rate tool. Non-hourly supports within the customized living tool, such as meals, transportation mileage, and use of a summoning device, would not count against the 24-hour limit. Current rates that have over 24 support hours per day would be modified by lead agencies to come into compliance upon service agreement renewal in 2022.

This strategy will resolve program integrity concerns by placing a cap on support hours that align with a reasonable expectation of support provided.

3. Supporting Evidence

The use of cost controls in the Aging customized living services has proven effective at controlling spending. Additionally, in upcoming years this service is expected to be used by fewer people under 55 years old on the CADI and BI waivers as DHS implements a new service, Integrated Community Supports, that better aligns with the program populations.

4. Populations Impacted

Customized living, available to people with disabilities receiving services through the CADI and BI waiver programs, provide an individualized package of regularly scheduled, health-related and supportive services provided to a person 18 years or older who resides in a qualified, registered housing-with-services establishment. During fiscal year 2019, 5,226 people received customized living through the CADI or BI waivers.

While this strategy does not create an increased burden for the State, it may create a financial concern for providers who currently receive rates that are determined using more than 24 hours of support. This strategy imposes an upper limit on the amount of allowable time spent providing this service each day. Because this change is made on the highest rates for this service, it could have an unintended impact on people with high support needs. However, DWRS rate exceptions remain an option for people with extraordinary support needs.

This proposal should not affect the support people receive via customized living, since it is not possible to receive more than 24 hours of support in a day.

5. Implementation Steps

This strategy requires DHS and MNIT to make changes to the MnCHOICES Support Plan rate tool in order to prevent calculation of rate with more than 24 hours of support. Changes must be completed by December 2021 in order to be implemented on a rolling basis beginning in January 2022. Implementation will occur as service agreements renew in 2022. Full implementation will be completed by January 2023.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish an equitable lens in the customized living tool
- Embed equitable process to curb residential costs
- How does this strategy meet current and growing demand for care and services and support for low-income residents in facilities that receive disability waiver programs?
- How will cost savings be defined?
- Does the strategy make provisions for accountability?
- Does the strategy pose a potential impact in access to disability waiver program recipients?

7. Public Comment

The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced support for this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

Support Planning for People Who Want to Move

1. Problem Statement

Spending on the DD, CADI, CAC, and BI waivers (collectively “disability waivers”) has increased significantly in recent years and is anticipated to continue increasing in the foreseeable future. One of the primary cost drivers in these programs is spending on residential services, specifically supports provided to people with disabilities in a corporate foster care and customized living setting. The [December 2018 DWRS Impact Study](#) found that, on average, residential service rates would increase by 14.8 percent after the Disability Waiver Rate System was fully implemented in 2021.

Many in the disability community believe the human services system should transition away from use of corporate foster care and customized living settings, sometimes referred to as “group homes” or “assisted living,” to support people with disabilities in their own home, family home, or apartment. These settings would provide a person more options about the services they receive and the providers that provide them. There are other lower cost services, often provided in 15-minute units, which provide people with more options to customize their supports and providers.

2. Strategy Proposal

This sub-strategy would provide additional support planning assistance to lead agencies for people who indicate that they prefer to move out of corporate foster care and customized living settings. Doing so would assist people in accessing services that meet their needs in other living settings. These resources may produce cost savings in the long-term through reducing use of these residential settings.

This strategy is modeled after promising practices identified from the Moving Home Minnesota federal demonstration program that could be adapted to apply to people leaving foster care or customized living settings. These practices may include:

- Identifying and designating a transition coordinator at the county level to support a person’s move; and
- Coordination with DHS Housing programs to ensure the success of a person’s move.

3. Supporting Evidence

Support planning strategies could be modeled after Moving Home Minnesota, which creates opportunities for people to move from institutional settings to their own homes in the community. In comparison, this work would focus on moving people who have expressed an interest in moving from corporate foster care, supportive living services, and customized living.

4. Populations Impacted

This strategy affects people who receive, and providers that render, residential services (such as corporate foster care, supported living services, and customized living) through the Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Brain Injury (BI) waivers. This strategy could increase incentives for people to access services that are alternatives to corporate foster care and customized living that encourage greater community inclusion. Long-term, a strong support planning infrastructure and proper fiscal incentives could reduce utilization of these services.

5. Implementation Steps

This strategy would require legislative approval and administrative resources to implement. The work would require coordination between DHS, county and tribal agencies, and provider organizations. This strategy will require increased state technical assistance to lead agencies and providers, which will require administrative support.

This strategy relies on the availability of affordable housing to be successful, which could present a challenge.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish an equitable lens in the customized living tool
- Embed equitable process to curb residential costs
- How does this strategy meet current and growing demand for care and services and support for low-income residents in facilities that receive disability waiver programs?
- How will cost savings be defined?
- Does the strategy make provisions for accountability?
- Does the strategy pose a potential impact in access to disability waiver program recipients?

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

Require Medicare Enhanced Home Care Benefit (Revised)

Problem Statement: Individuals enrolled only in Medicare do not have access to low-cost, high-return- on-investment long-term services and supports that would help older adults remain in their homes.

Strategy: Require Medigap policies to cover certain benefits to support enrollees in the community over the long term.

1. Problem Statement

This strategy addresses the lack of access to low-cost, high-return-on-investment long-term services and supports that would assist older adults to remain in their homes and communities, instead of prematurely moving to congregate facilities. These facilities, such as assisted living, are more expensive to both older adults and the state and federal governments and are often less safe for older adults with disabilities and chronic conditions. Use of private long-term care insurance is rare for middle and lower income older adults. A nonmedical, enhanced home care benefit embedded in Medicare supplemental plans would be especially beneficial for older adults who live alone and are at highest risk of spending down to Medicaid-funded services.

Medigap policies supplement traditional Medicare benefits by providing coverage for all or a portion of Part A and B co-pays and deductibles. In addition, they provide coverage for some non-Medicare covered benefits as described in state law. These policies are guarantee issued for a six-month period at the point of Part B eligibility. Thereafter, health underwriting is allowed. A policy contract is between the individual and the Medigap carrier. The premium reflects the cost of the supplemental benefits. There is no additional payment from the Center for Medicare and Medicaid Services (CMS) to the Medigap carrier. The product is guaranteed renewable. Regulation is, essentially, at the state level.

This strategy will make it easier for a broad group of older adults to access a set of nonmedical services that can help support their decision to live in the community, and to expand coverage for such services in Medicare supplemental plans. Current law limits access to such services to people with very low-incomes who enroll in Medicaid programs like Elderly Waiver, Alternative Care and Essential Community Supports.

2. Strategy Proposal

Mandate that all newly-issued Medicare supplemental (Medigap) health plans sold in Minnesota offer a set of nonmedical services (including personal care assistance up to an internal limit) to all enrollees in their health plans. The set of services are:

- Chore services;
- Homemaker services;
- Family caregiver training and education;
- Community living assistance;
- Home-delivered food and produce;
- Home-delivered meals (to the extent not provided by other programs);

- Personal care assistance (up to an internal limit or scheduled benefit); and
- Personal emergency response systems (scheduled benefit);
- Service coordination.

It is important to note that the above list of covered services is dynamic and could change based on further conversations with stakeholders.

The set of services were defined to be a basket of in-home services which were utilized most frequently by seniors. A review of current programs operating in Minnesota suggests that the average utilization rate is much lower than one would expect, i.e., policy holders use 65% of the available benefit. If the beneficiary changes plans, the lifetime maximum is portable. Once met, coverage does not reset even on a new policy.

An actuarial analysis in 2017 estimated that for Medigap, a mandate to include a basket of long-term care services would result in a premium increase for the base rate for the Essential Community Service package (without PCA) of \$8.49/month more in premiums. A more recent actuarial analysis found that the increase would be between \$4.95 to \$17.90 depending on the policy level and utilization (trial or full utilization).

3. Supporting Evidence

The goal of the proposal is to help a large population of Medicare beneficiaries (estimated at about 120,000) remain at home in their community and delay their entrance into congregate settings such as assisted living facilities. It is hoped that the greater availability of in-home services would achieve this goal. This pilot will test the hypothesis that the addition of more support from nonmedical services would extend the length of stay in independent homes and make that stay safer for longer. The expected result (over approximately the next decade) is an increase in the number/proportion of Medicare beneficiaries living independently in their homes without the need for more expensive Medicaid-funded long term services and supports. At the heart of this support strategy are the family caregivers who want to keep their older relatives in their homes and communities, but need services they can rely on to help them care for these family members.

The table below shows the most recent estimates of a modest Medical Assistance (MA) savings if the enhanced home care benefits were offered as part of a Medigap policy in Minnesota rather than through the MA program.

Projected Fiscal Effects of Including Coverage of Enhanced Home Care Benefits in All Medigap Policies in Minnesota

YEAR	2022	2023	2024	2025
Annual Number of Beneficiaries-CY	18,620	35,577	51,607	66,658
Annual Benefit Costs-CY	\$4,181,518	\$12,215,158	\$25,471,641	\$38,568,233
Total MA Annual Costs-FY	\$(74,000)	(684,000)	(2,467,000)	(5,379,000)

YEAR	2022	2023	2024	2025
Federal Share-FY	\$(37,000)	(342,000)	(1,233,500)	(2,689,500)
State Share-FY	\$(37,000)	(342,000)	(1,233,500)	(2,689,500)

4. Populations Impacted

The main populations to be affected by this strategy are older adults and persons with disabilities in Minnesota who are eligible for a Medicare supplemental plan (“Medigap”). Population impacts would be positive, in that older adults would be able to access services and programs that help them meet the goal of remaining in the community. This strategy defines low-income older adults as those with income of 150% of federal poverty level or about \$19,140 for a senior household of 1.

An actuarial analysis of this proposed strategy could identify unintended consequences such as impact to Medigap policy take-up rates and the potential for adverse selection, when compared to competing Medicare Advantage products. The cost of Medigap premiums and price sensitivity among this population may mean that additional premium increases need to be subsidized or offset in order to avoid disenrollment.

The legislature may consider whether to recommend a premium support subsidy for Medigap enrollees to cover the increase in premium costs resulting from the mandated benefits.

5. Implementation Steps

The 2021 Legislature would need to enact legislation regulating Medicare supplemental products to add mandatory coverage for these services in all new Medigap health plans sold on or after January 1, 2022.

In summer and fall 2021, the MN Department of Commerce would approve product designs, rates and regulatory steps needed to implement the mandate.

Beginning in plan year 2022, newly-issued Medigap policies sold in Minnesota would need to meet the minimum coverage requirements for all of the mandated services for enrollees whose health conditions require these services to avoid hospitalization or a nursing home stay and to continue to live in the community.

Medicare enrollees would purchase the new Medigap products beginning with the 2021-22 open enrollment period.

If there will be a premium support subsidy, the State (through DHS) would need to implement system capacity to provide the subsidy to the Medigap enrollees.

The Minnesota Department of Human Services (DHS) would develop an evaluation plan, to track the cost of providing these services and health outcomes for older adults who receive these supports, to determine any cost savings and improved outcomes tied to social determinants of health.

DHS and Commerce, through publication of evaluation research and reporting, would encourage health plans issuing Medicare Advantage products to include these same services in their products on a voluntary basis.

In terms of the provider impact on health plans providing Medigap services and products, it is likely that providers of these nonmedical services will seek contracts or other relationships with the health plans.

The provisions established by the Department of Commerce will be monitored by DHS to ensure that adequate measure have been taken to prevent adverse selection.

The Department of Commerce would have primary responsibility for to develop regulations to require the addition of the new mandated benefits in newly-issued Medigap plans. Health plans would need to follow the Commerce Department's regulations, as well as meet any federal requirements or oversight for this process.

DHS will complete evaluations on the cost and effectiveness of this approach to keeping seniors in their homes longer.

6. Equity Considerations

The equity review raised a number of questions, which were addressed during the strategy development process.

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-030620-minutes_tcm1053-423682.pdf

Update Value-Based Reimbursement in Nursing Facilities

Problem Statement: Nursing facility rates continue to grow at significant rates with limited incentive for improved quality of care.

Strategy: This strategy proposes an update to the nursing facility rate methodology.

1. Problem Statement

Value-Based Reimbursement (VBR) was passed by the legislature in 2015 in response to an industry proposal to address workforce issues and create incentives to invest in direct care and improve quality. Key features of VBR are that care related costs are reimbursed at actual costs subject to a quality limit, other operating costs are reimbursed using a pricing model and health insurance costs are treated as a pass-through. It was a large investment by the legislature designed to re-base nursing facilities rates to cover their actual costs however the legislation did not include limits on future spending growth. This strategy is a comprehensive budget change proposal to address the spending growth and strengthen the quality incentive.

VBR incorporates pay for performance by setting nursing facilities' care-related payment rate limits based on their quality. Under the current rate calculation methodology, most nursing facilities are significantly under their care-related spending limits. With the gap between actual costs and the facility specific rate limit, there is no incentive for the facility to improve its quality performance as they are being reimbursed for all their direct care costs regardless of the quality of their services.

Another aspect of VBR rate determination is the capping of other operating costs to slow the growth rate of this rate component. The strategy also includes the elimination of the hold harmless clause in VBR; suspension of APS inflation and continued suspension of Critical Access Nursing Facility Program (CANF).

Under current law, a nursing facility may assess a resident as needing therapy services (physical, occupational or speech). This addition of therapy services often results in an increase to the resident's daily payment rate. The need for this therapy might end before the next quarterly assessment is due and current law does not require nursing facilities to complete a new assessment to indicate that therapy services have been discontinued. This results in residents remaining at a higher daily payment rate even after therapy services are no longer being provided, yet the resident continues to be billed for this service until the next scheduled assessment.

2. Strategy Proposal

This is a cost savings proposal with four sub-strategies to the rate setting formula including:

- Suspend the Critical Access Nursing Facility Program (CANF) funding as it has no value under VBR.
- Suspend the Alternative Payment System automatic property inflation adjustment.
- Eliminate a hold harmless clause which states that facilities at least receive the rate they had for the year prior to the implementation of VBR.

- Add an assessment when therapy services are discontinued, which will result in a decrease in the resident's daily payment rate because the assessment will reflect that the service is no longer needed and no longer being provided.

Continued suspension of CANF, a program designed to preserve access to nursing facility services in isolated areas of the state under financial distress by establishing rates based on actual costs and other rate enhancement features. With the enactment of VBR, which implemented full rebasing of payment rates to facility costs, the partial rebasing under the CANF program was not of value and the program was suspended for two years. This proposal continues that suspension into future years.

Under current law facilities receive an annual inflation adjustment to their property rates based on the change in the Consumer Price Index. The APS property rate inflation adjustment was suspended from October 1, 2011 until January 1, 2018. The inflation rate adjustment for property rates effective January 1, 2019, was 2.45%, which increased the property payment average rate per day by \$0.45. The inflation rate for property rates effective January 1, 2020 was 1.87%, which increased the property payment average rate per day by \$0.36. Facilities with a moratorium exception project approved and completed after March 1, 2020 will be ineligible for the annual APS property rate adjustment once they are transitioned to the new Fair-Rental Value property rate system.

VBR contains a hold harmless clause which states that facilities at least receive the rate they had for the year prior to the implementation of VBR. This hold harmless clause is no longer needed as facilities have had time (four years) to adjust to VBR.

MN law establishes a Resident Reimbursement Classification system based on assessments of residents to determine a resident's clinical and functional status, which determine the daily rate that the facility charges for the resident's care. Assessments intervals are specified by statute. Each resident receives a quarterly assessment every 90 days. Residents assessed at a higher therapy RUG at the beginning of a quarterly assessment may not need or receive therapy after a certain point into the quarter after the assessment, but will remain in (and be billed for) that therapy group for the entire 90 days regardless of how many days therapy is actually provided. While this proposal affects the MA budget, it also affects what private pay residents will pay for nursing home care. The number one complaint by private paying residents to the Minnesota Department of Health (MDH) Case Mix Section is having to pay for services at a higher level when the services are not provided.

This set of strategies are expected to have savings between \$1 million and \$9,999,999 in the next biennium.

3. Supporting Evidence

This strategy supports modification to the formula that limits the reimbursement of care-related expenditures in ways that are more sensitive to individual nursing facilities. The impact will be positive if the revised formula incentivizes poorer performing nursing facilities to improve the quality of care and quality of life they provide to residents. The proposed changes are likely to reflect a nursing facility's effort to provide authentic, person centered care. Person centered care done in a culturally competent manner will ensure that the individual needs of all residents, including those who are ethnically and racially diverse, are being met.

4. Populations Impacted

This strategy will impact the daily Medicaid and Private Pay per diem rates determined by DHS for nursing facility care. All nursing facility residents who either pay for their care with private resources or are eligible for

Medicaid will be impacted. Some residents receiving therapy may be impacted by a proposed change to the resident assessment schedule.

This is a cost savings strategy that will result in smaller rate increases from year to year and could have a positive impact if the revised rate setting formula incentivizes nursing facilities to improve the quality of care they provide to residents.

However, stakeholders including providers, union representatives and some legislators are likely to see these strategies as “cuts” to nursing homes. Most components of this strategy were included in the 2019 Governor’s proposal and was met with very strong resistance. Union representatives have expressed concerns that placing a cap on the other operating rate component could suppress wage increases for dietary, housekeeping, laundry, and maintenance workers. Some providers may view the addition of the end of therapy assessment as a loss of revenue due to the inability of providers to bill for therapy services that are not being provided until the next regular assessment is due.

5. Implementation Steps

The Department of Human Services (DHS) will develop draft legislation for the changes to VBR and the additional end of therapy assessment. The legislature will need to enact new law. If passed during the 2021 session, implementation could begin effective January 1, 2022.

If the changes to VBR are enacted, DHS, Division of Nursing Facilities Rates and Policy (NFRP) will need to provide education and outreach to make certain providers are aware of the changes and how the changes may impact their nursing facility

If the requirement for the additional end of therapy assessment is enacted, education and training time will be needed to make certain providers are aware of the new requirement. The MN Department of Health will need to be directly involved in these efforts.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- What is the population and geographic impact?
- What equitable mechanisms are being used in the modification of the rate setting formula?
- How does this strategy impact consider stakeholder engagement?
- How is this strategy impacting wages?
- How will this strategy promote equitable access?
- What accountability measures will be built in the assessment process?

7. Public Comment

- At the March 6, 2020 Commission meeting, Ethan Vogel, Legislative Director for Minnesota AFSCME Council 5, spoke in support of the 2015 VBR legislation and voiced opposition to the Value-Based Reimbursement Strategy in Nursing Facilities (VBR) strategy that the Commission would be discussing. Minnesota AFSCME Council 5 represents 43,000 workers in Minnesota, including from some nursing home facilities. He said savings shouldn’t be found on the back of front-line workers who have

experienced chronic underfunding. He noted that nursing facility rate increases had leveled off and predicted that quality improvement will come. He asked that the strategy not advance, and if it ever were to, that there be protections for the lowest cost workers.

- At the March 6, 2020 Commission meeting, Carrie Kranz from Augustana Health Care Center in Hastings asked for no cuts to long-term care facilities. She said that currently there was not sufficient staffing to meet the needs of the facility where she worked. In addition, she said it was hard to recruit new workers because of the stress of the work given the staffing level challenges. She said her facility was a five-star facility, but was struggling, and asked for no cuts.
- At the March 6, 2020 Commission meeting, Mike Dreyer from United Food and Commercial Workers International Union (UFCW), representing workers in Minnesota and Wisconsin, said that nursing facilities are suffering worse than he had ever seen in terms of staffing. He said that the VBR strategy was a good thing when it was launched. He worried what would happen if cuts were made.
- At the March 6, 2020 Commission meeting, Reverend Doctor Jean Lee spoke in favor of home repair, provision of medical and non-medical devices, First Alert-type systems, service plans involving families and friends, and delivery of the right type of services especially for people who are uninsured. She expressed concern with disparities, and with racism among service providers.
- At the March 6, 2020 Commission meeting, Toby Pearson spoke on behalf of Care Providers of Minnesota. He asked the Commission to remember that nursing home services are an entitlement. He recalled that VBR passed the legislature and with Governor Dayton's support in 2015. He noted that the VBR program in 2020 was just stabilizing. He said his organization was ready to work with the Commission and the Department.
- On March 5, 2020 the LTC union representing nursing home workers submitted a comment letter to the Blue Ribbon Commission encouraging it to "drop consideration of the cuts to nursing home reimbursement rates as proposed in the Value-Based Reimbursement in Nursing Facilities priority strategy."

[Written public comment: LTC Unions, March 6, 2020 \(PDF\)](#)

- The Long Term Care Imperative, a Minnesota Collaboration for Changes in Older Adult Services, submitted a letter of concern regarding this strategy as well as supplemental documentation – see links below.

[Written public comment: Long-Term Care Imperative 1, March 6, 2020 \(PDF\)](#)

[Written public comment: Long-Term Care Imperative 3, March 6, 2020 \(PDF\)](#)

[Written public comment: Long-Term Care Imperative 4, March 6, 2020 \(PDF\)](#)

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-030620-minutes_tcm1053-423682.pdf

Pursue Fraud, Waste, or Abuse Prevention Enhancements

Problem Statement: DHS' ongoing fraud prevention strategy is not identifying all fraud due to resource constraints.

Strategy: Expanding investigatory capacity, strengthening policy framework, and improving internal processes will lead to a higher return on investment in identifying fraud, waste, and abuse.

1. Problem Statement

Nationwide, fraud, waste, and abuse are estimated to comprise 10-25% of healthcare costs. This represents a very high price tag, both financially and in the perception of the integrity and value of our health care system. For example, in 2019 approximately \$12.5 billion in state and federal funds were paid to 240,000 Medicaid providers as part of the Medical Assistance (MA) program, representing enormous exposure for fraud, waste, and abuse.

By continuing to strengthen its overall approach to combating fraud, waste, and abuse, the State of Minnesota has the opportunity to demonstrate a significant return on investment by identifying and recouping overpayments, discouraging aberrant behavior of providers and recipients of public assistance, and instilling the public's trust and confidence in program integrity.

2. Strategy Proposal

This strategy would reduce waste in administrative and service spending in health and human services. By expanding investigatory capacity, strengthening the policy framework, and improving internal process efficiency and effectiveness, the Department will realize higher returns on investment in identifying fraud, waste, and abuse within the public assistance programs under the purview of DHS' Financial Fraud and Abuse Investigations Divisions (FFAID) program. This will create a substantively more difficult environment for aberrant provider and recipient behaviors, and contribute to improvements in overall program integrity of public assistance programs administered by DHS.

The following high-level, initial strategies focus on process improvements designed to optimize program integrity by better preventing and detecting fraud, waste, and abuse. FFAID will continue to collect information to customize recommendations based on DHS experiences to provide meaningful and actionable details.

- **Expansion of Investigatory Capacity.** Pursue incremental expansion of investigatory capacity within the Department's Surveillance and Integrity Review Section (SIRS), focused on Medical Assistance providers, and the Fraud Prevention Investigation (FPI) grants program, focused on supporting county-level recipient investigations. Dedicating resources in these critical areas results in a demonstrated significant return on investment. Expanding these programs shall include appropriate equity considerations, including consideration of how SIRS actions may impact the availability of providers within underserved areas, as well as how to help Tribes benefit from the FPI grant program.

- **Policy Development.** Propose changes to Minnesota statutes that continue to enhance the Department's ability to combat fraud, waste, and abuse. For example, the Governor has proposed an anti-kickback statute modeled on federal statute that also expands restrictions across a wider set of public assistance programs and criminalize provider and recipient kickback. Providing this type of additional tool aides in the State's overall effort for program integrity in the use of public healthcare and childcare funds.
- **Information Sharing, Integration, and Data Reporting.** Ensure all relevant Departmental functions are interconnected and able to collect, share, and report on relevant information efficiently, effectively, and appropriately. Identifying and mitigating organizational stovepipes that are unnecessary to program integrity will increase the effectiveness of fraud, waste, and abuse investigatory activities.
- **Workflow Management.** Ensure all investigatory processes advance through each stage without unnecessary bottlenecks or delays. Develop a decision making framework for promptly identifying and resolving issues as they arise (e.g., reallocating resources and/or streamline processes where unnecessary bottlenecks or avoidable holdups occur). Ensure proper management of performance and productivity in each activity area.
- **Balanced Use of Tools.** Utilize an effective combination of investigatory approaches to combat fraud, waste, and abuse. For example, the Department employs data-analytics, complaint, and tip driven reviews in determining where to deploy investigatory resources. It also conducts both onsite visits and desk audits to maximize the efficiency of investigatory activities.
- **Use of Data Analytics.** Data analytics is an invaluable set of tools and techniques that are critical in identifying fraud, waste, and abuse. DHS will leverage all available data to provide a comprehensive tool for modeling trends and identifying anomalies that may point to possible problems.
- **Return on Investment (ROI).** The Department will continue to refine its methodologies for quantifying the cost and benefit of its initiatives to help inform the allocation of resources. The Department has previously leveraged industry-standard methodologies that include recovery of overpayments, as well as savings derived from suspended or terminated payments to providers. In particular, it will examine how industry has included equity as a component in ROI calculations.
- **Reporting.** The Department will generate data and reports in order to monitor and improve productivity and enhance program integrity. These reports will include both internal operational functions as well as linkages to collections and fiscal impact.

This strategy is expected to save up to \$1 million in the next biennium.

3. Supporting Evidence

By expanding investigatory capacity, strengthening the policy framework, and improving internal process efficiency and effectiveness, the Department will realize higher returns on investment in identifying fraud, waste, and abuse within the public assistance programs under the purview of the FFAID program. This will create a substantively more difficult environment for aberrant provider and recipient behaviors, contribute to improvements, and instilling the public's trust and confidence in program integrity.

Investigations conducted by SIRS and supported by FPI grants yield recoveries which are returned to the General Fund as non-dedicated revenue. A key performance measure for this strategy is the increase in federal and state funds recovered by SIRS and FPI grant supported activities, as well as future costs avoided by suspending or terminating payments, because of the increased investigation capacity included in this proposal. How these

calculated cost savings may be accounted for in budget proposals as a formal offset to appropriations is being assessed by State staff.

Additionally, providers found to have committed significant program violations because of fraudulent or abusive conduct are terminated or suspended from the public program. Recovering funds paid to these providers is very difficult, but by removing them from the program, fraudulent payments are stopped. An increase in program integrity staff will increase the number of fraudulent providers removed from public programs. A well-recognized benefit to program integrity activity is the prevented loss of funds associated with terminating, suspending, and/or withholding payments that were otherwise being paid to providers acting in violation of program requirements.

If enacted, ROI impacts from the SIRS and FPI grants portion of this strategy would be experienced as early as 9 months from the beginning of the fiscal year for which funding was made available, taking into consideration time required to onboard and train investigators, and the subsequent lag time in beginning and completing investigations. The Department will work to ensure its return on investment (ROI) methodology includes an equity component, and will assess industry-standard approaches to incorporating equity.

In accordance with Minnesota Statutes, section 256.983, the FPI grants program has operated on a cost-neutral basis for 30 years. Benefit savings include identified overpayments and recovered funds, as well as monies that are not paid because claims were determined to represent real or potential fraud.

With regard to process improvements, in 2019 the Department undertook a very successful continuous improvement project focused on its Child Care Assistance Program investigations activities. Working across divisions and administrations, the Department has significantly improved the performance of this function. This effort serves as a model for future process improvements envisioned by this strategy.

4. Populations Impacted

Strengthening the State of Minnesota's overall approach to combating fraud, waste, and abuse impacts a variety of populations. Most notably, providers subject to investigatory scrutiny of billing practices to determine fraudulent activities, and recipients and other vulnerable populations who may indirectly benefit from improved program integrity and more effective stewardship of resources allocated for public assistance.

In addition, this strategy supports county governments in Minnesota, who are responsible for carrying out recipient fraud investigations. There are potential, unintended impacts that may occur from halting fraud, waste, and abuse, including the limiting provider options for vulnerable populations in underserved locations across the state. Considering the activities described in this strategy through an equity lens will be instrumental in helping avoid such unintended consequences.

Increased scrutiny may discourage positive collaborative relationships with provider communities if it is not accompanied with an appropriate level of transparency. In addition, providers found to have engaged in fraudulent activities may become ineligible to receive public funds, potentially impacting the availability of MA services in underserved areas or to underserved populations. Finally, recipients found to have engaged in fraudulent activities may become ineligible for some public assistance, increasing their vulnerability. The Department will take deliberate action in the implementation of this strategy to identify and mitigate possible unintended consequences. For the FPI program, equity will be a core consideration of the RFP process, to include aspects of geographic distribution and opportunities for tribal governments.

5. Implementation Steps

Many of the components of this strategy include current activities, with a renewed focus on process improvements aimed at enhancing investigatory efficiency, effectiveness, and contributing to overall improved program integrity.

Incremental expansion of SIRS and FPI activities, and would require increased appropriations, with the intention of realizing a higher returns on investment in identifying fraud, waste, and abuse within the public assistance programs under the purview of the Office of Inspector General's (OIG), Financial Fraud and Abuse Investigation Division (FFAID). Previous expansions have been achieved through budget proposals within the Governor's budget request that have subsequently been accepted and modified by the legislature.

For SIRS, this strategy would add 5 full-time equivalent (FTE) (4 investigators and 1 operations support analyst) staff to DHS' SIRS unit, bringing the total number of investigatory staff to 33 FTEs.

For the FPI program, this strategy would expand state grant funding by \$425,000 per year to provide counties with additional resources to investigate recipient fraud in human services programs. The increased state funding would be matched with federal funds of \$311,000, increasing grant funding for the program by \$736,000 per year. This would increase total grant funding for county fraud investigations to approximately \$4.6 million. The Department currently administers a \$3.9 million (\$2.3 million state funds, \$1.6 million federal funds) annual grant that funds investigator positions in counties and regions covering 86 of Minnesota's 87 counties.

Finally, an anti-kickback statute has been proposed by the Governor for the 2020 legislative session, which would expand restrictions across a greater range of public assistance programs and criminalize provider and recipient kickback.

This strategy will be driven internally by DHS leadership, and substantively informed through collaborations with external stakeholders. Where additional policy or fiscal resources are needed, the Department will make proposals to the Governor for inclusion in future budget requests. The legislature will determine whether to support additional programmatic investment. The strategy reflects an on-going commitment to enhancing program integrity. For the SIRS expansion, the Department assumes that the full return on investment of new investigators takes approximately nine months from the beginning of the fiscal year in which expansion funding is made available. This includes three months for hiring and an additional six months of training and initial investigatory work before a return is anticipated. For the FPI grants expansion, following the receipt of new funds, the Department will invite counties to submit applications for additional grant funding. Generally, new awards are made within approximately six months from the beginning of the fiscal year.

While this strategy does not identify any specific systems impact, it is reasonable to assume that process improvements will include modernization of systems supporting fraud, waste, and abuse investigations. Presently, the Department is developing an RFP for a new case tracking system for SIRS, for which funds were provided during the 2019 legislative session.

This strategy relies heavily on internal process improvements to be directed within current resource allocations. For the SIRS expansion, adding 4 SIRS investigators would cost appropriately \$350,000. The full cost (salary, fringe, and overhead) of each additional investigator FTE is approximately \$88,000. To support this increase in investigatory capacity, one operational support FTE is required, at approximately \$75,000. These costs are offset by federal financial participation (FFP) reimbursement and anticipated recoveries that are returned to the

General Fund. The FPI grants expansion entails a \$425,000 increase in appropriation. This would fund approximately seven additional FPI investigators in counties, assuming an average of \$100,000 in personnel costs per FPI investigator. This average considers that the cost of an FPI investigator varies significantly across the state.

There are potential internal and external implementation challenges. Internally, leadership must establish strong collaborative relationships between programs spanning different administrations and divisions to foster appropriate information sharing and other process improvements. Externally, expansion of investigatory capacity and development of policy is reliant on external action (e.g., legislature). In addition, provider groups may be wary of increased policy requirements/scrutiny. The Department must strive for appropriate levels of transparency and accountability, consistent with the fidelity of its investigatory responsibilities. Within the FPI grants program, successful county fraud investigations are dependent upon county human services workers making fraud referrals to investigators when they see conflicting information or suspect that fraud is occurring. It is also dependent upon having investigator positions filled; turnover in these positions reduces overall benefits derived until the positions can be filled and new staff is trained. Administratively, no burden is anticipated from this expansion. The SFY 2020-21 biennium budget included funds for an additional FTE within the Office of Inspector General to support the administration of the FPI program.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process across each of the high-level strategy enhancements:

- Expansion of Investigatory Capacity: develop equitable standards for Medical Assistance providers, and the Fraud Prevention Investigation (FPI) grants program when supporting county level recipient investigations, including:
 - How does the strategy minimize unintended consequences?
 - How will the strategy develop provisions to ensure accountability among MA providers?
 - What will be the impact on most vulnerable populations if their providers become ineligible, including making provisions to help connect MA recipients with new providers?
 - Will this strategy have any equity implications among tribal governments?
 - How will this strategy identify the geographic impact potentially affected by this strategy, including consideration of all 87 Minnesota counties under the FPI grants program?
 - How will this strategy support county governments during the expansion process, including addressing any unintended consequences?
- Policy Development: establish equity and inclusion impact on proposed changes to Minnesota statutes that enhance the Department's ability to combat fraud, waste, and abuse.
- Information Sharing and Integration: establish equitable mechanisms to ensure all relevant functions are sharing information efficiently and appropriately.
- Workflow Management: embed an equity framework in the decision making framework to advance equitable outcomes.
- Balanced Use of Tools: establish an equity lens in combination with investigatory approaches.
- Use of Data Analytics: utilize equity analysis processes to aid in the development of a comprehensive tool.
- Return on Investment: establish an equity review process to assess impact while continuing to refine methodologies.

- Reporting: Establish provisions to accountability and intentional efforts to promote transparency.

Further considerations across all strategies:

- Follow equitable practices in the collaboration process with external stakeholders.
- Establish on-site training and technical support to improve compliance.
- Embed equitable practices in the recruiting, hiring, and onboarding process of the new staff for OIG and for new FPI investigators at the counties
- Develop training components in cultural competency for counties.
- Establish an equity lens on the Departments return on investment methodology.

7. **Public Comment**

The Commission received the following public comment letters related to fraud, waste and abuse prevention.

[Written public comment: Faye Burnstein 1, Nov. 7, 2019 \(PDF\)](#)

[Written public comment: Faye Burnstein 2, Nov. 7, 2019 \(PDF\)](#)

[Written public comment: Nokomis Health, March 12, 2020 \(PDF\)](#)

8. **Commission Discussion**

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-050820-minutes_tcm1053-432937.pdf

Reduce Low Value Services in Minnesota

Problem Statement: Research estimates that waste in health care accounts for about 25% of total health care spending.

Strategy: Quantify low-value services in Minnesota and develop a statewide campaign to reduce low-value services.

1. Problem Statement

Recent research estimates that waste in health care accounts for about 25 percent of total health care spending. If those estimates hold in Minnesota, Minnesota would be wasting about \$13 billion annually. A considerable portion of this amount is due to the provision of low value services, services that do not add value to patients in particular circumstances and can result in patient harm. Though providers and health insurance carriers are aware of low value care and many have worked to reduce the volume of it, national data suggest we have not made sufficient progress, let alone been successful in identifying the full scope of low value services.

2. Strategy Proposal

This strategy would increase administrative efficiencies and improve program simplification within health and human services public programs. The strategy involves quantifying how often low value services are delivered in MN, how much they cost, and who they impact. Also, part of the strategy is to develop a statewide campaign to reduce low value services and an approach to holding payers and providers accountable for taking action to measurably reduce low value services.

3. Populations Impacted

The provision of low value services has the potential to add significant costs to Minnesota's health care system. These unnecessary costs lead to higher premiums and out of pocket costs for individuals and families, regardless of where they receive their care.

Some providers who have grown accustomed to providing certain services may be reluctant to move away from that approach, even in the face of clear evidence that the service is low-value and endorsement of the concept of low value services by professional organizations. Some patients have grown accustomed to receiving certain services and may be concerned when the service is not being offered / no longer available. Payers and providers may also be reluctant to have accountability mechanisms applied to them. Clinical champions will need to be engaged to help influence cultural elements that contribute to the provision of low-value services, and the State will need to lead efforts in accountability

4. Supporting Evidence

In one state that has implemented a very similar initiative (VA), the collaborative set a target of reducing the incidence of a set of 7 provider-driven low-value services by 25 percent within three years. Depending on the services selected, a similar outcome for Minnesota, even if focused just on existing metrics of low value services,

could result in savings of \$15 million per year or greater. Savings potential could be substantially higher if additional identification of procedure-based low value services took place and methods for their systematic reduction were successfully implemented.

Numerous studies have affirmed that a significant percentage of health care spending is associated with waste, including through the provision of low-value services. A study by RAND in 2016 (https://www.rand.org/pubs/external_publications/EP66620.html) found that spending on a group of 28 low value services totaled nearly \$33M in 2013 among a group of approximately 1.5M people. In Minnesota, a study by the Minnesota Department of Health using the MN APCD found that, in 2014, there were approximately 92,000 encounters associated with low-value imaging, 69,000 instances of low-value screening, and 15,000 instances of low-value pre-operative testing. Total spending on these services was nearly \$54M, with \$9.3M paid by patients as out of pocket expenses.

5. Implementation Steps

The strategy includes four components: 1) estimating the volume of provider-driven low value services for which there is already broad consensus; 2) working with a group of stakeholders and experts to identify additional areas for low value care analysis and publicize results of measurement; 3) working with employers and providers in Minnesota to implement a statewide strategy to reduce the provision of a defined set of low value health care services; and 4) developing coordinated approach to accountability of payers and providers..

MDH would lead the analytic effort to update existing estimates of the volume (# of procedures, cost) of low value services in MN, the selection of additional metrics of low value services, and analysis of that expanded set of metrics, in consultation with individuals and organizations with relevant expertise. MDH would use existing data available in the MN All Payer Claims Database (MN APCD) for this work.

A public/private collaborative that includes, as appropriate, MDH, DHS, MMB, employers, payers, and providers would implement a statewide initiative to reduce low value services. The collaborative would likely include a clinical learning community of providers who would develop best practices, protocols and reporting vehicles for reducing the incidence of low value services; an employer coalition that would explore opportunities to reduce low value services through benefit design, employee education, a commitment to submitting data into the MN APCD for analysis, and identify appropriate accountability mechanisms. MDH could convene this collaborative partnership to lead the effort, or make use of existing collaborative frameworks that have the expertise to take on that role.

The MN legislature would need to authorize the use of the MN APCD beyond 2023 for this effort and authorize funding. Resources would be needed to fund analytic efforts, to support the work of advisory bodies selecting low-value services for analysis and improvement, and to support the efforts of the public/private collaborative in establishing statewide and/or provider-specific targets, developing communications and reporting frameworks or dashboards, and developing clinical best practices and protocols for reducing low value services. . Assuming legislative authority and funding are received in 2021, work could begin in the latter half of that year. This is likely to be a five year effort.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- What is the impact associated with most vulnerable populations?
- How will this strategy identify the full scope of low value services?
- How will this strategy consider cultural implications in its efforts to implement a statewide initiative to reduce low value services?
- What are the possible unintended consequences that this strategy could have?
- What are the programmatic and population impacts?
- Establish an equity analysis to determine the strategies potential impact.
- Establish training tools to broaden cultural competency skills for patient advocates and community members.

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-050820-minutes_tcm1053-432937.pdf

Align State and Federal Health Care Privacy Protections

Problem Statement: The misalignment of Minnesota’s privacy requirements with federal privacy requirements complicates care coordination, increases administrative burden, and can lead to duplicate testing.

Strategy: Modify Minnesota’s privacy requirements to align with federal privacy requirements.

1. Problem Statement

Misalignment of Minnesota privacy requirements and federal privacy requirements complicates care coordination (e.g., patients with complex care needs have to wait longer to be seen by specialists or their care team does not have the necessary information at the time they need it), increases administrative burden and record-keeping requirements (e.g., manual work around processes are needed outside of the normal electronic health record workflow), and can lead to duplicate tests and imaging (e.g., duplicate services are needed due to not having the information needed in a timely fashion resulting in increased burden on patients, increased costs, and slower responses to essential care). Patient care is compromised due to Minnesota’s additional consent requirements.

2. Strategy Proposal

This strategy is aimed at reducing waste in administrative and service spending in health and human service. This strategy proposes to align Minnesota privacy requirements with federal requirements. The Minnesota requirements that would need to be modified include: the Minnesota Health Records Act, the Minnesota Government Data Practices Act, and statutes related to insurance consent. These changes would maintain patient privacy protections while eliminating burdensome requirements for physicians. Currently, Minnesota law requires consent for disclosure of patient information for treatment, payment, and health care operations. Federal law does not require consent for those purposes. This strategy would remove the consent requirement for treatment, payment, and health care operations purposes while maintaining the privacy and security provisions of HIPAA.

Implementing the strategy alone will not fully resolve the need for improved data interoperability across provider systems, but it will significantly improve care coordination, decrease the administrative burden, and reduce duplicative testing.

3. Supporting Evidence

An MDH report, Impacts and Costs of the Minnesota Health Records Act (February 2017) highlighted a number of findings:

- The Minnesota Health Records Act (MHRA) does not adequately support the majority of patients whose preference, as reported by providers, is to share their health information to ensure they receive appropriate care.
- If the consent requirements of the MHRA remain in place, some clarifications to operationalize the current MHRA intentions are needed.

- Education, resources, and legal assistance related to the MHRA are needed by providers, especially providers in smaller practices. Education and resources are also needed by patients.
- Implementing MHRA often requires a manual (work around) process for obtaining patient consent outside of the electronic health record system digital workflow. This implies more resources are needed for implementation of customized systems that are MHRA-compliant.
- It will be difficult for Minnesota to achieve its goals related to coordination of care for complex patients, improved quality of care, and cost savings due to varied interpretations of the consent requirements of MHRA.

The report can be found at: <https://www.leg.state.mn.us/docs/2017/mandated/170396.pdf>.

A National Governor’s Association report, “Getting the Right Information to the Right Health Care Providers at the Right Time: A Road Map for States to Improve Health Information Flow Between Providers” (2016) identified state strategies to address legal barriers, including:

- Fully align state privacy laws with HIPAA
- Partially align state privacy laws with HIPAA
- Create standardized consent forms
- Issue state guidance and education

This report can be found at: <http://gettingtherightinformationtoproviders.cwsit.org/>.

An HIE Study conducted by MDH (2018) recommended draft legislative changes to the Minnesota Health Records Act in attempt to align Minnesota statutes (including the Data Practices Act and Minnesota law for insurance consent purposes). This report, with recommended language in Appendix B, can be found at: <https://www.health.state.mn.us/facilities/ehealth/hie/study/docs/studyreport2018.pdf>.

Since the HIE study recommended draft legislative changes were released, an HIE Task Force of the Minnesota E-Health Advisory Committee has also identified potential additional changes to the Minnesota Health Records Act that may be needed, including review of the patient information service restrictions regarding what organizations can access information through a query of a patient information service. For example, both MDH and payers are prohibited from accessing information through a patient information service, even if they were using the service to obtain information that they are legally authorized to obtain. This additional complexity is burdensome in the system.

4. Populations Impacted

This strategy impacts the total population of Minnesotans. The strategy affects the total population overall; however in terms of state agency impact, the strategy affects those served by the Department of Human Services and Corrections where HIPAA and the Minnesota requirements apply to the specific programs within those agencies. This population includes those most impacted by health disparities. Possible unintended consequences could include that individuals do not fully understand the new policy. There could be information sharing about individuals in ways that are not fully understood by them.

5. Implementation Steps

State law would need to be changed to align Minnesota requirements with HIPAA. Provider organizations, including some state agencies (such as Human Services and Corrections) would need to update their policies and

procedures and any patient notices related to privacy practices. In addition, MDH would need to update resources and materials related to Minnesota privacy laws. This includes a standard consent form and a privacy toolkit specific to Minnesota. Each of these steps would need to be taken immediately upon the effective date of the change in statute. Implementation would require some lead time for preparations, potentially over an estimated 3-6 months.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Would there be any equity implications with the alignment of state and federal health care privacy protections?
- How will this strategy promote system efficiency?
- How will this strategy aid in the alignment of similar statutes?
- How will this strategy impact the most vulnerable, geographic, and racial/ethnic populations?
- How has other statutes that could potentially impact this strategy been considered?
- What will be the impact on patients that do not prefer to share their health information?
- How will this strategy make provisions for accountability?
- This strategy could potentially alleviate care coordination burden for smaller organizations.
- Would there be an option to opt out of record sharing without patient's approval?
- What would be the additional protections for records related to Chemical Health, HIV, etc.?
- Embed equitable practices in the communication of a patient's privacy rights.

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-050820-minutes_tcm1053-432937.pdf

Improve MnCHOICES and LTSS Processes

Problem statement: MnCHOICES and other elements of the LTSS eligibility process can take a long time and be frustrating for enrollees.

Strategy: Work with counties and tribes to streamline the MnCHOICES and overall eligibility process for LTSS by addressing pain points that have been identified in the current process.

1. Problem Statement

The MnCHOICES Assessment is a part of a larger eligibility process for long-term services and supports that is complex and involves many different roles and systems. There are three main pieces of eligibility required for a person to qualify for LTSS:

- Functional eligibility; confirming the person has support needs that meet the criteria for LTSS. MnCHOICES only determines functional eligibility.
- Certified disability determination; a person must be “certified disabled” via Social Security or State Medical Review Team (SMRT)
- Financial eligibility; confirming the person qualifies for medical assistance. County and tribal nation financial units process the required applications to determine financial eligibility.

The process can be complicated for the person being assessed and depending on the agency, could involve multiple staff from different departments completing work before eligibility is determined and services and supports are initiated for the person. There are seven high-level steps associated with the process: receive request for assessment; assign and schedule assessment; conduct assessment; determine eligibility; complete paperwork; close assessment and Community Support Plan (CSP); close Coordinated Services and Support Plan (CSSP).

A common misconception is that MnCHOICES is what holds up the process; however, there are many other steps involved in the eligibility process that cause delays. Examples of these steps include: wait time, ongoing follow-up related to determination of financial eligibility, obtaining necessary medical documentation, and collecting diagnostic information. Therefore, the timeframe from initial request for help to the initiation of services could take several weeks.

Additionally, because the LTSS assessment and eligibility process is delegated to counties and tribal nations, it has been implemented in various ways depending on each individual county’s or tribal nation’s processes. These differences in agency practices create variations in determining eligibility, length of time to complete the processes, and inconsistent experiences for the people asking for help.

2. Strategy Proposal

This strategy will increase administrative efficiencies and improve program simplification for the state, counties, and tribes. As proposed, the DHS would create and implement a process improvement plan with counties and tribal nations across the state building on the LTSS process mapping done in 2019 with selected county

representatives from 11 different agencies which identified approximately 50 steps and 34 pain points (specific problems where there are opportunities for improvement) within the assessment and eligibility process.²² Using these findings, DHS would work with pilot counties to implement changes and streamline the LTSS process across the state. As part of this work, DHS will incorporate feedback from people who have had a MnCHOICES assessment, and work with counties and tribal nations on specific changes to their organizational structure while identifying best practices that can be implemented across similar agencies. The work will also include producing a guide for families and people requesting assessment that provides a clear explanation of the process and spans the assessment and eligibility process.

Upon completion, this project will:

- Improve clarity for people who are requesting LTSS services by improving behind the scenes processes
- Increase the consistency of the LTSS processes across the state
- Ensure equitable access to services
- Streamline the behind the scenes processes by counties and tribal nations and increase their staff capacity

3. Supporting Evidence

DHS engaged in a business process review with one county and found the results to be informative. DHS was able to implement some statewide changes as well as identify key opportunities specific to that agency that if implemented would reduce volume, improve efficiency, and contribute to more equitable services. By conducting this type of review with a broader sample of counties and tribal nations additional process improvements can be identified and applied across the state.

4. Populations Impacted

All people who are in need of Long-Term Services and Supports (LTSS)²³ can request a comprehensive and person-centered MnCHOICES assessment in order to determine need and eligibility. As of January 2018, there were 116,593 Minnesotans receiving LTSS. Of people receiving services, 66% were white and 30% were non-white. Minnesota's overall population was 79.9% white in the same timeframe.

The impact of this project will be to:

- Improve experience for people and families requesting LTSS services
- Increase increasing consistency throughout the state, providing for a more equitable experience for underrepresented populations.
- Increase process improvements, workflow, capacity, and opportunities for cost savings after implementation for counties and tribal nations

²² Of the 34 "pain points" identified, five were specific to MnCHOICES, 11 were attributed to factors outside of the assessment process, and the remaining pain points were related to the general LTSS processes that were present with assessment tools prior to MnCHOICES.

²³ Long-term Services and Supports include nursing facilities or Intermediate Care Facilities for Persons with Developmental Disabilities (ICF-DD), Home and Community Based Services (HCBS) waiver programs, Alternative Care, Consumer Support grants and State Plan Home Care.

- Develop a shared understanding among counties and tribal nations of standards to ensure individuals served understand the process and receive person-centered services, including those in underrepresented populations.
- Reduce state and federal costs for administering the programs from reductions of lead agency reimbursable time to complete LTSS process

The overall impact of this work will vary depending on the findings and the level of change needed. Individual findings to improve processes in an individual lead agency could be made immediately. Complex state systems will take time to analyze and implement and could take several years

5. Implementation Steps

We anticipate the strategy will take approximately one year after legislative approval, and will require the following implementation steps:

- Obtain a qualified vendor to complete process improvement reviews
- Identify and work with a pilot group of counties and tribal nations to analyze assessment and eligibility processes (assumes two days per pilot site)
- Work with Health Care Administration to incorporate financial eligibility process including the SMRT process.
- Identify opportunities for efficiencies and streamlining
- Use identified best practices to develop new statewide requirements/policies/processes
- Use experience and findings from the pilot group to determine if process review should be conducted with all counties and tribal nation

Given the need for county and tribal participation in this strategy, there are some potential challenges to implementation relative to level of interest in changing processes and ability to prioritize this work and implement any identified efficiencies and improvements.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Embed an equity lens throughout the business process review including selecting the vendor and in the recommended improvements.
- The business process reviews will include an equity-based evaluation of the diversity of populations served and the strategies used to ensure equity. The review will include the cultural and linguistic competency of each participating agency and provide recommendations for improvements.
- This strategy promotes service eligibility for individuals regardless of background, race/ethnicity, and geographic location by allowing counties and tribal nations, who know their populations best, to identify opportunities to improve outreach and interaction with underrepresented populations that they serve.
- What process will this strategy take to ensure equitable access to services?
- How will this strategy mitigate unintended consequences?
- How does this strategy improve experiences for underrepresented populations requesting services?
- Considering the variations in county processes, how does this strategy promote service eligibility for individuals regardless of background, race/ethnicity, and geographic location?

- Develop a shared understanding among counties and tribal nations of standards to ensure individuals served understand the process and receive person-centered services.
- How does the strategy consider unconscious bias in the MN CHOICES assessment interviewing process?
- Considering the impact of COVID-19, will this strategy require modifications to MN CHOICES & LTSS process improvement plans?
- Perform an equity analysis in the vendor selection process.

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-060420-minutes_tcm1053-438061.pdf

Improve Dental Access in Public Health Care Programs

Problem Statement: Access to dental care is limited for Medical Assistance and MinnesotaCare enrollees and the current delivery system is administratively complex with low overall reimbursement rates and uneven and disparate rate structures.

Strategy: Contract with a dental administrator to improve access to dental care and implement a new rate methodology which is more equitable across providers.

1. Problem Statement

Access to dental care is limited for Medical Assistance and MinnesotaCare enrollees. Studies performed by DHS in 2014 and 2015 show that due to administrative complexity, overall low reimbursement rates and uneven and disparate rate structures that go to only a small number of providers that are already well beyond capacity to serve additional patients, many dentists, and particularly small clinics in rural areas of the state are discouraged from serving public program enrollees.

Minnesota ranks near the bottom nationally in the percentage of children enrolled in the Medicaid program who are able to receive dental services. More than 60 percent of children in the Medical Assistance program did not see a dentist in 2016 and 2017. Minnesota is currently under a corrective action order from the Center for Medicaid and Medicare Services (CMS) due to substandard dental access rates for children.

Without dental coverage, people access care in the emergency room and are often prescribed prescription drugs to manage pain without resolution of the dental issue. If an enrollee can find a provider that will see them, enrollees in rural areas often have to drive great distances to see those providers, while unable to see a provider within or closer to their community. Likewise, community dental providers are turning away their neighbors and friends who request an appointment because they cannot afford to take them as patients. A comprehensive approach that restructures both the administrative and payment structure for dental services is needed to address the lack of dental care access and restore the ability of enrollees to seek care close to home in the same manner those in their communities who are not on public health care programs do.

The dental providers currently serving Medical Assistance and MinnesotaCare enrollees are at capacity and unable to see all the recipients in need, this is true even for providers who are receiving enhanced rates. Additionally, if a provider sees enrollees in the managed care and fee for service programs, they must navigate anywhere from two to eight different sets of provider enrollment, billing, and other administrative rules and processes, which takes resources away from patient care.

2. Strategy Proposal

This is a strategy to advance health equity across geographies, racial and ethnic groups. The strategy establishes a simpler and more efficient model for purchasing dental benefits through a common administrative structure, updated and simplified payment methodology, and increased provider rates. Implementing a streamlined

structure for dental services will result in increased administrative efficiencies for providers, and improve the consumer experience.

Additionally, this proposal will equalize payment rates by providing a 54 percent rate increase over the current Medical Assistance fee schedule for adult dental services and a 24.4 percent rate increase for children's dental services (children's dental services rates are currently higher than rates for adults). This investment is made possible in part by repurposing both the critical access and rural dental add-on payments for an across-the-board increase that will remove the payment disparities among dental providers across the state.

Administrative simplification combined with an equitable rate structure that pays all dentists the same rates for providing the same services helps to create an environment where dental practices throughout Minnesota, including rural areas, can serve all people in their communities. Making dental care accessible to people in their local communities strengthens those communities by helping to reduce inequities that exist across racial, ethnic, and socio-economic groups. Accessible local dental care also reduces the long distances people on state health care programs currently must travel to receive dental care, if they are fortunate enough to find a provider that will see them.

3. Supporting Evidence

Other state Medicaid programs such as Tennessee, Virginia, and Connecticut (states that were interviewed as part of the 2014 study and connected to Minnesota by CMS) all cited historical issues with dental access before employing similar strategies.

- Tennessee – moved to a common administrator and raised provider rates. Provider participation increased by more than 120 percent and annual dental services utilization by children under 21 enrolled in the Medicaid program increased from 36 percent to 51 percent.
- Virginia – moved to single administrator and increased their fee schedule. The number of participating providers doubled and the percentage of children enrolled in Medicaid receiving dental care annually increased from 29 percent to over 60 percent.
- Connecticut – moved to a single administrator and increased rates. Participation by private practice dentists throughout the state increased and the percentage of children receiving dental services annually increased from 35 percent to nearly 63 percent, transforming their state from one of the lowest performing states to second in the nation.

4. Populations Impacted

This proposal will impact individuals on Medical Assistance and MinnesotaCare seeking access to dental care. It is aimed at increasing access to care. Additionally, this proposal includes program simplification that will reduce administrative burdens on dental providers. Some dental providers however may see decreased reimbursement for providing dental services in instances where the provider was eligible for multiple rate add-ons which, when combined, have a compounding effect.

5. Implementation Steps

DHS must enter into a contract with a dental administrator, amend managed care contracts, complete systems work, adjust rates within the Medicaid Management Information System (MMIS), and communicate changes in process to providers. It will take approximately 12-18 months to enter into the necessary contracts and

smoothly transition administration to the new structure. The expected cost to implement this strategy is approximately \$14 million.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish a mandatory comprehensive benefit plan for all Medicaid and MinnesotaCare recipients that includes full dental benefits.
- How will this strategy improve access to and increase tele-dentistry services to further meet individuals where they are?
- Expansion of dental providers would allow for enrollees to access dental care they need, when and where they need it further reducing disparities in oral health. How will administrative simplification and equitable rate methodology specifically expand MinnesotaCare and Medicaid dental providers and its workforce?
- What are the possible unintended consequences?
- How will this strategy promote oral health equity?
- Will this strategy have any equity implications among tribal governments?
- How will this strategy establish an equitable dental delivery system?
- How does this strategy address social determinants of health as it relates to dental care access?
- How does this strategy consider equity implications of COVID-19 and its impact on dental care access?

7. Public Comment

The Commission did not receive public comment specifically related to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-052120-minutes_tcm1053-434690.pdf

Ensure Equitable Access to Aging and Disability Service Programs

Problem Statement: There is a disparity in the rate that racial and ethnic minorities access services available through home and community-based service (HCBS) waivers when compared to white people accessing the same services.

Strategy: Work with stakeholders to understand assessment process from their perspective and implement systematic changes to address barriers to receiving all HCBS waivers.

1. Problem Statement

Research across home and community-based services (HCBS) show clear differences in patterns of enrollment, service use, and self-reported satisfaction by race/ethnicity. These differences suggest the existence of disparities among people of color and American Indians who are enrolled in HCBS programs.

The HCBS waiver programs, which provide a more robust set of services, are much less diverse than the state plan personal care assistance (PCA) program. In 2018, about 60% of PCA participants were people of color or Native American. In comparison, about 14% of DD waiver participants and 27% of participants in the other three disability waiver programs were people of color or Native American. Understanding why these differences exist is key to understanding whether there are disparities that prevent some people from accessing the full home and community-based service benefit.

Since the formal and informal assessment process is the first doorway to services, further understanding how communities of color and American Indians experience it will inform policy and operational efforts to reduce potential disparities in HCBS programs.

Identifying institutional biases and promising practices to address them will improve the assessment process for many communities. This work will not only explore potential barriers for African Americans, but will also look at barriers that may exist in Minnesota for American Indians communities, Asian American communities, Latinx communities and people who are multiracial. The process of exploring racial/ethnic disparities in the HCBS assessment process will help ensure equitable access for all people with disabilities and older adults

2. Strategy Proposal

This strategy is focused on health equity. DHS is currently engaged in phase one of a multi-phase project to identify racial/ethnic disparity in waiver access with a specific focus on the assessment process. This project will examine institutional biases built into policies and practices and make recommendations to address them. In addition, this project will work to identify and share practices that are successfully addressing disparities. The project's first phase has been funded through Moving Home Minnesota (a federal demonstration project through CMS).

Working with partners at the University of Minnesota and Purdue University, the first phase is focused on setting the stage for the next phases by analyzing DHS assessment data and conducting an inventory of existing research to understand and measure racial/ethnic disparities in the assessment process for HCBS programs. The

findings of the analysis will be reviewed by community stakeholders that are involved in aspects of the assessment process. This includes a review of the findings by an advisory board of community members. The advisory board will target membership from affected communities who have a working knowledge of human services and their specific communities. This feedback will determine the approach for the project's second phase.

This strategy proposes resources and the implementation of the next two phases of the project. The strategy will result in identifying systemic or policy changes that will remove barriers for racial and ethnic minorities to access waiver services. Phase two is focused on working directly with stakeholders using a continuous improvement approach to understand the assessment process from their perspectives. In this phase we plan to:

- Partner with communities and people requesting HCBS services to understand their experiences,
- Partner with lead agencies to systematically review assessment processes with an equity lens, and
- Engage with stakeholders providing HCBS services.

The goal is to partner with community members in development of future work which includes:

- Conduct qualitative research by:
 - Holding focus groups of people of color throughout Minnesota to understand and document their experiences with accessing HCBS services. In order to ensure broad and equitable engagement, participants will be compensated for their time and feedback.
 - Conducting case study evaluations of lead agency assessment processes to understand promising practices and areas for improvement.
- Identify best practices to share and changes to policies and practices that will increase equity throughout the HCBS programs. Recommendations might include changes to current statutes (legislative change), policies, practices and trainings.
- Ensuring communities of color (African-American, American Indian, Asian American, Latinx, people who are multiracial, etc.) are engaged in the process and can see how their feedback is implemented in system, policy or other changes.

The goal of phase three is to embed findings into our work. This will be done by

- Developing systematic measures to examine disparities in the assessment process.
- Developing recommendations that identify potential methods to address disparities.
- Developing a framework/methodology for lead agencies to use to assess racial/ethnic disparities in assessment.

3. Supporting Evidence

More information about LTSS demographics is available on the [LTSS demographic dashboard](#). In addition, Minnesota measures the performance of our HCBS programs, including trends by race/ethnicity on the [LTSS performance measures dashboard](#). This strategy is intended to produce further evidence that inform policies to address disparities.

4. Populations Impacted

This strategy impacts racial and ethnic minorities with a disability or who are older adults who apply for and would otherwise be eligible to receive HCBS waiver services. This includes people who may not be aware that services are available to support their disability specific needs

5. Implementation Steps

Phase one of this project, where DHS is partnering to complete a literature review, forming an advisory board and analyzing assessment data, will be completed December 2020. Phase two, which includes small group community engagement, qualitative feedback and review of lead agency assessment process, should begin shortly after phase one of the project is completed and is anticipated to run from 2021-2022. Phase three, will begin implementing findings from the first two phases into policy and system changes. This is expected to continue implementation of findings post project. (2021-post project)

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Does this strategy consider disaggregated data of disparities and disproportionalities among African Americans, Latinx, American Indians, Asian Americans, and multiracial and ethnic groups with disabilities?
- Does the strategy specifically include racial and ethnic disparities as a result of barriers to accessibility in waiver programs?
- What approach does this strategy use to examine institutional racism?
- How will this strategy specifically address systemic or policy changes to remove barriers experienced among African American, Latinx, Asian American, American Indian, and multiracial groups?
- There is no one size fits all approach as needs vary among racial and ethnic communities. How will this strategy make provisions to ensure equitable outcomes?
- Could the discrepancy between rates result in disparate/adverse impacts?
- Does the strategy consider geographic impact as a potential barrier of accessibility to waiver programs?
- How will this strategy make provisions for accountability among lead agencies?
- How will person-centered thinking be embedded into this strategy?
- How does the strategy plan to engage with community members and provide mentoring?
- How will the strategy hire staff that is representative of the target communities?

7. Public Comment

The Minnesota Consortium for Citizens with Disabilities (MNCCD) submitted a letter of public comment on June 24, 2020 that voiced support for this strategy. See link below.

https://mn.gov/dhs/assets/mnccd-letter-062420_tcm1053-438232.pdf

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-060420-minutes_tcm1053-438061.pdf

Redesign Targeted Case Management to Reduce Disparities in Access to Medical, Behavioral and Social Services or Supports

Problem Statement: There are significant disparities in access to medical, behavioral, and social services based on an individual’s county, race, and ethnicity.

Strategy: Redesign targeted case management services to provide prevention-focused targeted case management services that support targeted populations to access medical and behavioral health care, benefits to meet basic needs, and community-based supports and services.

1. Problem Statement

Minnesota sees disparities in access to medical, behavioral health, and social services or supports. Medical Assistance is a needs-based health insurance program available to adults and children living in poverty. Medical evidence has clearly established the connection between the impacts of poverty and a person’s overall health and wellness. Lack of access to: safe and stable housing; transportation; nutritious and adequate food; childcare; education; and job training opportunities result in poor health outcomes.

The COVID-19 emergency has shown a light on our state’s existing economic and health disparities. The intersection between poverty and a person’s health is undeniable. Medical Assistance has an incredibly generous covered benefit set. Despite that, Minnesota has been shown to have one of the nation’s highest rates of health disparities.

Minnesota also sees disparities in financing of the local safety net. Counties have historically been tasked with ensuring the safety of their residents. For example, counties are responsible for children or vulnerable adults at-risk of or experiencing maltreatment. Similarly, counties are responsible for meeting the mental health treatment needs of all county residents, regardless of the person’s ability to pay. This county function is often referred to as the “local mental health authority.”

The idea of a locally controlled safety net is important in terms of ensuring that resources match the needs of a particular community. However, over the last two decades, in response to strained local budgets, counties and the state has chosen to use Medical Assistance dollars to pay for many of these safety net services. For example, child welfare targeted case managers perform the tasks associated with ensuring the safety of a child who is in an out-of-home placement. A vulnerable adult targeted case manager will perform the tasks associated with obtaining safe housing for a vulnerable adult who had been determined to be a victim of neglect.

While Medical Assistance does provide a source of federal funding that helps to offset county costs, it does not fully fund the activities that counties are responsible for under current state law. Financial data shows that counties spend a significant amount of money addressing the needs of residents who require targeted case management services, but who are not eligible for Medical Assistance.

Further complicating things is the fact that under current state law, counties set their subcontracted vendor rates for targeted case management. This has resulted in significant disparities in the rates paid to targeted case

management providers across the state. Small, rural counties are not able to pay targeted case management rates equal to the rates paid in large, urban counties. In some instances, the rates paid in rural parts of the state are less than half of the rate paid in more urban parts of the state. The disparities in the sub-contracted provider rates is an example of how the current targeted case management rates structure lacks transparency and fairness.

Sub-contracted community-based providers are vital to ensuring culturally specific services. For example, community providers that serve multi-county regions have the capacity to develop and operate programs that are tailored to meet the needs of an immigrant community in which English is not the primary spoken language. The options provided to counties through community-based provider organizations underscores the need to ensure an equitable and transparent subcontractor rate structure.

2. Strategy Proposal

This strategy is aimed at reducing health care disparities. Targeted case management is an evidence-based intervention that bridges the distance between access to public benefits and social services or supports to meet a person's basic needs, and medical and behavioral health treatment, and long-term supports and services. Targeted case managers work with a person and their family, or other identified sources of support, to do four basic things: (1) assess the person's needs and goals; (2) develop a plan and timeline for meeting those needs and goals; (3) make linkages between the person and the referred service or provider; and (4) serve as a source of ongoing support to make sure that the treatment, services, and support continue to meet the person's needs.

Targeted case management can be effective in addressing the connection between poverty and health care. For example, in DHS' community outreach over the past year, we have heard time and time again about how a case manager helped arrange transportation for a person who had "bad hip and bad knees" so that she could get to her medical appointments. Or, how a case manager helped a person apply for public housing. These are examples of how a case manager can address the impacts of poverty and remove a potential barrier to a person's ability to effectively engage in medical or behavioral health treatment, or long-term supports and services.

By exploring ways to expand the populations eligible to receive targeted case management, Minnesota has the opportunity to connect people who have fallen through the cracks of our current system to medically necessary care and social services or supports. We know that poverty is a driver of health disparities. If we are going to reduce health disparities, we must find a way to address the impacts of poverty more effectively. Until we do that, communities of color, Tribal nations, the LGBTQ community, the Veterans community, and other communities will continue to experience significant health disparities.

In addition, by developing a uniform methodology for the rates paid to county subcontracted case management providers, Minnesota will take an important step in addressing the current disparities between rural and urban parts of the state. The state must take the next step, which is to establish a statewide case management rate structure that is transparent and in compliance with federal Medicaid regulations.

The expansion of targeted case management eligibility, and the establishment of a statewide targeted case management rates methodology is a massive undertaking. It will require the development of policy to ensure consistency of services across the state. It will also require monitoring, quality improvement strategies, and outcome measurement to ensure accountability and fidelity to case management principles. DHS has been actively engaged in this work for the past four years. This strategy helps move that work forward.

- 2017:
 - DHS publishes the [Case Management Redesign Background document](#).
 - DHS leadership establishes joint leadership structure (“Leadership Alignment Team”) with Tribal governments and Counties to pursue Case Management Redesign.
 - DHS conducts a day-long public listening session at the Humphrey Institute to gather input from community members and stakeholders on case management. Stakeholder vision statements are available on the [DHS Case Management Redesign website](#).
- 2018:
 - DHS convenes an “Initial Design Team” with representation from the following groups: community members who rely on case management services; community-based subcontracted case management providers; managed care organizations; counties; and DHS policy leads.
 - *Tribal governments and Urban Indian Organizations chose to work in a parallel process to the Initial Design team to develop policy recommendations specific to the American Indian community.
 - DHS convened a Case Management Finance team consisting of Minnesota Association of County Community Services (MACSSA) representatives and DHS staff to document the current state of case management financing across the state and to provide recommendations on case management finance options.
 - DHS hires Navigant, a contractor to help the state understand the current financial state of case management, to conduct a national survey of case management financing structures, and to work with the state and its partners on developing a new statewide rate structure.
 - DHS begins statewide community engagement in partnership with local community organizations. DHS follows the Governor’s Civic Engagement policy in doing this work, and provides a meal and gift cards to participants in community engagement sessions.
- 2019 –
 - The Initial Design Team developed a [Draft Service Design](#) document that provided recommendations for core service requirements for case management. DHS solicited input from the public by posting the Draft Service Design online and conducting online surveys.
 - Navigant conducted a pilot cost survey with selected counties across the state, conducted a cost survey of case management community provider organizations, and began work with counties for a statewide county cost survey.
 - DHS developed a summary of what we have learned so far through our community engagement work. This document has been shared with DHS leadership, County, and Tribal partners, and other stakeholders.
 - The Leadership Alignment Team approved a multi-phase legislative approach. The proposed timeline for legislative action was:
 - **2021** - Meet CMS expectation that payment rates are under the control of the State Medicaid agency by creating mandated rate(s) for contracted providers.
 - Request legislative funding to support: Ongoing financial analysis; development of training requirements across case management services; outcomes work with Minnesota Management and Budget; address specific policy changes as needed.
 - Commit to coming back in 2023 legislative session with full policy and fiscal proposal for all MA-funded case management services and provider types
 - **2023** - DHS would bring forward the full targeted case management redesign proposal.

There are significant implementation challenges inherent in the process of establishing a statewide targeted case management rates structure. Inevitably, some counties will gain and some will lose as we move away from the current rate methodology. However, our communities, the Governor, and the legislature, have made clear that meeting the needs of the people and families experiencing unacceptable health disparities is paramount. A transparent and equitable rate structure is a necessary part of this work. Additionally, the new rates structure and financing mechanisms must obtain CMS approval. CMS has signaled through the publication of a proposed rule that it will require states relying on local government financing of the non-federal Medicaid share to use accounting methods that are not currently required. This change in accounting requirements will require significant state and county resources to implement and operate.

The strategy will mitigate disparities in access to medical and behavioral health treatment, long-term supports and services, and social services or supports by doing the following:

- **Early intervention** - Under the current targeted case management eligibility rules, a person must have already significantly engaged with county human services or medical and behavioral health treatment in order to demonstrate that they qualify for targeted case management. Under this strategy, a person would be eligible based on identified risk factors, as well as the existing bases of eligibility.
- **Clear and consistent service delivery standards** – This strategy relies on the development of a clear and consistent understanding of what targeted case management services are. Right now, the rules for how targeted case management services are delivered differ based on the population served. In some cases, the specialization of each targeted case management service obscures the core obligation of a case manager to ensure that their clients’ basic needs are met. The net result of this siloed and specialized targeted case management model is that there are gaps that too many people fall through.
- **Outcome measurement and quality improvement** – This strategy includes the development of outcome reporting measures and quality improvement processes to ensure accountability and fidelity. DHS must have data that tells us whether people receiving targeted case management services are actually getting the services and support that they need to achieve stability and to move forward in their lives.
- **Financial transparency and fairness** – Right now targeted case management financing is complex and opaque. In order to ensure that resources are being equitably distributed, we must have a rate structure that is clear.

3. Supporting Evidence

DHS developed a report with its recommendations to reduce health disparities among Medicaid and other DHS program participants. It shows results and progress toward the legislative direction to reduce stark differences in health outcomes among the state’s various populations. A section includes results from research on case management and care coordination interventions that could support people with any social risk factors. (See MN DHS Accounting for Social Risk Factors in Minnesota Health Care Program Payments (<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7834-ENG>))

4. Populations Impacted

Targeted case management services can be focused or “targeted” on any MA-eligible population. The goal of this strategy is to make targeted case management services to people earlier and to ensure that targeted case management helps people address the impacts of poverty so that they can more effectively engage in medical, behavioral health, education, or job training.

5. Implementation Steps

As stated above, case management redesign will use a multi-phase approach.

2021-2022

- DHS and its partners will work with Navigant to develop a single statewide subcontractor methodology to ensure ongoing federal Medicaid reimbursement of targeted case management rate(s).
- Establish state law authority for Tribes to deliver vulnerable adult/developmental disability targeted case management services.
- Obtain a commitment from the legislature to fund the development of the expanded targeted case management service model and development of a statewide rates methodology for targeted case management services.
- DHS will continue to do community engagement to hear from the communities about how targeted case management services can best meet their needs and help them reach their goals;
- Further develop and finalize:
 - targeted case management eligibility criteria;
 - uniform definition of what are “targeted case management” activities;
 - staff training protocols and professional qualifications for targeted case managers;
 - provider entity standards; and
 - A statewide targeted case management rate methodology.

2023 - DHS will present to the legislature an expanded targeted case management service structure and a statewide targeted case management rate methodology that is equitable and transparent.

6. Equity Considerations

The equity review raised a number of recommendations and questions for consideration during the implementation process:

- Establish an equity lens in the implementation of this strategy.
- How does this strategy consider continuity of care?
- How will this strategy specifically identify and address gaps in service provisions?
- Establish an equity analysis/criterion in the determination of need under target case management.
- How will this strategy make provision for accountability?
- How will this strategy address quality of care, safe/efficient transitions, timely access/service availability, cultural responsiveness, and person centered practices to promote equitable outcomes?
- How will an equitable rate methodology be established?
- Considering COVID-19 how will this strategy ensure the most vulnerable populations that need/receive targeted case management services have access?

7. Public Comment

The Commission did not receive public comment specific to this strategy.

8. Commission Discussion

Minutes of the Commission meeting during which this multi-part strategy was discussed may be found at the following link: https://mn.gov/dhs/assets/BRC-052120-minutes_tcm1053-434690.pdf

Appendix 6: General Public Comments Received by the Blue Ribbon Commission

- [Written public comment: Unite Us, May 6, 2020](#)
- [Written public comment: Minnesota Leadership Council on Aging, April 15, 2020](#)
- [Written public comment: Rachel Spaulding, March 14, 2020](#)
- [Written public comment: Reuben Moore, March 2020 \(PDF\)](#)
- [Written public comment: Courage Kenny, March 6, 2020 \(PDF\)](#)
- [Written public comment: Long-Term Care Imperative 4, March 6, 2020 \(PDF\)](#)
- [Written public comment: Senator Dibble, Feb. 13, 2020 \(PDF\)](#)
- [Governor's "This is Medicaid" letter - July 30, 2019 \(PDF\)](#)
- [Governor's "Take Action" letter - July 10, 2019 \(PDF\)](#)