Provider and Payer Advisory Task Force

March 27, 2026

Today’s Objectives

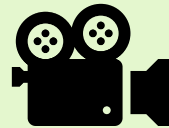
- Review PPATF survey results and get task force reactions
- Update the task force on the HCAATF’s progress and gather feedback
- Gather information and perspectives from the PPATF to support future HCAATF discussions of population-based payment (PBP) and insurance benefit design

Today's Agenda

- PPATF Survey Results – **Mathematica**
- Recap and reactions: Health Care Affordability Advisory Task Force – **CHCA**
- Value-Based Payment – **Mathematica**
- *Break*
- Insurance Benefit Design – **Mathematica**
- Closing and next steps – **CHCA**

Housekeeping

- Slides and recording of meeting will be available on the Center's website
- Bathrooms are outside the room on the right side of the hallway
- Please remain on mute when not speaking
- Tech problems? Please try logging back in, or email Health.Affordability@state.mn.us



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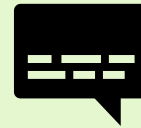

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Roadmap to Recommendations: Round 1

1. Understand the Charge	2. Review the Landscape	3. Narrow and Prioritize	4. Develop Policy Options	5. Refine Re-commendations in June 2026

Ongoing advisory input into Center’s research, stakeholder engagement, and communications

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Survey Results

Julie Sonier| Mathematica

“Prior authorizations are usually the top complaint of our providers and patients: denying care, requiring extra administrative time (and costs)”

- Task Force Member

“Lack of true interoperability across health systems and payers leads to repeated labs, imaging, and diagnostic tests because clinicians cannot reliably access prior results—adding cost without improving care”

- Task Force Member

"Addressing non-value-added care can help with affordability, but I don't believe it will be sufficient. Ultimately, healthcare needs to have a transformation similar to most other industries, especially as it relates to its largest expense (i.e. labor)"

- Task Force Member

Survey Topics and Responses

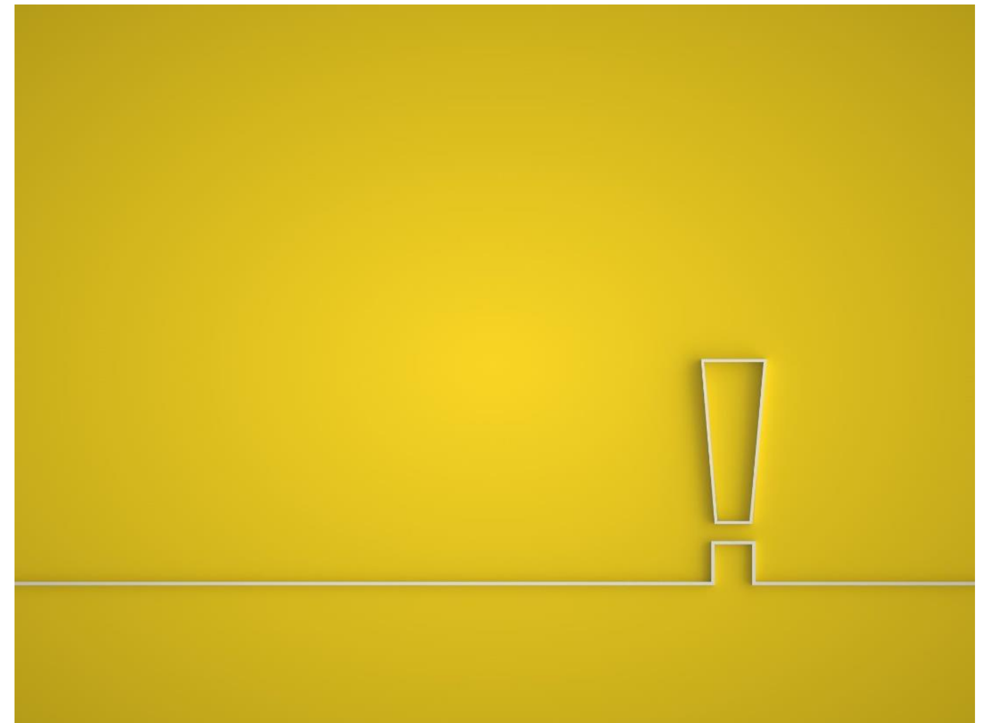
Survey Topic	Responses	
Non-value-added spending examples	• Prior authorization (delays, denials, rework) • Revenue cycle complexity (billing, coding, debt collection) • Duplicative credentialing & reporting requirements	• Quality measurement misalignment • Regulatory audits and non-standard reporting • EMR non-interoperability leading to duplicative testing

Opportunities to reduce non-value-added spending	• Prior authorization reform
	• Administrative simplification
	  • Standardize billing and reporting
	  • Align quality measures
		• Upstream investment in primary care and prevention
		• Improve data-sharing infrastructure
		• Licensing reform

Opportunities to reduce the underlying cost of providing health care	• Increase productivity (How do we leverage AI and telehealth?) • Address workforce shortages • Shift focus to personnel, such as primary care doctors, care coordinators, and community health workers that can help address upstream drivers of health	• Create shared data standards • Reduce duplicative testing and reporting • Look to other states and industries for insights into how the health care system can be fundamentally transformed

Key Takeaways from PPATF Survey

- Administrative complexity consumes substantial labor and financial resources without clear patient value
- There are clear "pain points" that are common across stakeholder groups, like prior authorization, lack of standardization, and lack of interoperability
- Long-term affordability will also require productivity gains, workforce strategy, and better data infrastructure



Group Discussion: Survey Results

- Do the results surprise you at all?
- Was there anything you thought would be more prevalent or was missing altogether?
- Conversely, is there a topic that came up that you did not expect?

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Recap and Reactions: Health Care Affordability Advisory Task Force (HCAATF) Meeting

Alex Caldwell | Director, Center for Health Care Affordability

HCAATF Meeting Focus

1. **Introduction to potential recommendation types**
   - Task force members were provided with a framework along with a series of examples for what recommendations could look like
2. **Deep dive on priority topics**
   - Non-value-added spending
     - Prior authorization
     - Intermediaries and PBMs
   - High and variable prices
     - Hospital price variation
3. **Brainstorming exercise**
   - Members were asked to identify potential priority topic areas for deeper exploration within:
     - Administrative complexity
     - Intermediaries & investor-related spending
     - High and variable prices
     - Other areas of interest (i.e. parking lot for ideas)
4. **Discussion and prioritization**
   - Members reflected on areas of strongest interest from the brainstorming exercise

Illustrative Examples: Potential Task Force Recommendation Types

Type	Example Recommendations
Exploratory	"The **HCAATF should further study** administrative cost savings associated with [*insert topic(s)*] and characterize each by savings potential and impact on other factors like quality"
Framework-setting	"MDH should develop a proposal for **adopting a statewide goal** to limit [*insert topic(s)*] to no more than XX% annually and assess options to enforce this target through contracting, legislation, or regulation"
Specific	"The **legislature should enact a law** requiring all commercial payors to adopt [*insert topic(s)*] practices statewide by 202X"

February 25 HCAATF Key Takeaways

- **Tactical and visionary changes are needed**
  - Minnesota needs both near-term, practical reforms and longer-term structural changes
  - Strong emphasis on clear, accessible framing
- **Administrative burden remains a focal point**
  - Prior authorization (PA) identified as a high-impact issue
  - Ongoing concerns about credentialing, interoperability, and fragmented data systems
  - Interest in understanding why past simplification efforts did not produce lasting change

February 25 HCAATF Key Takeaways Cont.

- **Prices and market structure**
  - High commercial prices seen as a major driver of spending
  - Significant variation across and within hospitals
  - Focus expanding beyond prices to market structure and efforts to increase transparency
- **Intermediaries and pharmacy benefit managers (PBMs): Growing focus**
  - Increased attention to PBM transparency, rebate flows, and vertical integration
  - Interest in alternative PBM models (e.g., administrative-fee-only structures)
  - Broader concern about the number of intermediary layers and potential extractive practices
- Although there was strong interest in pursuing PA, PBMs, and pricing, HCAATF members said it is important not to focus too narrowly in just a few areas

HCAATF Brainstorming Exercise

Focus areas for future recommendations:

Administrative complexity

- Uniformity
- Prior authorization (PA)
- Other administrative cost drivers such as capping administrative fees charged by insurers

Intermediaries and investor-related spending

- Pharmacy benefit manager transparency and restructuring incentives
- Discouraging extractive financial behavior and evaluating the role of private equity and the corporate practice of medicine

High and variable prices

- Price caps and regulation
- Additional research priorities such as reviewing past and present polices in other states

Consumer-facing strategies

- Price transparency
- Facility costs
- Medical debt and interest rates
- Tax relief

Priority Area Selection Criteria

- We are mapping the brainstorming ideas generated by HCAATF using a set of selection criteria we first discussed with them in the fall:
  - Size and/or timing of potential impact on health care spending
  - Is the topic relevant across stakeholder groups, or limited to certain groups?
  - Is the topic's relevance systemwide, or limited to specific payers/services/populations?
  - Factors playing the biggest role in Minnesota health care spending growth (e.g., specific services, price vs utilization)
  - One-time vs ongoing savings
  - Is this topic something that state policymakers can influence directly?

Group Discussion: HCAATF Reactions

- What are your reactions to the summary of the HCAATF discussion and brainstorming activity?
- What structures or conditions must be in place to achieve success in these areas?
- What advice do you have for the HCAATF as it moves toward developing its first set of recommendations on these topics?

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Value-Based Payment

Julie Sonier| Mathematica

Definitions

- **Fee-for-service**: Providers (doctors, hospitals) are paid for each individual service they deliver
- **Value-Based Payment (VBP)**: A broad approach to paying for health care that rewards quality and cost control, rather than volume
  - **Alternative payment models (APMs):** Payment approaches that move away from fee-for-service and instead reward value, quality, or cost control
    - **Types of APMs:**
      - **Population-based payment**: A provider or health system receives a fixed payment to care for a group of people over a period of time
        - **Global budgets**: A type of population-based payment where a provider (often a hospital system) gets a fixed total budget to cover all care for a defined population
      - **Shared savings**: A payment model where providers can share in the savings if they keep costs below a target while maintaining quality

Value-Based Payment Models

Category 1:

Pure Fee-for-Service (FFS)

- Payment for each service
- No link to quality or cost

Category 2:

FFS + Quality Incentives

- FFS remains dominant
- Bonuses/penalties tied to quality metrics

Category 3:

Alternative payment models (APMs) built on FFS architecture

- Shared savings (upside only)
- Shared savings + downside risk
- Total cost of care accountability layered on FFS

Category 4:

Population-based payment

- Prospective per member per month or global budgets
- Payment not tied to specific services
- Providers assume meaningful financial risk

Key Distinction: Categories 3 and 4 introduce accountability for total cost of care. Category 4 moves furthest from volume-based payment.

Source: Adapted from HCP-LAN, 2025

Strengths and Challenges of Value-Based Payment

Strengths

- Greater flexibility in care delivery
- Incentives for prevention and coordination
- Budget predictability
- Explicitly considers quality and value
- Can also have incentives around reducing disparities
- Some evidence of savings in population-based payment models

Challenges

- Savings can be modest and uneven
- Administrative burden and complexity (e.g., quality measurement/reporting, payment reconciliation)
- Potential for increased market concentration
- Concerns about patient mix and risk adjustment
- Generating critical mass across payers

References: Health Affairs, 2023; Zirui et al., 2019

Population-Based Payments

- **Definition**: A provider or health system receives a fixed payment to care for a group of people over a period of time.
- Shifts the focus from volume of care delivery to the total cost of care for a specific population and the quality of that care
- Core features:
  - Defined population (e.g., attributed patients)
  - Total cost of care target (prospective or retrospective)
  - Quality accountability
  - Financial incentives tied to performance
  - Increasing levels of financial risk

Reference: HCP-LAN, 2025

Why Pursue Population-Based Payments as a Policy?

- Goals:
  - Align incentives with value rather than volume
  - Encourage prevention and chronic disease management
  - Provide flexibility in care delivery
  - Moderate spending growth
  - Encourage better communication and coordination across providers
- The theory behind the policy:
  - If providers are accountable for total cost and quality, they are incentivized to reduce avoidable utilization and manage resources more effectively

Reference: HCP-LAN, 2025

Minnesota VBP example: Medicaid Integrated Health Partnership Model

- **Program Overview**
  - Launched in 2013 as Minnesota Medicaid's accountable care model
  - Voluntary participation for provider organizations
  - Population-based payment tied to total cost of care for attributed Medicaid beneficiaries
  - Shared savings model; some participants take downside risk
  - Quality performance requirements tied to savings eligibility

- **How it works**
  - DHS sets a total cost of care target
  - Providers share in savings if spending is below target and quality thresholds are met
  - Flexibility to invest in care coordination, primary care, and non-traditional services
- **Additional details**
  - As of July 2024, there were 25 total IHP partnerships covering more than 505,000 beneficiaries
  - As of 2022, total savings from IHPs reached $546 million.

Reference: Gowlovech, 2024

State Examples: Value-Based Payment

Maryland – All Payer and Total Cost of Care Model

- Policy: Hospital global budgets (fixed annual revenue regardless of volume), later expanded to total cost of care accountability.
- Successes: Slowed hospital spending growth; reduced readmissions; met Medicare savings targets.
- Challenges: Limited early impact on non-hospital spending

Massachusetts – Blue Cross Blue Shield Alternative Quality Contract (AQC)

- Policy: Commercial global payment model with multi-year population-based budgets and quality bonuses
- Successes: Early evidence of slowed spending growth and improved quality performance
- Challenges: Savings moderated over time; dependent on market dynamics and contract design

References: CMS, n.d.; Song et al., 2019

Group Discussion: Value-Based Payment

- Do you think value-based payment strategies are a valuable tool for improving health care affordability in Minnesota? Why or why not?
- From your perspective, are there successes or bright spots in Minnesota related to population-based payment? What are the pain points or potential challenges, and how might they be addressed?
- What else would you want the HCAATF to know as context for a future discussion?

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Insurance Benefit Design

Julie Sonier| Mathematica

Insurance Benefit Design: Definition

- **Definition**: refers to the rules that determine what services are covered, which providers patients can see, and how much they pay out of pocket (e.g., deductibles, copays, coinsurance). Benefit design influences consumer behavior and can potentially steer patients toward higher-value care.
- Key levers:
  - Enrollee cost sharing
    - Deductibles
    - Copayments/coinsurance
    - Out-of-pocket maximums
  - Network structure (e.g., referrals, tiering)

Reference: Catalyst for Payment Reform, n.d.

Cost Sharing Effects on Utilization

- Research shows that higher cost-sharing:
  - Reduces overall utilization
  - Reduces both high- and low-value care
  - Can create barriers to chronic disease management
  - Can cause people to avoid or delay care, especially people with low incomes
- As a result, policymakers have explored targeted approaches (e.g., value-based insurance design) to better align cost-sharing with clinical value

Reference: Hwang et al., 2022.

Benefit Design Strategies

- Value Based Insurance Design (VBID): a benefit approach that aligns patients' out-of-pocket costs with the clinical value of services by lowering cost-sharing for high-value care and, in some cases, increasing it for low-value care.
- Primary care first designs: Make primary care very low-cost (or free) to the patient to encourage early, continuous, and preventive care.
- Reference pricing: A benefit design approach where the insurer sets a maximum payment amount for a service (the "reference price"). If a patient chooses a provider that charges more than that amount, the patient pays the difference.
- Site-of-care optimization: A strategy that steers care to lower-cost settings when clinically appropriate (e.g., outpatient surgery center instead of hospital outpatient department).

Minnesota State Employee Health Plan (SEGIP): Benefit Design Approach

Tiered network design based on total cost of care

- Clinic systems are tiered based on total cost of care; member cost sharing varies by tier to encourage use of lower-cost providers

VBID Elements in pharmacy benefit design

- Reduced or eliminated cost-sharing for certain high-value medications (e.g., chronic conditions such as diabetes, hypertension)
- Incentives to improve medication adherence and chronic disease management
- Focused on aligning cost-sharing with clinical value

- **Successes**
  - Encourages choosing lower-cost providers - about 90 percent of SEGIP's membership is enrolled in cost levels 1 and 2
  - Incentivizes providers to lower prices or enter risk-sharing arrangements to remain in a tier with lower cost sharing
- **Challenges**
  - Both tiering and VBID add to administrative complexity

Reference: McDonald, 2023; NASHP, 2023.

State Example: Insurance Benefit Design

California – Public employee plan reference-based benefits

- **Policy**: Implemented in 2011 the policy set a maximum payment amount the plan will cover, requiring members who choose higher-priced providers to pay the difference, thereby encouraging use of lower-cost facilities.

- **Successes**: Setting standard prices the state employee health plan (CalPERS) would pay for certain procedures helped lower prices (~18 percent by 2013) and resulted in cost savings for the plan.

- **Challenges**: Requires strong member education and does protect against surprise bills from high-priced providers

References: Robinson et al., 2015; Zhang et al., 2017

Group Discussion: Insurance-Benefit Design

- Do you think an approach that leverages insurance benefit design has potential value for improving health care affordability in Minnesota? Why or why not?

- From your perspective, are there successes or bright spots in Minnesota related to insurance benefit design? What are the pain points or potential challenges, and how might they be addressed?

- What opportunities exist or don't exist, to influence benefit design at the state level? What might that look like?

- What else would you want the HCAATF to know as context for a future discussion?

Please Nominate Potential PPATF Co-Chairs

Role

- Represent PPATF
- Liaise with HCAATF co-chairs
- PPATF meeting support

Next Steps

- Nomination form – submit by Friday, April 10th
- Selected by MDH by end of April
- Estimated 3 hours a month commitment

Next Steps

What: Provider and Payer Advisory Task Force Meeting

When: June 11th, 2026

Where: Wilder Foundation

Stay tuned for:

- Next Health Care Affordability Advisory Task Force meeting on Tuesday, April 21st from 1pm-4pm
- Co-chair nomination form

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Thank You!

Center for Health Care Affordability

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