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MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

Legislative Report

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

Sept. 24, 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 within the legislation to identify $100 million to be saved within the next biennium,[1] the Commission focused its early discussion of strategies on ideas that would result in those savings without negatively impacting eligibility or access and puts those strategies forward for the Legislature's consideration. In addition to strategies focused on cost savings, the Commission also reviewed strategies included for the Legislature's consideration focused on administrative simplification, reducing waste, and addressing health equity as directed by the Commission's authorizing statute.

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 develop all of its initially 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 retained 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 fully 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.
2. Any Commission strategies selected for implementation should first 1) have design details developed with health equity in mind, and 2) have the health equity considerations identified by the Commission reviewed and addressed.

[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.

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 of systemic inequities and to create pathways out of poverty. Our current systems often trap people in poverty and create unnecessary bureaucracy to get help at high costs 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 include 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 proposes 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
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

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
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 prices. The commission would develop a strategy related to pharmacy pricing, focused on prescription 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 tasked with developing a strategy related to the regulation of pharmacy pricing. It is anticipated that this commission, would effectuate stable or lower spending on prescription drugs by individuals and health plans 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 include 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. Housing Opportunities for People with AIDS (HOPWA) Home and Community Bases Services Settings Rule Appropriation	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.	$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	This strategy is comprised of multiple strategies to reduce utilization of high-cost services in the Medicaid disability waivers. Strategies include: • 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
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 savings in future years.

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
f. Update Value-Based Reimbursement (VBR) in Nursing Facilities	This strategy proposes a significant revision to VBR in nursing facilities to reflect appropriate rates over time and incentivize quality care, 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.	$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 include 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	This strategy includes the following four areas of activity: • 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	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 savings in future years.

4. Strategies Focused on Administrative Efficiencies and Simplification

Based on its initial discussion, the Commission agreed to include the following strategies 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 include 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 and through a Coordinated, Statewide School-Based Oral Health Program	This two-part strategy proposes 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. In addition, the strategy proposes expanding dental access through a coordinated, statewide school-based oral health program.
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 systemic inequities 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 re-awakening to the reality of structural racism. 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 11 additional members appointed by the Governor.[3] Commission members were appointed in September 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 charged the Commission to identify strategies in the final action plan (report) that would enable the legislature to enact future legislation that would 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 draft Final Report by July 2020 for public comment. In its first four meetings, the Commission received an orientation to Minnesota health

[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.

and 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 and the re-deployment of many Department of Health employees, 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 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

In October 2019, 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 ideas from Commission members, state staff, and Bailit Health. In offering strategies, submitters were asked to submit ideas that:

1. possessed a high probability of achieving the aim of the defined focus area that the strategy 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 strategy 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?

[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/

6. Does it create an administrative burden or additional staff costs?
7. What steps are required?
8. What equity considerations are associated with the strategy?

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 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 review[7] – 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

[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.

strategies for further discussion as a Commission became no longer possible. In addition, two strategies were developed but not presented to the Commission due to timing at meetings, and an additional 18 prioritized strategies remain undeveloped.

The Commission was charged with identifying 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 included 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 strategies 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 underserved 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 approximately 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 a culturally 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 strategy: 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.

In addition to applying an equity review to each of the developed strategies, a final equity assessment was conducted. The final equity assessment was completed after public input was reviewed and incorporated into the final report. Two main opportunities and four recommendations were identified during the final equity assessment and included:

Opportunities

1. Community engagement is vital to improving access to services and increasing access to services for more people who need services.
2. Further development of the strategies should address how service access will not only be assessed but also remedied for marginalized communities.

Recommendations

1. Review short and long term efforts in proposed strategies that yield equitable outcomes
2. Track impact of strategies on communities overtime to analyze the community condition
3. Transparency and Accountability: ensure ongoing conversations with the community, and intentional interagency and stakeholder collaboration
4. Lead with race: dismantling racist barriers will lead to improved lives

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, particularly individuals most likely to be impacted by the strategies including individuals who are Black, Indigenous, People of Color (BIPOC).

Through its public website, the Commission aimed to be transparent and open with its approach to meeting its legislative charge and the 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 either at the meeting or via other opportunities to provide feedback on the strategies and the Commission's work generally. 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. The State posted Commission meeting information, meeting notes and presentations to its public website.[10]

[10] The public website includes notes from each Commission meeting, which reflect discussion at the meeting but which not approved by Commission members.

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), the Health Equity Advisory & Leadership Council (HEAL) and Tribal Health Directors. Members from the CECLC and HEAL participated 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. DHS Staff invited organizations routinely participating in Blue Ribbon Commission meetings to attend a webinar in mid-July, which provided an overview of the developed strategies and instructions on how to provide public comment. Approximately 100 individuals participated in this event. 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 Public Health Association (LPH)
13. MACSAA (MN Association 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 Consortium of Citizens with Disabilities
18. Minnesota Health Action Group
19. Minnesota Home Care Association
20. Minnesota Leadership Council on Aging
21. MOHR (MN Organization for Habilitation & Rehabilitation)
22. Patient Advocacy Coalition
23. This is Medicaid
24. Tribal Health Directors

Stakeholder input was requested on the draft version of this Final Report. The Commission received nearly 100 written submissions. A synthesis of this feedback was shared with and discussed by Commission members during their meeting on August 19, 2020. Stakeholder input is included throughout the report. Stakeholder comments on specific strategies are included as part of each strategy included in Appendix 5. A synthesis of general comments received from stakeholders is included as Appendix 6. Public comments may be accessed on the Blue Ribbon Commission's website.

Strategies for Consideration

Of the 24 strategies the Commission fully considered, the Commission included the following 22 strategies for further consideration, not because it necessarily supports or recommends them, but so that legislators may benefit from the policy analysis. 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 Commission meeting notes 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.

- ### Cost Savings Strategies: Health Care

Based on its initial discussion, the Commission agreed to include 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 proposes 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
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

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
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 prices. This commission would develop a strategy related to pharmacy pricing, focused on reducing prescription 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 tasked with developing a strategy related to regulation of pharmacy pricing. It is anticipated that this commission would effectuate stable or lower spending on prescription drugs by individuals and health plans over time.	This strategy has the potential for savings based on future solutions identified in the proposed commission

- **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 include 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. Housing Opportunities for People with AIDS (HOPWA) Home and Community Bases Services Settings Rule Appropriation	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	This strategy is comprised of multiple strategies to reduce utilization of high-cost services in the Medicaid disability waivers. Strategies include: • 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
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

Strategy	Strategy Summary	Potential Scope of Savings in FY22-23 Biennium
		are potential savings in future years.
f. Update Value-Based Reimbursement (VBR) in Nursing Facilities	This strategy proposes a significant revision to VBR in nursing facilities to reflect appropriate rates over time and incentivize quality care, 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.	$1 million to $9,999,999

- **Strategies Focused on Waste, Including Fraud and Program Integrity**

Based on its initial discussion, the Commission agreed to include 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	This strategy includes the following four areas of activity: • 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.

- ## Strategies Focused on Administrative Efficiencies and Simplification

Based on its initial discussion, the Commission agreed to include the following strategies 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.

- ## Strategies Focused on Health Equity

Based on its initial discussion, the Commission agreed to include 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 and through a Coordinated, Statewide School-Based Oral Health Program.	This two-part strategy proposes 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. In addition, the strategy proposes expanding dental access through a coordinated, statewide school-based oral health program.
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 Improvements[11]
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

[11] 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 re-awakening to the reality of structural racism. A concerted effort to truly transform DHS and MDH programs and the health care system and services across Minnesota 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 of systemic inequities and to create pathways out of poverty. Our current systems often trap people in poverty and create unnecessary bureaucracy to get help at high costs 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. Housing Opportunities for People with AIDS (HOPWA) Home and Community Bases Services Settings Rule Appropriation
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 Improvements*[12]

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

6. *Pilot Project Focused on Intensive Care Coordination for High Cost High Need Members*

Health Equity

1. Improve Dental Access in Public Health Care Programs and through a Coordinated, Statewide School-Based Oral Health Program.
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 strategies 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 strategy works for our most vulnerable communities, it works for everyone. The reverse, however, is not true.

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

That use of the review may not be linear. 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 by 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.

Strategy 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 strategy?
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.

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Appendix 5: Strategies Developed and Considered by the Commission

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

For this strategy, the Commission received 33 comments.

- Comments in support of the strategy noted current access issues that might be addressed by this strategy, including access for older adults and particularly older adults in rural areas, as well as individuals with disabilities and low-income populations, individuals with mental illness, and those with vision loss. Others in support commented that the strategy would help individuals with transportation to preventive health care services. One supportive commenter, Mid-Minnesota Legal Aid, expressed

concern that the strategy needs to "complete equity reviews and incorporate robust stakeholder" before moving forward.

- Three professional associations voiced opposition to the strategy. The Minnesota Hospital Association noted that it had opposed a similar proposal in past, adding that involving a new third-party entity would simplify administration, but at the expense of shifting payments from providers to a new vendor. The Minnesota Council on Health Plans noted that health plans already have transportation networks and coordinate rides for members. The Association of Minnesota Counties expressed concerns about how this strategy would be developed given the critical role of counties, and questioned the meaning of a uniform approach with a single administrator.
- Other comments touched upon poor experiences with the current system, including safety concerns, and complaints about current reimbursement levels. Others expressed hope that a redesigned system would improve ridership experience, including reasonable wait times and safe drivers. Several commenters expressed concern that the strategy would inadvertently decrease access to care. Another noted that this strategy could lead to a decrease in socialization in rural counties where volunteer ride service programs are available.
- A number of comments referenced the previous work of the NEMT Advisory Committee, which developed an NEMT proposal in the past. These commenters urged the Commission to examine the work of the Committee in this area.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Arrowhead Area Agency on Aging**	Community organization	Director	Support	Many older adults in rural areas lack access to transportation programs, but a single administrator could result in higher cost down the road. Recommend administration go out for public bid every two years.
2.	**Wellness in the Woods**	Consumer organization	Executive Director	Support	Support.
3.	**Touchstone Mental Health**	Community organization	Executive Director	Support	"as long as it is well coordinated, easy to use and responsive to customers' needs… this seems like a fine approach"
4.	**Catholic Charities of St. Paul and Minneapolis**	Provider organization	Public Policy Manager	Support	Support as way to create better transportation options for older adults, individuals with disabilities and low-income populations, while also reducing costs. "Implementing a uniform approach to NEMT is important to establishing a more consistent, efficient and equitable program."
5.	**Metropolitan Area Agency on Aging**	Community organization	Executive Director	Support	Support, provided that fees paid to drivers cover the cost of services at market rate and are adjusted every two years to keep up with market rates.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
6.	**Minnesota River Area Agency on Aging**	Community organization	Executive Director	Support	This will assist individuals with transportation and staying on top of their health care needs.
7.	**Southeastern Minnesota Area Agency on Aging**	Community organization	Executive Director	Support	Strategy would have positive impact on individuals who experience difficulty with securing rides to medical appointments for preventive health screenings and check-ups.
8.	**Fraser**	Provider organization	Public Policy and Compliance Counsel	Support	"We support the move to a single administrative structure for NEMT services. However, much more detail will be needed in order to evaluate the Commission's recommendation. Stakeholders have spent several years working together on this complicated issue, including through the NEMT advisory committee. The reason that stakeholders have continued to stay at the table so long through the oftentimes contentious conversations is because we all agree on the most important priority -- that any change to the NEMT program must start with the goal of improving quality, safety, and experience for the individuals being served. The existing NEMT statute provides a comprehensive plan for doing this, including the use of a web-based tool for both individuals as well as providers."
9.	**Vision Loss Resources**	Community organization	CEO	Support	Would be beneficial to individuals with vision loss. Would allow people to age in place.
10.	**Riverview Adult Day Services**	Provider organization	RN Manager	Support	Comment appears supportive. "Most of our clients do not have the ability to transport to and from services without community contracted transportation."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
11.	**Mental Health Minnesota**	Community organization	Executive Director	Support	"We are supportive of a single administrative structure for NEMT, as we believe that it will reduce costs of this important service over time. Referenced work of NEMT advisory committee including its recommendation for a Web-based single administrative structure assessment tool.
12.	**Corner Home Medical**	Provider organization	Clinical Director	Support	"This is a needed service since there are many times citizens have issues getting to appointments and having the access to leave their homes. Only concern is the vetting process of the background (of drivers or subcontracted agency)."
13.	**NAMI Minnesota**	Consumer organization	Public Policy Coordinator	Support	"NEMT is an important service for people with mental illnesses. However, a patchwork of NEMT providers across the state has led to significant issues with program integrity, including billing challenges and disqualified drivers moving to another NEMT agency. Developing a single administrative structure will reduce program costs and ensure that all drivers bill appropriately and follow the rules." Encourages the BRC to follow recommendations of NEMT advisory committee from several years ago, and consult with Committee members.
14.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organization	Supervising attorney and staff		"We support expanding access to transportation, which is a critical need for many Minnesotans, especially Minnesotans with disabilities. Whether this strategy expands access likely depends on the details of implementation…Our concern about this proposal highlights the need to complete equity reviews and incorporate robust stakeholder feedback while developing details and before deciding to implement strategies."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**All Trans Software**	Other	Vice President		"look at technology to solve this issue" "The strategy indicates the use of contracted drivers which from my perspective has been the majority of the issue in terms of compliance.… I would avoid bus passes as I've seen it implemented and failed in other states as well as counties in MN."
16.	**CLUES**	Community organization	Senior Manager of Community-Based Mental Health Services		"Reasonable wait times and safe drivers are minimal expectations for this service, and mechanisms to ensure such need to be built into this program redesign." Described several poor experiences with current system, including safety concerns.
17.	**Reverend Dr. Jean Lee**	Individual	NA		Recommended the use of bus cards for greater flexibility.
18.	**Central Minnesota Council on Aging**	Community organization	Executive Director		Transportation is one of the biggest obstacles for older adults who do not drive but want to live at home. An NEMT program is a positive step in ensuing older adults and disabled individuals have access to medical appointments. Recruitment of drivers in rural communities is a challenge.
19.	**DARTS**	Provider organization	President		Strategy needs defined scope to ensure use of costliest ride type does not increase. "DARTS agrees that more access to affordable ride options to medical appointments and for those needing specialized medical transit will improve health for Minnesotans.…To expect one administrator to effectively contract with such varying providers seems unlikely."
20.	**Nicole Noblet**	Individual	NA		Complaints about past drivers due to driver safety and rudeness issues.
21.	**Mount Olivet Day Services**	Provider Organization	Program Director		Complaint about current reimbursement levels. "Our costs for providing transportation for our participants far outweigh the reimbursement."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
22.	**Gillette Children's Specialty Healthcare**	Provider organization	Medical Director		"We ask that any reform of the current NEMT system focus first and foremost on the needs of the children and adults who rely on NEMT to get to and from non-emergency medical service appointments. We recognize that the current system has many areas where improvement is needed." Strategy should focus on the needs of children and adults first.
23.	**Minnesota Consortium for Citizens with Disabilities**	Community organization	Policy Co-Chair		Believe more work needs to be done on proposal to be sure it does not inadvertently decrease access. "We support making NEMT more accessible to people with disabilities, including in rural areas, but we believe more work needs to be done on this proposal to be sure that this proposal will not inadvertently decrease access."
24.	**Minnesota Inter-County Association (MICA)**	Professional association	Executive Director		Submitted general comment letter that touches on NEMT, recalling that, prior to 2009, the State administered nonemergency medical transportation (NEMT) rides throughout the state. "Under the proposed change, it is unclear who will be the single administrator, if that service would go back to the state, and how various regions of the state might be impacted differently."
25.	**Medicaid Services Advisory Committee**	Other	NA		At a February meeting, the Committee offered input, including: Could be an opportunity to ensure there is common training for serving people with particular needs. Could lead to a decrease in socialization in rural counties where volunteer ride service programs are available, such as the Aitkin County Angels program. Consolidation can narrow choice and concerns that one type of service can't meet everyone's needs. Engage local agencies and tribal organizations in decision making.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
26.	**Individual – not identified**	NA	NA		"while this may lower costs, it puts the control in an administrator's hands rather than the person - people should be able to use the transportation that is available to them, when they need it without the bureaucracy of someone controlling the scheduling of those rides."
27.	**PrimeWest Health**	County-based purchasing organization	CEO	Oppose	"Standardized approach to NEMT as envisioned by this strategy is implausible given disparity in resources from county to county. Access to NEMT in rural areas is a challenge that has been best addressed by highly localized solutions. These will be very difficult for a single administrator to replicate across the entire state. Failure to do so will reduce timely access to care, threaten enrollee health, and increase health care costs."
28.	**Minnesota Hospital Association**	Not self-identified (professional association)	CEO	Oppose	"MHA has concerns with the recommendation to implement a uniform administration of non-emergency medical transportation (NEMT). The provider and patient community have opposed this proposal on several different occasions in the past. Involving a new third-party entity in the process would add administrative simplification for the Department of Human Services but would most likely come at the expense of moving payments from providers to this new vendor who would be awarded a DHS contract."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
29.	**Minnesota Council of Health Plans**	Professional association	Director of Research and Health Policy	Oppose	Health plans already have established, robust transportation networks and coordinate rides for their members. Submitted accompanying letter with expanded commentary, excerpt: "Continuing to include NEMT as part of the managed care contracts also provides the state with budget and stability." Encourage further equity review to determine impact on rural communities.
30.	**John Klein**	Individual	NA	Oppose	"This strategy would decrease integration, increase costs, and undermine the effectiveness of local initiatives….A one-size-fits-all model imposed from St. Paul would replace these effective local initiatives, and future innovation, with a cumbersome, inflexible model disconnected from the rest of Medicaid…"
31.	**Association of Minnesota Counties, Local Public Health Association of Minnesota, Minnesota Association of County Social Service Administrators**	Professional association	Executive Director/Director	Oppose	"Counties have serious concerns about how this strategy should be developed as counties play a critical role throughout the state. This strategy needs further analysis as counties raised numerous questions. If well implemented, this strategy would provide statewide consistency…However, there is serious concern about the effect on people trying to navigate the system...What does 'one administrator' mean?...'uniform' may be difficult to achieve…Counties recommend exploring options around efficiencies that do not directly impact clients as a better starting place."
32.	**Amherst Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator		The *This is Medicaid Coalition* neither opposes nor supports; half of coalition said they'd need more information.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
33.	**Interact Center for Visual and Performing Arts**	Individual			"Interact quite literally saved my life. After six months in the hospital treating my brain injury and attendant complications of my TBI I was released. … Because my hospitalization was so protracted i lost my house, marriage, job, and every activity of my pre TBI life. I was completely untethered, and the ensuing depression was completely debilitating…I came into contact with Interact and they invited me [to] come for an experience day. Over the course of the last 9 years they have given meaning and purpose to my life...Interact has profoundly changed my life and i am thriving with my disability being accepted, and encouraged to enrich my life."

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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

In total, the Commission received 15 comments for the strategy.

- Commenters noted that further reductions to DME reimbursement for the Medicaid population would have a devastating impact on providers serving the Medicaid population. Others expressed concern that individuals with disabilities would lose access to specialized medical equipment. Several commenters expressed concern with the potential impact of this strategy on rural communities.
- One commenter noted general support of consistency in payment rates, but felt that this strategy merits additional analysis to ensure it does not limit access to needed DME services. This commenter further requested that an equity lens be applied to this strategy.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Anne St. Martin**	Individual	NA	Oppose	The Commission received a letter in June 2020 from Anne St. Martin who is part of a group 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.
2.	**Midwest Association for Medical Equipment Services and Supplies (MAMES)**	Professional Association	Executive Director	Oppose	MAMES expressed its opposition both in conjunction with the early March Commission meeting and then again as part of the public comment process in July. MAMES stated, in part, in its March 2 letter: "Further reductions to DME reimbursement for the Medicaid population to the items not already reduced to the Medicare fee schedule will devastate all providers who care for the Medicaid population." In its July 30 letter it wrote: "if Minnesota makes additional cuts to DME for items such as enteral nutrition, feeding tubes, medical supplies, etc., DME providers would likely no longer be able to provide the same products and services…" MAMES also noted that any Medicaid savings would likely result in increased spending on long-term care or hospitalization.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
3.	**Minnesota Consortium for Citizens with Disabilities (MNCCD)**	Professional Association	Board Chair, Co-Chair, Co-Chair	Oppose	MNCCD expressed its opposition, both in conjunction with the Commission meeting and then again as part of public comment process, stating in part: "This is likely to result in people with disabilities losing access to needed specialized medical equipment. Most DME is currently reimbursed at the Medicare rate; the items reimbursed above the Medicare rate are specialized supplies that are medically necessary for certain people but may be costly. …We are concerned about the equity impacts of this proposal. Parents shared stories at our town hall about the need for specialized equipment, including how county barriers created unnecessary delays and costs ..."
4.	**Sanford Home Medical Equipment**	Provider Organization	Manager of District Store Operations	Oppose	"Please do not pass this cap on payment rates. We serve medically challenged individuals that require special DME supplies and equipment that allow them to stay in their homes and not be institutionalized. The rates Medicare has set are not feasible and are forcing DME providers to close their doors or not provide to Medicare patients. We do not want that to happen in MN to our most vulnerable patients. Caring for them at home will save millions, so please allow us to stay open… and provide for these patients!"
5.	**APA Medical Equipment Company**	Provider Organization	Owner	Oppose	"Capping rates at the bare bones Medicare rates, for all intents and purposes, discriminates against Medicaid clients…The unintended consequence of this policy will be to, effectively, create a two class system for equipment and supplies. The "haves" will receive the products they choose while the "have-nots" will be forced to accept inferior products. Medicare success at reducing monetary cost is inversely proportional to quality of life cost to their members."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
6.	**Anderson Wheelchair**	Not specified	President	Oppose	"These rates are not sustainable and will cause us to drop several products that are not profitable. These savings to the State of Minnesota will not even be a factor in budget. Doing this during a Pandemic is unbelievable, we are trying to abide by new rules and regulations while still serving our clients. It will be easier to say we no longer can provide these services than to lose money."
7.	**Sanford Health**	Provider Organization	Senior Legislative Affairs Specialist	Oppose	"Only a handful of DME and medical supplies categories are not paid at the same rate for both Medicaid and Medicare. In our rural communities, we are concerned that any further rate decrease could make continuous services in these communities unsustainable for DME suppliers, and further impact the patients that we serve."
8.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Oppose	"We have concerns about this strategy.…This strategy is likely to result in people with disabilities losing access to needed specialized medical equipment and is not necessarily likely to offer savings…. Reducing reimbursement for specialized DME and supplies will have a disproportionate impact on diverse families and individuals that need it to live safely at home."
9.	**Amherst Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator	Oppose	Oppose – no further comment.
10.	**Minnesota Hospital Association**	Not specified	President and CEO	Oppose	"MHA is concerned that durable medical equipment companies, particularly in rural communities, may not have the volume of customers to continue to provide a durable equipment item if the price is arbitrarily set at the Medicare rate."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
11.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organizations	Supervising attorney and staff	Oppose	"We oppose this strategy as a potential cost saving that will compromise essential care. Medicare rates will impede people's access to specialized equipment. For many children and adults with disabilities, the right equipment is necessary for life in the community. This proposal has been presented in the past and rejected because of the impact on access to needed equipment."
12.	**Gillette Children's Specialty Medical Services**	Provider Organization	Medical Director	Oppose	"Capping payment rate for DME and supplies at the Medicare rate doesn't take into account the different populations served under the Medicaid program or the often specialized DME needs of both children and adults with disabilities and complex medical conditions who rely on Medical Assistance.... We worry that this strategy could result in Gillette patients losing access to the DME that they need to live safely at home and in their communities if there are fewer DME providers …"
13.	**Corner Home Medical**	Provider Organization	Clinical Director	Oppose	"People want to be mobile and independent as much as they can. If the state does try to match Medicare Rates, there will be a number of very upset citizens. Their medical supplies that they would receive normally will be decreased, thus not able to have the independent lives they live today. The rental of a medical device includes more than just the device."
14.	**Riverview Adult Day Services**	Provider Organization	RN Manager	Oppose	"Our medical reimbursement often doesn't even cover the cost of staff wages and the cost to operate."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager		"While generally supportive of consistency in payment rates, we feel additional analysis is needed to ensure this strategy would not limit access to needed DME. Doing so with an equity lens also is important to ensure populations, such as the elderly, are not inadvertently impacted, as pricing changes could have negative impacts on clients who already face greater budget restraints."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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 strategy 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Blue Ribbon Commission received 18 comments on this strategy.

- In general, opposition to this strategy revolved around the following issues: 1) concern that this strategy would limit access to specialized DME products for individuals with disabilities and other marginalized

populations, and 2) concern that adoption of this strategy could put some DME providers out of business, particularly in rural areas of the state.

- Several commenters referenced DHS' prior experience in trying to shift incontinence supplies to volume purchasing, noting that this resulted in strong opposition from consumers and a court injunction.
- One commenter expressed concern that this strategy could result in reduced compliance by patients receiving enteral nutrition.
- One commenter noted that patients with disabilities may have more specialized needs that are not well served by volume purchasing supplies, and that the strategy should allow room for exceptions for people with complex needs.
- One commenter noted that the disability community spent considerable time in 2018 and 2019 working with DHS and the legislature to address the impact of volume purchasing on key products. The commenter asked DHS to refer to those stakeholder conversations before making final decisions.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**APA Medical Equipment Company**	Provider Organization	Owner	Oppose	"Volume purchasing would create a one size fits all program that would not take the needs of individual members into account. This would be especially true for incontinence products…DHS was sued during the previous implementation. I would expect, at least with the incontinence program, that a similar lawsuit would be filed again …"
2.	**Sanford Home Medical Equipment**	Provider Organization	Manager of District Store Operations	Oppose	"Please reconsider and do not pass expanding DHS use of volume purchasing of DME and supplies. We need to be able to serve these vulnerable patients in their homes and this is not the answer…Volume purchasing is not the answer and will hinder access of equipment and supplies for patients."
3.	**Minnesota Consortium for Citizens with Disabilities (MNCCD)**	Professional Association	Board members	Oppose	MNCCD submitted two letters of public comment that voiced concerns regarding this strategy, raising concern over equity impacts and noting that "expanding volume purchasing to these items will make it difficult for people with disabilities to access the supplies they need. Volume purchasing has historically reduced the quality and variety of products available, which means that many people cannot access products that work for them."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
4.	**Midwest Association for Medical Equipment Services and Supplies (MAMES)**	Professional Association	Executive Director and others	Oppose	MAMES' Al Newman commented at the March 6, 2020 Commission meeting, stating 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. MAMES also submitted similar comment letters in March and July, stating "In 2017, DHS claimed it would reduce incontinence spending by 35% in a failed volume purchase program for incontinence items. There was consumer opposition and a court injunction against DHS leading to the repeal of the law..."
5.	**Amherst Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator	Oppose	*This is Medicaid Coalition* opposes this strategy. "Could support if it reduces costs without reducing access."
6.	**Anne St. Martin**	Individual	NA	Oppose	The Commission received a letter in June 2020 from Anne St. Martin who is part of a group 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.
7.	**Sanford Health**	Provider organization	Sr. Legislative Affairs Specialist	Oppose	"We are concerned that the volume purchasing of certain DME supplies by DHS will add an extra level of complexity on patients in getting these supplies, and that it will result in losses for DME providers... there is the potential of a loss of care compliance. … Especially for enteral nutrition, used for a chronic digestive condition, this potential loss of care compliance could result in later, more expensive care."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organizations	Supervising attorney and staff	Oppose	"…we have concerns with this proposal. Clients need to be able to get the products that work for them. Our clients have experienced the challenges of incontinence and other products that don't meet their needs and they should have access to appropriate equipment and supplies. Volume purchasing was adopted and later repealed by the legislature. We remain concerned about how this strategy would approach volume purchasing differently from the approach recently rejected by the legislature. We do not support advancing this proposal without robust community input about how to expand volume purchasing in a way that works for people who use the relevant equipment."
9.	**Volunteers of America Minnesota**	Community organization	Vice President Mission Advancement	Oppose	"We have concerns about this strategy. Expanding volume purchasing will make it difficult for people with disabilities and other marginalized communities to access the supplies they need. Volume purchasing has historically reduced the quality and variety of products available, which means that many people cannot access products that work for them."
10.	**Corner Home Medical**	Provider Organization	Clinical Director	Oppose	"Purchasing equipment in bulk does not solve the issue. Do you understand that the Physician, Dietician, Respiratory Therapist, Registered Nurse, Physical therapist actually orders the supplies or devices? You will have more costs, delayed discharges …"
11.	**Minnesota Hospital Association**	Not specified	President and CEO		"There may be potential opportunities for savings here, but they would need to be under very cautious consideration. For example, various wheelchair models and size specifications for children with a disability would likely need to be a carve-out from volume purchasing. More details are needed on this recommendation …"

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
12.	**Gillette Children's Specialty Healthcare**	Provider organization	Medical Director		Concerned that this could result in children and adults with disabilities not having access to the products that meet their individual needs, and for Gillette patients who are already using a product that works best for them or have a relationship with a vendor that best meets their needs. Shared the experience of Amanda Adkins whose son Peter has Spastic Quadriplegic Cerebral Palsy uses a wheelchair, stander, adaptive bicycle, IV pole for his g-tube pump, g-tube pump, nebulizer machine, and baclofen pump.
13.	**Medicaid Services Advisory Committee**	Other	n/a		In a February meeting, the Committee provided input, including: Patients with disabilities may have more specialized needs that are not well served by volume purchasing supplies. Allow room for exceptions for people with complex needs. Patients with disabilities may have more specialized needs that aren't served by volume purchasing.
14.	**Reverend Dr. Jean Lee**	Individual	NA		Noted the purchasing power of the counties, and said it would help to have them undertake volume purchasing. In terms of volume purchasing, Also 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.
15.	**Anderson Wheelchair**	Not specified	Owner		"Sounds like you have no idea of savings 1,000,000 to 10,000,000 do some research"
16.	**Catholic Charities of St. Paul and Minneapolis**	Provider organization	Public Policy Manager		"…we feel additional analysis and an equity review of this strategy is needed to ensure it would not create barriers to accessing needed DME."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
17.	**Fraser**	Provider organization	Public Policy and Compliance Counsel		"The disability community spent considerable time in 2018 and 2019 working with the Department of Human Services and the legislature to address the impact of volume purchasing on key products. Please refer to those stakeholder conversations before making final decisions."
18.	**Riverview Adult Day Services**	Provider organization	RN Manager		"Staff have been known to buy supplies for arts/crafts out of our pockets because of the limited budget. The medical equipment is sometimes donated to the facility such as a wheelchair, walker or cane …"

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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)[13] 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.

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

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.

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

3. Interest in use of the service for populations beyond Medicaid.
4. Deeper community discussion about data sharing hurdles including need to review patient consent notices.
5. 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The State received 30 comments on this strategy. The comments received by the Commission were overwhelmingly supportive with the majority of commenters expressing their support, many of them enthusiastically. Commenters noted the benefits of this strategy, including: better care coordination across systems of care, better coordination with social service agencies and community supports, improved timeliness of communications, and especially improved communication with emergency departments. Several commenters offered additional feedback. One recommended that the State offer training to providers as the alert system is brought online.

The Minnesota Council on Leadership in Aging provided the following resource: *Financing and Funding Minnesota's Long Term Services and Supports, December 2019* and *Needs Assessment of Older Adults in Minnesota's Diverse Communities, April 2019*.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Psychological Association**	Professional Association	Legislative Chair and Federal Advocacy Coordinator	Support	"The Minnesota Psychological Association strongly supports this strategy. Expanding the Encounter Alerting Service (EAS) to more community providers will result in better care coordination across systems of care. Providing more integrated care will reduce overuse and costs. But most importantly, Minnesotans will have more high quality healthcare. Using the EAS does not represent risks to privacy as only basic information about admissions, discharges, and transfers to different levels of care would be communicated. This is an easy way to integrate care when Minnesota has yet to invest in a robust Health Information Exchange that could more fully integrate care."
2.	**Touchstone Health**	Community Organization	Executive Director	Support	"I think this is a great strategy and would love to see this expanded in which we could message back and forth through the portal and not just receive notifications. If there was an ability to have Epic care everywhere portals for community based mental health providers, this could greatly improve care coordination."
3.	**Vision Loss Resources**	Community Organization	President/CEO	Support	"This recommendation would be a great benefit to Minnesotans, of all ages and all disabilities. It would also make care coordination better between all parties."
4.	**Sanford Home Medical Equipment**	Provider Organization	Manager of District Store Operations	Support	"This is a very exciting development and use of existing systems that can impact our services in a positive way."
5.	**Minnesota River Area Agency on Aging**	Community Organization	Executive Director	Support	"Through this service, community-based organizations can efficiently respond to an individual need that will assist them to be successful in avoiding a hospital re-admission."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
6.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Support	"Expanding participation in the Minnesota Encounter Alerting Service (EAS) will reduce costs and improve outcomes for some of the highest risk patients in our state. When someone receives treatment in the emergency department for a mental health crisis, there were likely many missed opportunities to avert the crisis…. NAMI Minnesota supports this effort to increase access to the EAS system in the mental health system and hopes that the Blue Ribbon Commission focuses on efforts to divert people with complex medical needs from expensive and intensive treatment in a hospital."
7.	**DARTS**	President	Provider Organization	Support	"This seems like a good strategy. Does the alerting system rely upon reliable internet and cell phone service? If so, the proposal needs a rollout plan to ensure all are in an area where the technology can be used."
8.	**Metropolitan Area Agency on Aging**	Community organization	Executive Director	Support	"Expansion will promote better coordination of healthcare and social services and other community supports in a timely manner. Informed providers will be able to close gaps in care more efficiently."
9.	**Catholic Charities of St. Paul and Minneapolis**	Provider organization	Public Policy Manager	Support	"We support expanded use of this service to improve care coordination and ask that you include community partners as part of this strategy, within the allowance of HIPAA. Currently when clients of Catholic Charities' aging and disability service programs experience a health event, staff are notified only when health plans send information based on billing systems. This method of informing is inconsistent and can lead to significant delays that prevent staff from helping clients modify and navigate services in a timely way. Expanding use of the Encounter Alerting Service to include community partners would promote better care coordination and outcomes for those we serve."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
10.	**Mental Health Minnesota**	Community organization	Executive Director	Support	"We are supportive of expanded use of this service to improve care coordination, especially the inclusion of community mental health providers in this service."
11.	**Arrowhead Area Agency on Aging**	Community organization	Director	Support	"Better communication will allow for a more timely response to needs; it will be important to have a uniform response protocol, improved health outcomes, cost savings for all."
12.	**Sanford Health**	Provider organization	Sr. Legislative Affairs Specialist	Support	"We support the expansion of the DHS Encounter Alerting Service as a tool for ensuring that care coordination can occur and provide care providers with a holistic understanding of the patient's care needs. By giving providers further understanding of when their patients receive care by others, providers can have a greater understanding of the patient's care needs earlier, and help prevent potentially more expensive later care due to a delay in care for the patient."
13.	**Minnesota Association of Community Health Centers**	Professional association	Director of public policy	Support	"We encourage the Commission to pursue this strategy in order to make it easier for more Minnesota providers to communicate, plan, and coordinate on behalf of their patients to increase positive health outcomes and deliver savings. We also urge the Commission to consider options to prioritize providers that have documented experience providing care to underserved Minnesotans in order to leverage expertise in caring for geographic, racial, and ethnic communities that experience intense health disparities."
14.	**Volunteers of America Minnesota**	Community organization	Vice President Mission Advancement	Support	"We support this strategy. Expansion of the Encounter Alerting Service will allow for better-coordinated services – especially among case managers navigating the complexities of seamless transitions of older adults between providers – as well as provide cost savings, improved health outcomes, and better alignment with federal requirements."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**Minnesota Leadership Council on Aging**	Other	Executive Director	Support	"We support this strategy. Expansion of the Encounter Alerting Service will allow for better-coordinated services – especially among case managers navigating the complexities of seamless transitions of older adults between providers – as well as provide cost savings, improved health outcomes, and better alignment with federal requirements."
16.	**PrimeWest Health**	Other	CEO	Support	"Excellent. This is an essential first step in developing the exchange of health information necessary to support the development and effectiveness of value-based care in Minnesota Health Care Programs and to reduce preventable and unnecessary utilization of costly health care services and resources. Providers engaged in value-based reimbursement should immediately realize the value of such data, if accessed and used in a timely and effective manner."
17.	**Southeastern Minnesota Area Agency on Aging**	Community organization	Executive Director	Support	Supports "concept of expanded notification of admissions, transfers and discharges among care coordinators. The improvements in the structure to this system will help care providers to respond to service needs in a timely manner and reduce the number of hospital re-admissions. We also see the potential benefits for improved coordination among social service agencies and other community supports ..."
18.	**Todd Bergstrom on Behalf of the Long-Term Care Imperative**	Professional Association	Director of Research and Data Analysis, Care Providers of Minnesota	Support	"We strongly support … will allow consumers, providers, and the state agencies to: Better coordinate care, inform case managers of consumer status and accessing of health care, align with federal mandates and rules, allow the state and providers to engage in reforming the payment arrangements made on behalf of Medicaid beneficiaries, create cost savings as well as improve health care outcomes."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**Central Minnesota Council on Aging**	Community organization	Executive Director	Support	"Support the statewide expansion of the Encounter Alerting Services to provide timely notification to case managers that their client has had an incident that requires transitional care planning."
20.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	"support expanding access to the Minnesota Encounter Alert System to include more providers…and also make it possible for health plans to receive alerts to use this information to support member care."
21.	**Minnesota Diverse Elders Coalition**	Community organization	Coordinator	Support	"Expanding the Minnesota Encounter Alerting Service to ensure care coordination and better, timely communication between an Emergency Room, hospital, or long-term care facility should be a high priority for development... This strategy would benefit cultural communities, populations with health disparities, non-English speakers, and people living with Alzheimer's ..."
22.	**Amherst H. Wilder Foundation** (*for the This is Medicaid)*	Community organization	This is Medicaid Coalition Coordinator	Support	"Supportive, but it should include community partners (within allowance of HIPAA) to promote care coordination."
23.	**Touchstone Mental Health**	Provider organization	VP	Support	"Strongly support!"
24.	**Hennepin Health**	Not specified	Interim Chief Medical Officer	Support	"Better care coordination on behalf of patients is of the highest priority, and must be accomplished in order to assure better patient outcomes. We support the development of a smooth Alerting Service platform that works well in hospitals and clinics throughout the state. .."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
25.	**Minnesota Hospital Association**	Professional association	President and CEO	Support	"Expanding the ability to get real-time notification of emergency room visits, hospital admissions, transfers and discharges would enhance our health systems' ability to provide more seamless coordination of care. This recommendation has a cost saving potential and will also enhance the quality of care particularly for low-income Minnesotans who may need a more assertive care coordination approach. It will be important for the state to closely partner with health care systems so that there is data sharing in order for our caregivers to take actions based upon this important data to improve the health of their patients."
26.	**Alzheimer's Association, Minnesota-North Dakota Chapter**	Consumer organization	Manager of State Affairs	Support	"Expanding the Minnesota Encounter Alerting Service to ensure care coordination and more timely communication between an emergency room (ER), hospital, or long-term care facility should be further developed as a policy recommendation either by the BRC or the Legislature."
27.	**Minnesota Medical Association**	Professional association	President	Support	"Having the tools available to manage an individual's entire health status is critical to both improving health outcomes and reducing costs. The MMA strongly supports the Commission's recommendation to expand and improve the utility of the Encounter Alerting Service."
28.	**Riverview Adult Day Services**	Provider organization	RN Manager		"Our ADS is under the umbrella of our hospital and directly more so under Homecare. We often have dual services for ADS clients and can access the EAS under the software that the hospital uses."
29.	**NUWAY**	Provider organization	VP Public Policy		"This is an example of the kind of tools providers need to do the work DHS would like them to do in terms of reaching out to clients, supporting transitions and integrating health … As you consider bringing tools online think about how you can help the end user … this may be through training"

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
30.	**Corner Home Medical**	Provider organization	Clinical Director		"This could be a great resource, yet the medical record systems across Minnesota are different. How would this be accomplished without a HIPAA violation? …I see this as very helpful for people that are addicted to medications and they go to different ERs for their medications. Also would allow multiple providers transparency of their patients."

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 strategy 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received four comments related to this strategy. One private sector commenter who is a vendor in this field submitted a five-page accompanying letter that may be helpful to state staff in case this strategy is pursued.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**HMS**	Not specified (HMS is a TPL vendor)	Director, Government Relations		"Having the ability to identify TPL for members at the point of enrollment and prior authorization offers significant advantages…Coordination of benefits between Medicaid and TRICARE has been suspended for approximately three years. This suspension has resulted in cost shifting by the Federal government onto state Medicaid programs. To offset the state Medicaid expense growth due to increased enrollment, states with HIPP programs may consider the following recommendations, while states without HIPP programs may consider establishing one, or at the least facilitating a COBRA coverage enrollment process for newly Medicaid eligible individuals."
2.	**Touchstone Mental Health**	Community organization	Executive Director		"As long as this didn't cause a confusion among recipients about covered services, delay payments and interfere with care."
3.	**Riverview Adult Day Services**	Provider organization	RN Manager		"I'm not sure about this strategy in how it relates to ADS?"
4.	**Amherst Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator		The *This is Medicaid Coalition* expressed its neutrality on this strategy.

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The State received 23 comments on this strategy.

- Commenters offered general expressions of support, with the Minnesota Association of Community Health Centers also cautioning the State to avoid "unintended consequences for Minnesotans served by MCOs that result in disruptions to coverage, access to providers, and continuity of care" if implementing this strategy.
- Several commenters expressed opposition, with two of those recalling DHS' prior experience with MCO competitive price bidding.
- Other commenters offered feedback on the strategy without taking a specific position, with numerous commenters expressing concern with the potential impact on provider reimbursement rates, and also recalling DHS' prior experience with MCO competitive price bidding. One commenter with constructive input noted that price, quality and access should all be included in the scoring, and that price should not be the only factor.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy	Support	"MNACHC encourages the Commission to pursue and implement this strategy without creating unintended consequences for Minnesotans served by MCOs that result in disruptions to coverage, access to providers, and continuity of care. We encourage the Commission to consider options to contract directly with IHP and ACO organizations in the bidding process to increase competition and continually prioritize the patient and their needs. Further, the Commission should explore requirements and incentives through the competitive bidding process for investment into primary care services, specifically for at-risk communities in underserved communities across geographic, racial, and ethnic barriers..."
2.	**AARP Minnesota**	Consumer organization	Advocacy Director	Support	"AARP supports this strategy."
3.	**SEIU Healthcare Minnesota**	Other	Political Director	Support	"We support this proposal because it allows the public to use our collective power to reduce excessive payments to powerful insurance groups. We supported DHS when they have used this strategy before and it has produced significant savings."
4.	**Vision Loss Resources**	Community organization	President/CEO	Support	"Competitive price bidding has shown to be very effective is managing cost. As a non-profit we working with industry we are often a part of this process and it really works to manage efficiency and cost savings."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**ALTAIR Accountable Care Organization**	Provider organization	CEO		During the Commission's February 6 meeting, George Klauser 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.
6.	**Minnesota Community Care**	Provider organization	CEO		During the Commission's February 6 meeting, Reuben Moore 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 through the competitive bidding process.
7.	**All Trans Software**	Other	Vice President		"Let's not forget the past when a MCO comes in and underbids the contract so it's awarded then pulls out of the contract when it becomes unsustainable for the MCO. Ensure the Bid aligns with the contract being offered."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**NAMI Minnesota**	Consumer organization	Public Policy Coordinator		"…NAMI Minnesota has seen that competitive bidding led to low bids which were paid for by low reimbursement rates to mental health providers and a void in terms of trying out new ideas to reduce costs. It is thus very important to ensure that the reimbursement rates are sufficient to sustain community based mental health programs. Mental Health rates under managed care contracts are extremely low, often below fee-for-services rates and do not cover the cost of providing the treatment or service. If the Blue-Ribbon Commission is committed to finding additional savings through competitive bidding, it is imperative that there are higher standards and a rate floor for mental health treatment that is not below the fee-for-service rate."
9.	**Catholic Charities of St. Paul and Minneapolis**	Provider organization	Public Policy Manager		At face-value, requiring MCO competitive price bidding is a reasonable strategy. However, steps should be taken to ensure that provider rates do not decrease as a result of price bidding, and the state should approach this strategy as setting a floor for MCO rates so that payments do not fall below the fee-for-service rate…It is also worth noting that, in the past, efforts by some organizations to secure a low bid led to their departure from the market shortly after—an act that created a whiplash effect for clients and negatively impacts continuity of care for vulnerable populations. Steps to regulate and protect against such actions should be taken if this strategy is pursued."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
10.	**Mental Health Minnesota**	Community organization	Executive Director		"We understand that this strategy saves money, but want to emphasize the importance of ensuring that provider rates do not decrease as a result of price bidding and that the state look at establishing a 'floor' for rates in MCOs, such as not lower than the fee for service rates."
11.	**Fraser**	Provider organization	Public Policy and Compliance Counsel		"Competitive price bidding, when combined with strategies that maintain sustainable provider rates, may be a reasonable way to save money. However, without safeguards such as a 'floor' for rates in MCOs, this plan could risk setting rates that are too low to cover the cost of services…"
12.	**TakeAction Minnesota**	Community organization	Director of Public Affairs		"…To the extent MCOs are used, we support ensuring they invest in health & do not profit excessively, but the greater value would be in moving away from the MCO model & toward more direct contracting with provider networks, & direct investment in the kind of care coordination we need to address social determinants of health."
13.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy		"We agree that a competitive price bidding process would theoretically help contribute to cost savings, but we are concerned that this approach may increase the risk that a carrier who is awarded the contract might not be able to sustain the Medicaid product at the level at which they bid, particularly for new entrants…Rather than limiting health plans rates year over year while requiring more and more benefits and reporting from Minnesota's nonprofit plans, we support a process that relies on statutorily required, best-value purchasing to advance the state's health and equity goals while still being cognizant of cost.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**Corner Home Medical**	Provider Organization	Clinical Director		"This could be a slippery path if all you are looking for is to decrease cost… Again this has to be carefully Vetted to function successfully. Otherwise you are just passing the cost to the hospitals and the Emergency Rooms."
15.	**Minnesota Hospital Association**	Professional association	President/CEO		"This recommendation calls for a continuation of the competitive price bidding procurement process for the managed care contracts. MHA has historically supported the competitive bidding process as an overall strategy to reduce the cost growth in the Medical Assistance program. However, the description of this recommendation states the base rate limit would reflect a projected decrease in the base rates from the previous year. MHA has significant concerns about this proposal if it reflects a real payment cut versus a cut in the anticipated growth rate of the PMAP payments. DHS should consider asking the health insurers what provider contracts they have in place for the upcoming year prior to awarding them a contract. Once the PMAP contracts have been announced, health care providers are in a situation of being forced to accept the terms of the contracts that are offered to them. In addition, DHS should explore what the health insurers are doing to advance equity rather than solely looking at price as part of the PMAP bidding procurement process."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
16.	**Association of Minnesota Counties, Local Public Health Association of Minnesota, Minnesota Association of County Social Service Administrators**	County associations	Executive Director/Director		"Counties are still feeling the effects of the tumultuous procurement process from five years ago, and the strategy does not include the downside of a bid process. The savings identified in 2016 from MCO bidding ultimately came from counties and providers in the form of lower reimbursement rates. Rural health systems are already fragile and counties have serious concerns about the lack of provider availability…When it comes to purchasing health care, counties strongly urge the state to consider value and develop sound principles that guide the purchase -- rather than price."
17.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organizations	Supervising attorney and staff		"This strategy risks incentivizing MCOs to cut costs by discontinuing some specialized services. This strategy should not be implemented in a way that deprives people of access to services they need."
18.	**Medicaid Services Advisory Committee**	Other	n/a		During a February meeting, the Committee provided input, including: Efficiencies associated with integrated care could be lost if care is siloed. Concern now to balance different considerations. Price, quality, and access should all be included in scoring, price should not be the only factor. Avoid unintended consequences.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**John Klein**	Individual	Retired	Oppose	"Competitive price bidding can be beneficial where it is well-suited to the characteristics of a specific market. Experience has been shown Minnesota Medicaid is not well-suited. Sound rates are better developed through objective actuarial analysis and negotiation, which Minnesota and other states use for most Medicaid programs. DHS's experience with MCO price bidding since 2011 has been a mess…"
20.	**WACOSA**	Provider organization	Executive Director	Oppose	"As a CARF surveyor, I have met with organizations taken over by managed care. This is a money saving strategy only. There is overwhelming agreement in the disability provider community nationwide from the individuals who administer these programs that managed care orgs do not understand the business of serving folks with disabilities…"
21.	**PrimeWest Health**	Other	CEO	Oppose	"'Going to the well too often' seems to apply here. All MCOs experienced significant financial losses on their F&C contracts in 2019…Another price bid that further reduces MCOs' MA/MnCare payment rates will: 1) harm providers most; 2) reduce access to care and provider choice for enrollees; 3) fail to meet Federal actuarial soundness regulations; 4) counter-productively reduce MCOs' capacity to improve quality, population health and cost; 5) raise serious questions of Medicare and the privately insured subsidizing MA/MnCare; and 6) harm future MHCP contract negotiations and procurements.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
22.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator		*This is Medicaid Coalition* is neutral on this strategy. Comments: "The impact for people who access MA through MCOs is unclear." "Should be a no-brainer but need to ensure it doesn't lead to worse care (by dis-incentivizing transformative work). If not managed well, frequent changes by MCOs can create a whiplash effect for clients and negatively affect continuity of care." "Concern about secondary effects of decreasing access to certain services. This should be avoided if this strategy is implemented."
23.	**Riverview Adult Day Services**	Provider organization	RN Manager		"The thing that comes to mind with this strategy is food nutrition services; we contract for meals served in ADS. This is contracted through our hospital nutrition services. We contract our rides through Tri Valley, however we are a small community with limited options for competition in public transport."

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 statues 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 20 comments on this strategy.

- Those in support noted that the strategy would boost the State's ability to negotiate the cost of prescription drugs for enrollees in all public programs, and expand the State's authority to negotiate drug prices for all state agencies.
- Several opposing commenters represented provider organizations, and noted that the strategy lacked evidence and/or would undermine existing processes in place within managed care organizations.
- Several commenters, including NAMI, which provided feedback on the strategy without taking a specific position, advocated for improved ability of consumers to provide input related to the preferred drug list, as well as transparency of the list and process.
- One comment asked the Commission to consider how this strategy might affect 340b rebates and also cautioned against using West Virginia as a model because their data are lagging and are heavily impacted by the opioid epidemic
- The Minnesota Council of Health Plans shared the following publications: Assessment of Report on Impacts of West Virginia Medicaid Prescription Drug Carve-Out, The Menges Group, April 2019, and The Value of Managed Care Organizations and Pharmacy Benefit Managers in Managing the Medicaid Prescription Drug Benefit, The Menges Group, October 2019.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Health Action Group**	Consumer organization	Vice President	Support	"There are several advantages with this strategy, and it should be developed further. It will provide a more uniform benefits for Medicaid beneficiaries (easier to understand and use), better data for State administrators, better formulary management, and significant cost savings. In implementing this strategy, it will be important to be clear about the role of the administrator and ensure that the State/DHS retains decision authority related to the benefit, rather than delegating this to a pharmacy benefit manager…"
2.	**AARP Minnesota**	Consumer organization	State Director	Support	AARP submitted a letter of support in conjunction with the February 3 meeting. "AARP also urges the Commission to include a Uniform Pharmacy Benefit strategy that would allow the state to negotiate the cost of prescription drugs for enrollees on all public programs; and further expanding the State's authority to negotiate drug prices for all state agencies..." AARP also submitted a public comment in July 2020, indicating it "supports this strategy to address the problem of rising pharmacy services cost by reducing profits of PBMs, and increasing transparency into the pricing of prescription drugs."
3.	**Vision Loss Resources**	Community organization	President/CEO	Support	"This would be a great benefit to those using public health care programs pharmacy services. It will save money and it will help people when moving from one plan to another."
4.	**Metropolitan Area Agency on Aging**	Community organization	Executive Director	Support	"Metropolitan Area Agency on Aging supports the recommendation to create a Uniform Pharmacy Benefit, provided there are sufficient processes in place for physicians to appeal medically necessary variation from the approved drug list."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Mental Health Minnesota**	Community organization	Executive Director	Support	"We support this strategy, but there is a need for significant improvement to the ability to provide input related to the preferred drug list, as well as transparency of the list and process. We want it to be as expansive as the Medicaid fee for service formulary."
6.	**SEIU Health Care Minnesota**	Other	Political Director	Support	"Drug companies are a major source of waste in our health care system. We support this modest proposal to use our collective power to restrain their excess profits. We have publicly testified in support of similar proposals before the legislature."
7.	**Arrowhead Area Agency on Aging**	Community organization	Director	Support	"AAAA Supports Benefits: Better health outcomes and a more well-rounded health approach with balanced drug costs. Challenges: no proposed solutions yet Population served: Older Adults struggling to pay for prescriptions, older adults unable to use the internet to 'shop' around, older adults unable to travel distances to purchase pharmaceuticals at a lower cost."
8.	**TakeAction Minnesota**	Community organization	Director of Public Affairs	Support	"We strongly support this effort to leverage the state's purchasing power to get a better deal, cut out middlemen and excess profits, and we hope this will result in an opportunity to eventually allow other purchasers to buy in and benefit as well."
9.	**Southeastern Minnesota Area Agency on Aging**	Community organization	Executive Director	Support	"The Southeastern Minnesota Area Agency on Aging supports strategies that would support balancing drug costs to older adults. This would eliminate the time spent searching for the lowest price and would result in improved health outcomes overall."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
10.	**The Arc Minnesota**	Community organization	Legislative Advocacy Coordinator	Support	"We support this strategy if individuals have a formulary exception process to allow individuals to seek drugs not on the formulary based on medical necessity." Excerpt from accompanying letter: "This would allow for an individual, based on medical necessity, to access drugs not on the formulary."
11.	**Corner Home Medical**	Provider organization	Clinical Director	Support	"great idea if the pharmaceutical companies stay out of this development. There are a number of positive sides to this type of program, I see many patients that the Physician will give them a medication sample and when I visit them in their home they will not have the medication filled because of...cost."
12.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organizations	Supervising attorney and staff	Support	"Legal Aid supports strategies to rein in the cost of prescription drugs. DHS is paying the prescription drug costs for over one million Minnesotans on public health care programs. DHS should leverage the state's purchasing power to decrease spending on prescription drugs to lower the overall cost of public health care."
13.	**Interact Client**	Individual	n/a		"I take many medications that are name brand and expensive, I cannot take generics and I have to get prior authorizations every single year and end up going without for a few months during this process. This is something that needs to change because I need this medication to function at my best."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**NAMI Minnesota**	Consumer organization	Public Policy Coordinator		"NAMI Minnesota supports efforts to carve-out the outpatient pharmacy benefit for Medical Assistance and allow the state to manage this program. However, if Minnesota moves in this direction it will be very important to significantly improve the ability of the public to make comments to the preferred drug lists…Changes in this area will be necessary to ensure that the community has a seat at the table when key decisions are being made on the uniform preferred drug list…"
15.	**Medicaid Services Advisory Committee**	Other	n/a		At a February meeting, the Committee offered input, including: If MCO formularies are more robust, this strategy could have an impact on providers who batch purchase. Consider how the change will affect 340b rebates. Look at continuity of care, don't add to fragmentation. Ensure MA copays are consistently collected. Be cautious when using West Virginia as a model, their data is lagging and is heavily impacted by the opioid epidemic.
16.	**PrimeWest Health**	Other	CEO	Oppose	"The evidence justifies further exploring this strategy, but it does not adequately support proceeding with its implementation given the huge amount of money, risk, and enrollees in play…If the strategy proceeds and the current analysis is inaccurate or incomplete, the projected savings could easily become a multi-million dollar deficit for the State. The stakes involved warrant a more thorough, objective third-party analysis and risk assessment of this strategy and the PDL."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
17.	**Sanford Health**	Provider organization	Senior Legislative Affairs Specialist	Oppose	"We are opposed to this proposal as we do not believe the savings that have been estimated will occur, and will cause administrative and care management issues. We are concerned that this proposal could impact medication adherence, will not provide any further savings due to the current use of the Preferred Drug List by the state's managed care organizations, will cause issues with care management, and will cause a ripple effect of higher priced care in our Medicare and private insurance population in the state."
18.	**John Klein**	Individual	Retired	Oppose	"A strategy of centralizing prescription drugs with DHS would decrease integration, undermine MCO-specific initiatives, and increase costs."
19.	**Minnesota Council of Health Plans**	Professional association	Director of Research and Health Policy	Oppose	"The Council opposes carve outs of services within Minnesota's health care programs. Managed care is most effective when care and utilization management activities extend across all health care services. Prescription drugs are a central component of health care services. Carving them out will remove vital opportunities to coordinate care – resulting in fragmented care and higher costs." The Council shared several resources linked below.
20.	**Amherst Wilder Foundation** *(for the This is Medicaid Coalition)*	Community organization	This is Medicaid - Coalition Coordinator		*This is Medicaid Coalition* is neutral on this strategy. Members stated they needed more information in order to decide where they stand. Comments: "Could support if there is the ability to get drugs not on the formulary if determined to be medically necessary by a doctor." "DHS' track record with its preferred drug list has caused concern for several patient organizations. If they use this tool to make certain specialty medications arbitrarily hard to get, that will hurt patients."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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.[14]

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

[14] 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.[15,16] 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.

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[15] Delaware General Assembly. Interagency Pharmaceuticals Purchasing Study Group. http://legis.delaware.gov/TaskForceDetail?taskForceId=410

[16] 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 16 comments on this strategy. The majority of commenters expressed support for the strategy, noting that it would be beneficial for citizens of the state, particularly older individuals who have difficulty affording prescriptions. Others noted that prescription drugs are a significant health care cost driver and that a council such as that proposed would help improve affordability of medications.

Others offered feedback, appearing to neither outright support or oppose, commenting on issues related to affordability of prescription drugs. Several commenters noted the need for transparency in terms of the Council's meetings and deliberations.

PhRMA shared a publication, *Revisiting the Pharmaceutical Supply Chain*, January 2020.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Metropolitan Area Agency on Aging**	Community Organization	Executive Director	Support	Metropolitan Area Agency on Aging supports Establishment of a Prescription Drug Purchasing Council. (No further comment.)
2.	**Minnesota River Area Agency on Aging**	Community Organization	Executive Director	Support	Supports the Commission's stance in working to lower pharmacy drug costs. "Many older adults are not able to pay for medications that result in further negative outcomes. Through these initiatives, medications will be made to be more easily accessible financially for the most vulnerable population."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
3.	**Mental Health Minnesota**	Community Organization	Executive Director	Support	"We support creation of this Council with emphasis on the need for input from providers and consumers, as well as transparency of the council (meetings/discussions/decisions)."
4.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"The establishment of a Prescription Drug Purchasing Council would provide the necessary oversight and structure to achieve better control of pharmacy pricing and ensure that individuals have access to the medications they need to maintain a healthy lifestyle."
5.	**The Arc of Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	"We support the establishment of a Prescription Drug Purchasing Council because certain drugs people need to stay alive are not always affordable. Many are faced with difficult financial decisions based on the cost of prescription drugs."
6.	**Corner Home Medical**	Provider Organization	Clinical Director	Support	"…could be a big benefit to the people of Minnesota. You would have better medication compliance from the patients, which decreases hospitalizations and ER visits."
7.	**Minnesota Health Action Group**	Consumer	Vice President	Support	"…a strategy worthy of pursuing. The literature shows that this strategy will deliver savings, and the key is providing the necessary statutory authority to achieve the benefits. Several suggestions were offered for successful implementation. 1. Pharmacy benefits are complicated, and it will be key to have a Commission/Council with deep expertise that is truly independent, working on behalf of purchasers (not on behalf of PBMs, consultants, or vendors). 2. Specialty drugs, a significant part of drug spend and trend, should be explicitly included in the authority of the Commission/Council. 3. This strategy challenges the status quo, so it will be important to recognize the implicit challenges and provide the necessary statutory authority for the Commission…"

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**Arrowhead Area Agency on Aging**	Community Organization	Executive Director	Support	AAAA supports. Rx costs are a significant driver of health care cost and long term health outcomes.
9.	**DARTS**	Provider organization	President	Support	"If there is a way to curb pharmaceutical costs without affecting quality, this would be a huge win for the senior community and those of any age."
10.	**John Klein**	Individual	NA	Support	"A strategy of centralizing prescription drugs with DHS would decrease integration, undermine MCO-specific initiatives, and increase costs."
11.	**Vision Loss Resources**	Community organization	President/CEO	Support	"Lowering the cost of Rx prices is on the minds of many older adults with vision loss. The cost of glaucoma drugs or food is often a conversation topic we have with blind and visually impaired clients."
12.	**Biotechnology Innovation Organization**	Professional Association	Senior Director, Health Care Policy	Oppose	"While we believe the State has a distinct interest in ensuring it can achieve volume discounts through negotiation when purchasing prescription drugs, such wide-scale adoption of these bulk purchasing arrangements in state-run health programs is not appropriate because it could have negative effects on a wide range of patients, from teachers to prisons."
13.	**PhRMA**	Professional Association	Senior Director - Public Policy		"PhRMA does not oppose multiple state Medicaid programs coming together to negotiate the purchase of medicines, but PhRMA does oppose bulk purchasing that combines Medicaid purchasing with other non-Medicaid programs as this could jeopardize patient health and extend government price controls."
14.	**AARP MN**	Community Organization	Advocacy Director		"AARP is unclear how this proposal relates to the Affordability Commission as the Commission would have authority to set upper payment limits for all State Agencies."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**Wellness of the Woods**	Consumer organization	Executive Director		"Wellness in the Woods recommends including consumers of mental health services be recruited for a position on the commission."
16.	**Riverview Adult Day Services**	Provider organization	RN Manager		"We have had clients who have had trouble getting some of their meds due to high pharmaceutical costs. We refer them to social services for assistance or advocate through their medical provider for help."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

Establish Prescription Drug Affordability Commission[17]

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.[18] 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

[17] Modeled after Senator Jensen's proposed SF353, the Prescription Drug Affordability Act.

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

month and 3.9 additional physically unhealthy days than their counterparts who did not report challenges with filling a prescription.[19]

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.
- 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 Maryland[20] and Maine [21] in 2019. Internationally, there is substantial evidence that the use of centralized, national

[19] MDH Health Economics Program analysis of 2013 and 2017 Minnesota Health Access Survey data.

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

[21] 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

reimbursement limits, or centralized negotiation with drug manufacturers, results in lower pharmaceutical prices.[22]

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.

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;

[22] 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

- 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the

comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 23 comments on this strategy.

- Those supporting the strategy noted that prescription drug affordability is a perennial issue for the citizens of Minnesota, particularly the elderly and vulnerable.
- Those opposing the strategy expressed concern that such a Council would cap or unilaterally set prices for certain prescription drugs.
- PhRMA shared a publication, *Revisiting the Pharmaceutical Supply Chain*, January 2020.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Health Action Group**	Consumer organization	Vice President	Support	"This strategy is very worthy of pursuing and was also included in the recent Attorney General's Task Force Report. Several implementation suggestions were offered. First, the Commission should set a "boundary" that represents potential price gouging that would trigger review...Second, this strategy is important, because it has the potential to benefit ALL purchasers and improve affordability statewide. Third, in implementing this strategy, it is essential to specify actions that can be taken by the Commission based upon findings (consequences, not merely a report of findings). Finally, MN should consider combining with other states to align purchasers nationally."
2.	**Vision Loss Resources**	Community organization	President/CEO	Support	"Reducing the cost of Rx's for people who need them to maintain and independent lifestyle and avoid hospitalization cannot be overstated."
3.	**Metropolitan Area Agency on Aging**	Community organization	Executive Director	Support	"…support Establishment of a Prescription Drug Affordability Commission and requests that one of the six regional Area Agencies on Aging be seated on the Council to represent older adult consumers. Area Agencies on Aging, in their Senior LinkAge Line role, assist older adults and adults of any age to obtain low and no-cost prescription drugs. Area Agencies on Aging have deep knowledge of the issues consumers face when they are unable to afford their prescription drugs."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
4.	**Minnesota River Area Agency on Aging**	Community organization	Executive Director	Support	"…support the Commission's stance in working to lower pharmacy drug costs. Many older adults are not able to pay for medications that result in further negative outcomes. Through these initiatives, medications will be made to be more easily accessible financially for our most vulnerable…"
5.	**Mental Health Minnesota**	Community organization	Executive Director	Support	"We support creation of this commission with emphasis on the need for input from providers and consumers, as well as transparency of the commission (meetings/discussions/decisions)."
6.	**Arrowhead Area Agency on Aging**	Community organization	Executive Director	Support	"A well represented and diverse in talent Commission could have economic impact on rural Minnesota small pharmacies/communities as well as improved health outcomes...Important to include the voice of aging community members with multiple chronic conditions who utilize a variety of insurance options."
7.	**Arc of Minnesota**	Community organization	Legislative Advocacy Director	Support	"We support this proposal. Eliminating Pharmacy Benefit Managers (PBM) from the process of negotiating the price of prescription drugs will allow the state to eliminate an unnecessary intermediary and reduce the costs to individuals." Excerpt from accompanying letter: "the need for prescription drug affordability has never been greater"
8.	**The Southeastern Minnesota Area Agency on Aging**	Community organization	Executive Director	Support	"…supports the opportunity for older adults and organizations that support them to have a voice in the on-going strategies related to regulating pharmacy pricing. It will be important to include the insight of rural providers to include the unique challenges they face around access and maintaining health outcomes in rural communities."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
9.	**Central Minnesota Council on Aging**	Community organization	Executive Director	Support	"Benefit: Minnesotan's across the state are struggling to afford the prescription drugs they need and all too often have to choose between their health and paying rent or groceries. Challenge: To impact fully and curtail the rising cost of prescriptions, the Commission should set a threshold review of new brand name prescription drugs which enter the market at costs that would greatly impact Minnesotans."
10.	**TakeAction Minnesota**	Community organization	Director of Public Affairs	Support	"…strongly supports the creation of a Prescription Drug Affordability (PDAB) board with the authority to review drugs that pose an affordability challenge to Minnesotans and, where appropriate, set an affordable, fair, and reasonable upper payment limit for purchases and sales of the drug in Minnesota. The COVID-19 crisis has highlighted the need to ensure access to affordable medications, especially when we, through the federal government, have so often heavily subsidized their development."
11.	**SEIU Healthcare Minnesota**	Other/labor union	Political Director	Support	"We strongly support this proposal. Prescription drugs are a public good just like utilities. The Public Utilities Commission gives the public a voice in determining the affordability of the power we need for daily life. This commission would give the public a voice over the affordability of drugs that are even more essential to daily life."
12.	**Living at Home Network**	Community organization	Executive Director	Support	"Support this recommendation. Prescription drug costs are a serious problem that affects most older adults, is growing worse and needs to be turned around."
13.	**Minnesota Leadership Council on Aging**	Community organization	Executive Director	Support	"We support this recommendation. Prescription drug costs are a significant driver of healthcare expense for Minnesota's older adults and the system."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**Volunteers of America**	Community organization	Vice President Mission Advancement	Support	"We support this recommendation. Prescription drug costs are a significant driver of healthcare expense for Minnesota's older adults and the system."
15.	**AARP Minnesota**	Consumer organization	Advocacy Director	Support	"AARP supports this proposal. The skyrocketing costs of prescription drugs are making it difficult for Minnesotans to afford their medications. The Commission will have the authority to set upper payment limits for high-cost prescription medications."
16.	**Corner Home Medical**	Provider organization	Clinical Director	Support	"Again Great Idea and this can work. You need Physician input also."
17.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer organizations	Supervising attorney and staff	Support	"Legal Aid supports strategies to rein in the cost of prescription drugs. DHS is paying the prescription drug costs for over one million Minnesotans on public health care programs. DHS should leverage the state's purchasing power to decrease spending on prescription drugs to lower the overall cost of public health care."
18.	**Minnesota Council of Health Plans**	Professional association	Director of Research and Health Policy		"The Council supports efforts to lower prescription drug costs but believes that before the state considers setting and enforcing reimbursement limits, that there first be increased study on the cost and therapeutic effectiveness of prescription drugs. In addition, this strategy does not address the primary issue with drug prices, which is the list price set by manufacturers. … we suggest that a Commission focus on drugs that have a high wholesale acquisition cost (WAC) price that qualifies as a high cost drug and requires manufacturers to make these drugs available for purchase to pharmacies at the ceiling acquisition price, or lower…"

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**PhRMA**	Professional association	Senior Director, Public Policy	Oppose	"PhRMA respectfully opposes the creation of a Prescription Drug Affordability Commission. Discussions about the affordability of drugs are important, but the intention of such proposals is to cap drug prices. Arbitrarily capping drug prices could lead to a shortage of or limit access to medicines for patients who may need a medicine…"
20.	**Minnesota Chamber of Commerce**	Other	Director, Health Care and Transportation Policy	Oppose	"We share the Commission's goal to lower health care costs by curbing the cost of prescription drugs. However, we do not agree with Commission's recommendation to create a Prescription Drug Affordability Commission. In particular, we are concerned with the fact that the proposal would allow the newly established Prescription Drug Affordability Commission to unilaterally set the price for certain prescription drugs for all non-exempt public and private purchasers in the state…"
21.	**Amherst H. Wilder Foundation** (*for the This is Medicaid Coalition)*	Community organization	This is Medicaid Coalition Coordinator		"*This is Medicaid Coalition* is mostly neutral on this strategy, while 30% are supportive. Comments: "We don't formally have positions on Rx cost-savings proposals like this, but it's still important to acknowledge the importance of exploring innovative paths forward in this arena.'"
22.	**Biotechnology Innovation Organization**	Professional Association	Senior Director, Health Policy		"…the proposal …misses the mark on its stated purpose…this proposal would ultimately establish price controls on pharmaceuticals in the commercial market that are already being held at lower rates when factoring in negotiated rebates. This proposal would do nothing to lower the costs health insurers impose on patients for prescription drugs…"
23.	**John Klein**	Individual	Retired	Comment not specific to strategy	"A strategy of centralizing prescription drugs with DHS would decrease integration, undermine MCO-specific initiatives, and increase costs."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

Housing Opportunities for People with AIDS (HOPWA) Home and Community Bases Services 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 strategy 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The State received six comments on this strategy.

- Comments in support of the strategy noted that the goals of the grants have been achieved.
- The comment in opposition noted that the grants are still needed to fill a funding gap and provide state technical assistance to support organizations to achieve long-term sustainability.
- One comment suggested that a health equity lens be used to evaluate this strategy and the potential impact on BIPOC and LGBTQ communities. Another recommended that the Commission examine a program in Wisconsin. A third comment advocated for an independent state audit of the strategies to

monitor how funds are being distributed, account for savings, and ensure actions are not having negative consequences.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**AARM**	Professional Association	CEO	Support	"ARRM does not have any opposition to discontinuing the grant programs as described."
2.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	"We support this proposal since the original purpose of the grants has been accomplished now."
3.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"We understand the strategies will need further development and suggest the inclusion of community engagement to inform development and health equity lens be used to evaluate all strategies and the potential impact BIPOC and LGBTQ communities. This is important because adult day providers are a key part of the network that support caregivers and help people remain in the community."
4.	**Achieve Services, Inc**	Community Organization	CEO	Oppose	"DWRS Transition Grants are still very much needed. The grant remains an essential component of our transition to a long-term sustainable business model and provides a gap in funding. In addition to the grant dollars, the Transition Grant program also includes technical assistance from DHS to help programs like Achieve develop sustainable business models that do not require additional assistance beyond the life of this 2-year grant program."
5.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid Coalition Coordinator		*This is Medicaid Coalition* is neutral on this strategy.
6.	**John Klein**	n/a	Individual		Recommends that the Commission review and "consider applying" Wisconsin's "Family Care" in Minnesota. The Wisconsin Dept. of Health Services recently announced CMS approval of a 5-year renewal of this nationally recognized program

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 proposed 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 34 comments on this strategy, nearly all in opposition. Comments opposing the strategy noted that it would create additional hardships for providers during a time when finances are already strained due to the impact of COVID-19. Comments indicated that any rate cuts would further strain the workforce, creating additional challenges recruiting and retaining providers and staff. There were many comments that indicated the data used by DHS to inform the strategy were flawed and that there have been repeated requests to re-examine the data. Respondents also noted that providers have little control over absences and the strategy would result in exceptions that would create additional administrative costs. Respondents were concerned about the impact on access and quality of care with further rate reductions and resulting consequences on provider ability to provide services.

Those respondents that provided feedback without specifically supporting or opposing the strategy noted concerns about the impact of cuts on the financial condition of providers and suggested further analysis be performed to assess the financial implications of the strategy. One noted that a health equity lens should be applied to further decisions.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Consortium for Citizens with Disabilities (MNCCD)**	Professional Association	MNCCD Board Chair MNCCD Policy Co-Chair MNCCD Policy Co-Chair	Oppose	Concerned about the impact of a rate reduction on workforce retention and recruitment. "Reductions in the factors in the rate setting formulas, including the Absence and Utilization factor, will make reimbursement rates even tighter and it will be hard for providers to pay adequate wages and benefits to people doing good and innovative work supporting people with disabilities to reach their employment and day enrichment goals." Strategy will "hinder progress" in efforts to improve outcomes for adults with disabilities in their employment and day enrichment goals. Rate cuts on top of Covid-19 impact would pose significant challenges.
2.	**Interact Center for the Visual and Performing Arts**	Provider Organization	Director of Licensing and Recruitment	Oppose	States this strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities." Cites concerns about the analysis used to inform the strategy and indicates that providers have asked DHS on multiple occasions to re-examine the data.
3.	**Nicole Noblet**	n/a	Individual	Oppose	States this strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities."
4.	**Jill Reedy**	n/a	Individual	Oppose	States this strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities." Cites concerns about the analysis used to inform the strategy and indicates that providers have asked DHS on multiple occasions to re-examine the data.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Office of the Ombudsman for Mental Health and Developmental Disabilities**	Other	Regional Ombudsman Supervisor	Oppose	"Any further reductions in payment rates could lead to fewer providers, fewer services and fewer consumers having access to these important opportunities."
6.	**Rock County Opportunities**	Provider Organization	Executive Director	Oppose	"Extremely concerned with this proposal given the impact of the recent pandemic on our ability to provide services. The data cited in the strategy does not include the current reality and our current absence rates. It also does not account for likely absences we will continue to have due to COVID-19 or other disasters. Providers have been asking for updated, more accurate data to be used for a long time. Please gather accurate data before implementing this strategy." States rate cuts will create barriers accessing care because it will hinder efforts to provide services.
7.	**Interact Center for the Visual and Performing Arts**	Other - Adult Day Program	n/a	Oppose	This strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities." Cites concerns about the analysis used to inform the strategy and indicates that providers have asked DHS on multiple occasions to re-examine the data.
8.	**Interact Center for the Visual and Performing Arts**	n/a	Individual services recipient	Oppose	This strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities." Cites concerns about the analysis used to inform the strategy and indicates that providers have asked DHS on multiple occasions to re-examine the data.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
9.	**Minnesota Disability Law Center, Mid-Minnesota Legal Aid, Legal Services Advocacy Project**	Consumer Organizations	Supervising attorney and staff	Oppose	"The current absence factor was enacted legislatively based on concerns raised by day and employment services providers. The current COVID-19 crisis has put extreme pressures on providers of these services, which many people with disabilities choose and enjoy as part of meaningful daily routines. This is a particularly challenging time to reduce rates for these programs."
10.	**Mount Olivet Day Services**	Provider Organization	Program Director	Oppose	"We are struggling to continue to offer services. What we are reimbursed does not cover the cost of staff."
11.	**Interact Center for the Visual and Performing Arts**	n/a	Individual	Oppose	This strategy would cause "further damage to the already fragile infrastructure for day services for Individuals with Disabilities."
12.	**Arrowhead Area Agency on Aging**	Community Organization	Director	Oppose	"Reducing or elimination of rate for unscheduled absences creates financial strain for ADS providers who have to adhere to strict staffing requirements and can't adjust for last minute absences."
13.	**WACOSA**	Provider Organization	Executive Director	Oppose	"Cutting rates by 5% will take our already depleting resources to new lows, providing safety concerns for providers who are still in business to meet the needs of our clientele and their families." Cites concerns over the data used to inform the strategy and indicates that "nonprofit disability service provider organizations have insisted be updated."
14.	**Health Care Plus, Inc.**	Provider Organization	Quality Assurance Director	Oppose	"The absence factor is extremely important in managing our operations/mitigating financial losses due to client transportation issues, last minute cancellations, inclement weather, etc."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Oppose	"This rate change would only further threaten the survivability of an already at-risk community-based service used by thousands of older Minnesotans, individual with disabilities, and their families…. This strategy would likely result in even more closures. This is a valued and cost-effective community-based service that should be enhanced, not cut." Cites equity concerns and implications of strategy
16.	**Minnesota Leadership Council on Aging**	Other - Statewide collaborative	Executive Director	Oppose	"This rate change would only further threaten the survivability of an already at-risk community-based service used by thousands of older Minnesotans, individual with disabilities, and their families…. This strategy would likely result in even more closures. This is a valued and cost-effective community-based service that should be enhanced, not cut."
17.	**Todd Bergstrom on Behalf of the Long-Term Care Imperative / Care Providers of Minnesota**	Professional Association	Director of Research and Data Analysis	Oppose	Suggests that this would lead to cuts to rates to day services providers. "Day services have always been in marginal financial condition so any cut will impact the ability to maintain staff and continue services...If DHS feels strongly that the absence factor is set at an inappropriately high level, then we recommend that they reconfigure the rates using the lower factor but retaining the funds in the rate system so that providers have access to that funding as they attempt to recover from the Covid-19 pandemic impact."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
18.	**Rise**	Provider Organization	President	Oppose	"Implementation of this strategy would further decimate a service sector that is already in crisis, due to the COVID-19 pandemic." Cites concerns about the methodology and data used to inform the strategy and reduced absence factor. "I have participated on the DWRS Advisory Committee for over a decade and worked in partnership with DHS on the rate components. DHS by its own admission does not have sufficient data related to the actual costs for this rate factor. The current factor should remain in place until cost reporting data is available, following delayed implementation in 2021." Does not believe the strategy will achieve cost savings goal and will have a negative impact on quality. Cites limited service provider ability to influence absences and utilization. States rate reductions will further strain the workforce, impeding ability to recruit and retain with competitive wages. Concerned about the impact to meeting state and federal mandates and achieving competitive employment goals. States increased administrative costs to the system from additional rate exception requests.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**Minnesota Organization for Habilitation and Rehabilitation (MOHR)**	Professional Association	President	Oppose	Asserts that the strategy will not achieve the desired effect of reducing costs. "Absence and utilization is a major cost driver for day and employment services and one that providers have little to no control over. " Concerned that a reduction will hamper efforts to improve the workforce crisis and make it difficult for providers to deliver services that meet state and federal mandates and initiatives, e.g., HCBS Final Rule, Olmstead Plan, Employment First. States strategy will result in requests for rate exceptions, leading to increased administrative costs for providers, lead agencies, and DHS to process requests. States strategy would negatively impact beneficiary eligibility and support. "With the destabilizing financial impacts caused by COVID19, this rate cut of approximately 5% would further damage the already fragile infrastructure for employment and life enrichment services for individuals with disabilities." Concerned about the analysis used to inform this strategy and "have asked on multiple occasions to work with DHS to re-examine the data."
20.	**Kevin P. Goodno, representative of MOHR**	Professional Association		Oppose	States this strategy will result in a rate cut for day services of about 5%. "With the current workforce shortage and high staff turnover rates this cut would be destabilizing to the day service component of community-based services for individuals with disabilities." Provides an analysis of the deficiencies with the specific studies DHS used to support reduced rate.
21.	**ARRM**	Professional Association	CEO	Oppose	Indicates that further analysis is needed before making any changes to the absence day factor.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
22.	**MSS**	Provider Organization	President/CEO	Oppose	Indicates that the strategy will not result in the desired effect of reducing health and human services budgetary costs to the level it intends. Adds that strategy will negatively impact retention and recruitment efforts, making it difficult to provide disability services that meet state and federal mandates and initiatives such as the HCBS Final Rule, The Minnesota Olmstead Plan, and Employment First. Notes absence and utilization are major cost drivers for day and employment services, and providers have little to no control over.
23.	**Achieve Services**	Provider Organization	CEO	Oppose	States service providers have little control over absences. Rate cuts, especially during a time "when programs like ours are struggling to survive" will create further financial hardships.
24.	**VINE Faith in Action**	Community Organization	Community Living Coach, VINE Adult Respite Center Director	Oppose	States service providers have little control over absences. "The shortage of people in the work force wanting to do personal cares has effected all the facilities including adult day services (ADS). COVID-19 hit and many small ADS programs went out of business. Currently we can only operate for 3 hours per day, adding more financial stress. Please don't treat outstate Minnesota, the same as the metro!"
25.	**DARTS**	Provider Organization	President	Oppose	Last minute cancellations mean the facility has already purchased most supplies for the day and staff cannot be adjusted down. Costs do not decrease because of absence. Concerned that cost savings from this strategy would result from service providers ceasing to operate, creating access barriers.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
26.	**Unique Adult Day Care Center, LLP**	Provider Organization	President/CEO	Oppose	Expressed opposition to this strategy. Concerned that the strategy would lead to rate cuts causing further financial strain during Covid-19. "Day services have always been in marginal financial condition so any cut will impact the ability to maintain staff and continue services…If DHS feels strongly that the absence factor is set at an inappropriately high level, then we recommend that they reconfigure the rates using the lower factor but retaining the funds in the rate system so that providers have access to that funding as they attempt to recover from the Covid-19 pandemic impact."
27.	**Metropolitan Area Agency on Aging, Inc.**	Community Organization	Executive Director	Oppose	"Reducing the rate for unscheduled absences places providers at risk for unsustainable financial consequences." Encourages adoption of best practices among providers to reduce unscheduled absences with support from state of Minnesota personnel.
28.	**Touchstone Mental Health**	Provider Organization	VP	Oppose	Concerns about financial viability of service providers, especially given the impact of COVID-19.
29.	**Minnesota Board on Aging**	Other - State board	Program Administrator		"Day services operate on the edge and closings can force people into nursing homes."
30.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager		Recommends evaluation using an equity lens. Concerned about financial viability, especially during a time of financial hardship due to COVID-19. "Many Catholic Charities care coordination clients use day services offered by ethnic providers. Reducing payment rates could lead to the closure of already limited day service options, which could result in reduced access to culturally appropriate services and greater inequities."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
31.	**John Klein**	n/a	Individual		Recommends that the Commission review and "consider applying" Wisconsin's "Family Care" in Minnesota. The Wisconsin Dept. of Health Services recently announced CMS approval of a 5-year renewal of this nationally recognized program.
32.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director		Calls for evidence that a cut would not have financial implications for the provider indicating "it is critical to have a full view of how this would impact the financial stability of providers." Encourages adoption of best practices among providers to reduce unscheduled absences.
33.	**Corner Home Medical**	Provider Organization	Clinical Director		"This could be a positive program if vetted correctly."
34.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid - Coalition Coordinator		Cites Coalition comments that expressed concerns that the strategy would "lead to cuts for providers and clients that are already disproportionately impacted by COVID19." Suggests financial impact analysis and nots that these organizations "often provide ethnic services."

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 strategy 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 proposed 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received nine comments on this strategy.

- Comments in support of the strategy noted the importance of the Life Sharing services in promoting individual choice, person-centeredness, and community-based living.
- The opposing comments were concerned about the impact on family foster care provider financial stability if there were rate cuts.
- Commenters who provided feedback without specifically supporting or opposing the strategy raised several questions about the strategy and urged the evaluation of the strategy using a health equity lens and targeting resources to providers of color to meet the needs of children of color receiving foster care services.
- Several commenters requested additional clarity on the rate methodology, citing concerns about financial stability, and the timing of rate changes.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Consortium for Citizens with Disabilities (MNCCD)**	Professional Association	MNCCD Board Chair MNCCD Policy Co-Chair MNCCD Policy Co-Chair	Support and Oppose[23]	"Strong support for new Life Sharing service indicating that it will lead to better community-based living and person-centered services for adults with disabilities." "We do not have enough information about how the rate change component of this strategy will impact people with disabilities living in family foster care and the availability of such settings. We would be concerned about decreased access or ability for providers to offer appropriate community-based services."

[23] Commenter supports one or more aspects of the strategy, and opposes one or more other aspects of the strategy.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
2.	**Lutheran Social Service of Minnesota**	Provider Organization	Senior Director of Advocacy	Support and Oppose	Concerns regarding the clarity of proposed changes to the rate methodology and how it will improve access to high quality, adequate support, but supports the promotion of Life Sharing.
3.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	Supports a transition to a tiered rate structure based on individual needs as this "will best support that model that provides more individual choice to the user of services. "The Arc Minnesota is also strongly supportive of increasing individual choice in family foster care. The Life Sharing model is a promising option… The transition to a tiered rate structure should include funding to incentivize use of the Life Sharing model, robust planning processes to support true informed choice, and technical assistance for both individuals with disabilities and those who support them, when choosing this option."
4.	**ARRM**	Professional Association	CEO	Oppose	Expressed concern "about the stability of family foster care providers with the rate increases expected in 2020 to be over 20% yet the following years, given this strategy, that rate would be reduced significantly."
5.	**Partnerships for Permanence**	Provider Organization	Founder		"Foster care services as a whole should be redesigned to better accommodate a disproportionate amount of children of color housed in shelters, group homes, and family homes etc. A focus on recruitment of families of color to help meet the cultural needs of our children is vital, when considering which agencies are receiving the service rates under disability waivers. A more robust criteria that includes better staff training in cultural competency, communication, and needs assessments are just a few steps to help children receive better care within wraparound services. The Life Sharing services must help each child address their whole lives. More targeted resources for providers of color is critically needed."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
6.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"Criteria needs to consider the sometimes-different presentations of physical and mental health needs by communities of color, indigenous communities, and those with limited English proficiency. A health equity lens should be used."
7.	**Mid-Minnesota Legal Aid; Minnesota Disability Law Center (MDLC); Legal Services Advocacy Project (LSAP)**	Consumer Organizations	Various - Supervising Attorneys, Staff Attorneys, Litigation Director		Raises several questions and notes concerns about the strategy, most of which relate to potential access issues if rate cuts lead to closures. The organizations also raise a question about whether the Department has "information about satisfaction and quality of care from the client perspective in family foster care compared to corporate foster care."
8.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid - Coalition Coordinator		*This is Medicaid Coalition* is largely neutral on this strategy, with 25% of members supportive. Comments: "Support increased life sharing, but have some concerns about the changed rate."
10.	**John Klein**	n/a	Individual		Recommends that the commission review and "consider applying" Wisconsin's "Family Care" in Minnesota. The Wisconsin Dept. of Health Services recently announced CMS approval of a 5-year renewal of this nationally recognized program

MINNESOTA
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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.

Public Comment

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid that follows the descriptions of the three parts of the strategy. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

In total, the State received 20 comments on the Curb Residential Costs in Disability Waivers strategy.

- Comments in support noted the importance of promoting choice for individuals and supporting continuity in services before and after a move and the potential for cost savings to the state. They opposed the notion of reducing statewide capacity when people move given the already limited housing options for many individuals. One respondent also expressed concern with the corporate residential billing framework as it may produce losses for providers.
- Comments in support of the strategy noted support for a new initiative and robust screening process to promote independence and choice. Two supporting comments indicated that moving / service planning assistance is integral to the strategy.
- Comments in opposition expressed concerns about lack of housing options and noted the strategy could result in increased homelessness or institutional care. Additional comments in opposition indicated the need for further analysis of the strategy, citing that it was not fully vetted by the Commission and urging that an equity lens be used to assess the strategy.
- Commenters who provided feedback without specifically supporting or opposing the strategy noted that more input and data are needed to evaluate the impact. One asserted that a comprehensive approach is needed to support individuals after a move. One respondent recommended expansion of the Transition Coordinator role in the Moving Home Minnesota program to provide support before and after a move and ensure continuity of services.

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?

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 strategy 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?

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:

3. Identifying and designating a transition coordinator at the county level to support a person's move; and
4. Coordination with DHS Housing programs to ensure the success of a person's move.
5. **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.

6. **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.

7. **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.

8. **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?

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	Supports a new initiative to assist people who want to move out of licensed services, indicating that it would build on already successful programs like the Housing Access Services/Housing Access Coordination (Housing Stabilization Services) that have helped thousands move to unlicensed housing with support services in place. Supports "a more robust process to screen people to avoid corporate foster care that involves reforming the CDCS Budget Methodology to provide more funding and having DHS work with other state agencies to expand the supply of affordable accessible housing." "Individuals' ability to leave corporate foster care is very limited now. Case managers frequently do not have the technical expertise to assist people in finding unlicensed housing that is affordable and accessible. Waiver budgets may decrease significantly if someone leaves corporate foster care, and many people who experience challenges with finding support staff are forced to move back into more restrictive, congregate settings." Suggests steps that DHS can take to support development and implementation of a new process, including reforming the budget methodology for the consumer-directed supports option; increasing cross-agency collaboration around affordable housing goals and changes to billing requirements.
2.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid Coalition Coordinator	Support	*This is Medicaid Coalition* is mostly supportive of this strategy. Comments: Coalition Member "Lutheran Social Services supports strategies one and two, but opposes three." "Hard to assess impact. Need to examine with equity lens. If access to these units is reduced, homelessness may be a consequence."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
3.	**Minnesota Consortium for Citizens with Disabilities (MNCCD)**	Professional Association	MNCCD Board Chair MNCCD Policy Co-Chair MNCCD Policy Co-Chair	Support	Indicates that the strategy promotes independence and choice and urges the State to take "swift and transformative action to ensure that all people who want to live on their own have access to the opportunity to do so." Notes that support planning should be a "key driver" of strategy overall. Cautions that bed closures and rate reform should not decrease access to residential settings / services.
4.	**Mental Health Minnesota**	Community Organization	Executive Director	Support and Oppose[24]	"Supportive of ensuring choice in where a person lives, and are interested in the development of a new initiative to help people move and ensure their success in their new home. However, we also believe that it is essential that the customized living/residential services that support people's mental health and well-being continue to have the support they need to serve those who prefer to live in those settings. We are, however, opposed to the suggestion that this strategy would include a reduction of statewide capacity after people move. At a time when more and more people are experiencing homelessness and any live with serious mental illness or other chronic health conditions, it would be a mistake to reduce HCBS residential capacity."

[24] Commenter supports one or more aspects of the strategy, and opposes one or more other aspects of the strategy.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Office of the Ombudsman for Mental Health and Developmental Disabilities**	Other	Regional Ombudsman Supervisor	Support and Oppose	"This proposal seems to indicate that once a person moves out of an Adult Foster Care or Customized Living, that bed may be eliminated which is, at best, a zero-sum game and, at worst, a loss in statewide capacity that would discourage some service providers, counties, and/or guardians from exploring independent setting options." Supports efforts to assist individuals wanting more independent living arrangements, citing the benefit to the individual and the increased capacity in Adult Foster Home or Customized Living beds. "Significant cost savings would result from getting individuals out of hospitals and other expensive institutional settings."
6.	**Lutheran Social Service of Minnesota**	Provider Organization	Senior Director of Advocacy	Support and Oppose	Supports the development of a new initiative to assist people who indicate that they want to move but has "concerns regarding the statement to 'then reduce statewide capacity available after people move.'" It is critical to ensure that reducing home and community-based residential capacity does not lead to exacerbating housing instability when there is a significant shortage of accessible and affordable housing across Minnesota. Concerned with strategy to "align corporate residential billing with the rate framework" suggesting that the strategy "may create losses for providers when individuals are absent for more than 15 days a year. Providers should have the ability to bill for every day that the individual receives services."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
7.	**Mid-Minnesota Legal Aid; Minnesota Disability Law Center (MDLC); Legal Services Advocacy Project (LSAP)**	Consumer Organizations	Various - Supervising Attorneys, Staff Attorneys, Litigation Director	Support and Oppose	Support expanding planning services to promote independent living, asserting that "Expanding access to independent living is not only important for choice and agency of people with disabilities, but it will likely also result in significant cost savings." "With regard to other components of this strategy, we urge that any transitioning of existing corporate foster care settings not result in closure of facilities that prevents people with disabilities from accessing housing."
8.	**Touchstone Mental Health**	Community Organization	Executive Director		Concerned about destabilizing "the already fractured supportive housing system in Minnesota" and notes that many individuals "already experience homelessness because of a shortage of supportive housing." Urges more public input and data to assess for negative impact.
9.	**N/A**	N/A	N/A		Indicates confusion about strategy and Identifies services already in place for people who want to move, including Housing Stabilization Services and Housing Access Coordination. States funds would be better used for "figuring out a way to offer more housing that meets people's needs is a better use of funds."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
10.	**Center for Healthy Aging and Innovation (University of Minnesota School of Public Health)**	Other	Research Coordinator		Regarding the "new initiative to assist people who want to move": identifies the additional needed supports for individuals moving out of residential care and the long-term follow-up required to avoid future costs. Recommends expansion of the role of Transition Coordinator (Moving Home Minnesota) with additional resources to include health needs assessment before and after move, ensuring access to needed level of supports and continued monitoring of unmet needs over time. Regarding the "more stringent guidelines for people not yet in corporate foster care...": states criteria must take into account sometimes different presentations of physical and mental health needs by communities of color, indigenous and those with limited English proficiency, adding more information is needed on these guidelines.
11.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"More attention is needed toward a comprehensive approach of assessing needs and long-term follow-up beyond immediate move from residential care."
12.	**Touchstone Mental Health**	Provider Organization	VP	Oppose	Concerned about lack of transparency, proper vetting and analysis. "Limiting these services would only result in significant difficulties including increased homelessness, increased mental health experiences, increased hospitalizations and ER visits, and overall decreased health and wellbeing of people living with disabilities and in poverty."
13.	**ARRM**	Professional Association	CEO	Oppose	"Oppose aligning corporate residential billing with framework rates" due to concerns of placing providers at "financial risk for people who stay under 351 days in their residence." Urges more data before making changes. "Capping the # of “appropriate” units in the calculation of customized living rates for CADI and BI runs counter to person-centeredness and choice."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Oppose	Opposes a “reduction in statewide capacity” when people with mental illnesses are homeless or discharged to the streets. "Seeking additional costs cuts in this area, particularly when the providers are reacting to new tiered standards, may create unexpected problems and may leave people without the options that will work best for them."
15.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Oppose	"The complexity of this issue requires additional analysis and equity considerations to determine its impact and inform a recommendation on this strategy." Raises concerns about lack of access to housing options and HCBS residential capacity that could lead to homelessness, noting "a significant increase in older Minnesotans becoming homeless, many of whom have serious mental illnesses and chronic health conditions."
16.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Oppose	Identifies the need for additional vetting of strategy, suggesting that "limiting services will make access difficult." In addition, “more stringent guidelines” consider sometimes-different presentations of physical and mental health needs by communities of color, indigenous people, and those with limited English proficiency. Additional discussion on how more stringent guidelines will be developed, by whom, and how they will address equity concerns is needed."
17.	**Todd Bergstrom on Behalf of the Long-Term Care Imperative**	Professional Association	Director of Research and Data Analysis	Oppose	Identifies the need for additional vetting of strategy, suggesting that "limiting services will make access difficult." In addition, “more stringent guidelines” consider sometimes-different presentations of physical and mental health needs by communities of color, indigenous people, and those with limited English proficiency. Additional discussion on how more stringent guidelines will be developed, by whom, and how they will address equity concerns is needed."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
18.	**Minnesota Leadership Council on Aging**	Other	Executive Director	Oppose	Identifies the need for additional vetting of strategy, suggesting that "limiting services will make access difficult." In addition, “more stringent guidelines” consider sometimes-different presentations of physical and mental health needs by communities of color, indigenous people, and those with limited English proficiency. Additional discussion on how more stringent guidelines will be developed, by whom, and how they will address equity concerns is needed."
19.	**Long Term Care Imperative (Care Providers of Minnesota and LeadingAge Minnesota)**		n/a	Oppose	Concerns with strategy, specifically "Guidelines to Access Customized Living Services" and the likelihood of unintended consequence of "forcing some individuals into more expensive nursing home settings where their care needs can be met, particularly in rural parts of the state where there are fewer overall care options." Reminds that "individuals go through person centered assessments to arrive at their payment rates, and unlike disability waivers, the individuals have a cap on rates."
20.	**John Klein**	n/a	Individual		Recommends that the Commission review and “consider applying” Wisconsin’s “Family Care” in Minnesota. The Wisconsin Dept. of Health Services recently announced CMS approval of a 5-year renewal of this nationally recognized program

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Require Medicare Enhanced Home Care Benefit

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 strategy 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

YEAR	2022	2023	2024	2025
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)
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 include 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 27 comments on this strategy.

- Comments in support of the strategy noted that the strategy would expand access to services and opportunities that promote independence, individual choice, and community-based living, allowing people to age in place. Supporters also commented on the potential for cost savings from avoiding or delaying institutional care.
- The opposing comment expressed concern that the strategy offers an untested approach that will result in increased premiums.
- A number of the additional comments that were received, which did not specifically support or oppose the strategy, indicated that the strategy would promote independence and choice and could

result in savings to the State. Yet some expressed concern about the cost implications of adding benefits and urged additional discussion and analysis to ensure premiums would remain stable for members and that rates will cover the costs of providing services.

- One commenter encouraged the Commission to explore existing programs that enable people to age in place, specifically PACE.
- The Minnesota Council on Leadership in Aging provided the following resource: *Financing and Funding Minnesota's Long Term Services and Supports, December 2019* and *Needs Assessment of Older Adults in Minnesota's Diverse Communities, April 2019*.
- The Alzheimer's Association noted its support during the 2020 legislative session for legislation that would expand covered services under Minnesota's Essential Community Supports Program to add respite care to the list of covered services and urges further development of this proposal.
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	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	Describes the strategy as "transformational" and indicates that it promotes independence and community-based living with support.
2.	**Minnesota River Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	Points to the benefit of allowing for choice in how individuals would like to receive services as they age in place. "With additional non-medical services in play, community-based organizations can offer more services to serve the older adult populations to assist them in being successful in remaining in their own homes."
3.	**Arrowhead Area Agency on Aging**	Community Organization	Director	Support	"Expands opportunities for individual choice in how people age in place."
4.	**AARP Minnesota**	Consumer Organization	Advocacy Director	Support	"By providing benefits such as care coordination chore services; and home-delivered meals, many Minnesotans can delay or prevent the need for costly nursing home services often paid for by Medical Assistance. More attention must be paid to what supports will be provided for low-income Minnesotans who may not be able to afford any additional costs to the premiums."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Support	Believes this will increase utilization of home care services and "require Medigap plans to include adult day benefits." Suggests that this will result in savings to the State. "Allowing people to age and receive care at home helps them to remain active in their community and is also cost-effective for the state."
6.	**Minnesota Leadership Council on Aging**	Other – statewide collaborative	Executive Director	Support	Believes this will increase utilization of home care services and "require Medigap plans to include adult day benefits." Suggests that this will result in savings to the state. "Allowing people to age and receive care at home helps them to remain active in their community and is also cost-effective for the state."
7.	**Living at Home Network**	Community Organization	Executive Director	Support	"It has potential for savings in future years and will help older adults stay living at home."
8.	**Care Providers of Minnesota**	Professional Association	Director of Research and Data Analysis	Support	"The strategy offers an avenue for a set of services to be provided and, over the next 30 years, create savings to the state's Medicaid budget."
9.	**TakeAction Minnesota**	Community Organization	Director of Public Affairs	Support	Indicates that the strategy will enable seniors to live in their communities and age in place. Advocates for increasing access to services that promote aging in place.
10.	**O'Leary Marketing Associates LLC**	Other - Consultant Aging and Long Term Care	President	Support	"This program provides an important solution to strengthening the availability and funding of care related services in the home. Long term this approach could have Medicaid savings and that, coupled with the benefits of keeping people at home longer, healthier, and safer makes this strategy worthy of continued state support."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
11.	**Minnesota Board on Aging**	Other – State board	Program Administrator	Support	"The Medicare Home Care benefit is underutilized, under supported and wonderfully helpful in making it possible for people to stay in their home. The expertise brought into the home reduces return hospital visits and supports caregivers to keep people out of nursing homes."
12.	**Metropolitan Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	Indicates that this strategy promotes independence and community-based living and could "delay premature entry into institutional care." Notes that this is an opportunity in Minnesota for "older adults to elect a more comprehensive and stable benefit in Medicare Supplement Plans" and that "a premium supported option would provide greater consistency in social services available than in Medicare Advantage Plans."
13.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"This will expand the opportunities for community-based organizations to offer additional services to ensure that all the needed supports are in place to help them remain in their own homes."
14.	**Lutheran Social Service of Minnesota**	Provider Organization	Senior Director of Advocacy	Support	"This proposal is a practical solution to reduce costs while supporting older adults to stay healthy and live at home longer."
15.	**SEIU Healthcare Minnesota**	Other – Labor Union	Political Director	Support	Indicates that the strategy is "an important step to expand access to home care services." Doing so will result in savings to the state by supporting community-based living and avoiding / delaying institutional care.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
16.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator	Support	This strategy "should be a high priority for BRC or legislative development." The Coalition provided several linked resources on racial equity in services for older adults.
17.	**Corner Home Medical**	Provider Organization	Clinical Director	Support	Indicates that this program would help support individuals' choice to remain in their homes.
18.	**Wellness in the Woods**	Consumer Organization	Executive Director	Support	Wellness in the Woods recommends that all strategies that provide independence for seniors be explored and implemented.
19.	**Vision Loss Resources**	Community Organization	President/CEO	Support	Indicates that this would be a "great benefit" to the state and describes how important educating clients about adaptive services and skills that support community-based and independent living.
20.	**Alzheimer's Association, Minnesota-North Dakota Chapter**	Consumer Organization	Manager of State Affairs	Support	Asserts that "development of an enhanced Medicare home care benefit could be beneficial in ensuring seniors can stay in their own home" and indicates that the "inclusion of family caregiver training and education in the set list of services provided under this benefit" is especially important.
21.	**Riverview Adult Day Services**	Provider Organization	RN manager		Advocates for benefits and services that promote independence and community-based living.
22.	**DARTS**	Provider Organization	President		Indicates that this "has the potential to be a great benefit and savings could be large" but cautions that the waiver reimbursement rates should be analyzed at the same time to ensure they can cover the costs of implementation.
23.	**n/a**	Other – State agency	n/a		Asked why this benefit should just apply to seniors.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
24.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy		Agrees with the "need for a more comprehensive method of providing various long-term care services (including nonmedical services) to enable older Minnesotans to remain in their homes." Raises concerns about the increase in costs to the state and premiums to members. Urges that an actuarial analysis be performed to account for recent changes to the state's Medicare market.
25.	**Minnesota Chamber of Commerce**	Professional Association	Director, Health Care & Transportation Policy		Encourages "more work and dialogue by the Commission and other interested stakeholders on this recommendation and a similar proposal by OYF [Own Your Future] to bring other, new long-term care insurance products to the market." Asserts that new benefits will "generate significant questions about cost and benefit" and that "such questions merit thorough investigation and discussion."
26.	**Sanford Health**	Provider Organization	Sr. Legislative Affairs Specialist	Oppose	Agrees that more comprehensive services are needed but expresses concern that this is an untested proposal that will increase premiums. Recommends that the Commission "explore other programs that are both reimbursed by Medicare and encourage Medicare enrollees to remain in their homes, such as Medicare PACE programs."
27.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid - Coalition Coordinator		*This is Medicaid Coalition* is largely neutral on this strategy, with 30% of the coalition supportive.

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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 strategy 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 strategy 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 strategy 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. They also question the effectiveness of the quality bonus system in general. 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 20 comments on this strategy.

- Comments in support of the strategy noted that the strategy will incentivize improved quality of care.
- Comments in opposition expressed concern about the financial stability of nursing facilities especially at a time when they are experiencing financial hardships due to COVID-19, and that major reductions to value-based reimbursement would destabilize rural nursing homes. There is concern that any reduction in revenue to nursing facilities will contribute to further strains on the workforce, impacting the ability of facilities to recruit and retain staff. Some doubted that the strategy would improve quality and efficiency citing mixed evidence.
- A number of the comments that provided feedback without specifying support or opposition to the strategy touched upon concerns about financial stability of nursing facilities and noted that additional research may be needed to determine the best reimbursement methodology for nursing facilities. Two comments urged the Commission to evaluate the strategy with an equity lens.
- The Minnesota Council on Leadership in Aging provided the following resource: *Financing and Funding Minnesota's Long Term Services and Supports, December 2019* and *Needs Assessment of Older Adults in Minnesota's Diverse Communities, April 2019*.
- The following organizations offered to serve as resource in further development of strategy: Care Providers of Minnesota and AFSCME Council 5.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota River Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	"Through this revision, it will continue to incentivize quality of care in skilled nursing facilities."
2.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"The revised approach would ideally result in improved overall quality of care being provided in nursing facilities."
3.	**Toby Pearson, Care Providers of Minnesota**	Professional Association	Vice President, Advocacy		Notes that the VBR program in 2020 "was just stabilizing" and is ready to work with the Commission and the Department.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
4.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"Critical access nursing facilities, which typically serve primarily racial/ethnic minority communities, may need different allocation of resources and supports, and VBR will need to take this into account."
5.	**DARTS**	Provider Organization	President		Reimbursement of long-term care facilities needs further study. "Fixed costs for the facilities will remain the same, which means the cost reimbursement per resident may actually need to increase."
6.	**Center for Healthy Aging and Innovation (University of Minnesota School of Public Health)**	Other - Academic/ Research Organization	Research Coordinator		"Critical access nursing facilities typically serve racial/ethnic minority communities & therefore need different allocation of resources and supports....Research has also shown that VBR can penalize facilities that primarily serve socially complex populations such as those from communities of color. This decision needs to be reconsidered with an equity lens."
7.	**AARP Minnesota**	Consumer Organization	Advocacy Director		Identifies a need for additional information and notes that "any funding tied to quality improvement must include reliable measures and demonstrate measurable outcomes."
8.	**Corner Home Medical**	Provider Organization	Clinical Director		"This would only increase the care our elderly or frail patient receive. Value not quantity."
9.	**Todd Bergstrom on Behalf of the Long-Term Care Imperative**	Professional Association	Director of Research and Data Analysis	Oppose	Impact of COVID-19 on occupancy and fixed costs will cause additional financial strain on nursing facilities. "While the Suspend the Alternative Payment System automatic property inflation adjustment is a minor reduction, nursing facilities require continued investment. The pandemic has caused us to rethink our physical layouts and the need to create avenues for investment and transformation."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
10.	**Sanford Health**	Provider Organization	Sr. Legislative Affairs Specialist	Oppose	"VBR brings value to those we serve and incentivizes good care. Any major reductions to VBR in the future would further jeopardize rural nursing homes." Concerned about impact on recruitment and retention of caregivers. "Specifically, with the daily therapy rate change, we believe that this will be an administrative headache for facilities as the therapy needs of residents can sometimes change often."
11.	**Minnesota Leadership Council on Aging**	Other - Statewide collaborative	Executive Director	Oppose	Concerned that suspending CANF program funding will negatively impact nursing homes in rural communities, calling the homes "a healthcare hub for older adults." The financial impact from reduced occupancy and fixed costs is concerning and the organization opposes suspending the Alternative Payment System property inflation adjustment noting that costs have increased during COVID-19 while occupancy declined. Notes the "federal transition to the PDPM will require Minnesota to modify and/or completely change the Medicaid-48 Group Case Mix System. Additional investment will be needed. It would make sense to address the therapy issue and any savings through this process."
12.	**Augustana Health Care Center**	Provider Organization	n/a	Oppose	Opposes any cuts to long-term care facilities, especially now due to COVID-19. Concerned that cuts would further strain the workforce, making it difficult to recruit and retain.
13.	**Minnesota AFSCME Council 5**	Other – Labor Union	Legislative Director	Oppose	"Savings shouldn't be found on the back of front-line workers who have experienced chronic underfunding." Notes that nursing facility rate increases have stabilized, and quality improvement will follow. Requests protections for the lowest cost workers should the strategy advance.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**AFSCME Council 5** **SEIU Healthcare Minnesota** **UFCW Local 1189** **USW District 11**	Other – Labor Unions		Oppose	Concerned that the strategy will further strain workforce, particularly in rural areas. Agrees that recent increases may be "excessive" and calls for increased transparency and regulation before moving to a cap, stating a "flat cap does not by itself promote greater efficiency and ignores the fact that we need to make up for decades of under-investment." Doubts the strategy will achieve the cost savings goal through more efficient care delivery and notes the evidence that quality and efficiency will improve is "mixed." Indicates that the legislature is unlikely to adopt such a strategy and therefore the Commission should focus efforts in other areas.
15.	**United Food and Commercial Workers International Union (UFCW)**	Other – Labor Union	n/a	Oppose	Notes that the nursing facility staffing shortage is a significant concern and worries that cuts would create even worse staffing conditions.
16.	**SEIU Healthcare Minnesota**	Other - Labor Union	Political Director	Oppose	States that the savings will not come from targeted efficiencies. "Instead of intentionally making current funding inadequate to make the value-based limit effective, we prefer to let homes continue growing towards the current limit." Cites mixed evidence on the impact of this strategy on quality and efficiency. Included a testimonial letter from a Nurse Assistant at Aicota Health Care Center: "…I want you to know that cutting nursing home funding would hurt me, my family, and my residents. The new reimbursement system has made a huge difference for the people I work with…"

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
17.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Oppose	Concerned that suspending CANF program funding will negatively impact nursing homes in rural communities, calling the homes "a healthcare hub for older adults." The financial impact from reduced occupancy and fixed costs is concerning and the organization opposes suspending the Alternative Payment System property inflation adjustment noting that costs have increased during COVID-19 while occupancy declined. Notes the "federal transition to the PDPM will require Minnesota to modify and/or completely change the Medicaid-48 Group Case Mix System. Additional investment will be needed. It would make sense to address the therapy issue and any savings through this process."
18.	**Long Term Care Imperative** (Care Providers of Minnesota and LeadingAge Minnesota)	Professional Association	n/a	Oppose	Concerned about jeopardizing the progress made in promoting choice for seniors and a strong continuum of care and straining the workforce further. "Within the VBR reduction proposal are provisions that would impact our staff wages and benefits and we urge the utmost caution." Notes that "when cuts are enacted to save state Medicaid dollars, those cuts also result not just in the loss of a federal match but also of private pay dollars." Agrees that there is an opportunity to strengthen the quality incentive in the reimbursement methodology and believes "change should be done collaboratively and based on research and impact analysis." "The VBR strategy as presented to the Commission is a bundle of individual proposals, some having system-wide impact and others impacting more targeted groups of providers. It will be important to understand and evaluate the impact of each."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**AFSCME Council 5**	Other – Labor Union	Executive Director	Oppose	Expresses continued opposition to this strategy, noting that it will lead to "reduced services, layoffs of front-line staff and no appreciable difference in the quality of care that residents receive." Asserts that "workers would bear the brunt of the consequences while the corporations that own the nursing homes would not."
20.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid - Coalition Coordinator		"This is Medicaid Coalition is 100% neutral on this strategy."

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.

<u>This strategy is expected to save up to $1 million in the next biennium.</u>

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 strategy. 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 statues 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 16 comments on the Pursuit of Fraud, Waste, or Abuse Prevention Enhancements strategy.

- Comments in support of the strategy noted that improvement of internal processes and a strengthened regulatory framework to identify fraud, waste, and abuse would be beneficial and could potentially achieve savings.
- Commenters who did not specifically support or oppose the strategy provided several specific suggestions, including the need to revamp whistleblower laws, include funding for cultural competence training, and perform an external racial equity review of investigations before expanding these efforts. Several also discussed the importance of targeting fraud accurately, and many expressed concern that the strategy could inequitably target individuals and providers based on race and unfairly punish overburdened providers.

- Two comments emphasized the need for process change over simply hiring more investigators. Two other comments recommended the use of payment integrity vendors or analytic software.
- Finally, at the May 8, 2020 Commission Meeting, the Commission received and discussed a proposal submitted by Nokomis Health dated March 12, 2020: Implementing a Comprehensive Payment Integrity Solution for the State of Minnesota.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Arrowhead Area Agency on Aging**	Community Organization	Director	Support	"Supports improvement of internal processes in order to achieve a higher return on investment in identifying fraud, waste and abuse"
2.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"Supports a strengthened regulation framework to improve internal handling of identifying fraud, waste and abuse."
3.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	"The Council supports efforts to reduce fraud, waste, and abuse within the health care system. The Council's member health plans have a long history of working with the Office of Inspector General and Department of Human Services SIRS to help make sure Minnesota's tax dollars are used for intended health care services."
4.	**Corner Home Medical**	Provider Organization	Clinical Director	Support	"Awesome idea to watch this. If we can decrease the waste and fraud that's savings that can be used for another person."
5.	**Mid Minnesota Legal Aid, Minnesota Disability Law Center, & Legal Services Advocacy Project**	Consumer Organizations	Staff Attorneys		"We have concerns about this strategy and suggested improvements. Terminating services with accused providers will mean fewer providers in areas with limited options and cutting off benefits will leave people without supports they need. A true equity review of this strategy should be completed before proceeding with this strategy. Further, this strategy should include more than simply hiring investigators; it should include changing the investigation process, offering due process to impacted people and communities, and resources to support cultural competence training."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
6.	**Association of Minnesota Counties; Local Public Health Association of Minnesota; Minnesota Association of County Social Service Administrators**	County Associations	Executive Director; Director; Executive Director		"Counties play a critical role in program integrity and are the recipients of the FPI grants---however, this proposal has very little reference to collaboration with counties. The proposed grant increase is a small drop in the bucket as compared to what would be needed to truly expand our FPI programs across the state. …The proposal to expand investigatory capacity does not address the inequitable distribution of funding that currently exists. There are areas of the state that do not have fraud prevention programs, and this should be a priority if it moves forward... Counties appreciate approaching this through an equity lens to avoid unintended consequences."
7.	**Faye Bernstein**	Individual Person	Contracts Attorney		Should include a review and revamp of whistleblower policies and laws, as "there is currently limited protection for those who report on fraud, waste, or abuse." Efforts to track down fraud, waste and abuse "will be stymied by the stifling and retaliation that DHS employees encounter when they report. Solve that and waste and fraud can be reported." Get cost savings information from DHS employees who have "1) dedicated their careers to this field, and 2) have these conversations on a day to day basis." Ask unions to gather this information.
8.	**Wellness in the Woods**	Consumer Organization	Executive Director		Recommends an easy-to-access format "for consumers of services to report fraud, waste, or abuse within the system."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
9.	**All Trans Software**	Other	Vice President		Needs more controls in place up front rather than relying on retrospective auditing where it's nearly impossible to recapture dollars lost to fraud, waste and abuse. Recommends similar review & analysis be done by MCOs/PMAPS with transportation, such as GPS tracking or a "bread crumb" trail of the transport.
10.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy		Encourages pursuing this strategy "with provider participation, transparency, and consideration for unintended consequences." "…providers must be able to participate in the effort with an appropriate level of ease that upholds integrity without creating additional costs to providers."
11.	**TakeAction Minnesota**	Community Organization	Director of Public Affairs		Pursuit of individual Medicaid fraud has a deeply racialized history, and "recent experience in CCAP investigations show that bias is also a concern in the pursuit of provider fraud." Recommends "an external racial equity review of Minnesota MA SIRS and FIP investigations, and corrective measures if necessary, before expanding these efforts, particularly in individual investigations." Encourages discretion in the use of the term "fraud," as receiving public benefits to which one is not entitled "could result from error anywhere within the complex application system, not necessarily fraud."
12.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"Should be evaluated through a health equity lens and may require community engagement."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
13.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator		"This is Medicaid coalition is largely neutral on this strategy." "Nobody supports fraud, waste, and abuse – at the same time, the limited amount of savings touted by the Commission should tell us that this line of argument should be used with care when evaluating state programs." "This should focus on process changes, not simply hiring more investigators. Should also include funding for cultural competence training."
14.	**Nokomis Health**	Other	CEO		Believe it is essential for Minnesota to "implement a complete payment integrity program which includes both internal staff and external experts who know how to mine claims data and to review claims and records." "…many payors do not have the resources or capabilities to look deeper at claims to uncover patterns which identify fraud, waste and abuse." "Many payment integrity vendors work on a commission basis, so the risk to the plan is very low."
15.	**Touchstone Mental Health**	Provider Organization	VP		"Focus on those committing fraud, not on all of us that follow regulations consistently"
16.	**NUWAY**	Provider Organization	VP Public Policy		"Prioritize investment in analytic software over staff increases," because software will help with quicker identification of cases and could help investigators prioritize their work on providers "who are fraudulently billing for services not rendered as opposed to providers who have paperwork out of order."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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 hum 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 seven 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 19 comments on the Reduction of Low-Value Services in Minnesota strategy.

- One supporter, the Minnesota Council on Health Plans, encouraged the State to build upon existing efforts in this area, rather than launching a new initiative. Another, the Minnesota Hospital Association, commented that it already has work underway in this area and encouraged the State to involve a broad cross section of parties before advancing any proposals.
- A number of commenters who did not specifically support or oppose the strategy expressed questions or concerns about the definition of "value." These commenters urged the Commission to carefully consider the process of defining "low-value services," and many commenters urged the Commission to seek broad and diverse participation in further developing this strategy. One commenter also pointed out the need to increase provision of high-value services.
- Several commenters expressed concern that the strategy did not provide enough detail to allow for meaningful feedback.
- The following organization offered to serve as resource in further development of strategy: Minnesota Council of Health Plans & Minnesota Medical Association.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	"The Council supports efforts to reduce overused, misused, and low-value services and is willing to participate in projects that support these conversations. We encourage the state to build upon any existing efforts rather than starting something new."
2.	**Minnesota Hospital Association**	Professional Association	President and CEO	Support	"In fact, the Minnesota Hospital Association and the Minnesota Chamber of Commerce have begun a partnership to use data from self-insured employers to reduce low or no-value care. MHA recommends that the Departments involve a broad cross section of parties before the state advances any proposals in this area. This idea should not be limited to the Medical Assistance program. If it does not include commercial payers, there is great risk of creating more disparity in health care services."
3.	**Doctors for Health Equity**	NA	NA	Support	"Good idea. However, we should also look at the corollary – where do we then increase high value services."
4.	**PrimeWest Health**	County-Based Purchasing Organization	CEO	Support	"As the research cited indicates, this effort is long overdue. The cost-savings and patient safety potential of this strategy are as high as seeing it through will be challenging. Special interests and professional preferences are in play here. Even a quick review of the Choosing Wisely recommendations reveals that what one provider considers trash is another provider's gold. Therefore, broad participation in identifying low-value/wasteful health care services and products will be essential—as will political fortitude when applying the scalpel."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Minnesota Medical Association**	Professional Association	Manager, State Legislative Affairs	Support	"The MMA is a long-time supporter of the "Choosing Wisely" campaign, a consortium of medical specialties who have partnered to identify services that have little demonstrated effectiveness for patients. The goal of the Choosing Wisely campaign is to foster conversations between physicians and patients about avoiding unnecessary medical tests, treatments ,and procedures. The MMA stands ready to partner with DHS and other stakeholders about advancing the goals of the Choosing Wisely campaign."
6.	**Minnesota Chamber of Commerce**	Professional Association	Director, Health Care & Transportation Policy	Support	"We agree that more must be done in Minnesota to reduce low value services. This is an issue that is of significant interest to our members. We are pleased that there is good, substantive work already underway in Minnesota to reduce low value care services through collaborative, private-sector partnerships. We stand ready to support all efforts aimed at reducing low value care, but we would encourage a focus on those efforts already underway, rather than the creation of new state efforts that may duplicate this work."
7.	**Touchstone Mental Health**	Provider Organization	Executive Director VP		"How is low value defined? One that doesn't have [cultural] competence or evidence to support [its] fidelity?" "Not enough information to understand what this is."
8.	**CLUES**	Community Organization	Senior Manager of Community-Based Mental Health Services		The group working on this strategy should be "highly diverse and representative of Minnesota communities. There needs to be a clear definition of 'low value' that takes into account social determinants of health and the diverse ways different communities and generations of people understand health and wellbeing."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
9.	**NA**	State Agency	NA		Low-value services should be defined by service users and not just by providers. "It is very important that people who use these services are part of the conversation. Just because a service isn't used widely, doesn't mean it isn't valuable – it may mean that people don't know it is an option for them, which means education and information is needed to ensure people understand their options and how to access a service."
10.	**DARTS**	Provider Organization	President		"Without the definition of 'low value' this is difficult to evaluate…Value cannot be defined by quantity, in our opinion."
11.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager		"More information is needed on the low-value services being considered as part of this strategy proposal in order to inform a recommendation. It is possible these programs serve as a safety net for a small but valuable part of our population. We recommend conducting a more thorough equity analysis to understand utilization rates and impact on people of color and Indigenous communities."
12.	**Fraser**	Provider Organization	Public Policy and Compliance Counsel		"This strategy raises many questions about how 'low value' will be measured and evaluated. Perhaps DHS could review 'low value' services and determine whether there are barriers to accessing the service that might make this a high value service if the barrier is removed."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
13.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy		Concerned about the definition of value. "MNACHC strongly urges the Commission to work closely with patients and providers to sufficiently account for preference and efficacy in determining which services are of high- and low-value relative to this strategy, specifically through a lens of geographic, racial and cultural competency...we urge the Commission to explore methods to address waste and decrease low-value care through increased and sustainable investment in preventative primary care services."
14.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement		"We urge great caution with this strategy, as these programs can often represent an essential safety net for a small but valuable part of our population. Review through an equity lens is essential before moving forward."
15.	**Minnesota Leadership Council on Aging**	Statewide Collaborative	Executive Director		"We urge great caution with this strategy, as these programs can often represent an essential safety net for a small but valuable part of our population. Review through an equity lens is essential before moving forward."
16.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator		"This is Medicaid coalition is split on this strategy. 33% need more information, 33% are neutral, 16% support, and 16% oppose. Comments: 'It is unclear what these services are. It would be good to do an equity analysis on this.' 'DHS should base which services are 'valuable' or not based on consumer experiences. That information could be gathered by DHS with claims information, or DHS could require plans to survey participants."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
17.	**Wellness in the Woods**	Consumer Organization	Executive Director		"Recommends increased support to peer specialists and peer recovery coaches to offer preventive, supportive mental health services, rather than awaiting the need for crisis services. Presently there is little support for peer specialists once the certification has been completed leading to low employment and utilization of peer staff."
18.	**Mid Minnesota Legal Aid, Minnesota Disability Law Center, & Legal Services Advocacy Project**	Consumer Organization	Staff Attorneys		"This strategy does not include information about potential unintended consequences or discussion with consumer stakeholders about these services. The goals of this strategy might be better served by ordering plans to survey consumer stakeholders about services they most and least value. Or, paid claims data could be used to survey patients. This sort of patient information should drive the direction of this proposal but the current proposal does not include this sort of outreach."
19.	**Corner Home Medical**	Provider Organization	Clinical Director		"Value Based Services"

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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 22 comments on this strategy.

- There was enthusiastic support for this strategy across stakeholder groups. Comments noted that this strategy would reduce administrative burden and improve care coordination, health outcomes, and access for clients with records in multiple states or health systems.
- Many commenters expressed frustration at Minnesota's uniquely burdensome privacy requirements, sharing that collecting written permission makes it very challenging for providers to obtain necessary medical records in a timely manner, which negatively impacts care coordination. Some commenters

shared that the burden falls even more heavily on underserved communities and communities suffering from significant health disparities.

- The one commenter in opposition expressed concern about creating limitations on patients' current right of access to their mental health records, which is not granted by HIPAA. The commenter was also concerned about the impact on the Family Involvement Law, which allows for information sharing with caretakers providing support to individuals with mental illness.
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	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Minnesota Psychological Association**	Professional Association	Legislative Chair and Federal Advocacy Coordinator	Support	"While this is a controversial topic, the Minnesota Psychological Association strongly supports the shift in privacy protections to the national HIPAA standard. The promise of interoperability of health care records across systems of care can only happen if this privacy standard is changed. The change in privacy standards will improve the quality of care and in the not too distant future, it should result in savings as duplication of services can be minimized."
2.	**Vision Loss Resources**	Community Organization	President/CEO	Support	"This would be very helpful to all be working in the same system"
3.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Support	"NAMI Minnesota supports efforts to align Minnesota health care data privacy protections with federal standards. If these changes move forward, we will see a reduction in administrative costs, strong data privacy protections under HIPAA, streamlining the process of sharing health records to ensure that patients receive the best possible care, and improved care coordination."
4.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	"We support aligning the Minnesota Health Records Act with federal HIPAA patient privacy protections, which will improve care coordination for clients, improve outcomes and reduce costs."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
5.	**Mental Health Minnesota**	Community Organization	Executive Director	Support	"We are supportive of aligning the Minnesota Health Records Act with federal HIPAA patient privacy protections."
6.	**Fraser**	Provider Organization	Public Policy and Compliance Counsel	Support	"Fraser supports this strategy. Aligning state and federal law not only eliminates burdensome requirements for clinicians, it also increases access for clients who have health care records in other states or across multiple health care systems."
7.	**Sanford Health**	Provider Organization	Sr. Legislative Affairs Specialist	Support	"We are incredibly supportive of this proposal. Since MHRA's enactment, federal health care privacy regulations under HIPAA were put in place to achieve the same goal as MHRA. These regulations provide effective protections of Protected Health Information (PHI), and provide guidance for when, where, and to whom PHI can be shared, making MHRA a duplicative effort. By aligning state and federal health care privacy protections, Minnesota would reduce administrative burden on health systems, providers, and health plans, facilitate patient-centered care, and be a cost savings."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy	Support	"MNACHC supports this strategy and strongly recommends the Commission to align state and federal privacy requirements. Unnecessary complexity resulting from the current misalignment too often results in patients and providers unable to complete treatment plans on time, receive and request appropriate care, and experience the level of care needed. The current state requirement for patient consent for disclosure is uniquely burdensome on underserved communities and communities suffering from significant health disparities…Minnesota's uniquely burdensome privacy requirements ultimately prevent providers from fully leveraging available data-sharing capabilities that keep data safe and secure, and also benefit the patient, maximize savings, and prevent administrative waste."
9.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Support	"We support this strategy. The incongruity of the Minnesota Health Records Act and the federal HIPAA patient privacy protections has created senseless and expensive workarounds for DHS, MDH, providers, health systems, and insurers. The costs of this is borne by the consumer and the taxpayer."
10.	**Minnesota Leadership Council on Aging**	Statewide Collaborative	Executive Director	Support	"We support this strategy. The incongruity of the Minnesota Health Records Act and the federal HIPAA patient privacy protections has created senseless and expensive workarounds for DHS, MDH, providers, health systems, and insurers. The costs of this is borne by the consumer and the taxpayer."
11.	**SEIU Healthcare Minnesota**	Labor Union	Political Director	Support	"We support this proposal. We have supported previous versions of this policy in the legislative process."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
12.	**Care Providers of Minnesota (Long-Term Care Imperative)**	Professional Association	Director of Research and Data Analysis	Support	"We strongly support this strategy. The incongruity of the Minnesota Health Records Act with the federal HIPAA patient privacy protections, has create senseless and expensive workarounds for DHS, MDH, providers, health systems, insurers etc. The costs of this is borne by the consumer and the taxpayer."
13.	**Minnesota Consortium for Citizens with Disabilities**	Community Organization	Policy Co-Chair	Support	"We support this strategy. This has long been identified as a need by people with disabilities and providers to ensure more seamless and timely medical care."
14.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	"The Council is supportive of this proposal as it increases efficiencies within the health care system and allows providers to communicate more easily with other providers about a patient's care. The additional requirements of the Minnesota Health Records Act that prevent health plans and providers from performing standard treatment and operational tasks are unnecessary and administratively burdensome. The protections offered under HIPAA are the industry standard and provide sufficient protections for beneficiaries."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
15.	**Gillette Children's Specialty Healthcare**	Provider Organization	Medical Director	Support	"We support the alignment of state and federal health care privacy protections. It is important that providers have a complete picture of a patient's health status and previous medical care. The separate consent requirements for release of health records under the Minnesota Health Records Act makes it more challenging for providers to obtain needed medical records on a timely basis and negatively impacts effective care coordination as collecting written permission adds significant time and burden when trying to proactively coordinate a patient's care."
16.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator	Support	"This is Medicaid Coalition is supportive of this strategy."
17.	**Touchstone Mental Health**	Provider Organization	VP	Support	"Please align these standards!"
18.	**Minnesota Hospital Association**	Professional Association	President and CEO	Support	"MHA strongly supports this recommendation to align state and federal health care privacy protections. MHA has advocated for this policy for several years, and there will be cost savings both to consumers of health care and in the administrative burden to the provider community. We look forward to having the public support of both the Department of Human Services and the Minnesota Department of Health in making this a public policy a priority and helping to advance this through the legislative process. Previous analyses from MDH have supported this approach in order to create consistency and improve coordination of care for Minnesotans."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**Hennepin Healthcare / Hennepin Health**	NA	Interim Chief Medical Officer & Chief Medical Officer	Support	"We appreciate proposals to align state and federal healthcare privacy protections, due to the better coordination of care between providers with less significant administrative burden. Modifying several acts, including the Minnesota Health Records Act, would be a particular advantage to all concerned because of the elimination of physician burdens involving consent to disclose patient information as needed from other facilities. There has been broad support for many years from health systems across the state, and we are pleased to see it included in the BRC report."
20.	**Minnesota Medical Association**	Professional Association	Manager, State Legislative Affairs	Support	"Alongside a broad coalition of health care providers, health plans, employers, labor, and patient advocates, the MMA has long urged the Legislature to align the Minnesota Health Records Act (MHRA) with HIPAA, the federal law that safeguards the privacy of health care records. Aligning HIPAA and the MHRA would maintain patient privacy protections while eliminating burdensome requirements that prevent physicians from providing the safest and most coordinated care possible. Physicians, nurses, and other health care staff routinely identify the MHRA as a barrier that results in interrupted care coordination and duplicative labs and testing because care providers do not have the information they need. The result is an increase in the overall cost of care and risks to patient safety with minimal additional patient privacy protections."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
21.	**Minnesota Chamber of Commerce**	Professional Association	Director, Health Care & Transportation Policy	Support	"Minnesota is one of only two states whose existing patient data privacy laws are narrower than federal law as it relates to patient consent for the sharing of information among health care providers. This presents barriers to delivering coordinated, cost-effective and high quality care. It also leads to higher health care costs as a result of duplicative and unnecessary tests and procedures. We support a change to the MHRA to allow Minnesota health care providers, in accordance with the strict and thorough requirements of HIPAA, to share a patient's information in the absence of written consent in a very narrow range of circumstances: for treatment, payment and health care operation purposes."
22.	**Office of Ombudsman for Mental Health and Developmental Disabilities**	Other	Regional Ombudsman Supervisor	Oppose	"OMHDD would have concerns about creating any limitations on patients' right of access to their mental health records, including psychotherapy notes, which is granted by the Minnesota Health Records Act and not HIPAA. OMHDD would also have concerns about any alignment that impacted or eliminated the Family Involvement Law, (as outlined in Minnesota 144.294 Subd. 3) allowing for limited, yet important, information sharing with caretakers providing support to individuals with mental illness, including those who may be experiencing a crisis."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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. [25] 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 of 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) [26] 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.

[25] 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.

[26] 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.

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
- 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 22 comments on this strategy.

- Comments in support of the strategy noted that a simplified process would improve the experience of members and promote person-centered care and urged that a health equity lens be used in discussions and decisions about process changes. Many noted a streamlined process could reduce delays in assessment and enrollment in waiver programs, confusion among individuals, and administrative burden on agencies.
- A couple of comments appeared to largely support streamlining the process as it would improve the individual experience and promote person-centeredness. One commenter was “encouraged” by the step to improve processes and another urged caution to avoid shifting costs to counties and tribes.
- Some comments noted the guide could assist members with understanding their options and acknowledged that it may be difficult to simplify a complex policy. Some urged using a health equity lens in establishing new processes and modifying existing ones.
- AFSCME Council 5 would like to be involved in future discussions about changes to the processes.

	Organizations or Individuals	Organization Type	Title	Position	Summary of Comments
1.	**CLUES**	Community Organization	Senior Manager of Community-Based Mental Health Services	Support	Indicates support for making "MnCHOICES assessments and their possible outcomes make more sense to community members and other providers."
2.	**Minnesota Board on Aging**	Other - State board	Program Administrator	Support	"Yes. Simplify!"
3.	**Metropolitan Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	"We frequently hear the frustrations of consumers about the delay in being assessed for and becoming enrolled in a long-term care waiver program. As consumers wait through this process their risk increases for premature institutionalization."
4.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	Indicates that this would streamline the process for LTSS and reduce administrative burden for agencies. Urges action on this proposal "with a health equity lens."
5.	**AARP Minnesota**	Consumer Organization	Advocacy Director	Support	"An effective and efficient assessment system will ensure services are provided based on individual needs and that uses a person-centered approach regardless of where one lives."
6.	**Fraser**	Provider Organization	Public Policy and Compliance Counsel	Support	Notes this would increase accessibility for individuals.
7.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Support	"Providing a shared understanding of the standards under the MnCHOICES assessment system will ensure all served by the system will receive the most effective and efficient person-centered care." Suggests streamlined processes be viewed with a health equity lens.

	Organizations or Individuals	Organization Type	Title	Position	Summary of Comments
8.	**Minnesota Leadership Council on Aging**	Other - Statewide collaborative	Executive Director	Support	"Providing a shared understanding of the standards under the MnCHOICES assessment system will ensure all served by the system will receive the most effective and efficient person-centered care." Suggests streamlined processes be viewed with a health equity lens.
9.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	Indicates that this could improve administrative efficiencies and reduce the "anxiety of older adults applying for long-term care waiver programs."
10.	**Minnesota Consortium for Citizens with Disabilities**	Community Organization	Policy Co-Chair	Support	Supports efforts to improve MnCHOICES, indicating that it "can be a major barrier to children and adults with disabilities getting access to the services they need and in a timely manner." Advocates for a person-centered process.
11.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	Agrees with streamlining the process and notes that it needs to be person-centered, keeping "the needs of the individual as the most important component." Notes the need for transparency and consistency. An accompanying letter excerpt reads: "We see a clear for changes in MnCHOICES and LTSS processes to meet individual needs of people with disabilities. Despite the exhaustive and iterative processes of implementing MnCHOICES, it has not consistently resulted in people having access to the appropriate amount of support at the right time..." The letter identifies areas for improvement.
12.	**Office of Ombudsman for Mental Health and Developmental Disabilities**	Other	Regional Ombudsman Supervisor	Support	Supportive of improvements to the assessment and eligibility processes and the development of a guide to assist individuals in understanding the process and available service options.

	Organizations or Individuals	Organization Type	Title	Position	Summary of Comments
13.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	Indicates a streamlined process will "help to increase access and creates a more favorable health care experience for enrollees." Urges alignment with other Medicaid eligibility renewal strategies / improvements.
14.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid - Coalition Coordinator	Support	This is Medicaid Coalition is supportive of this strategy.
15.	**Vision Loss Resources**	Community Organization	President/CEO	Support	Notes it would improve efficiencies and make process more accessible.
16.	**Touchstone Mental Health**	Provider Organization	VP	Support	"Improvements are certainly needed; the processes are cumbersome and do not result in consistent needed supports for people served."
17.	**Alzheimer's Association, Minnesota-North Dakota Chapter**	Consumer Organization	Manager of State Affairs	Support	Asserts that assessment processes differ across the state and in tribal nations, causing individuals "to experience delays because of inconsistencies in the system." Suggests that streamlining the process will "ensure those served by the system will receive the most effective and efficient person-centered care" and advocates for applying a health equity lens to process changes.
18.	**Mid-Minnesota Legal Aid;** **Minnesota Disability Law Center (MDLC);** **Legal Services Advocacy Project (LSAP)**	Consumer Organization	Various - Supervising Attorneys, Staff Attorneys, Litigation Director	Support	States that it is "essential" for the assessment to be person-centered and consistent and that "the process connects people to services in as timely and seamless manner as possible." Also notes that "…whether and how any changes improve the experiences and access to needed services for people with disabilities depends on what changes are made and the extent of consumer input." Urges that changes to the process use an equity lens.

	Organizations or Individuals	Organization Type	Title	Position	Summary of Comments
19.	**AFSCME Council 5**	Other – Labor Union	Executive Director		Indicates that the organization is "encouraged" by the strategy to streamline processes in MnCHOICES and agrees that improvements are needed. Urges the Commission to engage the union in further decisions and discussions about process changes.
20.	**Association of Minnesota Counties;** **Local Public Health Association of Minnesota;** **Minnesota Association of County Social Service Administrators (MACSSA)**	Other – County-based associations	Executive Director; Director; Executive Director		Indicates that counties are engaging with DHS on MnCHOICES work. "Counties recognize the need for efficiencies and have communicated ideas broadly and directly. Counties urge caution as changes can shift costs and responsibility to the counties and tribes. This could be a blind spot not only with the Waiver Reimagine strategy but with the efficiency strategy as well."
21.	**Arrowhead Area Agency on Aging**	Community Organization	Director		Advocates for a simplified process but acknowledges that developing an easy-to-understand guide is difficult given the complexities of the system. Also notes "opportunities for improvement in service delivery with tribal nations."
22.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		A health equity lens should be used to support streamlining the system.

Improve Dental Access

1. Improve dental access in Public Health Care Programs
2. Increase children's dental access through a coordinated, statewide school-based oral health program

Problem Statement: Minnesota ranks towards the bottom of states in provision of dental services to children under 19.

Strategy: This two-part strategy is aimed at improving access to dental programs by:

1. Contracting with single administrator for dental services and updating the dental rate methodology
2. Increasing access to dental service through a coordinated, statewide school-based oral health program.

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 strategy 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 strategy will impact individuals on Medical Assistance and MinnesotaCare seeking access to dental care. It is aimed at increasing access to care. Additionally, this strategy 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 37 comments on this strategy.

- Comments in support of the strategy noted the important linkage of dental health to overall health, and highlighted current issues with dental care faced by the state: historically low reimbursement rates for dental providers, preventable dental-related emergency room visits, and limited access to dental care for children and older adults – particularly in rural areas.
- Comments in opposition noted that this strategy offers a one-size-fits-all approach that doesn't address the unique needs of various populations, or recognize existing local efforts.
- A number of commenters expressed concern over funding loss to Critical Access Dental (CAD) providers, and the potential for increased overall spending, and decreased access. Several commenters expressed support for a rate increase, provided that it could be done without negatively impacting CAD providers.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**CLUES**	Community Organization	Senior Manager of Community-Based Mental Health Services	Support	"Increasing dental healthcare access is very important given correlations between dental health and children attending school consistently, for example. The current network for many people on MA and PMAP plans is very limited and often does not provide access to providers who specialize in working with children who have complex needs ..."
2.	**Vision Loss Resources**	Community Organization	President/CEO	Support	"This strategy would be so helpful in helping more people have access to dental care. Better dental care means better overall heath."
3.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Support	"Minnesota has very uneven access to dental programs on public health programs, with unsustainably low rates for providers. With low access for public health enrollees – especially for children – it is much more likely that people seek dental treatment in more expensive settings like an emergency room..."
4.	**DARTS**	Provider Organization	President	Support	"Dental care is linked to overall health and we support efforts to make affordable dental care available for anyone, particularly the older population."
5.	**Metropolitan Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	"Oral health is a critical component of overall health. Improving access through the strategies noted are long overdue and essential to overall population health in Minnesota."
6.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	"We strongly support strategies to improve dental access in public health care programs. Medical Assistance enrollees face challenges in accessing dental care because there aren't enough providers, but there aren't enough providers because reimbursement rates are too low. This is an equity issue."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
7.	**Minnesota Dental Association**	Professional Association	Executive Director	Support	"The Minnesota Dental Association (MDA) has historically advocated for administrative simplification for medical assistance dental benefits. The current dental medical assistance program is complex and the proposed change will drastically improve transparency. A simplified administrative system will improve accountability by giving DHS more authority to prevent inappropriate billing practices and protect the use of public funds. Transitioning to this new system would save the state dollars which can be better used to provide quality care...Raising the reimbursement rates for dental care is essential to improving oral health outcomes in Minnesota by improving dental participation rates."
8.	**Mental Health Minnesota**	Community Organization	Executive Director	Support	"We support this strategy, recognizing the difficulties many people have accessing this important piece of health care."
9.	**Arrowhead Area Agency on Aging**	Community Organization	Director	Support	"Benefits: Improved overall health – with improved dental health; opportunities for the many older adults without a comprehensive dental plan to access the care they need. Reduced emergency room visits for dental care. Challenges: Population Served: Older Adults"
10.	**AARP Minnesota**	Consumer Organization	Advocacy Director	Support	"AARP supports this strategy to ensure access to oral health statewide."
11.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Support	"We support this strategy for older adults. Improved oral health care across the lifespan creates improved health and sizable savings over many years. There is a strong need for access to dental services by older adults."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
12.	**Minnesota Leadership Council on Aging**	Statewide Collaborative	Executive Director	Support	"We support this strategy. Improved oral health care across the lifespan creates improved health and sizeable savings over many years. There is a strong need for access to dental services by older adults."
13.	**Care Providers of Minnesota (Long-Term Care Imperative)**	Professional Association	Director of Research and Data Analysis	Support	"We strongly support this strategy. There is a strong need for access to dental services. Effective oral health care (from fluoride shellacking for youths to dentures) will create sizeable savings over many years."
14.	**TakeAction Minnesota**	Community Organization	Director of Public Affairs	Support	"In over a decade of conversations with community members about what they need out of a healthcare system, dental care is one of the top concerns we have heard at TakeAction Minnesota. For those who gain access to Medical Assistance or MinnesotaCare, many report feeling great relief at finally having dental coverage. However many have also reported difficulty finding a dentist to see them or their children, and frustration with the limited coverage of important dental services… TakeAction Minnesota supports this approach to increase payments for dental providers in MPHP, and centralize administration of those benefits rather than continue our current patchwork system."
15.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"Enhancements in the rate structure and enrollment process will ensure positive experiences for older adults that will directly contribute to their health and independence. This is an area that deserves more attention with improved access to services in rural areas through the support of mobile services and other enhanced service delivery models."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
16.	**Gillette Children's Specialty Healthcare**	Provider Organization	Medical Director	Support	"… we support higher base rates for all Medicaid dental providers. We ask that the Critical Access Dental program remain in place and that any changes to the current program be made in consultation with and in collaboration with current Critical Access Dental providers."
17.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator	Support	"Should be a high priority for BRC or legislative development."
18.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator	Support	"This is Medicaid Coalition is supportive of this strategy."
19.	**Touchstone Mental Health**	Provider Organization	VP	Support	"Strongly support."
20.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy	Support	"MNACHC encourages the Commission to pursue this strategy to the extent that a single administrator and new rate methodology will improve access to dental care for MHCP enrollees and will not negatively impact critical access dental providers. Minnesota's FQHCs serve as a dental safety net in underserved communities statewide and any changes that create real gains in access to dental care across geographical, racial, and ethnic groups must be pursued...."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
21.	**Mid Minnesota Legal Aid, Minnesota Disability Law Center, & Legal Services Advocacy Project**	Consumer Organizations	Staff Attorneys		"Legal Aid has long advocated for increasing access to dental services for people who use Medicaid. This is an urgent need in our state. However, we have concerns about increasing rates by decreasing funding for Critical Access providers which risks closing off access to the limited providers who currently are accessible to people who use Medicaid. Increasing rates may not provide enough of an incentive for dentists to accept Medicaid enrollees who they perceive as being a difficult population to serve. This strategy, which proposes to pay more to providers who are refusing Medicaid patients now, is another example of the critical need for equity review before seriously considering implementing it."
22.	**Interact**	Individual Person	NA		"Currently the dentists that do accept MA treat me very poorly and don't listen to my concerns. They rush to finish their job so they can see their higher paying customers. More dentists need to be trained to work with individuals with Autism and Intellectual and Developmental Disabilities so that we can be treated with respect and feel comfortable..."
23.	**Riverview Adult Day Services**	Provider Organization	RN Manager		"It can be very hard to find dental services in rural communities under MA insurances due to local dentists are not taking new clients. Transportation for these long distance dental appt's can also be a hurdle."
24.	**Minnesota Board on Aging**	State Board	Program Administrator		"The current rates are a joke."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
25.	**SEIU Healthcare Minnesota**	Labor Union	Political Director		"If Minnesota moves to a single administrator system, it should find some way to accommodate the unique structure of HealthPartners. Unlike almost all other dental providers, HealthPartners fully integrates dental care with health care. While a single administrator generally reduces complexity and barriers, for HealthPartners it would create a barrier to integrating dental with health care..."
26.	**Minnesota Consortium for Citizens with Disabilities**	Community Organization	Policy Co-Chair		"strongly support efforts to increase Medicaid dental rates but have strong concerns about the specifics of this proposal. Access to dental care for people on Medicaid is extremely limited in Minnesota, often due to depressed rates causing many providers to not accept Medicaid. We applaud the portion of this strategy that increases rates for dental care but are concerned about any cuts in funding or rates to Critical Access providers..."
27.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator		"We support an increase in rates for children's and adult's dental services. Dental services are hard to access in many parts of the state. However, we are concerned about any loss of add on services for critical access dental (CAD) providers. The goal of improving access to dental services will be hard to accomplish if critical access dental providers end up with less overall revenue." Per accompanying letter, strongly support simplified administration and increased rates, but concerned over impact on CADs.

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
28.	**Gene Martinez**	NA	NA		"The rate increases seem like an improvement. However, we are hearing that Critical Access Dental providers will lose add-on payments for providing other services and have concerns about this proposal. Will critical access dental providers lose funding of any kind under this proposal?"
29.	**Sanford Health**	Provider Organization	Sr. Legislative Affairs Specialist	Oppose	"We support an exploration of measures that incentivize more dental providers in our service area of Western Minnesota to provide dental services to this population. However, we would like to be ensured that the current safety-net dental providers will be held harmless in any rate increase to dental providers. Any rate increase which is used to bring more dental providers into the Medicaid/MinnesotaCare program should not come about by cutting rates to the providers currently willing to provide care in the program."
30.	**PrimeWest Health**	County-Based Purchasing Organization	CEO	Oppose	"One-size-fits-all approach. It under-represents the rural perspective and risks reducing access to dental care in rural Minnesota if the approach does not fit the local and personal dynamics affecting dental utilization. Increase dental reimbursement? Yes! But the strategy's scheme risks harming critical providers..."
31.	**NA**	Individual Person	Medical Consultant for Wright County Public Health	Oppose	"I have concern that a new administrator will add competing desires and speaking in different terms for our county with many varied needs. We believe that finding what WORKS in our various populations is better than a one size fits all approach."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
32.	**NA**	Individual Person	NA	Oppose	"Integrated responsibility for Medicaid coverage aligns incentives to manage the total efficiency and effectiveness of care. This strategy would decrease integration and undermine local initiatives. County-Based Purchasing plans, for example, have already achieved the best access to dental care according to DHS data. With extensive outreach, County-Based Purchasing plans have increased dental rates, improved transportation, and invested in new vans and clinics to improve access. A one-size-fits-all model imposed from St. Paul would replace these local initiatives, and future innovation, with a cumbersome, inflexible model disconnected from the rest of Medicaid."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
33.	**Dental Access Partners**	Provider Organization	Policy Director Apple Tree Dental	Oppose	"DHS' proposal to pay all providers the same rates without regard to their performance is strongly opposed by Critical Access Dental (CAD) providers who deliver almost 2/3 of Minnesota Medicaid services. DHS data shows that CAD providers deliver affordable solutions and have capacity to expand access, while most other providers can't deliver Medicaid services at costs that taxpayers can afford. A "Dental Home Solution" exists: 1.DHS's goals can be accomplished through an evidence-based Dental Homes Solution that targets very limited state healthcare dollars at proven delivery models, while requiring transparency and accountability for Health Plans and providers alike. 2. Recent analysis of DHS data proves that CAD provider have expanded the reach of clinic-based services that are encouraged by CMS and leaders in many other states. 3. A more transparent dental home reimbursement model will create incentives to expand access and assure continuity of care."
34.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Oppose	"We are unclear how moving to a single administrator will increase dental access for enrollees. Rather than contracting with a dental administrator, the Council recommends pursuing other, lower-cost ways of improving access to dental care... An additional concern is that the proposal negatively impacts safety net providers, such as rural dentists and critical access dentists who are serving the bulk of Medicaid members despite introducing increased cost to the system. The Council is in support of increasing Medicaid state-set dental rates … and recommends this step be pursued as part of an iterative process."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
35.	**Minnesota Hospital Association**	NA	President and CEO	Oppose	"We certainly embrace the goal of this recommendation, but the identified strategy calls for contracting with a third-party administrator to take over this challenge. We question whether this approach will work. Several MHA members are involved with providing critical access dental services and they are providing greater access to underserved populations. Any changes to improve the overall Medical Assistance payment rate to all dentists should not be made if it is at the detriment of the critical access dental providers."
36.	**Hennepin Healthcare / Hennepin Health**	NA	Interim Chief Medical Officer & Chief Medical Officer	Oppose	"The Commission proposes a single rate for dental care provided to Medicaid patients. Hennepin Healthcare dentists often perform complex dental work for people who require general anesthesia, multiple tooth extractions, custom dental appliances, and other costly, necessary measures ... While we appreciate this proposal's intent, we do not believe moving funds from the Critical Access Dental program to increase reimbursements to all dentists will be an effective strategy to improve access."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
37.	**Minnesota Oral Health Alliance**	Professional association	Signed by member organizations	Oppose	Commenting on the first part of the strategy, the Alliance stated in a July 31, 2020 letter that "…the approach outlined in the Draft Report would permanently damage the state's safety net providers and result in a reduction in access to dental care among low income children and families…The Minnesota Oral Health Alliance is concerned that he proposal's reliance on the historical Medical Assistance FFS rate does not accurately reflect what critical access providers are currently being paid and therefore creates a very real possibility that these essential safety net providers could see a reduction in reimbursement as a result of reform.

Increase Children's Access to Dental Services through a Coordinated, Statewide Oral Health Program

Problem Statement: Access to dental care is limited for children in Minnesota.

Strategy: This strategy is aimed at improving access to dental services for at-risk children through development and implementation of a coordinated, statewide oral health program and utilization of Collaborative Practice Dental Hygienists (CPDH) and other professionals.

1. Problem Statement

The primary problem is the system-level barriers to preventive and restorative dental care that exist in Minnesota, leading to oral health disparities and disproportionate disease burden among at-risk children that result in higher costs to the State of Minnesota.

The American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend at least one dental visit each year.[27] Early dental care is important in prevention of early childhood caries. As with routine medical check-ups and recommended vaccine schedule, preventive dental care ensures children have a healthy start and improves school readiness.

Unfortunately, not all Minnesota children have the opportunity to access dental care. Overall, during 2017-2018, 4 in 5 Minnesota children 1-17 years old had an annual dental visit.[28] Only 2 in 5 children aged 1-20 enrolled in a Minnesota Health Care Program (MHCP) visited a dentist in 2018.[29] Moreover, preventive dental services are underutilized. Only 38% of Child & Teen Checkup Medicaid enrollees had a preventive dental visit in 2018[30] . Thirteen percent received fluoride varnish application from a non-dental and 14% of 6-14 year olds received a dental sealant. [31]

Several factors affect access to oral health care in Minnesota. First, 3 in 5 Minnesota counties are designated as Dental Health Professional Shortage Areas (HPSA). Dental HPSAs are areas that have insufficient numbers of dental providers proportional to the service population.[32] Second, not all Minnesotans have dental insurance and those who do may have an insufficient dental benefit set to cover their needs. Thirteen percent of children

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[27] Dental Visits. American Academy of Pediatrics. http://www2.aap.org/oralhealth/pact/ch5_sect5.cfm Retrieved March 2017.
[28] Health Resources and Services Administration, Maternal and Child Health Bureau. National Survey of Children's Health. Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: MN Public Health Data Access Portal. https://data.web.health.state.mn.us/nsch-use Retrieved March 2000.
[29] Minnesota Department of Human Services. Child and Teen Checkups Program (CMS-416 Report). Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: Accessed from MN Public Health Data Portal. https://data.web.health.state.mn.us/web/mndata/service-use-child Retrieved March 2020.
[30] Minnesota Department of Human Services. Child and Teen Checkups Program (CMS-416 Report). Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: Accessed from MN Public Health Data Portal. https://data.web.health.state.mn.us/service-use-child-sealants Retrieved March 2020.
[31] Minnesota Department of Human Services. Child and Teen Checkups Program (CMS-416 Report). Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: Accessed from MN Public Health Data Portal. https://data.web.health.state.mn.us/service-use-child-non-dentist Retrieved March 2020.
[32] Dental Health Professional Shortage Areas. Minnesota Department of Health, Office of Rural Health and Primary Care. Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: MN Public Health Data Access Portal. https://data.web.health.state.mn.us/web/mndata/hpsa-metadata#criteria Retrieved March 2020.

0-17 years old did not have dental insurance in 2017.[33] American Indians (42.1%) and Hispanics (33.6%) in Minnesota had the highest rates of being uninsured.[34] However, having dental insurance does not guarantee access, as plans cover different services at different levels and not all dentists accept certain types of insurance. The following are several other factors that influence access to oral health care [35,36]:

- **Household income**: Living in a lower income household (i.e. 200% or more of the federal poverty level). This affects the ability to pay for out-of-pocket expenses and travel to and from a dental appointment.
- **Paid leave:** Parent/guardian workplaces may not have paid time off to take their child to and from a dental appointment. Other family priorities and hardships may also compete for time.
- **Health literacy:** Parent/guardian may not understand the importance of oral health, how to navigate the complex oral health system, how to cook healthy foods and limit dietary sugars, or may not know proper oral hygiene techniques.
- **Special health care needs:** Children with chronic disease, disability or special health care needs often experience oral hygiene/self-care challenges and transportation barriers to reach a dental clinic. Some dental clinics are not wheelchair accessible and many dentists have not had training in working with children with special health care needs.

A secondary problem is the lack of a coordinated, statewide oral health delivery system that integrates and tracks Collaborative Dental Hygiene Practice and community and clinic-based dental services.

In evaluating existing school-based oral health programs, the MDH Oral Health Program and community partners have identified lack of collaboration, alignment and integration between oral health programs, school health, and education as key barriers to improving children's oral health. Minnesota has a small and uncoordinated set of dental providers working in schools, which duplicates efforts and is not sufficient to address the state level dental needs at large. Absence of supportive policy and direct reimbursement for Collaborative Dental Hygiene Practice also contributes to these problems.

2. Strategy Proposal

This proposal will use a community-based participatory strategy that includes multi-level (state, regional, school district, school, community and family) collaboration in the planning and development, implementation, evaluation and maintenance phases of Statewide School Oral Health Program. This will involve (1) conducting a needs assessment, (2) developing a statewide coordinated school oral health program to improve dental access, (3) recruiting regional coordinators and providing Dental Access Grants to dental hygienists, (4) removing administrative barriers to strengthen Collaborative Dental Hygiene Practice, (5) providing resources and training

[33] Minnesota Department of Health Oral Health Program. Minnesota Department of Health, Health Economics Program. Collected by the Minnesota Oral Health Program. St. Paul, Minnesota: MN Public Health Data Access Portal. https://data.web.health.state.mn.us/web/mndata/mnhas-insurance Retrieved March 2020.
[34] https://data.web.health.state.mn.us/web/mndata/mnhas-insurance Retrieved March 2020.

[35] American Dental Association. Breaking Down Barriers to Oral Health for All Americans: 2011 Report.
[36] Bersell, CH. Access to Oral Health Care: A National Crisis and Call for Reform. Journal of Dental Hygiene. 2017; 91(1): 6-14.

to support the integration of oral health in the Whole School Whole Community Whole Child (WSCC) model,[37] and (6) continuing monitoring and evaluation of the project.

This proposal seeks to reduce the burden of oral disease and oral health disparities in children through development of a Minnesota School Oral Health Program (MNOHP), a statewide, coordinated program that:

(1) creates statewide reach through alignment of school-based oral health strategies with the Centers for Disease Control and Prevention's WSCC Model;

(2) ensures regional reach through outreach and coordination of communities, school districts, schools and families of children facing oral health disparities with school-based oral health providers (i.e. dental hygienists in collaborative practice) and area programs and services;

(3) eliminates administrative barriers to Collaborative Dental Hygiene Practice as recommended by the DHS Dental Services Advisory Committee including adding coverage for screenings, oral and risk assessments and removing the 501c requirement for direct reimbursement;

(4) involves multi-level community engagement through key stakeholders' state level advisory group (with regional representation) and local level community partnerships to share resources and provide support to plan, implement, and evaluate components of WSCC model.

(5) develops a data collection system and monitors comparable, consistent, and reliable data for the statewide oral health delivery system to remove redundancy and increase coordination among the oral health service providers serving children.

(6) provides children with equitable, cost-effective access to preventive oral health services where they live, learn and play. Preventing and decreasing the burden of oral disease will reduce disparities, improve health and drive down overall costs.

3. **Populations Impacted**

This strategy primarily serves children enrolled in PK-12 Minnesota public schools[38], especially those who are at high-risk for dental disease and American Indians/Alaska Natives children. Secondary targets include communities and families from high-risk schools experiencing oral health disparities.

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[37] *https://www.cdc.gov/healthyschools/wscc/index.htm.*

[38] *School selection criteria*

- *Schools with fifty-percent or greater free and reduced price lunch eligibility.*
- *Schools with physical address in a rural location, defined by Rural/Urban Community-Area taxonomy (RUCA-zip) developed by the University of Washington, Rural Health Research Center.*
- *Schools in Dental Health Professional Shortage Area (Dental-HPSA).*

Dental hygienists in collaborative practice will provide key dental disease prevention services at schools. Removing barriers to provide services in community settings such as schools can also benefit other vulnerable populations in the community (e.g. adult foster care, nursing homes and assisted living) creating greater savings to the State of Minnesota through reduced spending on emergency department visits and overall medical spending for people with chronic diseases/conditions.

4. Supporting Evidence

National and local resources that provide supportive evidence for this strategy include:

Improving Oral Health through WSCC

- Centers for Disease Control and Prevention (CDC). Whole School, Whole Community, Whole Child (WSCC) Model. Retrieved 3/20 from https://www.cdc.gov/healthyschools/wscc/index.htm
- Association of State and Territorial Dental Directors (ASTDD). Improving Children's Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model. March 2017. https://www.astdd.org/bestpractices/wscc-bpar-final-3-2017.pdf

Use of Collaborative Dental Hygiene Practice in Dental Access Program Model

- The Network for Public Health Law. Collaborative Practice as a Strategy for Increasing Access to Oral Health Care in Minnesota. Oral Health Issue Brief. https://www.networkforphl.org/wp-content/uploads/2020/01/Collaborative-Practice-Strategy-for-Increasing-Oral-Health-Care-Access-
- Network for Public Health Law. Policy Frameworks Supporting School-Based Dental Sealant Programs and Their Application in Minnesota. Oral Health Issue Brief. https://www.networkforphl.org/wp-content/uploads/2020/01/School-Based-Dental-Sealant-Programs-Issue-Brief.pdf
- Minnesota Department of Health. Strengthening the Oral Health System in Rural Minnesota: Findings and recommendations from the Rural Health Advisory Committee. MDH Office of Rural Health and Primary Care. August 2018. https://www.health.state.mn.us/facilities/ruralhealth/rhac/docs/2018ruraloral.pdf
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5. Implementation Steps

The Minnesota Department of Health Oral Health Program will develop, coordinate, and evaluate the Minnesota School Oral Health Program in collaboration with a stakeholder group. It will ensure collaborative partnership with Minnesota Dental Hygienists' Association. Policy changes and removal of administrative barriers may require partnership with other state agencies and stakeholders. The following steps are required to implement this strategy:

- Recruit Minnesota School Oral Health Program (MNSOHP) staff including program coordinator and eight regional program coordinators.
- Identify key stakeholders to serve on a MNSOHP Advisory Group; leverage expertise and agency representation of the WSCC Statewide Interagency (formerly School Health & Education) Committee. These groups will guide strategic direction and activities of the program, including development of a Minnesota specific plan for integrating oral health into the WSCC model, developing the Dental Access Grant RFP and creating key performance metrics.
- Conduct needs assessment/SWOT analysis with MNSOHP Advisory Group.
- Remove administrative barriers to Collaborative Dental Hygiene Practice through policy changes.

- Develop MNSOHP Evaluation and Communications Plans.
- Create RFP for Dental Access Grant, design review guidelines, and deliver awards.
- Implement MNSOHP at statewide and regional level. First piloting and making changes as needed before wider roll out.
- Conduct outreach activities to bring together state agencies, school districts, schools, and programs providing health and oral health services to children.
- Plan and implement public health surveillance activities to measure change in dental disease rates over time.
- Include Plan-Do-Study-Act (PDSA) model for continuous program improvement.
- Conduct utilization-focused evaluation process and outcome evaluation.
- Conduct a cost-effectiveness analysis.
    -

Efforts to remove administrative barriers to Collaborative Dental Hygiene Practice are already underway and will be continued. Assuming legislative authority and funding will be received in 2021, work on the Minnesota School Oral Health Program could begin in the latter half of that year. The strategy will be implemented in six phases namely; planning -pre-program data collection and regional planning, implementation (pilot), implementation (scale-up), implementation (full), maintenance and evaluation. It will take approximately 5 years to fully implement this strategy and an additional year to collect post-program impact data.

The strategy requires funding for Dental Access Grants, state and regional staffing, consultants and contractors, Minnesota Information Technology (MN.IT) Services, educational materials, supplies and equipment. In addition, a change in Medicaid policy to allow for direct payment to Collaborative Dental Hygienists will require additional Medicaid funding.

6. Equity Consideration

The strategy meets the criteria for addressing health equity in school-aged children. The Minnesota School Oral Health Program will reach children throughout Minnesota based on dental need/risk, including children from rural locations and Dental HPSAs, children of color and American Indians and children with disabilities. We will take a community-based participatory approach to program development, implementation and evaluation.

7. Public Comment

There was no public comment to this strategy it was not presented to the Commission until its August 19, 2020 meeting, which was after the public comment period ended.[39]

[39] Due to a miscommunication between MDH and DHS, this strategy was not initially included as part of the dental strategy. To correct this oversight, the strategy was presented during the August 19th meeting.

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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 is 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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 27 comments on this strategy.

- Comments in support of the strategy noted the stark disparities in access to services between white people and Black, Indigenous and people of color (BIPOC) within the state's aging and disability service programs, and supported the Commission's development of this strategy.
- Several commenters highlighted the need to consider all underserved populations, which include but are not limited to particular racial and ethnic groups. In particular, several commenters noted the absence of the LGBTQ community from the Commission's charge to advance health equity and urged the Commission to add this community to its work in the area of health disparities and health inequities.
- Several commenters agreed upon the importance of a community engagement initiative, which is core to this strategy.
- One commenter recommended diversification of the workforce alongside these efforts.
- A number of commenters who did not specifically support or oppose the strategy recommended listening to communities, detailing plans for data collection, and planning out how service access will be assessed and remedied.
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	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**Mid Minnesota Legal Aid, Minnesota Disability Law Center, & Legal Services Advocacy Project**	Consumer Organizations	Staff Attorneys	Support	"We strongly support this proposal (we submitted it!). People with disabilities who are white disproportionately access disability waivers, which typically provide far more extensive service offerings than other programs, like PCA. Further, the services available through Medicaid for people with disabilities may not reflect cultural competence or meet the needs of people from all backgrounds. Much work needs to be done to make appropriate disability services in Minnesota truly accessible to all Minnesotans. This strategy is an important first step."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
2.	**Minnesota Consortium for Citizens with Disabilities**	Community Organization	Board members	Support	"We applaud DHS for establishing the HCBS Disparities Advisory Group and urge the Commission to push for the legislature and DHS to implement the plans outlined in this strategy."
3.	**Vision Loss Resources**	Community Organization	President/CEO	Support	"This would have a great impact on the older adults we serve. Community engagement is vital to improving access to services. Increasing access to services for more people who need services."
4.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Support	"NAMI Minnesota strongly supports efforts to reduce racial disparities in accessing Home and Community Based Services (HCBS). Addressing institutional bias in the assessment process is a good start, as well as efforts to engage communities of color in this process. It will also be very important to continue making investments in diversifying our health care workforce and focusing on culturally competent care."
5.	**Metropolitan Area Agency on Aging, Inc.**	Community Organization	Executive Director	Support	"Increased flexibility and cultural requirements will improve access and utilization of services that can help reduce health care costs and delay premature institutionalization."
6.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	"We support strategies to ensure equitable access to aging and disability service programs….Inclusive discussions with BIPOC communities and their ongoing, direct participation are necessary to inform specific actions for this strategy proposal."
7.	**Mental Health Minnesota**	Community Organization	Executive Director	Support	"We are supportive of efforts to ensure equitable access to all physical health/mental health care and services, including aging/disability service programs."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**Fraser**	Provider Organization	Public Policy and Compliance Counsel	Support	"Fraser supports efforts to make sure that all Minnesotans have access to services and can make an informed choice about the most appropriate services for themselves."
9.	**Living at Home Network**	Community Organization	Executive Director	Support	"Support this strategy as creating health equity is critical."
10.	**Southeastern Minnesota Area Agency on Aging**	Community Organization	Executive Director	Support	"The Southeastern Minnesota Area on Aging supports strategies to improve equitable access to aging and disability service programs to racial and ethnic communities including persons with disabilities and older adults. Enhanced program design will allow for a better connection to services without delays or experiencing other barriers."
11.	**The Office of Ombudsman for Mental Health and Developmental Disabilities**	NA	Regional Ombudsman Supervisor	Support	"OMHDD supports this effort to increase access to waiver services to POC (people of color)."
12.	**Lutheran Social Service of Minnesota**	Provider Organization	Senior Director of Advocacy	Support	"LSS supports developing a community engagement strategy to implement systemic changes to address disparities in the rate that racial and ethnic minorities access services available through home and community-based service waivers."
13.	**Minnesota Council of Health Plans**	Professional Association	Director of Research and Health Policy	Support	"The Council supports further analysis of disparities in home and community-based services (HCBS) utilization and recommends making sure that health plans' experience with these programs be part of the study."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
14.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator	Support	"Supportive, but it is important to recognize that there are additional underserved populations beyond those defined by race and ethnicity -- as the report itself acknowledges on p.13. This goal should reflect that equitable-access concerns are shared by many different populations, in addition to those named."
15.	**Touchstone Mental Health**	Provider Organization	VP	Support	"Strongly support"
16.	**Hennepin Healthcare / Hennepin Health**	NA	Interim Chief Medical Officer & Chief Medical Officer	Support	"Access to these programs and eligibility for Medicaid should be fair and equitable for all seniors and people with disabilities who need to apply. We especially want to highlight the need for equal access of people in communities of color, indigenous people, Latinx, Asian, Pacific Islanders, non-English speakers, veterans, and any other communities experiencing discrimination and disparities."
17.	**TakeAction Minnesota**	Community Organization	Director of Public Affairs	Support	"It is particularly important that this strategy begins with listening to communities, who are experts on the barriers they face. TakeAction Minnesota supports implementation of this strategy."
18.	**DARTS**	Provider Organization	President	Support	"We agree with this work and add the LGBTQ community to the list. As this strategy is implemented, it will be critical to not add administrative overhead to the agencies providing the services. Sometimes state provided questionnaires are off-putting to older clients as they are viewed as too intrusive."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
19.	**Wellness in the Woods**	Consumer Organization	Executive Director		"Wellness in the Woods encourages the development of a contract with a consumer organization representing and advocating for consumer needs."
20.	**NA**	State Agency	NA		"Isn't this what Disability Hub Minnesota and Senior Linkage Line already do? They are our state's Aging and Disability Resource Center and their job is to provide people with disabilities and those in the aging population with information, resources and options, so the person can make an informed choice. These services are already in place and already have funding, and they are available to all people statewide. If this is to provide funding to get the word out, great!"
21.	**Center for Health Aging and Innovation (University of Minnesota School of Public Health)**	Academic/Research Organization	Research Coordinator		"This recommendation needs specifics beyond the general information that is offered. While having a community engagement strategy is important and necessary, it is but one step toward ensuring equitable access. The report needs to address how will service access not only be assessed but also remedied for those from marginalized communities, which will also require resources."
22.	**Riverview Adult Day Services**	Provider Organization	RN Manager		"Our community is not as diverse as the larger urban areas but we engage in civil rights and no one is denied adult day services (ADS) for race/ethnicity/disability/age or otherwise."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
23.	**JustUs Health**	Community Organization	NA		"It is critical to assure equitable access to aging/disability services to ALL Minnesotans, particularly including all the historically underserved populations identified in this report. Racial and ethnic considerations are critical, but this report also identifies, e.g., veterans, LGBTQ, greater-Minnesota, and other populations. To assist, it is critical to have pertinent data related to these populations. We would strongly recommend that the Commission report call for the gathering of relevant data on these populations to inform the State's efforts to best achieve this equitable access."
24.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement		"This recommendation needs specifics beyond the general information that is offered. While having a community engagement strategy is important and necessary, it is but one step toward ensuring equitable access. The report needs to address how service access will not only be assessed but also remedied for marginalized communities."
25.	**Minnesota Leadership Council on Aging**	Statewide Collaborative	Executive Director		"This recommendation needs specifics beyond the general information that is offered. While having a community engagement strategy is important and necessary, it is but one step toward ensuring equitable access. The report needs to address how service access will not only be assessed but also remedied for marginalized communities."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
26.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator		"The Arc Minnesota supports the stated intention to gather extensive feedback from different people of color and culturally specific communities to determine the best way to expand access to services and supports, but unfortunately, do not believe that was realized in the process of developing this report. Identifying barriers to access and developing specific remedies will be critical to the success of this initiative. It is important to begin making progress on this important goal that has not been addressed for so long."
27.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator		"This recommendation needs specifics beyond the general information that is offered. While having a community engagement strategy is important and necessary, it is but one step toward ensuring equitable access. The report needs to address how will service access not only be assessed but also remedied for those from marginalized communities, which will also require resources? In addition, the LGBTQ community is missing from the Commission's charge to advance health equity and needs to be added due to health disparities and inequities that exist in that underserved community as well."

MINNESOTA
HEALTH AND HUMAN SERVICES
BLUE RIBBON COMMISSION

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**

Comments submitted to the Commission as part of its stakeholder engagement process are included in the grid below. Comments are categorized by the position they reflected, either: support or oppose. If it is not clear whether the commenter supported or opposed the strategy, if they expressed a neutral position or if the comment was not specific to strategy, the column is left blank. The summary of comments in the right-hand column provides highlights and/or excerpts of the submitted comments.

The Commission received 18 comments on this strategy.

- Several comments in support of the strategy noted that targeted case management could serve as an effective means of reducing health disparities across the state.
- Several comments in support of this strategy applauded the goal of this strategy to allow individuals earlier access to targeted case management, and also to streamline the process.
- Several commenters stated that this strategy had been discussed by various groups for years without leading to any meaningful change, and they expressed hope that the legislature could follow through this time.
- One commenter expressed concern that the current survey tool used to establish new rates does not allow for rates that would cultivate a competitive workforce and allow financial sustainability. Another recommended using FQHC cost-based reimbursement principles when establishing a new targeted case management rate methodology.
- The following organization offered to serve as resource in further development of strategy: Care Providers of Minnesota (Long-Term Care Imperative).
-

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
1.	**NAMI Minnesota**	Consumer Organization	Public Policy Coordinator	Support	"We appreciate the focus on a uniform rate methodology, as well as expanding access to case management services to help more people access the right supports at the right time. Having said that, a case management redesign has been discussed by various groups and task forces for years without meaningful changes. NAMI Minnesota hopes that this recommendation provides the necessary momentum for much needed reforms to targeted case management."
2.	**Catholic Charities of St. Paul and Minneapolis**	Provider Organization	Public Policy Manager	Support	"We support a redesign of targeted case management to reduce disparities in access. Catholic Charities serves many individuals who would benefit from targeted case management; unfortunately, we also see the significant disparities that exist for BIPOC in accessing more intensive medical, behavioral and social services. A redesign of case management has been under discussion by various groups and task forces for years with no substantive changes. We hope this recommendation finally moves forward."
3.	**Mental Health Minnesota**	Community Organization	Executive Director	Support	"We are supportive of a targeted case management service that meets the needs of people who otherwise are likely to fall through the cracks of the current system, as well as reduces disparities in access. However, the redesign of case management has been under discussion by various groups/task forces for a number of years with no substantive changes made to expand the service to more people or address disparities in access. It is our hope that this recommendation moves forward and produces real and lasting improvements to targeted case management."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
4.	**Arrowhead Area Agency on Aging**	Community Organization	Director	Support	"AAAA supports with an emphasis on individuals living in deep rural areas of the state with limited access to service delivery."
5.	**AARP Minnesota**	Consumer Organization	Manager, State Legislative Affairs	Support	"AARP supports this strategy. Now is the time to work collectively— across all levels of government, non-profit, and the private sector— to expose and address structural inequities that adversely affect communities of color. It is a matter of life and death."
6.	**Fraser**	Provider Organization	Public Policy and Compliance Counsel	Support	"Fraser supports expanding access to services"
7.	**Sanford Health**	Provider Organization	Sr. Legislative Affairs Specialist	Support	"An unfortunate fact of life in Minnesota is that we have some of the greatest racial disparities in health care in the nation…However, it is harder for our rural counties to work to eliminate these disparities because they are limited in what they can pay for targeted case management. We are supportive both of the expansion of eligibility for targeted case management and the establishment of a statewide case management rate methodology to provide consistent support of targeted case management across the state."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
8.	**Volunteers of America Minnesota**	Community Organization	Vice President Mission Advancement	Support	"We support this strategy and encourage its expansion to Community Health Workers…Healthy aging is both a public health and health disparities issue. Differences in education, income, and wealth, along with the impact of chronic stress and social exclusion associated with race and language barriers negatively impact the health of BIPOC, older adults, and people with disabilities. The lack of equity (social, health, environmental) impacts the health and well-being of all Minnesotans and their families and creates health disparities. The Commission must continue to advance this focus on eliminating health, economic, and social disparities if our state is to thrive for all Minnesotans."
9.	**Minnesota Leadership Council on Aging**	Statewide Collaborative	Executive Director	Support	"We support this strategy…Healthy aging is both a public health and health disparities issue. Differences in education, income, and wealth, along with the impact of chronic stress and social exclusion associated with race and language barriers negatively impact the health of older adults. The lack of equity (social, health, environmental) impacts the health and well-being of all older Minnesotans and their families and creates health disparities. The Commission must continue to advance this focus on eliminating health, economic and social disparities if our state is to thrive for all older Minnesotans."
10.	**Care Providers of Minnesota (Long-Term Care Imperative)**	Professional Association	Director of Research and Data Analysis	Support	"We support this strategy and to the extent this is aimed at reducing disparities in the provision of long-term care services and supports, we would like to join the effort and help fill in the policy details."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
11.	**Office of Ombudsman for Mental Health and Developmental Disabilities**	Other	Regional Ombudsman Supervisor	Support	"OMHDD supports this effort to expand eligibility for TCM to allow individuals earlier access. Earlier access to the services could reduce the need for more costly services in the longer term. OMHDD also supports developing a statewide rate structure so TCM services are equitable for individuals regardless of where they reside."
12.	**Minnesota Diverse Elders Coalition**	Community Organization	Coordinator	Support	"…should be a high priority for BRC or legislative development. Community engagement, partnerships, and culturally appropriate message and delivery methods are required for success."
13.	**The Arc Minnesota**	Community Organization	Legislative Advocacy Coordinator	Support	"The Arc Minnesota supports providing counties with additional resources to increase targeted case management in order to reduce disparities, provide culturally competent services, and promote access for people living in more rural areas of our state. There needs to be extensive management of resources to ensure that there is an approved methodology, manageable caseloads, uniform gathering of data and reporting to DHS for further evaluation and reports to the legislature."
14.	**Corner Home Medical**	Provider Organization	Clinical Director		"need to streamline the process and make it easier for families."
15.	**Touchstone Mental Health**	Community Organization	Executive Director		"I have concerns that the current cost study is looking at retroactive costs to determine a future rate structure. As a provider that wants to retain culturally competent staff, we need a rate system that will allow us to pay living wages that are competitive with county and hospital systems. Perhaps a competitive workforce factor could be built into the rate methodology that is mandated to be spent on staff wages and training."

	Organization or Individual	Organization Type	Title	Position	Summary of Comments
16.	**CLUES**	Community Organization	Senior Manager of Community-Based Mental Health Services		"There needs to be parity between what counties and contracted agencies are paid for TCM services, and we need to be paid a rate that makes statutory limits on our caseloads (which I support) financially sustainable. However, there is significant concern about the survey tool currently being used to help establish new rates. The tool asks for our current costs, not the costs we could incur if we were able to pay staff better and provide increased training dollars."
17.	**Minnesota Association of Community Health Centers**	Professional Association	Director of Public Policy		"MNACHC encourages the Commission to consider all options to increase access to coordinated public benefits and social services in order to meet a person's basic needs beyond medical and behavioral health care…As the Commission works to establish new TCM rate methodologies for counties and their subcontracted vendors, we encourage the Commission to consider modeling such methodologies after established FQHC cost-based reimbursement principles regulated in federal law."
18.	**Amherst H. Wilder Foundation** *(for the This is Medicaid Coalition)*	Community Organization	This is Medicaid – Coalition Coordinator		"This is Medicaid Coalition is neutral on this strategy, with 30% of members supportive."

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

The following general comments were received by the Commission or the Governor's Office throughout the course of the Commission's work.

- 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)

Additional comments to public input

The following list includes a summary and excerpts of responses to the prompt, "Please provide comments in this box" as part of the Commission's request for stakeholder comments In addition, this table includes a listing of general comment letters uploaded as part of the public comment tool process on the Commission's website.

Each entry includes the following information.

Organization or Individual

- Organization Type
- Title
- Summary of Comments

Minnesota Psychological Association

- Professional Association
- Legislative Chair and Federal Advocacy Coordinator
- "The Minnesota Psychological Association would ask that the Commission revisit the topic of embracing robust Health Information Exchanges that have the potential to improve quality of care and reduce costs."

Rise

- Provider Organization
- President
- "Thank you for the opportunity to provide feedback on this important work."

Wellness in the Woods

- Consumer Organization

- Executive Director
- “Consumer representation and representation from diverse underserved communities is a huge gap when creating new plans and programs. Instead policy and plans are created and then presented for approval after the fact. Consumers need to be on board from the very beginning including gaps assessments.”

Minnesota Health Action Group

- Consumer Organization (Employer/Purchaser Coalition)
- Vice President
- “The purchasers wish to thank the Blue Ribbon Commission for their important work. In selecting strategies to advance, the purchasers recommend that policymakers consider strategies that meet the Commission's charge, while also improving access and affordability for ALL purchasers in the state, including governments, employers, and individuals. The pharmacy strategies included in the report, and commented upon here, offer this potential. While time did not allow the purchasers to provide detailed suggestions related to other strategies, it was noted that Waste Strategies A, B, and C also offer significant value/savings and create important alignment of purchasers. These strategies are also highly recommended for further analysis and potential implementation.“

Amy Barrett

- Individual Person
- Information Officer (DHS)
- “Rent for the Andersen Building downtown St. Paul has to be exorbitant. Now that the pandemic has required employees working there and in 444 Lafayette to work from home, why not let them continue to do so and save the cost of renting office space? Or if some employees need to be in an office setting, consolidate them at the 444 Lafayette Building. Perhaps the Andersen Building could then be converted into affordable housing, which is clearly desperately needed.”

Alzheimer’s Association, Minnesota-North Dakota Chapter

- Consumer Organization
- Manager of State Affairs
- “Thank you for the opportunity to provide feedback on the report.”

Vision Loss Resources

- Community Organization
- President/CEO
- “I would like to thank the Governor and the Commission for the work done here. This work will benefit many.”

NA

- State Agency
- NA
- “it was disappointing to see the list of who was involved in this Commission, and that it didn't seem to include people receiving services. It was also disappointing to hear that community engagement opportunities were cancelled because of Covid-19 - in state government, we need to be more flexible and offer opportunities to participate online and provide feedback. if we're stuck in only doing in-person events, then we're missing out on valuable input from people who may not be available to join meetings during the workday, or who cannot get transportation to attend meetings in-person.”

The Improve Group

- Professional Consulting Organization *(“a hybrid between community & provider”)*
- Founder & CEO
- “With 20 years of work in health and human services we have a passion for equity, connections to communities and deep knowledge. We know engaging community members ensures systems are responsive to their needs and strengths. While we were tasked by the Blue Ribbon Commission to engage stakeholders and communities, the work was discontinued. We recommend the Commission and policy makers pause before adopting strategies to connect more fully with communities. This pause would address flaws in the process and advance the Commission’s dual mission of cost savings and equity: • Strategies were gathered early in the Commission’s lifecycle, when it hadn’t yet clarified its purpose and processes. The strategies diverged wildly, were minimally connected to its mission, and weren’t as innovative as they could have been with deeper engagement. • The double crises of George Floyd’s murder and COVID impacted Minnesotans extensively. These highlight the importance of truly transformative changes to improve equity and sustainability, and that opportunity was missed. • The Commission was significantly under resourced so strategies did not get a full analysis or equity review. • The current strategies are separated by focus: equity vs. cost savings. Each strategy should be analyzed by both factors, or else risk working at cross purposes.”

Health Care for All Minnesota

- Community Organization
- Board Chairman
- “We are pleased to see that the Commission realized the potential benefits of more centralized purchasing of transportation services, durable medical equipment, and drugs. Centralized bulk purchasing is a core principle of single-payer approaches to health care delivery. We encourage future commissions to take a serious look at other core principles of single-payer approaches such as unified financing of health care without the need for insurance company intermediaries.”

Interact Center for the Visual and Performing Arts

- Provider Organization
- Director of Licensing and Recruitment

- "For further information about the "LTSS Strategy B- Update Absence Factor in Day Services'" impact on access to services, see the multiple letters of concern shared with the Commission on page 75 of the draft final report."

Nicole Noblet

- Individual Person (affiliated with Interact)
- NA
- "The service I receive through my CADI wavier benefit me and help me be active in my community. I don't want them to change when the waivers are changed to the 2 model system next year."

Jill Reedy

- Individual Person (affiliated with Interact)
- NA
- "I receive services at Interact Center, a nonprofit provider of Adult Day services for Minnesotans with disabilities. I am very concerned about the proposal to reduce the Day Service Absence Factor. With the destabilizing financial impacts caused by COVID19, this rate cut of approximately 5% would further damage the already fragile infrastructure for day services for individuals with disabilities. Too often, DHS fails to ask US, the recipients of these vital services, for OUR opinion on matters such as this. As an individual receiving these Adult Day services, it is so important to me that my program is funded adequately and appropriately to ensure my safety, health, and happiness. I urge you to reconsider cutting the Absence Factor. For further information about this proposal's impact on access to services, see the multiple letters of concern shared with the Commission on page 75 of the draft final report."

All Trans Software

- NEMT Software Vendor
- Vice President
- "In regards to NEMT I'm concerned that a single administrative entity would affect many small minority business owners and the drivers they employ as well as potentially take away any type of client choice in terms of the provider they which to utilize. It does make sense for example that a Somali member be transported by a Somali driver that can relate to the member and speak the language, and that would apply across the board. There also are a lot of administrative oversight done by the NEMT providers to ensure vehicles are inspected daily, dot inspections are done timely, back ground checks, OIG checks, initial and on-going training of the drivers, specialized training of drivers related to Special Transportation (wheel chair, stretcher, protected as well as mental health) to ensure consistent and safe transport of members. One of the biggest compliant I've heard when BCBS outsourced transportation to Logisticare is that members with mental health issues, autistic kids, who rely on structure and consistency all of a sudden had new drivers rather than the driver that has been taking them for the past year. If a single entity is your ultimate goal however I would recommend looking at relationships within MN that's knowledgeable with the industry (like us) that has relationships with a large number of

current providers (both within the 7 county metro and more so rurally), counties and the R80. I open to any further discussion, questions and appreciate you taking the time to read my input."

Center for Healthy Aging and Innovation (University of Minnesota School of Public Health)

- Academic/Research Organization
- Research Coordinator
- "CHAI believes that focusing entirely on costs savings does not address the full picture of long-term services and supports (LTSS). LTSS should be viewed as an investment against subsequent healthcare costs, versus as a "wasteful" budget item to be cut. Therefore, in addition to the cost "savings" benchmark for MN budget savings, policies should take into account and seek to measure and capture actual costs savings (as well as costs) for clients, family members and the healthcare systems."

Eric Jokinen

- Individual Person
- Registered Nurse
- "In October of 2019 the Office of the legislative auditor found an estimated loss of over $400 million dollars and the "dysfunction at DHS caused the problem" since 2014. It should be included that either the OLA or another independent auditor separate from any MN state office audit the spending and submit a report at least twice a year to authenticate that both the money being distributed and the estimated savings are all accounted and documented. Along with that, supporting that the savings did not have a negative impact on the areas from which they came from." This statement was also submitted separately for each strategy.

VINE Faith in Action

- Community Organization
- Community Living Coach, VINE Adult Respite Center Director
- "Please take into consideration that when you treat greater Minnesota the same as the metro area, you are not comparing apples to apples. When COVID closed the ADS in the state, this had adverse effects on the families served. Most of those we serve in our program are elderly, have cognitive impairments, and ADS was their only activity/outing. Families lost contact with others and became socially isolated as we serve the most vulnerable population. Family caregivers were stuck at home with their loved ones, receiving no respite or reprieve from caregiving responsibilities. Now having ADS open for 3 hours per day is also taking it's toll financially. How long can small non-profits survive on 25% capacity? Funding ADS is difficult with waivers because they pay a tiny piece of what it costs to operate. The VA is slow to pay ADS fees and we can talk to 3 different people at the VA and get 3 different answers, all of which may not be true. We are required to pay for dieticians to look at our menus, offer special diets, pay for RN's and PT's to oversee our programs, all of these things cost $$$ each month. Our participants may come one day and be gone the next, but our output of dollars doesn't decrease, we still have to pay to keep the lights on and pay the staff. It is a hardship when we lose participants. While it's admirable to try and save dollars, those cuts have top down consequences for providers. The purpose of ADS is to

delay placement into a more costly option. I know this to be true for our program has served many who attended until they passed. It seems providers are continually asked to do their jobs with one or both hands tied behind their backs. Very frustrating!"

Prairie Island Indian Community

- Community Organization
- Family Health Manager
- "All of these strategies are important for the Indian communities represented by IHS and MHD. They were descriptive and concise."

Riverview Adult Day Services

- Provider Organization
- RN Manager
- "Our ADS is now down to 4 clients, two of whom live in congregate setting. The same congregate setting is the site of our ADS in the community room. Under the current ruling, the congregate setting people can not attend. The other two are not daily people so setting up a staffing schedule is so inconsistent. The clients left that could attend, do not want to come out of their setting for only 3 hours per day. In fact, they are nervous about integrating into a group setting period even with the consistent disinfecting, distancing and facial coverings because they have so many underlying risk factors. We also share a community bathroom with other habitants who live in the building. We have to pass through a lobby to get to and from this bathroom. These challenges make it very difficult for us to even think about opening at this time."

APA Medical Equipment Co, Inc

- Provider Organization
- Owner
- "I think that there could be room for cost savings in the Cost Savings Strategies: Health Care area (b). But I think these adjustments would need to be done on an individual procedural code basis (starting with the products that produce the largest outlays to the program). Of course no supplier wants to receive less for their services or products. But if DHS and suppliers could work together, I think we could come up with some mutually agreed upon some cost savings. I'd like to think we could join together to enhance what matters most to both of us, outcomes to the Medicaid members, while providing relief to tax payers and a fair business environment for suppliers."

DARTS

- Provider Organization
- President
- "Thank you to all the Blue Ribbon Commission members and the state staff who worked to provide the group the data. These are difficult discussions and there is an opportunity to really transform how we deliver services, keeping Minnesota on a leading edge. We are a great state in which to age!"

Mount Olivet Day Services

- Provider Organization
- Program Director
- "We are a non-profit organization. The cost of providing services to waivered participants does not come close to the actual cost of our quality program."

Region 3 Public Health & Human Services Directors

- Other
- Aitkin County Public Health & Human Services Director
- "Of the original 42 strategies considered, 20 were not fully reviewed. The Public Health & Human Services Directors from Region 3, including the counties of Aitkin, Carlton, Cook, Itasca, Koochiching, Lake & St. Louis, encourage the Blue Ribbon Commission to further explore one of the strategies that was not fully reviewed, #7, 'Develop a Single, Inter-Operable, Secure, Low-Cost Telepresence Network'"

Unique Adult Day Care Center, LLP

- Provider Organization
- President/CEO
- "Unique ADC has faced financial hardship due to the mandated closure and the limitations currently placed on provider operations due to COVID-19."

Metropolitan Area Agency on Aging, Inc.

- Community Organization
- Executive Director
- "Metropolitan Area Agency on Aging applauds the Commission for its work in difficult circumstances during a pandemic. We appreciate the inclusion of strategies that could improve the health and well-being of older adults. We ask the Governor and Legislature to make the growing older adult population and their family caregivers a focus for policy and funding transformation in this administration. States such as Washington are innovating and leading on this front. Minnesota must also become a leader by developing and resourcing a collective vision and innovating through well-conceived and scalable strategies that ensure equity for all."

Catholic Charities of St. Paul and Minneapolis

- Provider Organization
- Public Policy Manager
- "We also encourage you to revisit the issue of modernizing Elderly Waiver rates. Providers across the state are subsidizing the cost of care in an unsustainable way. As a result, many are transitioning to discontinuing service or limiting the number of Elderly Waiver clients—both of which threaten to further limit choice and access for individuals. Attention to this issue is needed now to help keep individuals out of more expensive skilled nursing facility settings and to avoid increased HHS costs in the future. Not

receiving attention in the draft report but warranting more consideration are the topics of housing instability and homelessness. Housing is inextricably linked to health. It is more cost effective to prevent homelessness than it is to address issues after someone becomes homeless, and it becomes harder and more expensive to re-house someone the longer that person is homeless. As Minnesota continues to experience a housing and homelessness crisis—a crisis that is likely to worsen due to COVID-19—we cannot ignore its impact and the cost of the state's response to the health and human services budget. As the Commission works to finalize its report and explore additional health equity and system transformation strategies, we urge you to recognize housing as healthcare and to acknowledge homelessness and emergency shelter as part of the housing continuum. We are happy to serve as a resource for discussions on these issues. Much attention has been given to identifying $100 million in HHS savings for the next biennium, but such savings and meaningful improvements to outcomes cannot be achieved through administrative efficiencies alone. We must also think about the return on investment of the programs and services we offer and recognize that we will never fully achieve transformational change and savings without addressing equity."

Minnesota State Advisory Council on Mental Health / Subcommittee on Children's Mental Health

- State Advisory Council
- Chair
- "The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health feel very strongly that the Commission should explore the development of a single, interoperable, secure telepresence network. This recommendation had strong merit pre-COVID, and is now clearly a priority need for public and private sectors. It will increase access to necessary services and promote effective collaboration among service providers. Telepresence can maximize the use of existing workforce capacity by reducing windshield time for clients/providers, reducing/eliminating lost time due to cancelled appointments, and providing access to services in homes/community-based settings across the state. Telepresence supports person-centered care, regardless of where in the state an individual resides. Allowing telemedicine visits, including phone calls, to be reimbursed at par with face-to-face visits has allowed greater access to services for underserved populations. We ask that you take the time to research the development of an interoperable telepresence network; its creation would support ALL Minnesotans to access vital mental health services."

Kathie Brinkman

- Individual Person (affiliated with Interact)
- NA
- "Attached below is a picture of my daughter, Katie Brinkman, with some of the pieces of art she is creating at Interact Center for the Visual and Performing Arts."

Midwest Association for Medical Equipment Services & Supplies (MAMES)

- Professional Association
- Executive Director

- “Please make sure to include uploaded documents for these 2 strategies: 2) Health Care Strategy B - Modify Certain Medical Assistance Durable Medical Equipment Payment Rates to Match Medicare Rates 3) Health Care Strategy C - Expand Volume Purchasing for Durable Medical Equipment”

DHS reviewed these letters as part of its synthesis of public comment on the draft report.

Minnesota Social Service Association

- Professional Association
- Director of Public Policy and Advocacy
- “We have attached a letter based on an undeveloped strategy, "Develop a Single, Interoperable, Secure, Low-Cost Telepresence Network" which we ask that the Commission further explore. Thank you for the opportunity to provide input!”

Dental Access Partners

- Provider Organization
- Policy Director (Apple Tree Dental)
- “DHS data does not support their strategy: New analysis of DHS data shows that CAD providers deliver affordable solutions and have capacity to expand access, while most other providers simply don't have the capacity to deliver Medicaid services at costs that taxpayers can afford. •CAD providers, whose costs are approximately 60% of submitted charges, increased dental visits by more than 500,000 in three years. •Non-CAD dentists, whose costs are 86% of submitted charges delivered fewer dental visits, limiting Medicaid to about 3% of revenues. CAD providers have developed innovative Dental Home models that make it possible to deliver better care at lower costs. We do this by bringing care to the patient using strategies that expand access, including: • Collaborative Dental Hygiene Practice and Dental Therapists • Providing preventive care in community settings, and • Triaging patients to clinics for follow up / more advanced care before dental emergencies occur. Many dental providers lack the advanced training needed to provide care for patients with complex medical conditions or significant physical, mental, or developmental disabilities. Instead, they refer them to safety net providers who step into these roles to assure not only access, but also health equity for all Minnesotans. Paying all providers the same rates has been tried, and failed in Minnesota and other states. •The DHS proposal isn’t new - it would be returning to DHS’s own single payer, single rate system that didn’t work more than 30 years ago and whose failure actually led to the successful CAD dental access incentive program. •Patient populations vary in their health and social complexity. Paying all providers the same for more or less complex care, makes no sense. •In 2016, a nearly identical Wisconsin Medicaid pilot project, more than doubled dental reimbursements to all providers in 4 counties. $13.8 million dollars produced a net increase in access of only 2%.”

Arrowhead Area Agency on Aging

- Community Organization
- Director

- "AAAA wishes to thank the Commission for its work and appreciates the inclusion of older adults of all backgrounds. We ask the Governor, legislature, staff and communities make the growing older adult population and family caregivers a priority focus for policy and funding transformation, that we pay special attention to language and policies moving forward as we work to create an Age Friendly State that seeks to create inclusion and opportunities for all ages to thrive. Thank you for your work!"

AARP Minnesota

- Consumer Organization
- Advocacy Director
- "AARP on behalf of our 650,000 members and all older Minnesotans, appreciates the work of the Blue Ribbon Commission. We are especially pleased that several recommendations put forth by AARP were selected including proposals to address the high cost of prescription drugs and the proposal to expand home care benefits through Medicare private plans. Both of these proposals will not only reduce spending in the Health and Human Services Budget, but also can address the increasing needs of older Minnesotans and the demographic shift we will be facing in our state. However, we ask the Commission to consider several other proven policies to address the significant demographic shift we will experience in the coming decades including: • New models for retirement savings to address the retirement savings crisis that will place significant pressure on state budgets; • Paid family leave proposals to support family caregivers who provide the bulk of long term care in our nation and; • Supporting the work of the Governor's Council on an Age-Friendly Minnesota. By committing to becoming more Age Friendly, Minnesota can solve for the very real and major challenges facing our state, and simultaneously progress toward creating communities where older adults can thrive. Finally, while we appreciate the Commission's work in beginning to address health disparities, so much more work will have to be done to address this public health crisis that has existed for decades in Minnesota. The ongoing coronavirus pandemic has once again sent a clear message — this time, perhaps louder than ever. Now is the time to work collectively — across all levels of government, non-profit, and the private sector — to expose and address structural inequities that adversely affect communities of color in our state. Thank you again for your work in ensuring older Minnesotans have access to the quality services they need. If you have any questions, please contact Mary Jo George at mgeorge@arrp.org"

Fraser

- Provider Organization
- Public Policy and Compliance Counsel
- "Fraser recognizes the importance of managing state resources prudently and the parameters within which the BRC must work. Unfortunately, many of the strategies proposed do not reflect a long term strategy to truly reduce costs and transform the system. We encourage the BRC to consider the impact of these proposals on Minnesota beyond the next biennium."

Volunteers of America Minnesota

- Community Organization

- Vice President Mission Advancement
- "Volunteers of America Minnesota provides essential community-based health and human services for over 25,000 low-wealth Minnesotans, many of whom access Medicaid and Medicare, across the lifespan every year. We along with other nonprofit providers are critical partners in meeting the needs of Minnesotans with complex support requirements and do so in a cost-effective manner. As an organization that provides vital services for populations facing significant challenges, much of our work continues to be both essential and in-person during this first wave of the COVID-19 pandemic. While we agree that HHS spending growth is an important consideration as we develop plans to ensure that Minnesotans continue to receive the coverage and care they need, we also recognize that spending growth is due in large part to growth in need for services, especially as it relates to populations with higher average costs such as older adults and people with disabilities. The Commission will need to take great care to ensure that improving outcomes and advancing equity remains at the forefront of decision making, and that this work does not cause harm at a time when demand for core services, especially in the wake of COVID-19, civil unrest and the economic fallout, is on the rise. We thank you for your leadership and for the time and energy by each of the Commissioners dedicated to this important work. We continue to believe it is essential for us to think creatively about our health and human services policies and programs and that proactive, future-oriented thinking carries the day."
- "The Blue Ribbon Commission's charge to find $100 million in cuts in the near-term HHS budget is deeply concerning, particularly within the context of the demographic shift. We are in many ways not prepared. As such, we wish to revisit the following concepts...Support Low-Income, At-Risk Older Adults...Living Well with Chronic Conditions...Age-Friendly Minnesota."

Minnesota Leadership Council on Aging

- Statewide Collaborative
- Executive Director
- "Supporting Low-Income, At-Risk Older Adults As reported by DHS, Elderly Waiver (EW) rates need modernization, including filling a nearly $400 million gap in investment. Providers are subsidizing the cost of care and many are discontinuing service or limiting the number of EW clients. These forced economic choices decrease choice and access for individuals. Further cuts or adverse changes to eligibility are short-sighted and limit access and increase costs of services in the future. Investments in the HCBS infrastructure through EW are common-sense and keeping individuals out of the more costly SNF setting. Living Well with Chronic Conditions Older adults are living longer, and for many that means managing chronic conditions that can threaten independence and quality of life. Significant spending occurs at the end of life, a curve that can be mitigated with early intervention and supports. The Commission should address older adults living with chronic conditions such as Alzheimer's Disease and related dementias. All Minnesotans should have access to early screening, diagnosis and competent LTSS, including the best in evidence-based health promotion and chronic disease management strategies. The Commission should support proven models such as palliative care and innovate new models of integrative services across community-based, acute and long-term care settings. This work must include considerations for friend and family caregivers who are key to ensuring high quality of life and cost containment strategies. Age-Friendly MN Purposeful involvement of older adults, their families, and the aging services workforce in systems design, programs and policies is critical. The

Commission must inform and support the work of the Governor's Council on an Age-Friendly Minnesota. Thank you for your commitment to ensuring older Minnesotans have access to the needed supports to age well.."

Living at Home Network

- Community Organization
- Executive Director
- "We support looking in the future at transformational ways to save costs such as focusing on developing more service models and service availability for less costly ways to help older adults stay living at home and to avoid spending down to needing public assistance"

John Klein

- Individual Person
- NA
- "The 1,000 character limit, basically one paragraph, allows very little detail and requires omission of important background, relevant facts, and relevant issues for consideration. I encourage the Commission to follow-up for more detail about any comments of interest."

SEIU Healthcare Minnesota

- Labor Union
- Political Director
- "It should be easy for a group of Minnesota health care policy experts to find a way to spend $100 million less on health care. The American health care system is the most expensive and wasteful system in the world. We spend twice as much per person as comparable countries for care that is not universal and is often inadequate. This waste has made executives in the insurance, hospital, and drug industries wealthy and powerful beyond all measure. For them, 'waste' is the goal. They have built our system, not to care for all of us, but to enrich the few. Because this waste is so deeply entrenched, it is not surprising that the Blue Ribbon Commission (BRC) was unable to find easy ways to immediately save large sums of money. To reduce waste, we need to provide greater opportunities to use our collective power take public control of our health care system. Then we will be able to root out the special interests who waste so many of our resources. We would also like to emphasize that, contrary to the draft report, there is no "requirement" that the BRC find $100 million in savings. Nothing in Laws of Minnesota 2019, 1st Special Session, Chapter 9, Article 7, Section 46 requires the BRC to identify savings of any amount. No dollar amount is listed in the "duties" of the BRC in Article 7. In fact, Article 14, the Appropriations article, provides a mechanism to accommodate the BRC recommending no savings at all, see Sec 11 (d) (3). If we propose no savings, it simply reduces the budget reserve $100 million. Recommending no savings is perfectly consistent with the legal duties of the Commission. If this report implies there is a requirement, it unfairly charges Commission members with failure to do their duty and improperly attributes an austerity goal to our elected government. Such references should be eliminated."

PrimeWest Health

- County-Based Purchasing Organization
- CEO
- "Committee members should be applauded for their hard efforts in fulfilling a very challenging mission. Many of the strategies should help reduce health care costs and disparities. However, there are three severe strategies that propose carving out benefits and services from managed care that should be pursued only as a last resort. The strategies are extreme far-end approaches when there are far less risk approaches and best practices that could be implemented to achieve the same objectives through collaboration between DHS, MDH, MCOs, and County-Based Purchasing organizations. The three proposed strategies are not the products of such a collaboration. A collaborative approach that combines and focuses the vast expertise and resources of these organizations on NEMT, pharmacy costs and dental access has yet to be pursued."

Minnesota Association of Area Agencies on Aging (m4a)

- Professional Association
- Board Member
- "The Minnesota Association of Area Agencies on Aging (m4a) is a coalition of the Area Agencies on Aging in Minnesota. M4a provides common voice for furthering the following goals; to assist people to age with dignity and independence, to ensure older adults are valuable contributors to society, to inform policymakers on issues affecting older adults and their families and to offer a comprehensive continuum of support services in communities. M4a supports the following strategies: • Expansion of the MN Encounter Alerting Service • Creation of a Uniform Pharmacy Benefit • Medicare Enhanced Home Care Benefit • Improvement of MnChoices and LTSS Processes • Ensure Equitable Access to Aging and Disability Service Programs and • Aligning State and Federal Health Care Privacy Protections. M4a would like to recognize the tremendous work the commission has taken on, especially during these difficult times. M4a is optimistic that many of these changes shall have a positive effect on our older population."

TakeAction Minnesota

- Community Organization
- Director of Public Affairs
- "Please see our uploaded letter commenting on weaknesses in the overall focus of the Commission's work and report."

American Cancer Society Cancer Action Network *(Submitted on behalf of the Minnesota Patient Advocacy Coalition)*

- Other
- Government Relations Director, MN; Patient Advocacy Coalition Chair

- "The Minnesota Patient Advocacy Coalition is a consortium of organizations which has come together to advocate at the state and federal levels for preserving and enhancing access to quality health care services for all Minnesotans. Representing millions of Minnesota patients, we are committed to ensuring access to meaningful and affordable health care coverage while lowering costs and improving quality of care. Together, we speak in one voice to ensure access to quality, affordable health care for all. Our comments are not directed at the technical scope of the Blue Ribbon Commission's draft recommendations. We recognize the value of simplifying programs, increasing efficiencies, and saving money when it can be done without causing harm to Minnesotans, and appreciate the Commission's efforts in this regard. Our comments are instead directed at the guiding philosophies of the Commission's work and the ways in which its recommendations will be put to use. Please see the attached letter uploaded as a supporting document for specific comments and the complete list of MN Patient Advocacy Coalition organizations submitting comments."

Southeastern Minnesota Area Agency on Aging

- Community Organization
- Executive Director
- "The Southeastern Minnesota Area Agency on Aging is appreciative of the efforts of the Blue Ribbon Commission to improve the overall well-being of older adults throughout the state of Minnesota. Thank you for your initiatives to improve policies and a structure for funding transformation, ensuring that older adults and their family members have access to needed services. Kudos to the Governor and Legislature for your focus on the growing adult population in our state and nation - your efforts in this regard will truly make a difference in the lives of seniors striving to live independently in communities of their choice."

Minnesota Consortium for Citizens with Disabilities

- Community Organization
- Policy Co-Chair
- "Strategies not developed: We note our strong support for a strategy that was not selected for development: Increasing Access of Home & Community Based Services for Older Adults. Other comments 1. Participation of Impacted People and Communities We understand the challenges to community engagement posed by COVID-19. Yet we believe there is more that could and should be done to hear and incorporate feedback from the people most likely to be impacted by these strategies and we believe that should be done before presenting any strategies as "developed." The "development" that was done was important and necessary work, but by only one of the stakeholders (the state agencies involved). We are concerned that submitting a version of this report to the Legislature that presents 22 strategies as developed with a few words about the need for further community engagement is not necessarily likely to ensure that such community engagement occurs. COVID-19 presents similar challenges to the Legislature for direct community engagement. 2. Equity Review We have similar concerns about the incomplete equity reviews undertaken for these sets of strategies. We are also curious about how and when equity reviews could be completed for the state's systems as a whole, rather than these individual strategies. We are concerned about stating the

importance of equity considerations, and yet continuing to focus the conversation on a set of strategies. 3. Process Suggestions: The Commission's report could present the need for stakeholder input and recommendations for how to do that as its core recommendations, rather than presenting "developed" strategies. The need for authentic engagement from impacted communities and true equity review is especially important as the 2021 Legislature faces a likely budget deficit. The Commission can and should set an example for prioritizing community engagement and equity before discussing substantive proposals."

Office of the Ombudsman for Mental Health and Developmental Disabilities

- Other
- Regional Ombudsman Supervisor
- "1. Framework Align Corporate Residential Billing with Rate OMHDD is concerned that further limiting the billable days for Corporate Foster Care providers could lead to decreased access to residential care for those individuals most in need of this level of care. Currently, the rate structure allows providers to absorb approximately 14 "absent" days/year. This helps providers remain solvent during those times when a consumer is away, for any reason, and the home cannot bill for services. For many, people with disabilities, health issues, including mental health issues, may require days away from their Corporate Foster Care setting. Providers may become reluctant to accept residents with a known history of needing days away from home if they perceive the financial impact to be too substantial. OMHDD would have concerns about changes that would financially disincentivize providers from serving individuals who may need, or want, more than 14 days away from the home per year. These are often the same consumers who need the support this level of care provides. 2. Curb Customized Living Service Rate Growth OMHDD supports this proposal insofar as it is aimed at reducing the excessive rate requests of providers who are not equipped to provide the level of service they advertise . There is a growing concern about the rapid increase in CL Customized Living facilities that are, for all intents and purposes, set up like Corporate Foster Care but because of their designation do not have to follow the statutory regulations required of Corporate Foster Care homes. This leaves very vulnerable clients at serious risk to their health, safety, and rights"

Lutheran Social Service of Minnesota

- Provider Organization
- Senior Director of Advocacy
- "LSS supports the Increase Access of Home and Community-Based Services for Older Adults strategy which was initially identified by the Commission for development but was not fully developed due to time constraints presented by the COVID-19 pandemic. LSS submitted this proposal as a transformational strategy that would reduce health care costs by providing additional support for services that provide an increase in social connectedness and access to community supports, such as Caregiver Services, Companion Services and Respite type care."

Minnesota Council of Health Plans

- Professional Association
- Director of Research and Health Policy
- "The Council recommends that the Commission consider the implementation of a statewide telepresence network, one of the proposals not yet developed by the Commission (Development of a Single, Interoperable, Secure, Low-Cost Telepresence Network). The current COVID-19 public health emergency highlights the importance telemedicine plays in increasing access to needed treatment for individuals. It has also highlighted the need for one statewide, interoperable, secure, low-cost telepresence network connecting people, particularly those in Greater Minnesota, with providers. We believe that investment in statewide infrastructure allows for greater continuity of care for members and helps to create a more administratively and cost-effective health care system."

Minnesota Diverse Elders Coalition

- Community Organization
- Coordinator
- "The Minnesota Diverse Elders Coalition (MNDEC) was formed by the Minnesota Leadership Council on Aging (MNLCOA) in 2019. The MNDEC convenes community and service providers to identify and implement activities that advance equity in Aging. We work with older adults to create healthy communities where older adults are valued and improves access to high quality and culturally diverse supports so that all older Minnesotans can be well and live healthy. We are pleased to offer the following comments on the Blue Ribbon Commission's (BRC) draft report. We appreciate the work of the BRC and want to thank the commission members for their time and their talents. Based on our conversations the BRC prioritized the cost savings and there was limited time available for the inclusion and engagement with BIPOC and LGBTQ stakeholders, elders, community organizations, and providers of senior service providers. We believe the community engagement is critical to ensure proposed Health and Human Services program align with community needs and priorities and cost savings recommendations do not have unintended negative consequences on the communities that rely on those programs. The recommendations discuss a health equity lens will be applied but we are concerned the modified timeline did not provide adequate time for a thorough assessment of the impact on the lives of seniors from culturally diverse communities. A mantra in the cultural communities which resonates with many is "Nothing For Us, or About Us, Without Us." We understand we are operating in unprecedented times, filled with uncertainty, but meaningful, authentic engagement going forward can provide the equity lens you desire and assist with development of concrete recommendations to improve and transform programs and services. Thank you again for the opportunity to provide feedback. We look forward to continued collaboration to improve health & human services."

Corner Home Medical

- Provider Organization
- Clinical Director

- “Telehealth in the home makes sense and works. Registered Respiratory Therapist managing COPD.”

Amherst H. Wilder Foundation (This is Medicaid Coalition)

- Community Organization
- This is Medicaid – Coalition Coordinator
- “This is Medicaid is a coalition of organizations that partner to protect Medicaid from harmful changes and funding cuts. The nonpartisan organizations advocate for, or directly serve, people who access healthcare and supports through Medicaid. Coalition members were surveyed on the 22 proposed strategies by the Coalition Coordinator, and the members' responses have been entered in the survey provided by the Blue Ribbon Commission. This is Medicaid coalition stands ready to continue collaboration with and provide support to the Blue Ribbon Commission in whatever capacity may be needed.”

Touchstone Mental Health

- Provider Organization
- VP
- “Please ensure adequate time to understand the complexity of the strategies. Do not rely only on DHS for information about impacts to people served nor those working to serve people at a time of significant challenge and unrest. Please focus on equal access to health care for everyone and quality of care; paying for burdensome oversight of overly complicated regulations only adds to the cost of care. When covid-19 hit, suddenly the system was able to waive so many burdensome requirements that one HAS to wonder, "How could we be this efficient and focused ongoing instead of only during a pandemic?" Consider cost saving strategies that simplify burdensome regulations as they are already extremely complex and time consuming to address for all of us involved. Don't limit access to Customized Living services; DHS consistently is working to interfere with services that are highly effective for people served. Instead, consider the enormous cost savings for hospitalization, ER and homelessness as a result of customized living services. People will unduly suffer otherwise.”

NUWAY

- Provider Organization
- VP Public Policy
- “I don't feel the equity analysis provided much information on what to do...mostly more questions asked with little support in how to assess if the strategy met the bar.”

Doctors for Health Equity

- NA
- NA
- Expressed interest in partnering to support reaching traditionally disadvantaged groups.

Association of Minnesota Counties; Local Public Health Association of Minnesota; Minnesota Association of County Social Service Administrators

- County Associations
- Executive Director; Director; Executive Director
- "The strategies lack detail. Strategies in the current form should only inform legislation that supports further analysis. Adequately developing the initiatives will take considerable engagement with counties and other stakeholders, additional data analysis, careful planning around unintended consequences and additional analysis around health equity. The strategies called out in the commission's plan are small scale approaches and identify potential cost savings in certain areas. Many of the strategies were aimed at a particular service or agency program. There is little attention on the broader approach to addressing the social determinants to achieve better outcomes and increased savings. Counties are excited to engage in a thorough and transformational process that reflects foundation change – the true change of the commission. Simply stated, the work of the commission has just begun."

Minnesota Inter-County Association

- Professional Association
- Executive Director
- "We are concerned…that the final product does not provide a pathway to transforming the complex and convoluted health and human services system under which we all operate. Instead, recommendations largely presume continuation of programs, services and technology that have been around for decades with some old ideas resurfaced as new."

HMS

- Cost Containment and Population Health Management Company (Vendor)
- NA
- Attached letter included recommendations on the following topics related to Medicaid Third Party Liability (TPL):
    - "Improve Medicaid TPL to harness advancements, garner efficiencies, plug budgetary holes, and maintain integrity"
    - "Move TPL further upstream"
    - "Adopt TPL best practices"
    - "Restart and Improve Medicaid Coordination of Benefits with TRICARE"
    - "Create and Expand Medicaid Health Insurance Premium Payment Programs"
    - "Establish a Robust HIPP Program"
    - "Maximizing Federal Funding under COBRA"

Alzheimer's Association

- Consumer Organization
- Manager of State Affairs

- Made comments on overall approach of Commission, under the following titles:
    - "Make distinctions around 'Twin Tragedies'"
    - "Prioritize Transformation"
    - "Prioritize Health Equity"
    - "Consider Minnesota's Changing Demographics"
    - Also previously submitted to the BRC additional strategies for consideration.

Region 3 Public Health & Human Services Directors

- Northeast Minnesota – Region 3 Public Health & Human Services
- Directors
- Requested that the Commission further explore the following strategy: "Develop a Single, Inter-operable, Secure, Low-Cost Telepresence Network"

Minnesota State Advisory Council on Mental Health / Subcommittee on Children's Mental Health

- State Advisory Council
- Chair
- Requested that the Commission further explore the following strategy: "Develop a Single, Inter-operable, Secure, Low-Cost Telepresence Network"

Minnesota Social Service Association

- Professional Association
- Executive Director; Legislative Co-Chair; Director of Public Policy & Advocacy
- Requested that the Commission further explore the following strategy: "Develop a Single, Inter-operable, Secure, Low-Cost Telepresence Network"

Minnesota Medical Association

- Professional Association
- Manager, State Legislative Affairs
- Shared several additional recommendations urging the Commission to consider:
    - "Limitations on Mid-Year Drug Formulary Changes"
    - "Additional investments and policy changes to address Minnesota's wide health disparities"
    - "Support Efforts to Improve Serious Illness Care"
    - "POLST Registry"
    - "Investment in public health infrastructure and policy changes to promote public health"

AFSCME Council 5

- Professional Association
- Executive Director

- "Instead of whittling down, refining, and improving on strategies for the legislature to pursue in 2021, the report has become a list of what the Commission heard. It's hard to look at the report and think that we are any closer to achieving transformative change in human service delivery than we were at the end of the 2019 legislative session. Furthermore, any findings of this commission need an additional layer of scrutiny because the problems in human services before COVID-19 are certainly different from the problems of the world roiling from a pandemic, and the problems of a world post-COVID will be different from today. We were disappointed in the lack of engagement with the public and with stakeholders, particularly pertaining to equity and how funding in human services is allocated between administrators, providers, and front-line staff. The underlying frame of the BRC's charge was that we spend too much on human services, and we need to find areas to improve efficiencies and better prescribe specific services in specific scenarios. AFSCME fundamentally disagrees with this frame: money in human services, particularly in long-term care, far too often ends up in the hands of corporations that extract wealth from clients while undervaluing the staff that actually care for thousands of Minnesotans. More consideration should be given to why the services cost so much, especially when considering that the people who do the work are overwhelmingly women, people of color, and immigrants and are paid far less than deserved."

American Cancer Society Cancer Action Network (Minnesota Patient Advocacy Coalition)

- Patient Advocacy Coalition
- Government Relations Director & Coalition Chair
- "First, we urge Commission members to remember the needs and interests of Minnesota's patients in all five of the Commission's charges, including improve access to health and human services programs to address geographic, racial, and ethnic disparities, among others. These programs exist to make lives better, and changes to these programs must always be considered through this lens. In future legislative proposals and budget-balancing conversations, we urge the Commission and state policymakers to prioritize protecting access to care and services for all Minnesotans. This need is doubly important in times of crisis: the last thing our state should do during an economic downturn is to reduce quality and access to key safety-net services that promote health, security, and wellbeing. Finally, we recognize the COVID-19 pandemic disrupted the work of the Commission, but we encourage decision makers and the Commission to continue its work on health equity strategies. Racism is a public health crisis, and now is the time for Minnesota to prioritize health equity and systems transformation if we truly aim to improve the health of all Minnesotans."

Mid Minnesota Legal Aid, Minnesota Disability Law Center, & Legal Services Advocacy Project

- Consumer Organizations
- Staff Attorneys
- Thanked the Commission for its work and urged the Commission to "take seriously its commitment to racial equity and propose bold action to transform the health and human services systems in Minnesota." Specifically, it outlined an "Equity Review," "Bold Action," and "Community Participation."

American Indian Mental Health Advisory Council

- State advisory council
- Council Co-Chairs and Secretary
- Submitted a letter in support of the "Single, Inter-operable, Secure, Low-Cost Telepresence Network" which was not considered by the Commission due to time limitations. The Council notes the importance of a telepresence system to ensure important access to services for the Indian Community.

Anne Jones

- Individual, retired registered nurse
- Submitted email in support of Sen John Marty SF 853, which "offers a description of arational approach to needed changes in how we deliver health and human services that would be a good start for the ultimate, truly transformative change that we need to make in Minnesota, which would be a state-based health plan, specifically the Minnesota Health Plan, which would cover all medically necessary care, allow providers to bill directly and eliminate third party payer waste and inefficiencies, cover all Minnesota residents, improve care coordination and consistency for patients with complex/chronic health care needs, including mental health, and remove the disincentives for providers to care for high-need patients, improving equity.