Testimony of Lucinda Jesson
Minnesota Commissioner of Human Services

Introduction

Thank you for the opportunity to discuss Minnesota's Medicaid program. Since taking office in January 2011 the Dayton Administration has made significant changes to improve Minnesota's Medicaid program. This includes providing increased health care coverage for low-income Minnesotans, making the state a better purchaser of health care services and providing better value and accountability to taxpayers.

Minnesota is justly proud of its nonprofit health care environment that has brought high quality, low cost care to its citizens. Frequently cited as a model for health system efficiency, we rank among the top in the country in overall population health, and our providers rank among the most effective and efficient in the country, as shown in the Dartmouth Atlas analysis. Further evidence of Minnesota's health systems effectiveness was recently demonstrated in the Commonwealth Funds Scorecard on Local Health System Performance, which ranked 4 of Minnesota's local areas (St. Paul (1st), Rochester (3rd), Minneapolis (4th), and St. Cloud (7th)) in the Top 10 in the country for overall system performance. Minnesota has a long history of providing good access to health care for all of its citizens and requiring a high bar for quality for providers and health plans. We have one of the nation's lowest rates of uninsured. The state also enjoys a health care system where both provider organizations and health plans work collaboratively to improve health care services and health outcomes of our population, such as requiring statewide reporting on quality measures, credentialing, evidence-based decision-making and reducing hospital readmissions.

Minnesota's Medicaid Program

Minnesota's Medicaid program has served as a model for other states over the past few decades. We have focused the program to ensure access to health care for our citizens, but are equally proud that we have done so with integrity and as smart stewards of state and federal resources. Our Medicaid program has focused on providing coverage well over the federal poverty guidelines. Minnesota currently operates both a fee-for-service and managed care Medicaid program, including an early expansion for adults without children that Governor Dayton signed into law January 2011 and became effective March 2011. Minnesota has also operated a Medicaid 1115 waiver since the early 1990's called MinnesotaCare that is a sliding scale premium health care program that serves families with children and single adults at income levels higher than regular Medicaid eligibility. Minnesota began this program long before the federal enactment of the Children's Health Insurance Program (CHIP).

Of Minnesota's 850,000 enrollees on public programs, approximately 580,000 are enrolled in managed care, which includes most families, single adults, and seniors and spends approximately

$3.2 billion per year (state and federal funds). The remaining 230,000 are enrolled in fee-for-service, which is primarily disabled individuals and spends approximately $2.0 billion per year (state and federal funds). Prior to the Medicaid expansion for single adults, Minnesota operated a state funded program for several years called General Assistance Medical Care (GAMC). Managed care delivery of GAMC was eliminated in March 2010 and GAMC was repealed in February 2011 when the Medicaid expansion was enacted.

Minnesota has also placed a high priority for many years on providing good access to health care for its low-income citizens on the state's Medicaid program and other state public health care programs. The state requires participation by our health plans and providers in its public health care programs if they also participate in the state employees' group insurance program, workers compensation, and other local government insurance programs. Managed care is available to enrollees statewide through non-profit HMOs and county-based health plans and has been critical to providing access to health care, behavioral health and long-term care services to our Medicaid population. Our enrollees can be assured of access to quality care in Minnesota.

Addressing Past Practices in the Medicaid Program

Although Minnesota has enjoyed good access to quality care for its Medicaid enrollees and a collaborative health care system that has benefited the health of Minnesotans overall, there were specific areas of serious concern Governor Dayton and I had regarding how the Minnesota Department of Human Services (DHS), under the previous administration, purchased health care for its Medicaid managed care program. We also had concerns regarding the transparency and oversight of its contracting process. In particular, we believed the state needed to be a smarter purchaser of health care for the Medicaid program and was not getting the best value for the taxpayers.

Our concerns stemmed from the increasing profit margins health plans earned from public programs, particularly during a recession with its attendant budget crises; the level of health plan reserves which resulted, in part, from profits on public programs; and with the contracting process itself. We were struck that the contracts offered few incentives for improving quality and reducing costs. Moreover, at a time when the private sector was making considerable progress on payment reform in Minnesota (to begin to move away from piecemeal payments to "total cost of care" payments) the state contracts remained static. While there were positive aspects to managed care in terms of bringing needed access to services, there was lack of creativity and focus on value in how health care was purchased in our Medicaid program.

We set about taking rapid action to get more accurate, complete information, make the process more open to the public and to make Minnesota a better purchaser of health care.

First, on March 23, 2011, Governor Dayton issued an Executive Order on disclosure and accountability for managed care contracts. The Executive Order specifically required: 1) all contracts and data on health plans serving public programs open to full public disclosure through a newly created managed care reporting website; 2) a comprehensive annual report on managed care that included information on health plan administrative costs, provider payments

arrangements, enrollee satisfaction, quality and performance measures; and 3) regular audits by the Minnesota Department of Commerce, the state's regulator of health insurance.

DHS began full and immediate implementation of this Executive Order. The website, at www.dhs.state.mn.us/ManagedCareReporting launched April 2011 includes all current managed care contracts and reports and data on health plan quality, performance, enrollment, finances, and capitation rates. The first annual comprehensive report will be available in the summer of 2012 for the 2011 contract year. We also began work with the Minnesota Department of Commerce on April 16, 2012 to begin the first round of audits of health plans under contract to serve Medicaid enrollees, based on the annual audited financial filings submitted to the state Departments of Health and Commerce on April 1. I attach this Executive Order as Exhibit 1.

Second, the Governor proposed and signed legislation in 2011 that provided more comprehensive financial reporting requirements for health plans contracting with Medicaid, including more detailed information on administrative costs and payments to providers. I attach a copy of this language as Exhibit 2. This will allow DHS to provide better oversight of health plan finances and gain a better understanding of how the health plans participating in Medicaid are spending their dollars. This information will help ensure that health plans are accountable for providing need services to our enrollees and paying providers in a way that brings value to the program and rewards them for good outcomes.

Third, while we inherited the 2011 contracts from the previous administration, we sought changes to them to address the overall concern regarding the level of health plan profits from the Medicaid program. We asked all four major health plans to voluntarily agree to cap their 2011 earnings at one percent of operating margin for public health care programs. We amended the contracts to reflect this cap and CMS approved the amendments. Any amount over the one percent will be returned to the state and the corresponding federal share to the Centers for Medicare & Medicaid Services (CMS). When the 2011 health plan financials were released April 2, we estimated that **$73 million** would be returned to the federal and state government due to the one percent cap.

Taken together we believe these efforts around improving transparency and public disclosure in our Medicaid managed care program can serve as a clear model for the nation as other states move more of their Medicaid populations into managed care.

Changing the Medicaid Managed Care Contracting Process

One of the largest and most important changes Governor Dayton and I made is changing the way we contract for managed care services under the Medicaid program. Governor Dayton proposed under his 2012-13 budget and successfully implemented a competitive bidding process for the 2012 managed contracts in the Twin Cities metropolitan area for approximately half (275,000) of the parents, children, and single adults enrolled in our Medicaid program and the 1115 Medicaid waiver program, MinnesotaCare.

In previous years, DHS set capitation rates and any health plan could participate in any county if they accepted rates set by the state. The state's contracted actuary developed one set of rates for each program in the aggregate for all plans contracting in each county. The rates would vary by demographics factors (e.g. age, gender, eligibility status) and by geographic area based on historic aggregate health plan claims experience by program, adjusted for the health risk of a health plan's population. As rates were set in the aggregate for each program, profit margins were as well, creating a situation where some plans may see a very healthy margin and others plans would see less or a loss. Minnesota has set rates using this method for Medicaid enrollees in managed care (fee-for-service providers are paid directly) as well as for MinnesotaCare and, in the past, GAMC. All program rates used this same methodology but rates were set separately.

Although this is a valid method of setting capitation rates, it did not incentivize value. For example, some of the state's health plans have created more efficient and higher quality networks of providers that would bring the state a better value. Under the previous method, the state would pay the same rate to plans contracting in the same area of the state even when one health plan had a lower cost, equal value network. We needed to create the right incentive for plans to bid their lowest cost for serving Medicaid enrollees in their networks and for the state and federal governments to realize savings from these efficiencies. In short, we needed to be smarter stewards of public dollars.

DHS started competitive bidding with our families and children population in the metropolitan area for two reasons: 1) this population is the largest group enrolled in managed care and their health risk is the most predictable which would encourage better bids; and 2) half of the population resides in this area where four of the major health plans already participate, also resulting in more robust competition. The competitive bidding RFP was issued in April 2011. Decisions on contract awards were based on an overall score of cost (50 percent) and network, quality and county-specific evaluations (50 percent). Consideration was also given to county board recommendations. To ensure adequate enrollee access, two plans were selected in each county and three plans for three of the more heavily populated counties. There were winners and losers among the health plans, which is the nature of competition. Because of the change in the number of plans, an unprecedented number of enrollees (approximately 78,000) were successfully transitioned to a new plan without any significant disruptions to our enrollees' continuity of care.

DHS awarded contracts in late August 2011 which resulted in $175 million in savings to the state (approximately $175 million federal share) for state fiscal years 2012 and 2013, a 6.9 percent reduction in managed care spending from previous projections. Our competitive bidding process received strong legislative support. Competitive bidding was part of a package of managed care reforms that totaled $300 million in savings for the state, and an additional $300 million in savings to the federal government. The other $125 million in savings came from rate reductions, trend caps and 5% reduction targets on hospital admissions, re-admissions and ER use.

Under both methods of contracting (rate-setting and competitive bidding), the state used its contracted actuaries to develop managed care capitation rates and provide actuarial certification of the rates according to federal Medicaid requirements. The state has always maintained compliance with submission of managed care contracts and rates to CMS and always received

approval. The state provides detail regarding changes to its contracts and description and documentation of its rate-setting methodology and ensures we are meeting all requirements and are responsive to CMS.

Going forward, our intention is to continue competitive bidding in other parts of the state where it is appropriate based on population and network access. We want to use it to produce more effective and efficient health care services and promote innovation. We are currently working with the University of Minnesota to conduct an evaluation of the 2012 competitive bidding process that will inform our future efforts.

In addition to providing better value to enrollees and the state through the competitive bidding process, several new and significant changes were made to 2012 Medicaid managed care contracts in an effort to increase the oversight of health plans as it relates to enrollee rights and program integrity. Specifically, DHS changed contract terms to: 1) allow for more flexibility to target financial penalties in accordance with the magnitude of the violation, increase the amount of the penalty to a potential $5,000 per day, and $15,000 per day related to violations of enrollee due process rights, in order to better achieve compliance on crucial requirements; and 2) added more detailed requirements to the health plans' annual report on program integrity, to provide more information on the number and types of penalties and sanctions assessed by the health plans, cases opened and resolved, funds recovered, and cases referred for criminal investigation.

New Ways of Purchasing and Bringing Accountability to Medicaid

Just as it is important to correct practices of the past and change the current process as it relates to purchasing health care for Medicaid, it's equally if not more important to improve and innovate with new purchasing models and strategies. In an effort to bring greater innovation to our health care purchasing, Minnesota has introduced a new payment demonstration called the Health Care Delivery Systems (HCDS) Demonstration that contracts directly with providers in a new way, allowing them to share in savings (and holds them accountable in the future for losses) for improving quality of care and patient experience and reducing the total cost of care for Medicaid enrollees.

The overall goal of this new purchasing model is to improve patient health and experience by leveraging the innovative work of Minnesota's provider organizations on new care delivery models and reducing the cost of care, providing better value to our enrollees and the state. We are also seeking to provide consistency in how we pay our providers so they can provide consistent and quality care to all patients and to effectuate the change needed in the health care systems by aligning with other payers. This includes requiring our Medicaid managed care plans to participate in the demonstration as a new 2012 contract requirement, as well as aligning with the Medicare Shared Savings and Pioneer ACO programs and other total cost of care arrangements that are currently occurring in Minnesota's commercial market.

DHS developed this new payment model with broad community input from providers, plans, counties, social service and other community organizations through a Request for Information (RFI) in April of 2011 to seek input on the major policy and design components. The final

model and Request for Proposals (RFP) were released in June and provider selection occurred in late November. We received an unexpectedly high response from nine large provider organizations representing both metro and rural areas of the state and providing care to an estimated 150,000 Medicaid enrollees. All nine organizations who submitted proposals to participate were ultimately selected to move forward.

We are currently in the process of contract negotiations with nine provider organizations with the expectation of executing our first round of provider contracts in July of 2012 with the goal of having all contracts complete by the end of 2012. We see this as the first step in significantly changing the way we pay for health care and improve health outcomes. We will continue to evaluate our progress and expand to other providers and populations.

Lastly, we continue to look for ways to enhance the transparency and integrity of our Medicaid managed care contracting process, even beyond Governor Dayton's March executive order. A bill is currently making its way through Minnesota's legislative process, strongly supported by Governor Dayton and Health and Human Services legislative leadership. The bill will bring outside third-party financial audits of Minnesota's Medicaid managed care plans, conducted through the State's Office of the Legislative Auditor; bring additional assurance of the independence of the state's actuarial certification process; and enhance and assure the accuracy of data submitted by Minnesota's managed care plans operating in Medicaid. A copy of this bill language, which we anticipate will become law shortly, is attached as Exhibit 3.

The Office of Inspector General

Another important step we took was the creation of the Office of the Inspector General this past August. This is the same model used by the U.S. Department of Health and Human Services as well as 16 other states and builds on 2011 bipartisan legislative initiatives that gave DHS additional authority and resources, including funding for data analytics, increased use of audit contractors and additional staff. This model has independence and strong mechanisms to monitor and report abuse. The establishment of this Office within DHS allows us to increase our focus on fraud prevention and recovery, streamline its external program integrity operations, and more effectively structure staff that investigate, audit and evaluate others.

This office, while still in its infancy, has already made great strides in increasing collaboration with other local and federal oversight entities, expanding data sharing agreements, and contracting with external vendors to expand our investigations.

I believe it is of particular interest to this committee that the Office of Inspector General is now enforcing increased accountability for the program integrity efforts of the managed care organizations under contract with the state. Starting this year, managed care organizations are required to report to the DHS Office of Inspector General on all cases they investigate to learn of the level and scope of their efforts. In the past they only reported fraud referrals. This new information, at a minimum, will provide a baseline and more data for us to compare their program integrity efforts in managed care with our investigations related to fee-for-service cases.

UCare Donation

I know there is interest among this committee about the recently settled issue of UCare's $30 million dollar contribution to the state in 2011, and so I would take this opportunity to say a few words about that. First off, it is important to make clear that we dealt transparently and in good faith with CMS around this issue. We notified them when we received the contribution, informed them of how we intended to characterize the contribution, and responded fully and in a timely fashion to all of their requests. Over the past months we were in earnest and productive discussions, and were able to resolve the issue to the satisfaction of both parties.

We have a strong partnership with CMS, and our disagreement over the UCare donation was one of any number we have with the federal government over jointly funded programs. In that regard we did not feel there was anything novel about the disagreement. In nearly every case of disputed funds the state will argue to keep the money in the state and the federal government will argue for what it believes it's entitled to. The UCare issue was a particularly complicated issue as there was no clear precedent for it, and from the very beginning we were open that there may be different interpretations about what to do with it. Oftentimes these disputes end up going to an appeals process, but in this case we are happy we were able to resolve the issue before that. Ultimately we agreed that the initial $30 million donation would have ended up being added to what UCare returned based on the one percent caps we negotiated, and decided that the fair way to handle it would be to treat it as if it were part of that return, thus entitling the federal government to its share. Since we didn't know what, if anything, the plans would be returning until early this month, we were unable to make any decision before then.

We are happy to say that, when added to the dollars received as a result of the voluntary, one percent cap, the Dayton Administration was able to recover over $100 million dollars in taxpayer dollars attributed to the 2011 managed care contracts we inherited from the previous administration.

Closing Remarks

Minnesota has long been a leader in how managed care plans serve our Medicaid enrollees. But changes needed to be made in the way we do business now and in the future. We have made an unprecedented number of reforms in purchasing and accountability in just the past 15 months. And we are not done.

Few understand the fiscal pressures of our current budget predicament and their effect on human service delivery better than Governor Dayton, the Minnesota Department of Human Services, the Minnesota Legislature, and most importantly, the clients we serve who are ultimately impacted by these decisions. We understand that every public dollar is more precious than ever, and in order to serve the people of Minnesota to the utmost of our ability, we need to be able to continue to do more with less. This includes how we pay for health care.

We are proud of the integrity with which Minnesota has operated our Medicaid program. We believe Minnesota is a national model, and the changes implemented under the Dayton Administration, working with the Minnesota Legislature, only serve to enhance our program. We understand that members of Congress may be interested in examining ways to bring even more accountability and transparency to the Medicaid program. We look forward to working with members moving forward on ideas you may have. Thank you again for the opportunity to discuss the changes we've made and our commitment to continuing to improve Minnesota's Medicaid program.

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON

GOVERNOR

Executive Order 11-06

Creating Public Disclosure for Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

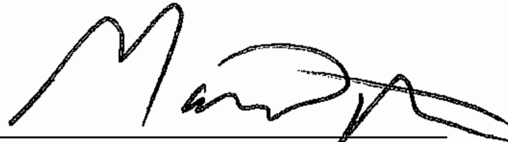
2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement

rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.



Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State

EXHIBIT 2

Subd. 9c.**Managed care financial reporting.**

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

EXHIBIT 3

Sec. 14. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9d. Financial audit. (a) The legislative auditor shall contract with an audit firm to conduct a biennial independent third-party financial audit of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the audit firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy, if available. The contract shall require the audit to include a determination of compliance with the federal Medicaid rate certification process. The contract shall require the audit to determine if the administrative expenses and investment income reported by the managed care plans and county-based purchasing plans are compliant with state and federal law.

(b) For purposes of this subdivision, "independent third-party" means an audit firm that is independent in accordance with government auditing standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. An audit firm under contract to provide services in accordance with this subdivision must not have provided services to a managed care plan or county-based purchasing plan during the period for which the audit is being conducted.

(c) The commissioner shall require in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audit of the information required under subdivision 9c, paragraph

(b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692, must provide the commissioner and the audit firm contracting with the legislative auditor access to all data required to complete the audit. For purposes of this subdivision, the

contracting audit firm shall have the same investigative power as the legislative auditor under section 3.978, subdivision 2.

(d) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols. The audit firm under contract to provide this evaluation must meet the requirements in paragraph (b).

(e) Upon completion of the audit under paragraph (a) and receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature. Upon completion of the evaluation under paragraph (d), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the health finance committees of the legislature.

(f) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

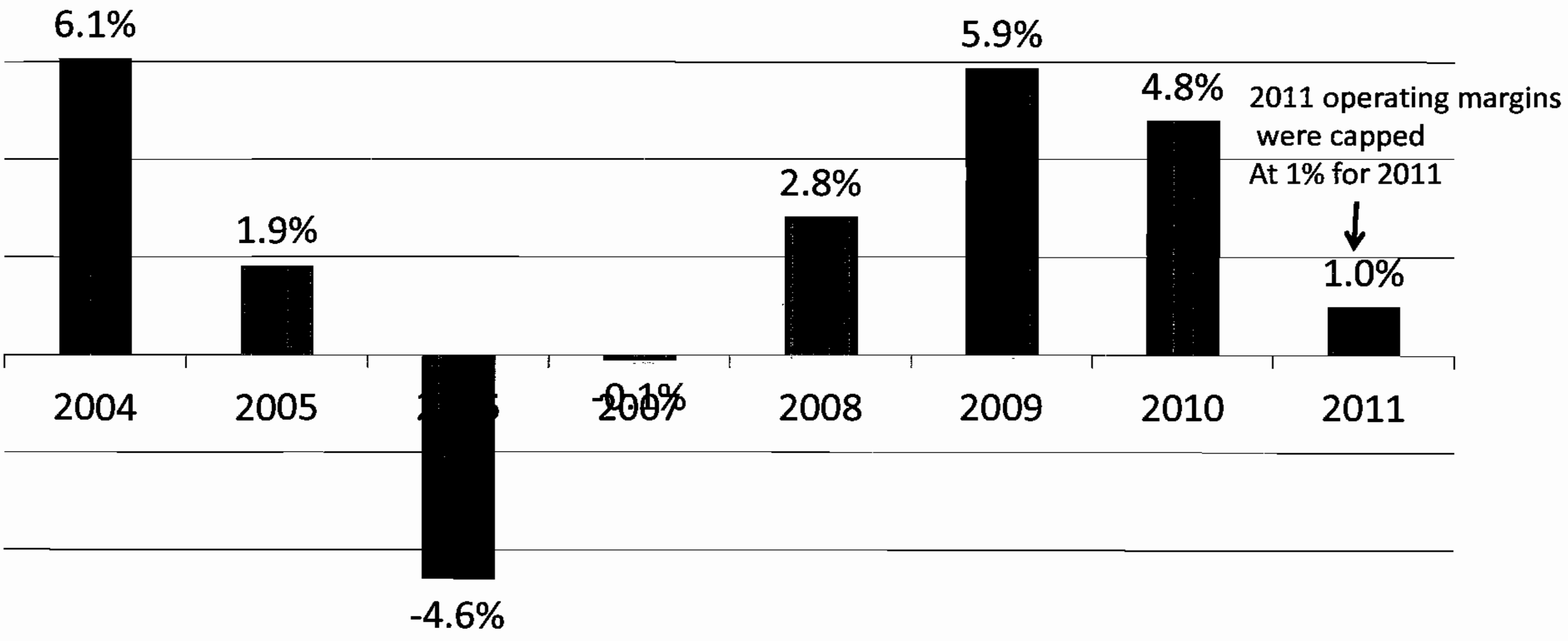
(g) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to the managed care and county-based purchasing plan contracts that are effective January 1, 2014, and biennially thereafter.

EXHIBIT 4

Historic Operating Margins in Minnesota's Prepaid Medical Assistance (PMAP) and MinnesotaCare Programs

2004-2011

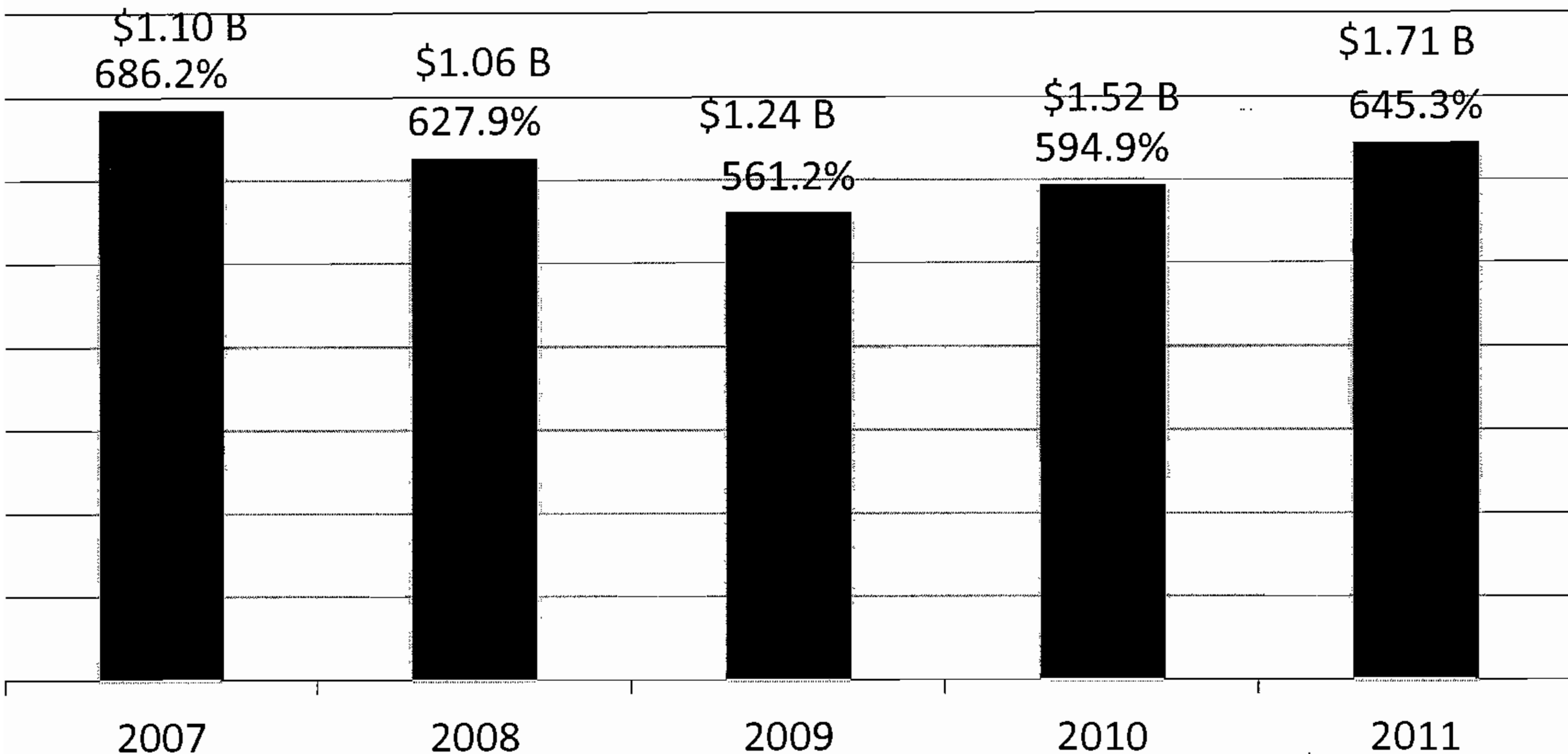


Margins associated with 4 largest non profit HMOs subject to the 2011 contract year 1% operating margin cap

EXHIBIT 5

Health Plan Reserves

(in total dollars, and as a percent of authorized control level)



Margins associated with 4 largest health plans subject to the 2011 contract year
1% operating margin cap

Minnesota Department of **Human Services**

Biographical Note

Lucinda E. Jesson
Minnesota Department of Human Services
Commissioner

Lucinda E. Jesson is commissioner of the Minnesota Department of Human Services. Prior to joining DHS, Jesson was an associate professor of law at the Hamline University School of Law in St. Paul where she also founded and served as director of the Health Law Institute. Before that, Jesson served in local and state government both as chief deputy Hennepin County attorney, and as Minnesota deputy attorney general. In addition, Jesson has extensive private sector experience, both as a partner in the law firm of Oppenheimer Wolff & Donnelly LLP, and in her own private practice. As commissioner, Jesson's priorities include making the state a smarter purchaser of health care; redesigning the care delivery systems through integration of primary care, behavioral health, social services and long-term care; keeping people fed and healthy; narrowing disparities; and reducing fraud, waste and abuse.