mn DEPARTMENT OF HUMAN SERVICES

Building Racial Equity into the Walls of Minnesota Medicaid

A focus on U.S.-born Black Minnesotans

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Executive summary

> "Of all the forms of inequality, injustice in health is the most shocking
> and the most inhuman."
>
> *– Dr. Martin Luther King, Jr.*

Racial health disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report focuses primarily on U.S.-born Black Minnesotans. Black/African Americans account for 13% of Minnesota Medicaid enrollees vs. 7% of the general population. However, data shows that Medicaid has an even more significant impact on access to care for Black Minnesotans. Analysis of 2019 data by the University of Minnesota's State Health Access Data Assistance Center showed that approximately 44% of African American Minnesotans under the age of 65 rely on Medicaid for health care coverage. Medicaid coverage for African American Minnesotans is higher outside the seven-county metro area, and 64% of Black Minnesotan children receive access to health care through Medicaid.

In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. University of Minnesota economist Dr. Samuel Myers coined the term "Minnesota paradox" to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while "African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers, 2020). These ongoing disparities reveal a system not broken but accomplishing what it was designed to do. Medicaid is a key component of that system in Minnesota.

A community-informed, iteratively developed report

This report aims to continue the evolution of how policy within the Minnesota Department of Human Services (DHS) is designed, proposed and considered by intentionally striving for community co-creation. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. At the outset of drafting this report, staff met with individuals from the U.S.-born Black community, leaders of organizations that are a part of the community and those working to advance racial equity in health care for Black Minnesotans.

The report's team then aligned the input received from those initial meetings with community collaborators with policy areas within DHS. The team then met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations informed draft "Calls to Action" shared during two public Community Conversations. The team sought further guidance from community members through facilitated discussion at those sessions, and the reflections and recommendations from all of these conversations have been incorporated into this report.

What levers Medicaid has to address racial equity for U.S.-born Black Minnesotans

Eligibility and enrollment
- **Who is eligible for Medicaid? What is the process for enrollment? For re-enrollment? How does someone get and keep their Medicaid insurance in the first place?**

Access
- **Once someone has Medicaid, can they access the care they need? Do they have access to primary care? Dental or behavioral health services? Do they have access to culturally relevant care or care from a provider who shares their cultural background? Do they have transportation or interpreter services?**

Quality
- **If they have access to care, are they getting quality care? Do the metrics Medicaid uses to determine quality care meet the community's definition of quality care?**

Early opportunities
- **Medicaid disproportionately covers pregnant people and children. Knowing the long term impact of the first years of a child's life, how can Medicaid ensure health and racial equity from the very start?**

When looking at how Medicaid can build racial equity for U.S.-born Black Minnesotans into its policies, the report team decided to approach the work by considering four key "levers" of Medicaid policy development: Eligibility/enrollment, access, quality and early opportunities.

What Medicaid can do now to continue to address racial equity for U.S.-born Black Minnesotans?

This iterative process resulted in **Calls to Action** for three Medicaid policies and programs that were most commonly cited by the U.S.-born Black Minnesotan community members the report team engaged with: Enrollment and renewal, access to culturally relevant care and, community engagement and co-creation. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, none of the Calls to Action seek to create

Medicaid-funded services that are racially exclusive. Instead, there is recognition of the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes available to all and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

Call to Action: Simplify and support enrollment and renewal

1. Pursue continuous eligibility policies

Continuous eligibility allows Medicaid enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time. The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for a period of up to 12 months. **DHS should pursue the state plan option under the Social Security Act to provide continuous eligibility to children.** Given what is known about the importance of the first five years on early brain development, consistent access to health care, screenings and services is critical. The state also now has experience with decreasing enrollment churn during the past nearly two years of the COVID-19 pandemic. **DHS should therefore explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 as well as establish 24-month continuous eligibility for all enrollees age 6 and older.**

2. Support navigators and simplify the enrollment and renewal process

Given the complexity of enrolling and renewing one's application, the fact that many people in poverty lack a home computer with internet access and that navigators live in communities, increasing the availability and utilization of navigators remains an important option to help people to apply. **DHS should work with navigators and the U.S.-born Black community to develop a plan focused on**

ensuring eligible Black Minnesotans gain and maintain Medicaid coverage throughout the year and in preparation for transitioning out of the federal public health emergency.

Call to Action: Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid

1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans

Addressing generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policy and programs that elevate strengths and address inequities. A division focused on Black Medicaid

enrollee health could also ensure that efforts throughout DHS and other state agencies (e.g., the Minnesota Department of Health) leverage all available funding sources to close the gaps seen in health outcomes.

2. Continue to prioritize and align standardization and disaggregation of race, ethnicity and language data

While an incomplete and imperfect proxy for culture, race, ethnicity and language data can serve as an important initial signal and help guide and inform conversation and collaboration with communities. One Community Conversation participant noted that there is a need to "proactively identify data — there's not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing." Standardized and disaggregated race, ethnicity and language data will be important for identifying communities as well as holding accountable DHS, managed care organizations, counties, clinicians and others who serve Medicaid enrollees.

Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives community the opportunity to "start a journey of trusting larger agencies that provide resources and services." Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into its routine policy, budget and administrative activities.** Seeing community as true

partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way to repairing the trust that has been broken.

Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from our conversations. First, there is a clear sense of urgency from community and DHS staff alike. Second, DHS divisions seemed empowered by their ability to effect intrinsic change. Success feels within reach. There was widespread agreement that DHS could be doing much more around racial health disparities, and there were many ideas to bring forward to community for further conversation around solutions. A final and critical theme identified in these conversations is the shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Yet, despite the weariness, both the community and DHS staff shared a willingness to try again.

The Calls to Action detailed and justified in this report therefore not only serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid but also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

I. Introduction

"There has never been any period in American history where the health of blacks was equal to that of whites. Disparity is built into the system" (Evelynn Hammonds)

Harvard science historian Evelynn Hammonds' reflection on who our health care systems have (Interlandi, 2019) and have not, been designed to serve has become inescapable in the wake of COVID-19. A novel viral respiratory illness that spreads quickly by symptomatic and asymptomatic individuals, COVID-19 has been indiscriminate in its transmission. However, as noted in the early weeks of the pandemic by social and public health epidemiologists and clinicians with extensive experience in health inequity, COVID-19's "propagation within a society steeped in structural racism will undoubtedly … lead to disproportionate impacts among marginalized racial groups in this country" (Bailey et al., 2020).

Before and throughout the pandemic, Black and Latino Minnesotans have worked in industries identified as "essential services or businesses" at disproportionate rates. They earn lower wages, have less access to adequate health care and experience higher exposure to COVID-19 since they are unable to work from home. MDH data has consistently revealed that Black, Indigenous and Latino Minnesotans have had the highest age-adjusted rates of COVID-19 cases, hospitalizations, intensive care unit (ICU) admissions and deaths (MN Gov, 2021)

Racial disparities in Minnesota

- The state of Minnesota as a whole has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents (Minnesota House of Representatives, 2020).
- Minnesota has one of the widest homeownership gaps in the nation. While 77 percent of white households own their home, 57 percent of Asian, 46 percent of Native American, 45 percent of Latino and just 24 percent of Black households own their home (Minnesota House of Representatives, 2020).
- In Minnesota, Indigenous students are ten times more likely to be expelled or suspended than their white peers. Black students are eight times more likely to be expelled or suspended than their white peers (Minnesota House of Representatives, 2020).
- Black and Latino Minnesotans have reported food insecurity at more than double the rate of white Minnesotans (Wilder Foundation, 2020).
- Black Minnesotans have been disproportionately affected by a loss of employment during the COVID-19 pandemic (MN Gov, 2021)
- Black, Indigenous and Latino Minnesotans have lower COVID-19 vaccination rates statewide (Minnesota Department of Health, 2021a) and among age-eligible Minnesota Medicaid enrollees (Infogram, 2021)
- Total mortality increased in 2020 by 14 percent for non-Hispanic White Minnesotans and 41 percent for BIPOC (Black, Indigenous, and people of color) Minnesotans (Wrigley-Field et al., 2021).

These disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report will focus primarily on U.S.-born Black Minnesotans. As noted in DHS' 2020 report on deep poverty (DHS, 2020), "historical atrocities, such as slavery and the Jim Crow era in the case of African-Americans, have huge effects on families through the formation of identity, values, attitudes, beliefs, and parenting practices developed over generations (Lichtman, 1984; Evans-Campbell, 2008) as well as clinically observable intergenerational health effects in current generations (Yehuda & Lehrner, 2018)." The historical and ongoing trauma experienced by U.S.-born Black Minnesotans, and its resultant impact on health and on the relationship and trust between the community and the state, is distinct from other communities in Minnesota who also identify as Black and from other historically oppressed communities, such as Native Americans.
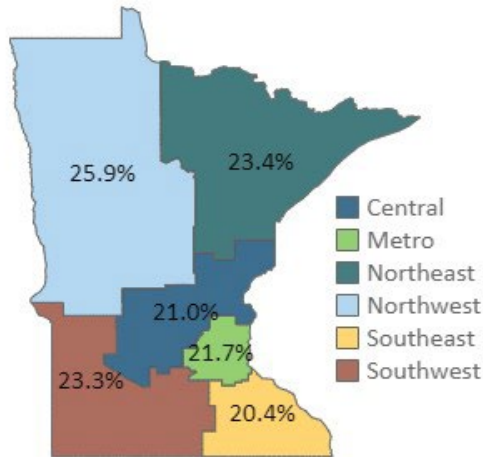
In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. Examples include:

- What is your level of education?
- Are you housed? Do you have access to a car?
- How easy is it for you to get fresh fruits and vegetables?
- Are members of your community disproportionately incarcerated?
- Do you have ample opportunity for employment with a livable wage?
- Do you experience the stress of institutionalized racism and unconscious bias?
- Do you live in a safe community, far from industrial sources of pollution and high crime rates?

Though it has not always been intuitive, answers to these questions influence people's health — as much or more than access to a doctor's office or hospital. The consistent denial to the same opportunities for housing (Horowitz et al., 2021), education (Grunewald & Nath, 2019), nutrition (Wilder Foundation, 2020), healthy neighborhoods (Reconnect Rondo, 2020) and justice under the law (Beckett & Ajasa, 2021) makes the resultant health disparities experienced by Black Minnesotans less surprising. University of Minnesota economist Dr. Samuel Myers coined the term "Minnesota paradox" to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while "African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers, 2020). These ongoing disparities reveal a system not broken, but accomplishing what it was designed to do. As noted in the 2020 Minnesota House Select Committee on Racial Justice Report to the Legislature, "Understanding that racially discriminatory public policy decisions shaped these disparities, the Legislature will need to consider and implement racially conscious policy changes to overcome these disparities" (Minnesota House of Representatives, 2020). Medicaid in Minnesota is an important program to begin ensuring racial equity.

Medicaid and related programs like Minnesota Care provide essential health care to people across Minnesota. Roughly 1.3 million people were enrolled in 2021. Medicaid serves more than half a million children each year, covering almost one- third of all Minnesota children before the COVID-19 pandemic. Geographically, the percent of Minnesotans served by Medicaid in Greater Minnesota is the same or slightly higher than those served in the Twin Cities metro area (Fig 1).

Percentage of the population within the region enrolled in Medicaid

Percentage of the population within the county enrolled in Medicaid

- Central
- Metro
- Northeast
- Northwest
- Southeast
- Southwest

25.9% 23.4% 21.0% 21.7% 23.3% 20.4%

11.2% 50.5%
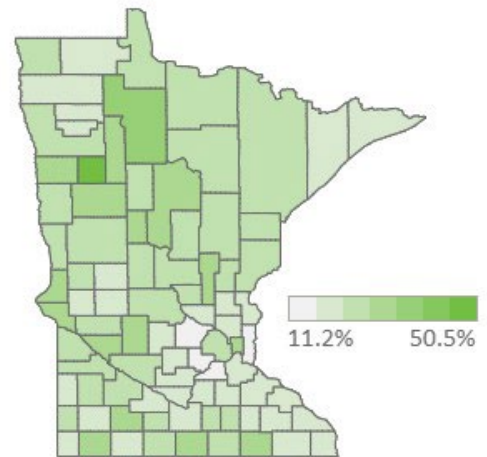
Fig 1. Percent of Minnesotans served by Medicaid based on geography, 2021

Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020. 2021 population estimates are not available yet. The denominator for the 2021 percentage enrolled by region and county is the 2020 population estimate.

These numbers are even more significant when examining the racial demographics of Minnesota's Medicaid program. Only about 73% of enrollees currently report their race and ethnicity upon enrollment in Minnesota's public health care programs, however racial demographic data provided to other public programs gives insight into around 93% of enrollees' identified race/ethnicity. From this, the data shows a disproportionate representation in Minnesota's Medicaid program among Black/African American people when compared to the general Minnesota population. Black/African American Minnesotans account for 18% of Medicaid enrollees vs. 7% of the general population (Fig 2).

Minnesota whole population racial breakdown - 2020

| MN | American Indian 1% 59,551 | Asian + Pacific Islander 5% 300,063 | Black 7% 395,983 | Hispanic 6% 321,686 | White 79% 4,444,391 | Two or more races 2% 135,668 |

Enrolled population racial breakdown - 2021

| MHCP | American Indian 3% 39,079 | Asian + Pacific Islander 7% 106,531 | Black 18% 275,798 | Hispanic 10% 143,240 | White 51% 761,085 | Two or more races 5% 69,355 | Unknown 7% 107,939 |

Legend: ■ American Indian ■ Asian + Pacific Islander ■ Black ■ Hispanic ■ White ■ Two or more races ■ Unknown
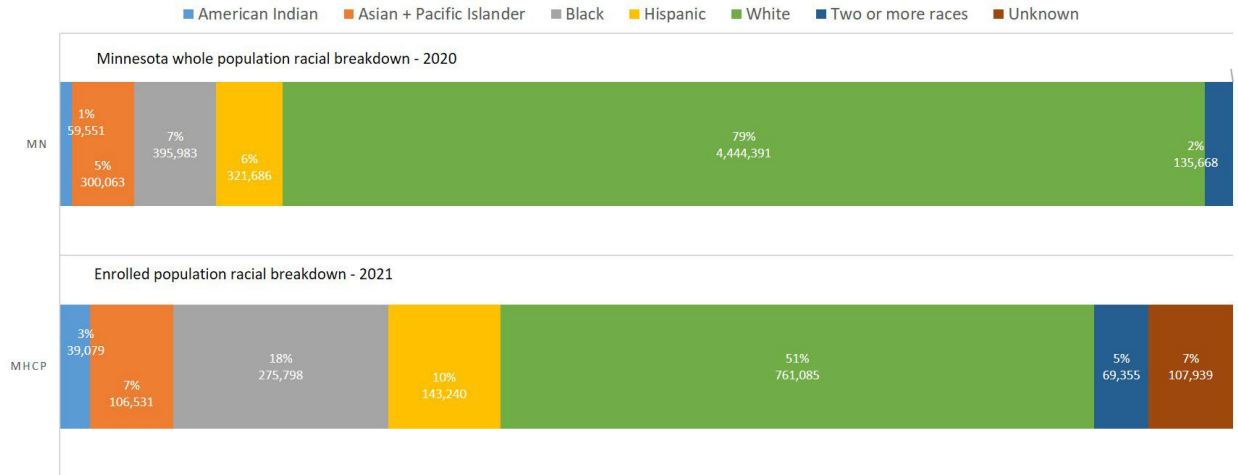
Fig 2. State of Minnesota demographics compared to Medicaid enrollee demographics, by race/ethnicity, 2021

Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020.

Data on how different racial/ethnic communities in Minnesota access care makes clear the significant impact Medicaid has on addressing racial health equity in the state. Data from a 2021 analysis of 2018-2019 data by the University of Minnesota's State Health Access Data Assistance Center (SHADAC) showed that approximately 41.5% of Black, 39% of Native American/Alaskan Native, 29.5% of Hispanic and 20.2% of Asian Minnesotans rely on Medicaid for health care coverage (Fig 3). Analysis of 2018-2019 data on Minnesotan children 0-18 years old who rely on Medicaid revealed that 64% of Black children, 59% of Native American/Alaskan Native children, 49% of Hispanic children, and 33% of Asian Minnesotan children rely on Medicaid, percentages that likely increased during the pandemic.

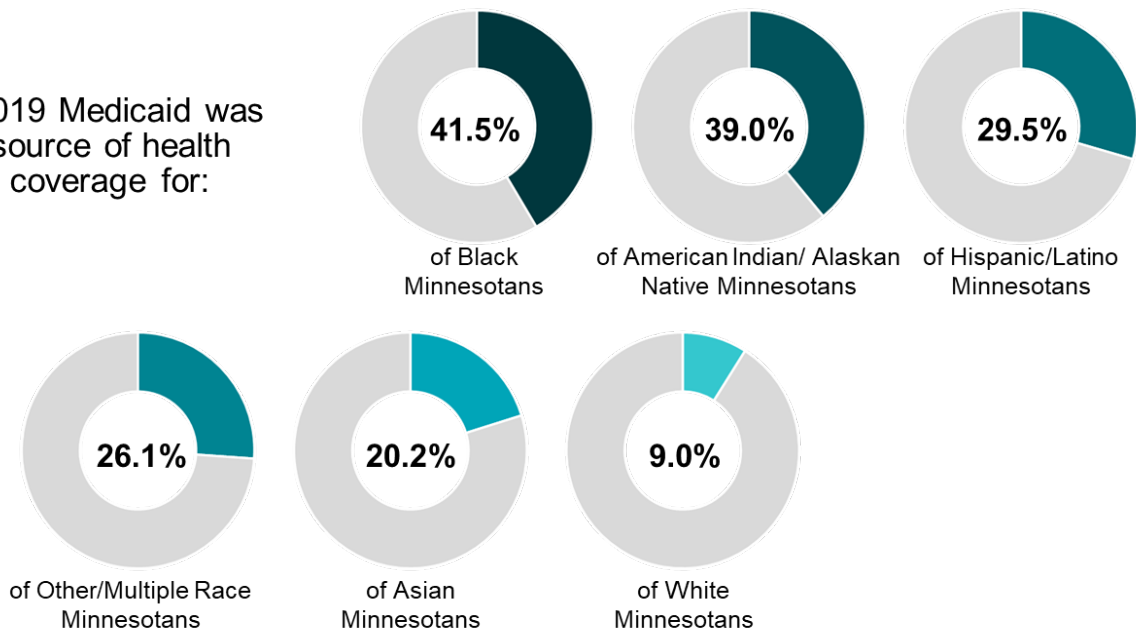In 2019 Medicaid was the source of health care coverage for:

41.5% of Black Minnesotans	39.0% of American Indian/ Alaskan Native Minnesotans	29.5% of Hispanic/Latino Minnesotans
26.1% of Other/Multiple Race Minnesotans	20.2% of Asian Minnesotans	9.0% of White Minnesotans

Fig 3. Percent of Minnesotans with Medicaid as source of coverage, by race, 2018-2019

Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2018 and 2019 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.

COVID-19 exemplifies the need for the Department of Human Services to examine its policies and programs in the context of their historical, current and future health and racial equity impact. This examination cannot be performed in government's usual silos. Communities impacted the most by structural racism and inequity need to be engaged early and provided accountability, as Minnesota strives to dismantle systems of harm and build systems that support the health of all. This report aims to continue the evolution of how policy within DHS is designed, proposed and considered by intentionally striving for community co-creation at the level of "Involve" along the International Association for Public Participation's (IAP2) spectrum (Figure 4).

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION →

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Fig 4. Spectrum of Public Participation. (c) International Association for Public Participation www.iap2.org.

To meet the level of "Involve," at the outset of this report staff met with individuals from the U.S.-born Black community and leaders of organizations that are a part of the community or working to advance racial equity in health care for Black Minnesotans. During these initial meetings, staff outlined four levers within Medicaid policy that could be used to continue to build racial equity for U.S.-born Black Minnesotans: Eligibility/Enrollment, Access, Quality and Early Opportunities.

Initial Community Contributors

- MDH Health Equity and Advisory Leadership (HEAL) Council
- DHS Cultural and Ethnic Communities Leadership Council
- Council for Minnesotans of African Heritage
- Voices for Racial Justice
- African American Leadership Forum
- Cultural Wellness Center
- Center for Economic Inclusion
- Former Minnesota State Senator Jeff Hayden

Community Conversation Participants

- Minnesota Health Care Program (Medicaid) enrollees
- Health Care Providers
- Community Based Organizations
- County Public Health and Human Service staff
- Managed Care Organization staff
- University of Minnesota School of Public Health and Medical School faculty
- Minnesota DHS and other State agency staff

Staff then took the input received from those initial meetings to relevant policy areas within DHS. Staff met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations further informed the initial "Calls to Action" drafted for this report. DHS then held two public Community Conversations to share the initial draft "Calls to Action" and sought further guidance from community members through facilitated discussion. Reflections and comments from all of these conversations have been incorporated into this report. The final report will also be purposefully shared back with community members upon release.

The hope is that through the path and guidance this report lays out, health and state policies continue to move toward a standard where the work is more fully informed by the communities that make up the state and that are served. And that work leads to rebuilding of trust with communities whose trust has been violated over generations. Ultimately, the state must realize its potential to offer all Minnesotans the same level of opportunity for health.

II. Why focus on racial equity

DHS' Equity Policy

DHS has worked for years on improving equity within the agency and in the experience of Minnesotans who rely on its services. In 2017, DHS institutionalized the agency's Equity Policy. This policy emphasizes the agency's commitment to "advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for all communities experiencing inequities." This policy models the Minnesota Department of Health's Health in All Policies (HiAP) approach, with the goal of having a human-centered design framework that considers achieving health beyond just the absence of disease, instead realizing a complete state of physical, mental and social wellbeing. Recognizing that Minnesota's structural inequities cut across sectors, DHS' HiAP approach requires solutions that both focus within DHS and also cut across agency and public-private sector boundaries to address the broad factors that make up the drivers of health (Healthy People 2020). This policy requires that communities experiencing inequities be consulted when programs are designed, implemented and evaluated. The DHS Equity Policy compels all DHS employees to include considerations for equity impacts on decisions specific to service delivery and workforce, program and project design and implementation, strategic planning, and legislative proposals, among other focus areas.

The State Medicaid Agency within DHS administers the Medicaid program and has worked to operationalize the DHS Equity Policy since its inception. Following the policy as a guiding principle, the Medicaid Agency institutionalized racial equity mechanisms and tools (Government Alliance on Race and Equity, 2022) to include an equity lens in all areas of work. The design has a process improvement lens, in which progressive development of trainings, beta testing and implementation of tools is done at a granular level. The Medicaid Agency's approach considered business needs and employee feedback, keeping the diverse needs and backgrounds of enrollees at the fore. The Medicaid agency's equity committee developed a comprehensive set of racial equity tools that have enhanced the effectiveness of Medicaid programs, policies, decisions and administrative procedures.

Know the History

Consider historical events that have negatively impacted Black, Indigenous, and Communities of Color. Acknowledge them and create space for communities to share as to not repeat the same mistakes.

Develop the Proposal

What is the policy, program, practice, or budget decision under consideration? What are the desired results and outcomes?

Monitor Data

What is the data? What does the data tell us? Are they disaggregated by race?

Engage the community

How have communities been engaged? Are there opportunities to expand engagement?

Analysis and strategies

Who will benefit from or be burdened (intent vs. impact) by your proposal? What are your strategies for advancing racial equity or mitigating unintended consequences?

Implementation

What is your plan for implementation?

Accountability and Communication

How will you ensure accountability, communicate, and evaluate results?

The Medicaid agency's equity tools and mechanisms support the DHS Equity Policy's goal of eliminating inequity. When incorporating an equity assessment analysis and best practices into program, policy and procedure decisions:

- How the equity tool is implemented and used will differ from program to program, department to department and county to county. Accountability for implementation and use within the Medicaid agency and to respective communities is essential.
- Approach equity analyses from a continuous improvement perspective, as opposed to a checklist. We will seek to strengthen programs, policies and procedures until health inequities are eliminated.
- That if the strategy, practice, policy or procedure works for the most disadvantaged communities, it works for everyone.

We have made strides in weaving equity considerations into everyone's work. While not yet where we aim to be, we are making progress on our commitment to equity. However, there is an awareness of the need to lead with a racial equity lens. This report therefore builds upon the work of so many others at DHS and in the communities we serve.

Why focus specifically on U.S.-born Black Minnesotans

All racially minoritized communities in Minnesota experience health disparities in one or more chronic conditions, however, U.S.-born Black Minnesotans notably have among the worst outcomes (Breslin et al., 2021):

- Adults experience increased rates of diabetes, asthma, HIV, hypertension, cardiovascular disease, substance use disorder and post-traumatic stress disorder.
- Children experience increased rates of preterm birth, low birth weight/very low birth weights, asthma, obesity, anxiety, suicidal ideation, potentially preventable emergency department visits and preventable hospitalizations.

Chattel Slavery

Jim Crow Laws

Mass Incarceration & Police Violence

Disadvantaged Neighborhoods, Less Wealth, Less Opportunity

Chronic Inter-Generational Stress

Racial Health Disparities

Fig 5. Structural racism's connection to U.S.-born Black health disparities

U.S.-born Black people are predominately descended from individuals and communities subjected to chattel slavery, Jim Crow segregation and mass incarceration. These features of structural racism directly contribute to the racial health disparities seen today (Fig 5). This legacy of chattel slavery is distinct to U.S.-born Black people.

Much of the available data understate the problems faced by U.S.-born Black Minnesotans, because the data clump immigrant and U.S.-born people together. As noted in the Minnesota Department of Health's 2019 report on culturally responsive care, the data "mask disparities impacting U.S.-born Blacks. This is in some part due to a healthy immigrant effect – a well-known phenomenon where immigrants are on average healthier than those who were born in the United States. The disparities are also attributable to structural racism and historical trauma that have negatively impacted outcomes across generations. We see these disparities between U.S. and foreign-born Black populations in Minnesota across education and health outcomes, such as: Minnesota Comprehensive Assessment test scores, high school graduation rates, infant mortality, and birth outcomes." (Minnesota Department of Health, 2019a)

Table 1 shows the notable health disparities between U.S.-born Black/African-American people enrolled in Medicaid programs compared with those who immigrated to the United States. Although the average age of enrollees in the two groups was the same, U.S.-born Black/African-American people had higher rates in every adverse outcome than those who immigrated to the United States. Between these groups, rates of asthma, heart failure/hospitalized heart conditions and depression were three times higher for U.S.-born Black/African-American people. And overall, U.S.-born Black/African-American people had the highest prevalence of asthma, hypertension, and heart failure/hospitalized heart problems of any group, and the second or third highest rates of many other medical or behavioral health conditions.

Changes in immigration law and the opportunities that came with it resulted in notable differences in how different communities who identify as Black interact with government institutions in the United States (Anderson, 2015). There are also differences in how other communities of color, refugees and other immigrant populations interact with government and medical institutions. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. This decision was not uniformly embraced by members of the Black community in Minnesota. During Community Conversations, several participants questioned this approach, citing that the data around a healthy immigrant effect was incomplete and therefore inconclusive, making exclusion of Black immigrant and refugee populations unnecessary. Other participants felt strongly that disaggregation was important given what is known about U.S.-born Black persons' health. One overarching intent is that this approach will lay the groundwork for similar, iterative work with other communities in Minnesota, including Black immigrants and refugees, who also face structural barriers to realizing health and racial equity. It is also important to note that neither the Black immigrant nor U.S.-born communities are monolithic. The experiences of Black Minnesotans can and do vary by their geography, income, sexual orientation and gender identity and the other communities and beliefs they identify with. However the impact of structural racism is felt by all to some degree and this is what guides the focus of this report.

Throughout the rest of this report, the term "community" will refer to the U.S.-born Black community in Minnesota. To maintain accuracy, however, the report will at times use African American or Black when referencing statutes, regulations, research or other data sources that use those terms to define individuals who identify as Black from the U.S.-born community.

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Mortality and Morbidity	Enrollees who were born in the U.S.						Enrollees who immigrated to the U.S.					All MA Enrollees
	American Indians*	African Americans	Whites	Hispanics	Asians	Others/ Unknown	African Americans	Whites	Hispanics	Asians	Other/ Unknown	
Mortality over 2.5 years	1.35	0.8	0.95	0.51	0.28	0.49	0.21	0.37	0.31	0.58	0.09	0.78
Type 2 Diabetes	12.37	8.28	6.19	7.6	4.9	5.32	7.66	7.54	10.88	9.71	6.52	6.95
Asthma	12.48	16.47	9.56	9.97	4.55	7.53	4.82	4.61	3.79	4.02	2.86	9.4
HIV/Hep-C	4.52	2.67	1.48	1.66	0.36	0.9	1.09	0.8	0.72	1.02	0.96	1.6
Hypertension	7.69	9.6	3.93	5.55	3	3.61	8.03	5.34	6.74	4.5	5.07	5.14
Heart failure, hospitalized heart conditions	2.05	1.96	1.46	0.65	0.57	1.08	0.64	0.96	0.79	1.27	0.59	1.37
COPD	11.91	8.4	10.17	6.72	2.98	6.33	5.1	5.65	3.92	4.46	2.74	8.53
Lung, Laryngeal Cancer	0.25	0.2	0.27	0.07	0.07	0.17	0.1	0.19	0.05	0.18	0.1	0.22
Behavioral Health												
Substance Use Disorder	35.37	20.09	15.64	14.12	4.33	12.34	2.56	3.75	3.97	2.78	2.37	14.42
PTSD	10.54	8.64	5.62	6.06	2.41	3.58	6.31	6.76	3.09	6.05	2.51	5.9
Depression	30.27	20.58	22.4	19.23	7.53	15.33	6.78	12.36	10.32	9.65	5.39	19.22
SPMI	7.36	7.09	6.19	4.77	2.94	3.68	2.73	4.47	1.59	5.48	1.38	5.55

Table 1. Prevalence of mortality and chronic conditions, by race/ethnicity and immigration status in Minnesota Medicaid enrollees, 2014. *All American Indians were included in this column. *Dark grey shading indicates the worst outcomes and light grey shading indicates the next worst. The values in the table are simple prevalence rates among all Medicaid enrollees, without any adjustments for other factors. For example, 6.95% of all Medicaid enrollees (in the far right column) had a diagnosis of type 2 diabetes.*

III. Levers within Medicaid to address racial equity for U.S.-born Black Minnesotans
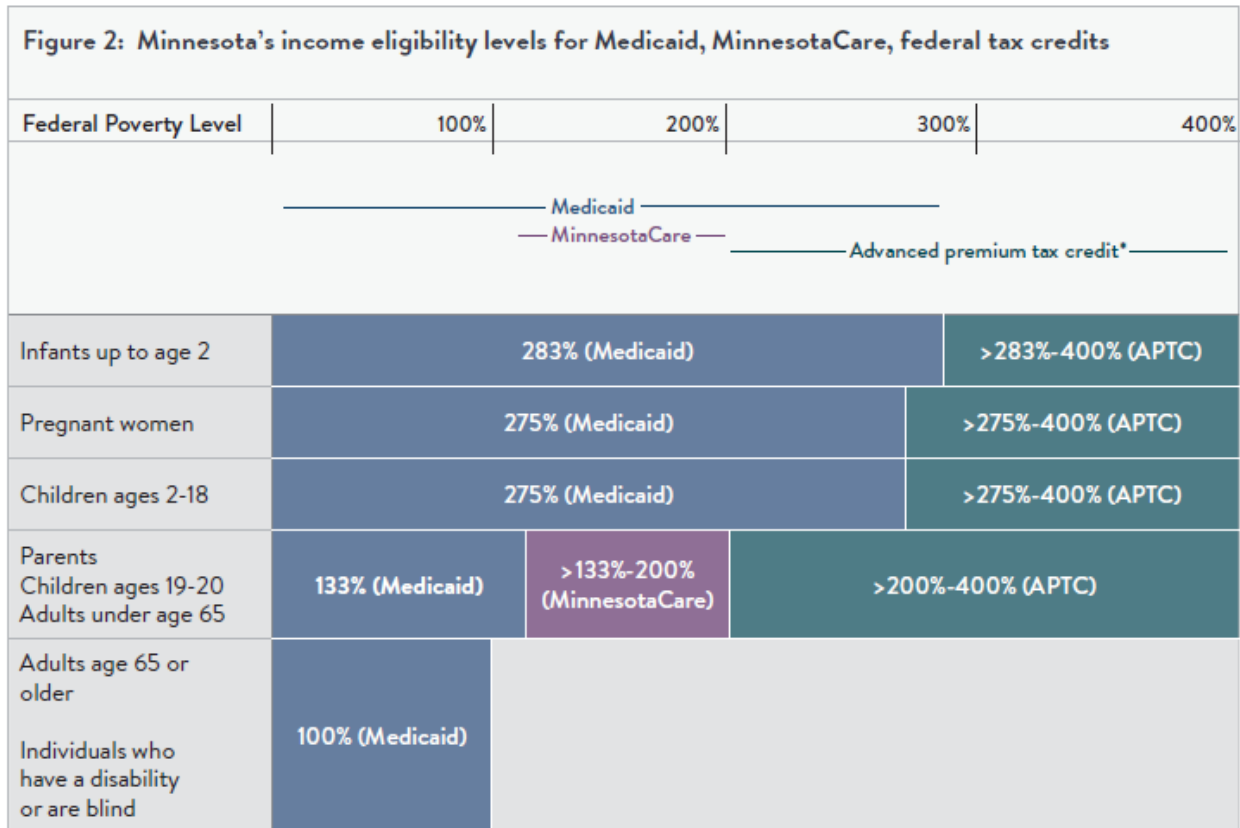
In his book, "How to be an Antiracist," Dr. Ibram Kendi defines an antiracist policy as "any measure that produces or sustains racial equity between racial groups." When looking at how Medicaid policies can build racial equity for U.S.-born Black Minnesotans, DHS approached the work by considering four key "levers" of Medicaid policy development: eligibility/enrollment, access, quality and early opportunities.

These levers capture multiple decision points where racial equity can be embedded: Who is eligible for Medicaid? How do they enroll and re-enroll? Are they able to access the care they need? Does that care meet the community's definition of quality? What role does Medicaid play in providing health equity from the very start in our community?

Eligibility and enrollment

Federal and state Medicaid policies, county-worker capacity, availability of a navigator, the complexity of information technology (IT) systems, and many other variables influence who is eligible for Medicaid and how easy or difficult it is to enroll and stay enrolled. In addition, the personal resources of the applicant can also make it easier or harder to enroll. These factors include their language and reading proficiency, technological expertise, understanding of health insurance and financial terminology, home address stability, and knowledge of their familial and social support networks. Most Medicaid enrollees must renew and prove their eligibility at least once a year. An individual's eligibility is based on factors such as household income and assets, family size, age, disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by eligibility category. In Minnesota, income eligibility ranges from 100% to 283% of the federal poverty level (FPL) depending on other factors (Fig 6).

Despite being eligible for Medicaid, many people who would benefit from Medicaid coverage aren't enrolled at all or experience gaps in their coverage. Forty-nine percent of uninsured individuals in Minnesota were estimated to be eligible for public health insurance programs like Medicaid in 2019 (Minnesota Department of Health, 2021b). Nearly one in four Medicaid enrollees nationally have had to change coverage within one year, and a majority experienced a gap in coverage (Sommers et al., 2016). This has been attributed to how frequently states require Medicaid enrollees to renew enrollment or re-verify their eligibility, the amount of time states provide enrollees to respond and the income fluctuation among populations covered by Medicaid. One survey found that the experience of income volatility differed by the race/ethnicity of communities, with 38% of Black households, 45% Hispanic households and 32% of white households reporting some income volatility (Sugar et al., 2021). Another study noted that Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months. Those who were off more than six months were less likely than those who stayed on to have a regular source of care, more likely to forego health care for financial reasons and more likely to report problems paying medical bills (Goold et al., 2020).

Figure 2: Minnesota's income eligibility levels for Medicaid, MinnesotaCare, federal tax credits

Federal Poverty Level	100%	200%	300%	400%

Medicaid
— MinnesotaCare —
Advanced premium tax credit*

Infants up to age 2	283% (Medicaid)			>283%-400% (APTC)
Pregnant women	275% (Medicaid)			>275%-400% (APTC)
Children ages 2-18	275% (Medicaid)			>275%-400% (APTC)
Parents Children ages 19-20 Adults under age 65	133% (Medicaid)	>133%-200% (MinnesotaCare)	>200%-400% (APTC)	
Adults age 65 or older Individuals who have a disability or are blind	100% (Medicaid)			

Does not reflect MinnesotaCare coverage from 0 to 200 percent of the federal poverty guidelines for lawfully present noncitizens who are ineligible for Medicaid.

* Advanced premium tax credits reduce the cost of premiums for coverage purchased through MNsure and were made available under the Affordable Care Act.

Fig 6. Minnesota's income eligibility levels for Medicaid, MinnesotaCare, federal tax credits * for 2021 and 2022, premium tax credits also apply to people above 400% FPG.

Access

Access refers to enrollees' ability to access care: Is there a primary care provider within a reasonable distance from home? Do they have access to culturally relevant care that is delivered with humility? Do they have reasonable access to specialists, behavioral health care or dentistry? There is ample evidence that access is a significant barrier for Medicaid enrollees. The Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of national household survey data has shown that "adults with Medicaid are more likely to report delayed medical care because of concerns about out-of-pocket costs, difficulty obtaining appointments, or because they do not have transportation" (MACPAC, 2021). Access to specific care like mental health providers can be especially inequitable. A 2014 JAMA study found that only 43% of psychiatrists accept Medicaid (Bishop et al., 2014). Barriers to care have been demonstrated among Minnesotans on Medicaid with a 2017 analysis of survey data showing that 55% reported some access barriers (Allen et al., 2017).

Access is a key lever to building racial equity within Medicaid. Black community members experience additional disparities in accessing care. The 2018 AHRQ National Healthcare Quality & Disparities Report noted that "12.3% of Black adults who had a doctor's office or clinic visit in the last 12 months and needed care, tests, or treatment sometimes or never found it easy to get the care, tests, or treatment compared with 6.8% of white adults" (U.S. Department of Health and Human Services, 2019). And while Minnesota DHS' 2021 Medicaid consumer satisfaction survey (Minnesota Department of Human Services, 2021a, c) found no difference in how Black respondents "felt judged or treated with disrespect by a health professional because of their race," they were statistically significantly more likely to be "told they showed up too late to an appointment to still be seen," a question Minnesota DHS added in 2021 as a proxy for missed opportunities for care. A 2017 analysis of Minnesotans on Medicaid found that 21% of enrollees who identified as U.S-born Black reported having foregone care in the past year, the highest percentage of any racial/ethnicity group surveyed. And Minneapolis and St. Paul both scored among the most segregated cities in the United States in 2019, according to the Othering & Belonging Institute at the University of California, Berkeley's *The Roots of Structural Racism Project* (University of California, Berkeley). This geographic segregation contributes to the barriers in access Black Minnesotans experience. For example, a JAMA study (Goedel et al., 2020) examining access to medication for opioid use disorder found that "counties with highly segregated African American and Hispanic/Latino communities had more facilities to provide methadone per capita, while counties with highly segregated white communities had more facilities to provide buprenorphine per capita." In Minnesota, buprenorphine is available in many primary care offices throughout the state while methadone at only 12 opioid treatment programs, highlighting the role geography and place play.

As the single largest payer for health care services in the state, Minnesota Medicaid has a critical role in driving increased racial equity in health care access, particularly in areas of care where Medicaid's footprint is largest, such as pediatric, obstetric and mental health services, and long-term services and supports. Given that nearly 80% of Medicaid enrollees are served by a managed care organization, it is also important that Medicaid work with, measure and incentivize managed care organizations' efforts to improve racial equity in access to care.

Quality

Once an enrollee successfully gets access to care, do they receive care at the same level of quality as other Medicaid members or other Minnesotans? Are the measures used to define "quality" consistent with what the community would define as "quality" care? It has been noted for more than a decade that enrollees in Medicaid managed care have significantly lower rates in common health care quality measures across the board compared to other payers (Minnesota Community Measurement, 2021a). Among Medicaid enrollees, Black/African-American members consistently experience even lower rates on a majority of measures than other groups of enrollees (Table 2). Minnesota Community Measurement's 2020 report on Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin states that "Black patients whose preferred language is English have significantly lower rates of optimal diabetes care, optimal vascular care, and depression remission at six months compared to Black patients whose primary language is not English" (Minnesota Community Measurement, 2021b). This speaks to additional barriers U.S.-born Black Minnesotans may face receiving the same level of

quality care in Minnesota. It also highlights the need for further disaggregation of race and ethnicity data used to measure quality and other metrics within the Medicaid program. Currently, Medicaid has racial demographic data for 93% of enrollees. To truly understand inequities in the quality of care received by Medicaid enrollees will require their trust in sharing their race and ethnicity data. Part of building that trust is having communities define what "quality care" actually entails.

MEASURE	2020 MHCP MCO Race Average*	RACE										2020 MHCP MCO Ethnicity Average*	ETHNICITY		
		Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian/ Other Pacific Islander	White	Chose Not to Disclose/ Declined	Patient Reported Race Unknown	Some Other Race	Unknown Race		Hispanic/ Latinx	Not Hispanic/ Latinx	Ethnicity Not Reported
PREVENTIVE HEALTH MEASURES															
Breast Cancer Screening	64.2%	▲	▼	▼	●	●	●	-	-	-	●	63.3%	▲	●	▼
Colorectal Cancer Screening	59.7%	▲	▼	▼	●	●	▲	▼	▼	●	-	59.7%	●	●	▼
CHRONIC CONDITIONS MEASURES															
Optimal Diabetes Care	35.6%	▲	▼	▼	▼	●	●	●	●	▲	-	35.8%	●	●	●
Optimal Vascular Care	47.2%	▲	●	▼	●	NR	●	▲	NR	●	-	47.5%	▲	●	NR
Optimal Asthma Control - Adults	45.2%	▼	▼	▼	●	●	▲	●	▼	●	-	45.2%	●	●	▼
Optimal Asthma Control - Children	53.4%	▼	●	▼	●	●	●	▼	▼	●	-	53.9%	●	●	●
MENTAL HEALTH MEASURES															
Adolescent Mental Health and/or Depression Screening	89.4%	●	▼	●	●	●	▲	●	▲	●	-	87.8%	▼	▲	●
Adult Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	48.5%	●	▼	▼	▼	NR	▲	▼	●	●	-	48.3%	▼	●	▼
Adult Depression: Response at Six Months	15.9%	●	▼	▼	●	NR	●	●	▼	●	-	15.8%	●	●	●
Adult Depression: Remission at Six Months	8.3%	●	▼	▼	●	NR	●	●	●	●	-	8.3%	●	●	●
Adolescent Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	41.8%	●	▼	●	●	NR	●	●	NR	●	-	41.4%	●	●	NR
Adolescent Depression: Response at Six Months	13.1%	●	▼	●	●	NR	●	●	NR	●	-	13.3%	●	●	NR
Adolescent Depression: Remission at Six Months	6.3%	●	●	●	●	NR	●	●	NR	●	-	6.3%	●	●	NR

▲ Significant above statewide MHCP MCO race/ethnicity average   ● Average   ▼ Significantly below statewide MHCP MCO race/ethnicity average

NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients   - Race category not reported for HEDIS/DDS measure

*Statewide MHCP MCO rates were re-calculated for those with race/ethnicity information available.

Table 2. 2020 Comparison of Minnesota Medicaid managed care enrollees' quality metric rates by race and ethnicity. *Source*: *Minnesota Community Measurement's 2020 Minnesota Health Care Disparities by Insurance Type report*

Early opportunities

Prenatal, maternal and early childhood health and development also play a significant role in the emergence of racial health disparities. In Minnesota, about eight in 10 births to mothers who identify as

Black are to people insured by Medicaid. Yet data from Minnesota Vital Records showed that between 2011 and 2017 African American/Black birthing people were 1.5 times more likely to die during pregnancy, delivery or the year post-delivery than non-Hispanic white birthing people. More specifically, U.S.-born African American/Black women are 2.8 times more likely to die during pregnancy, delivery, or the year post-delivery than non-Hispanic white women (Minnesota Department of Health, 2019b). Other studies have shown that Black pregnant women have a substantially lower likelihood of receiving any medication for the treatment of opioid use disorder, and when they do receive treatment, they have a lower likelihood than white non-Hispanic pregnant women of receiving buprenorphine treatment compared with methadone (Schiff et al., 2020).

Minnesota also has some of the nation's worst disparities in birth outcomes for Black people. Black birthing people have higher rates of giving birth prematurely (9.3%) than white birthing people (8.6%) as well as having a newborn with low birth weight (9.5% and 5.9%, respectively). Among births covered by Medicaid in 2019, the low birth weight rate was 6% for white birthing people, and 12% for U.S.-born Black birthing people with the preterm birth rate landing at 9 and 12%, respectively. Prematurity, low birth weight and neonatal opiate withdrawal are the leading causes of costly neonatal intensive care unit admissions. These adverse birth outcomes are strongly associated with lifelong health problems like illnesses that affect breathing, feeding and digestive problems, cerebral palsy, and intellectual and developmental delays that lead to challenges in school.

The environment and level of support children are raised in during their first five years is critical to reaching their full potential. Early experiences shape brain development in a way that impacts not only education and school readiness, but lifelong health (Center on the Developing Child at Harvard University, 2017). Minnesota has numerous opportunity gaps when it comes to providing an equitable start for our youngest Minnesotans (Chomilo, 2019). Minnesota Medicaid has previously participated in grant-funded planning work around a newborn child's first 1,000 days on Medicaid that identified several key areas critical to provide them with an ideal start: integrating cross-sector data, identifying assessment tools and shared metrics, building state and community-level cross-agency partnerships, creating new clinical models and community linkages to medical practices and targeting highest risk infants, families and neighborhoods (Somers & Maul, 2021). Black children are among the groups more likely to experience interruptions in coverage, which has been shown to lead to delayed care, unmet medical needs and unfilled prescriptions (Olson et al, 2005). As noted earlier, in Minnesota 64% of Black children are covered by Medicaid (Fig 7). Therefore focusing on how we explicitly build racial equity into eligibility/enrollment, access, and quality for our mothers and youngest Minnesotans is critical. A failure to address racial equity in maternal and early childhood policy will set the health and opportunities presented to Black children on a different trajectory and make the state's commitment to equity that much more difficult to achieve.
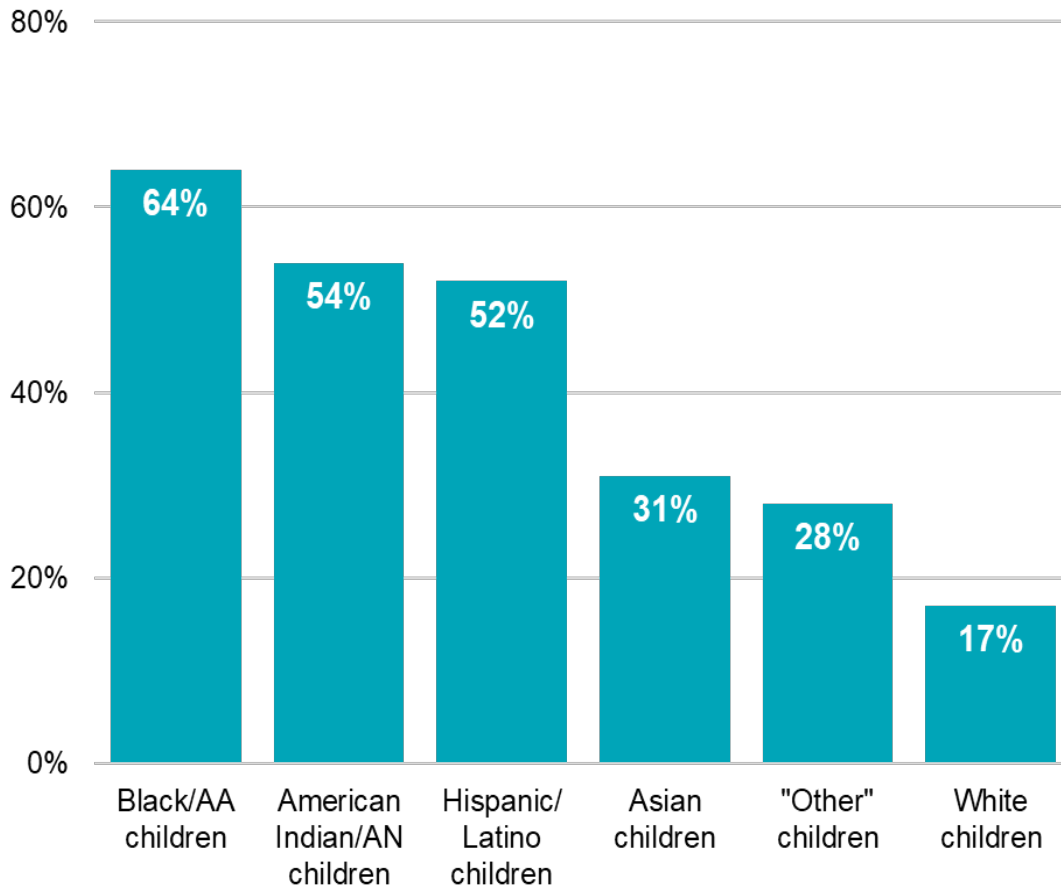
Fig 7. Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

Source: SHADAC analysis of the 2017-2018 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2017 and 2018 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.

IV. What Medicaid can do now to address racial equity for U.S.-born Black Minnesotans

The result of the iterative process described above, this report lays out the Medicaid policies and programs most commonly cited by the U.S.-born Black Minnesotan community members involved: Enrollment and renewal, access to culturally-relevant care, and community engagement and co-creation. The report shares the problem as well as opportunity in each of these areas. It then tries to answer the following questions: Why does the problem exist? What has Medicaid done to address it? And finally, the report provides one to two "Calls to Action" that are needed right now to build racial equity into the walls of the Medicaid program along with potential indicators of progress to set some initial degree of accountability.

> **What will accountability to U.S.-born Black Minnesotans look like for Medicaid?**
>
> Recognizing that changes in Medicaid policy can require state or federal legislative authority or funding, accountability for the Calls to Action covered below can be difficult to place. These call outs intend to present broad outcomes that the Medicaid agency within DHS can be accountable to with the U.S.-born Black community in Minnesota. The aim of that accountability is to be Medicaid-focused and on the outcome of racial equity and not just the process. The Calls to Action are some of the ways proposed to improve racial equity for U.S.-born Black Minnesotans based on the iterative process involving community members and DHS staff. However, many actions can realize racial equity. The process is important, but accountability ultimately comes from a change in outcomes.

Importantly, since Medicaid service eligibility cannot currently be dependent on an individual's racial background, none of these calls to action seek to create Medicaid-funded services that are racially exclusive. Instead, they recognize the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes, which will be available to all, and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

Enrollment and renewal

What is the problem, and why does it exist?

U.S.-born Black Minnesotans enrolled in Medicaid programs often talk about challenges they face in enrolling in Minnesota Health Care Programs (Medicaid and MinnesotaCare).

Public programs of all types are criticized for difficult enrollment processes. There are many reasons for this, including complex federal and state eligibility rules, requirements for extensive documentation, the need to go to a county or tribe or to use an online system to apply. Medicaid enrollment is no exception.

Many barriers exist outside of DHS' control. However, there are some barriers which DHS, in collaboration with agency partners, could improve upon.

In interviews with families with children who were living in poverty (DHS, 2020) (Minnesota Department of Human Services, 2020), of the 27 parents asked about health insurance, six (22%) appeared to be income-eligible for Medicaid but were not enrolled. This was concerning as all six families had significant health care needs. Two parents were pregnant or just had a baby, one parent had diabetes, and three parents had serious mental illness.

Some of the uninsured parents were confused by the Medicaid enrollment process. Two parents had submitted applications but were unsure where they were in the process. For example, a mother of two teenagers has urgent needs for health care. She has diabetes, and she wants help for one of her children who is having emotional outbursts.

> *"We applied for MNSure, but I didn't do it through there. I did it on paper. They say it's backed up on paper, so I should have done it online because it's quicker. I wonder if I should do it online. But they said what would happen is I would get knocked off the list for already having it. It's confusing."*
>
> — *Female, African American*

When she contacted the consumer helpline to find out why her paper application was taking so long, they were only able to tell her that it was being processed, and did not seem to have access to any other information. This is probably because the county was processing her application, and DHS did not have up-to-date information on it. However, it is frustrating for applicants to call the DHS Health Care Consumer Support line and be unable to get questions answered about their particular case.

Enrollment and renewal: Lack of communication with applicants and enrollees

Once a person has enrolled, DHS needs to continue keeping them up to date on their case, and there are many indications that this does not always happen. The Improve Group conducted interviews with people in the Twin Cities area who were living in poverty, people who are homeless and people who have immigrated (The Improve Group, 2016). They noted that several people described going to a health care appointment or to a pharmacy to fill their prescription, and were surprised to learn that they had lost their Medicaid coverage. As a result, they sometimes had to go without the care or the medication. One woman described this experience.

> "It was difficult to get MA [sic]. The first time I applied for MA it took 2-3 months to get it, but it was a while longer before I got my card. Then I had it and they cut me and my kids off, I don't know why. I was only on MA a couple months, and they said I needed a renewal, so I did my renewal but went to get my birth control and my MA was inactive."
>
> — Female, African American, 18-25 years old (MA stands for Medical Assistance, Minnesota's Medicaid program)

The Improve Group also described some situations where the paperwork to renew a person's Medicaid eligibility found its way to them *after* the renewal deadline, so they lost their coverage. Others described

discovering that they had been moved to a different managed care organization and didn't understand how this happened or if their benefits changed.

In a discussion with DHS staff who attended a 2020 presentation on how chronic stress adversely impacts clients, many were aware of and concerned about a lack of communication, and described the challenges noted above from their own points of view. Staff in one of the help desk areas noted that "the frustration of having to make multiple calls and wait to get one's questions answered is exacerbated by the urgency of people's questions … People are already in a state of stress when they are contacting DHS — often with health conditions that they need to see a doctor for."

In these first-hand accounts, people had many complaints about the enrollment system, but they often seemed most upset by the lack of communication. Their application was stalled and they couldn't find someone who could tell them what was going on, even when they called the help desk. Their coverage was dropped, and they only found out about it when they tried to get health care. These comments suggest that even if the application form is complex and the methods for applying are less than ideal, DHS could make the application process much less frustrating if there were reliable ways for applicants to get all of their questions answered and for them to get regular updates on their application and renewals. One way this might be improved is if DHS stopped relying exclusively on paper notices that are sent through the mail and made notices available online. If these could be accessed through a mobile phone or other modes of communication, people might be more likely to receive them when and where they need them.

Enrollment and renewal: Opportunities and strengths identified by community

Multiple sources suggested the value of having navigators help people apply for coverage through the MNSure portal. Navigators are located within health care systems, county or tribal human services agencies, and trusted community nonprofits. They help people apply, enroll and manage their paperwork and will sometimes help people find a health care or other provider. They play an especially important role in helping people overcome technology barriers when applying for coverage online through MNSure. This is particularly valuable for people without a computer or internet access at home. The paper application alternatives require completing and mailing in or dropping off a form, and then waiting for the county or tribal agency to process the form and send notice of the determination. However, access to a computer and internet is far from universal; only 69% of African Americans in the United States have a computer at home, and 71% have broadband internet (Pew Research Center, 2021) (Atske & Perrin, 2021).

As mentioned by the Community Wellness Center staff, navigators can be located within culturally-specific organizations. Working with a member of their community can be important for Black Americans, given the unethical treatment they received historically from the medical industry (e.g., the Tuskegee syphilis study) as well as the unequal treatment that continues today (Epstein et al., 2000; Petersen et al., 2002). Working with a trusted individual who shares a common history with them may make it more comfortable to share sensitive information about themselves, and thus enable the navigator to help them access all the services they need.

The Improve Group (The Improve Group, 2016) found that "participants who received help applying for coverage from MNsure navigators reported a far better experience and fewer challenges in getting started with MA than those who did not" (p. 20). In a discussion with the Cultural Wellness Center, their staff lauded navigators as providing people with help to enroll, but also to help guide families to other services they may need. They emphasized that their value comes from their location within the community, and living and working alongside the families they support.

Two of the stakeholder groups named continuous enrollment as a potential solution. The African American Leadership Forum expressed interest in the idea of continuous enrollment at a state or even a federal level, and asked what it would take to make that happen. This group also asked whether it would be possible to give more leeway to people who were enrolled but have a lapse in enrollment due to a glitch in the notification process. Leaders in the Center for Economic Inclusion asked about auto enrollment or auto re-verification of these programs. Participants of the Community Conversations hosted by DHS also deemed continuous enrollment important. Of all the Calls to Action, participants were most excited about proposals to extend periods of continuous enrollment among enrollees.

Enrollment and renewal: What is Medicaid doing to address this?

One of the ways DHS has tried to support people applying for Medical Assistance, is to ensure that community navigators stay in business during the COVID-19 pandemic. DHS staff learned from the Navigator Coalition that navigators were adversely impacted by significant funding shortfalls. The steps DHS took to help Minnesotans maintain health care coverage during the emergency resulted in a steep decline in the number of new applications and suspended virtually all renewal activities. This caused a decrease in navigator incentive payments, funds navigators receive when they help applicants and enrollees successfully apply and renew health care coverage. DHS sought and the Minnesota Legislature approved a state law change to distribute unused 2021 incentive payment funds as grants to help support navigators during the pandemic. It is critical that navigators remain available to assist enrollees when standard eligibility and enrollment activities, particularly annual renewals, resume at the conclusion of the public health emergency.

DHS plans to make the Medicaid application process simpler by allowing people to apply using an online portal and phone app called MN Benefits. This tool allows Minnesotans to simultaneously apply for programs such as SNAP (food stamps), MFIP (cash assistance for families with children), emergency assistance, housing support, and child care support. This tool could allow people to apply for Medicaid at the same time. DHS has received positive feedback from users on the tool's ease of use. At the time of this report's publication, DHS is in the planning phase of this work.

Improving Medicaid enrollment and renewal policies for justice-involved populations provides another step in improving racial equity among Medicaid enrollees. In 2015, Black Minnesotans were incarcerated 9.1 times more than white Minnesotans. While research shows that this disparity in incarceration rates contributes to racial health disparities (Wildeman & Wang, 2017), it also points to how increased access to care may lead to improved outcomes, such as decreased hospitalization or recidivism (Guyer et al., 2019; Plotkin & Blandford, 2017). No federal law, statute, regulation or policy prevents individuals from being enrolled in Medicaid before, during or after incarceration in jail or prison (McKee et al., 2015).

However, under federal regulations, federal Medicaid funds may not pay for services provided to people who are inmates of a public institution, other than for inpatient hospitalization. As a result, Minnesota has traditionally terminated people's Medicaid coverage upon incarceration. This requires them to reapply for Medicaid when they are about to be released, which can be very challenging to do from prison.

During the COVID-19 emergency, DHS put in place a procedure to ensure that Medicaid enrollees remain enrolled in Medicaid without interruption, creating a special code to ensure that Medicaid funds only inpatient hospitalization. Under this new policy and procedure, Medicaid enrollees remain enrolled during incarceration and have full coverage restored upon release. DHS is currently working to make these changes permanent in all Medicaid eligibility systems.

> **What will accountability to U.S.-born Black Minnesotans look like for Medicaid in enrollment and coverage renewals?**
>
> - Advancing proposals to change Minnesota laws regarding continuous eligibility for those aged 0-19.
> - Taking demonstrable steps to improve enrollment and renewal processes.
> - Continuing to support navigators.
> - Making renewal notices more accessible to enrollees, e.g., available electronically in addition to mailed paper documentation.
>
> Outcome: Minimal disparity in the percent of U.S.-born Black Minnesotans who maintain coverage at the end of the federal public health emergency compared to average Medicaid enrollees.

Call to Action: Simplify and support enrollment and re-enrollment

DHS eligibility policy and operations staff have many ideas for making enrollment easier, preventing lapses in eligibility and communicating more effectively. Many of the recommendations simplify the application process but require significant technical changes to the Minnesota Eligibility Technology System (METS). Given the high costs, lengthy timelines and even lengthier queues for any modifications to the online system, these recommendations must be thought of as long-term goals, and they are identified with an "IT" indicator. Other ideas could be implemented in the shorter term, especially once changes are completed to bring the system back to pre-pandemic rules. Based on iterative discussions with community and DHS staff, DHS should focus on two steps to simplify and support enrollment and renewal in a way that will improve racial equity for U.S.-born Black Minnesotans on Medicaid in the near term:

1. Pursue continuous eligibility policies

Continuous eligibility (also referred to as continuous enrollment) allows enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time.

Twelve-month continuous eligibility for children is a long-standing retention strategy for states, and 32 states already offer this (Medicaid, 2021). The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for up to 12 months. This means that the child's enrollment cannot end, regardless of any changes in circumstances, unless the child

- a) reaches the end of the 12-month period and is no longer eligible;
- b) reaches age 19;
- c) ceases to be a state resident; or
- d) passes away.

States also have the flexibility to tailor continuous eligibility for children to the specific needs of the state, such as choosing the age range for continuous eligibility and length of the continuous eligibility period. For example, Florida provides continuous eligibility for 12 months for children under age 5, while children ages 6 through 18 receive six months of continuous Medicaid eligibility (Kaiser Family Foundation, 2020). Indiana provides 12 months of continuous Medicaid eligibility only to children under 3 years old (Kaiser Family Foundation, 2020).

Minnesota has no continuous eligibility policy yet for children. However, Minnesota currently provides continuous eligibility to pregnant people (recently extended in the 2021 legislative session from 60 days to 12 months following the end of pregnancy) and their newborns through the first year of life. Philosophically, adding continuous eligibility for children is the logical next step. Providing continuous eligibility to children reduces churn during the year, which is administratively expensive and a barrier to children getting needed care (Brooks, 2021). In addition, changes that may be temporary or permanent, such as a new job or taking on more hours of work during the busy season, would not impact children's eligibility until their next annual renewal. Continuous eligibility could also benefit the entire family by keeping the family's case open even when adult family members lose eligibility. Once a family's case is closed, they have to complete a new application to reapply. If their child had continuous eligibility, parents whose eligibility is terminated due to a change in circumstances or for failure to comply with an eligibility requirement could be reinstated on their child's case if they become eligible again during the year or at the next renewal without having to complete and submit a whole new application. Given the many ways outlining how structural racism impacts families of color, it is little surprise that gaps in coverage due to churn are more likely to impact Black and Hispanic children, with this report also showing that the Midwest had one of the highest gaps in coverage by region (Alker & Osorio, 2021).

The importance of continuity for children is further emphasized by its inclusion in the federal Build Back Better Act, which at this writing has been passed by the House and is being considered in the Senate. While states currently have the option to provide continuous eligibility to children under age 19 through the Social Security Act, this bill would make it a *requirement* for states to do so. All children under age 19 eligible for Medical Assistance would receive continuous enrollment for a 12-month period, beginning on the date of the determination of eligibility. States will no longer have the option to limit the child's age or the time length of the continuous eligibility period.

If this bill becomes law, it will require changes in the IT systems at both MNsure (METS) and the system used by counties (MAXIS). However, even if the Build Back Better Act is not passed, **DHS should pursue**

the state plan option under the Social Security Act to provide continuous eligibility to children. This can be accomplished by submitting a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval. When given the option, Minnesota should choose to provide the full 12 months of continuous eligibility to all children under age 19. This aligns with the continuous eligibility period for both pregnancy people and newborns.

Additionally, DHS should pursue additional expansion of continuous eligibility. Given what is known about the importance of the first five years on early brain development and what has occurred in the past two years during the COVID-19 pandemic, **DHS should explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 and establish 24-month continuous eligibility for all enrollees age 6 and older.**

Both of these changes have recently been proposed by Oregon's Medicaid Agency, the Oregon Health Authority, in its 2022-2027 1115 Medicaid Demonstration Waiver proposal (Oregon Health Authority, 2021). In it, they note that 72-month eligibility for children up to age 6 will, "stabilize their insurance coverage and thus increase access to early-childhood screenings and necessary treatment … reduce frequent enrollment and disenrollment in this vulnerable population and allow for more predictable access to care, which is an important driver of improved health. Because many of these children remain eligible for coverage, eliminating churn also reduces state administrative costs and burden for families in application reprocessing. Further, expanding the pool of children who are continuously covered may ultimately reduce per member costs of coverage, as children who stay on OHP [Oregon Health Plan] longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care. Increasing the time between eligibility reviews for other family members will further ease the administrative burden on families and increase coverage stability for individuals and families on OHP." Regarding 24-month continuous eligibility for all enrollees age 6 and up they argue that, "Establishing continuous enrollment and increasing the length of time between eligibility renewals will preserve the coverage continuity gains achieved in the wake of federally enacted COVID relief bills passed in 2020. In 2018 and 2019, nearly 25% of new OHP enrollees had been enrolled in OHP within the previous 6 months. Over the last 6 months of 2020, this rate fell to just 5% of new enrollees. The speed with which people re-enrolled in OHP suggests that they may have been losing OHP coverage despite being eligible. The drop in the new enrollee rate suggests that federal policies enacted around the pandemic to keep people covered successfully reduced Medicaid churn."

2. Support navigators and simplify the enrollment and renewal process

Comments on the enrollment process emphasized applicants' frustration that they were not kept up to date on the progress of their applica*tion, and that help desk staff were unable to answer questions on their particular case.* People also felt frustrated that they received no notification when a change had occurred, e.g., they lost coverage. Given the complexity of enrolling and renewing coverage, how many people in poverty lack a home computer with internet access, and that navigators are located within communities, increasing the availability and utilization of navigators is an important way to help people to apply. Navigator funding comes from contracts with counties, health care systems or other organizations. **DHS should therefore work with navigators and the U.S.-born Black community to**

develop a plan focused on ensuring eligible Black Minnesotans gain or maintain Medicaid coverage throughout the year but in particular as the federal public health emergency ends.

Access to culturally relevant care

What is the problem?

"Culture is missing"

— Community leader

Improving eligibility and enrollment in Medicaid and the care it covers is not synonymous with improving care and access for all communities. Studies of the impact of Medicaid expansion under the Affordable Care Act have had mixed results when it comes to decreasing racial disparities in several markers of access and care (Guth et al., 2020). A participant in the Community Conversations reflected, "They [medical practitioners] don't listen to us [Black people] when we explain our problems; Black patients do not receive the same treatment as white patients." A significant amount of literature validates the lived experience shared by this community member, both in how Black adults (Ayotte & Kressin, 2010; Federspiel et al., 2011; Angraal et al., 2018; Hsia et al., 2011; Mortensen et al., 2004; Green et al., 2007) and children (Todd et al., 2000; Goyal et al., 2015) are the recipients of unequal care. The 2017 analysis of Minnesotans on Medicaid found that 49% of enrollees reported experiencing some discrimination (described as unfair treatment due to gender, ability to pay, enrollment in Medicaid, or race/ethnicity/nationality). This highlights the need for systems of care to be intentional about connecting community members to health care professionals who provide culturally relevant care. As another community member shared during the Community Conversations, "relational care matters more than some medical care."

This sentiment was echoed in meetings with multiple community leaders who stressed the importance of culture in the health and well-being of community members. Culture was described as the fabric that links an individual to their community through shared beliefs, knowledge, practices and protections. Loss of culture in the healing space therefore contributes to illness by separating an individual from one of their shared strengths. This has been seen over time by racist policies that attempted to strip communities of their culture and codify a white supremacy approach to health as the only legitimate path (United Nations, 2016; Edwards, 2021; Yearby, 2020; Crear-Perry et al., 2021). In the face of this, many communities, including the U.S.-born Black community, have maintained their culture and the strength that comes with it. Health care systems are only beginning to value this resilience, and access to care that honors culture remains difficult.

MDH noted in its 2019 report on Culturally Responsive Care that "Cultural competency is critical to providing equitable, effective and respectful care and services. It includes but is not limited to being responsive to diverse beliefs and values related to health and wellbeing, delivering services in preferred languages, and being mindful of health literacy and numeracy. Providing culturally appropriate care is increasingly important as Minnesota becomes more diverse … Providing culturally responsive care to U.S. born black women and children living in Minnesota includes (but is not limited to) acknowledging

the historical trauma that has affected black communities in Minnesota and the current oppression and racism that restrict access to resources, education and health care."

Lastly, one of the ways to identify and prioritize culturally relevant services is via information technology systems. Unfortunately, many remain archaic and were not designed with the end user in mind. Culturally specific data needs to be integrated into technology systems. Modernization of these systems is complex, bringing with it multiple layers that may from the outside appear simple. Adding to this is that until relatively recently differences between the U.S.-born Black community and Black immigrant and refugee communities weren't acknowledged and therefore these communities have not been involved as end users in conversations about developing an equitable IT infrastructure.

Access to culturally relevant care: Opportunities and strengths identified by community

Community leaders emphasized a strong need for culturally specific care in conversations. Panelists consistently discussed the important role culture plays in an individual's health and a community's health. One interviewee called for a new definition of health that emphasizes a community's (cultural group's) ability to care for each other. Trauma-informed care also emerged as a theme in many conversations. In health care, trauma is often understood as specific events and their impacts on an individual's life and wellbeing. However, when a cultural lens of health care is applied, trauma can be viewed in a macro-sense and the impacts of historical and systemic racism become very relevant. Many DHS interviewees discussed the pressing need for more focus, training and attention on historical and ongoing trauma. Community interviewees noted that Medicaid and other state agencies can support culturally relevant care in concrete ways, such as incentivizing and building a stronger infrastructure of Black clinicians and clinics centered on care that values culture along with an allopathic approach to health and healing.

Access to culturally relevant care: What is Medicaid doing to address this?

Recognizing the problem and addressing it are two different things. Among DHS staff, a consistently noted barrier to addressing culturally relevant care was a lack of routinely and standardly disaggregated racial demographic data — data that would allow a better understanding of where specific communities experienced barriers and successes. Without good data, even staff aware of issues creating barriers found it very difficult to prioritize specific communities, health plans or providers with interventions (e.g., quality benchmarks, payment withholds, incentives).

Many DHS staff also observed the lack of trauma-informed providers in the community. It was also noted that most trauma-informed practices are not well designed to capture the historical and ongoing trauma that can often face U.S.-born Black community members.

Physicians who share the same racial background as the communities they serve often improve culturally relevant care. Reduced racial discrimination and bias is one of the cited reasons that racial provider-patient concordance, where providers and patients share the same racial background, has been shown to impact outcomes positively for Black patients (Shen et al., 2017; Greenwood et al., 2020). In Minnesota, although Black residents make up 7% of the general population, only 2.6% of Minnesota physicians and 1% of physician assistants identified as Black or African American in 2019

(Minnesota Department of Health, 2019c). Care provided by paraprofessionals who live in the same communities as patients experiencing disadvantage has also been shown to decrease disparities (Redding et al., 2014).

DHS has attempted to foster more culturally relevant care via non-licensed paraprofessionals who are more likely reflect the diversity of their patients. DHS staff observed that the agency has expanded coverage for doulas, community health workers (CHWs) and community emergency medical technicians (EMTs). Unfortunately, these benefits are not highly used. In partial response, DHS increased doulas' reimbursement rates. But in addition to reimbursement, DHS realizes it, and its county and managed care partners, must find ways to support the development of a community-based workforce and the awareness among Medicaid providers that these services are available and clinically beneficial.

Minnesota Medicaid's approach to improving culturally relevant care is evolving. There are several ongoing efforts to improve the race and ethnicity demographic data of our programs but nothing focused on disaggregating Black community members. Similarly, no specific withhold measures or incentives are in place to target U.S.-born Black enrollees or culturally specific care delivery. The Integrated Health Partnerships (IHP) program (Minnesota Department of Human Services, 2021b) does have requirements that participating partnerships have a patient board with representation from the community it serves, however there is no specific racial group requirement. DHS highlighted the importance of racial equity and culturally specific needs for Black pregnant people in its most recent managed care request for proposals for pregnant people and children and is looking at ways to decrease barriers to non-licensed provider participation in Medicaid.

> **What will accountability to U.S.-born Black Minnesotans look like for Medicaid in access to culturally relevant care?**
>
> - Ongoing development and funding of programs that include a U.S.-born Black Minnesotan-specific focus
> - Contracting with managed care and other organizations that provide culturally relevant training to Medicaid providers.
>
> Outcome: Increase in number of and utilization of culturally specific providers.

Call to Action: Increase investment in culturally relevant care

A culturally specific lens to health can better orient systems to strengths instead of deficits. Instead of asking where the most illness is seen, the focus can be on where health is seen — particularly in spite of numerous systems that have been built to a community's disadvantage. Viewing health through this lens is crucial as DHS aims to continue to rebuild trust that has been violated and whose loss has contributed to the inequities occurring today. Based on the iterative discussions with community and DHS staff, DHS should focus on two steps to address access to culturally relevant care for U.S.-born Black Minnesotans on Medicaid in the near term:

1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans

As illustrated above, within government, U.S.-born Black people face structural disadvantage yet do not have any specific institutional power. To address generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policies and programs that elevate strengths and address inequities. A division focused on Black Medicaid enrollee health could also ensure that efforts throughout DHS and other state agencies, e.g., the Minnesota Department of Health, are leveraging all available funding sources to close the gaps seen in health outcomes. Participants in Community Conversations expressed a desire for DHS to find ways to incentivize or require larger health care and insurance companies to train their employees and clinicians on how to engage with people of color. They also seek accountability measures around disparities in outcomes and experiences of racial discrimination. While engaging physicians and other licensed providers, DHS staff from this division could also ensure Medicaid providers are aware of the evidence and efficacy of referring their patients to culturally relevant services and paraprofessionals, such as doulas, CHWs and community EMTs. Staff dedicated to health services utilization research would be able to identify which services are being used, when and where, as well as highlight successes and opportunities to improve. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, this division wouldn't create racially exclusive policy or programs. Rather, it would help focus the agency's efforts around changes that will be available to all yet notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

There is some precedent for this approach. In April 2020, DHS launched the African American Child Well-Being Unit to help address structural racism in the child welfare system by providing oversight and assistance to county agencies as well as grants to community-based organizations working with African American families.

Recently passed legislation improving the allergy and asthma benefit set for Medicaid enrollees might serve as an example of what this division could do on a much more regular basis. The legislation aims to address health disparities for those living in urban areas. The bill seeks to improve health outcomes for children with asthma and reduce asthma-related emergency room visits and hospitalizations. This is accomplished through reimbursement for environmental specialists to complete home evaluations and coverage for certain equipment and supplies ordered in the evaluation (e.g., allergen-rated air filters, dehumidifiers, HEPA air cleaners). An analysis of adult Medicaid enrollees age 18-64 found that U.S.-born African Americans had dramatically higher rates of asthma (16.5%) than any other racial or ethnic group (Minnesota Department of Human Services, 2018). It is therefore noteworthy that this legislation was initiated by the community and included the American Lung Association, Ramsey County, the city of Minneapolis and the Minnesota Department of Health based on a program previously piloted in Ramsey County. A division with a U.S.-born Black Minnesotan focus could therefore conduct a retrospective evaluation of this legislation, and others similar to it, to identity what critical components could be applied to other racial inequity-related projects. Domains for consideration could include legislation, resource allocation, community support, constituent engagement and political will.

Another example of what the division could focus on is how services intended to address social drivers of health perform in the U.S.-born Black Minnesotan community. In July 2020, DHS launched Housing Stabilization Services, an innovative and nation-leading Medicaid home- and community-based service to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. Interest and enrollment has far outstripped the initial projected estimates. A division with a U.S.-born Black Minnesotan focus could ensure that U.S.-born Black Minnesotans know about this benefit while taking steps to create more culturally specific features in the benefit to improve racial equity and inform other policy development around the social drivers of health.

2. Continue to prioritize standardization and disaggregation of race, ethnicity and language data

Race, ethnicity and language (REL) demographics of communities are among the few ways systems can get some insight into the impact of and need for culturally relevant care. While an incomplete and imperfect proxy for culture, REL data can serve as an important initial signal and inform conversation and collaboration with communities. One Community Conversation participant noted a need to "proactively identify data — there's not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing." In fact, many of the reflections and solutions proposed by participants in the Community Conversations would rely at some point on precise REL data. Ideas such as assessing if a health plan's network of providers reflects the communities they serve or tying payment incentives or withholds based on decreases in racial health outcome gaps require reliable REL data. To use as much information as possible about where gaps persist, Medicaid REL data also needs to align with public health REL data.

In 2021, CMS classified Minnesota's Medicaid race and ethnicity data as "medium concern" because 10-20% were missing and out of alignment with the U.S. Census Bureau's American Community Survey (SHADAC, 2020).

A number of strategies have been suggested to improve the collection of REL data during enrollment and renewal (Lukanen & Zylla, 2020). DHS staff are considering updated wording on enrollment forms, engaging enrollment navigators about the importance of enrollees volunteering their REL data and imputing REL data from other publicly available sources. These approaches are most effective when informed and led by community. Both community members and staff acknowledge a general lack of trust in government. Building that trust will be a critical component of ethical and accurate data utilization. As noted earlier neither the U.S.-born Black community, nor any other community as captured by our current, broad racial and ethnic definitions, is monolithic. Further disaggregation will therefore lead to where within communities gaps are largest and opportunity the least. To accomplish this DHS must improve how it communicates the benefits of sharing one's demographic data and balance the protection of data with the ability to close clear and present gaps.

During the COVID-19 pandemic, the Minnesota Electronic Health Records Consortium has grown to include all of Minnesota's large health care systems and the Minneapolis Veterans Affairs Medical Center. A partnership with the Minnesota Department of Health has allowed the pooling of aggregate data from health care systems' electronic health records to provide insight into COVID-19 testing and vaccination. This has resulted in the identification of gaps in Minnesota's COVID-19 response and

allowed the state to achieve 93% REL data completion as it reports vaccination rates by race and ethnicity. Once REL data categories become disaggregated and standardized in Minnesota, collaboration between the consortium and DHS could lead to better identification of where gaps and strengths exist within the U.S.-born Black community and other historically disadvantaged communities. This can then inform investment in interventions that work as well as structure incentives around closing gaps.

For example, all DHS managed care organizations must conduct performance improvement projects to improve the care and services provided to Medicaid enrollees. Project goals must be clear, precisely defined and address a critical issue that enrollee's face. Moreover, the managed care organizations must provide objective, measurable indicators to assess the effectiveness of the interventions. These projects could be one lever to engage community about defining quality care and services. Standardized and disaggregated REL data will be important for identifying communities as well as holding DHS, the managed care organizations, counties, clinicians and others who serve Medicaid enrollees accountable.

Engaging the communities and families Medicaid serves

What is the problem?

The importance of community engagement cannot be overstated. Health inequities and the social conditions, including racism, that cause disparities have existed for centuries. Top-down policy solutions have been tried for at least a generation, and yet disparities continue to grow. Meaningful solutions must be found in consultation and partnership with communities (Interlandi, 2019). While engaging enrollees in heterogeneous groups (e.g., engaging people from multiple racial and ethnic backgrounds or people with and without disabilities at the same time) can be very helpful, culturally specific engagements are equally important. Focused engagement is more likely to draw out some of the different barriers and strengths of various groups of people as well as the common experiences that cut across racial and ethnic or other categories. This theme echoed through DHS conversations with U.S.-born Black leaders. All stressed the need for community consultation in general and for culturally specific consultation. One group expressed regret that they had not been consulted even earlier in the process of this report. All also expressed the desire to be kept in the loop as work to complete this report and implement its recommendations progress. It's important that what DHS learns is "given back to community."

This extended to how staff throughout DHS, not just those in the Medicaid program, looked to work with community directly. They wish to do so in a way that community members understand who is working with them and that it was doing so in a coordinated way.

Engaging the communities and families Medicaid serves: Opportunities and strengths identified by community

Community members expressed skepticism about "engagement," citing experience that it's been merely a check-the-box exercise in the past. They asked for more tangible work to address disparities, including sustained funding for racial equity work. One person said that she was tired of pilot programs that end when the funding ends. Addressing racial disparities was noted to require an authentic, ongoing, and

intentional commitment to community engagement. "Be real and honest about engaging people; people can pick up on that [lack of authenticity] right away, and will not be open but will close down."

Many also stressed that engagement about Medicaid should encompass engagement about how providers treat patients and families. One person observed that Black providers experience bias from their white colleagues in the same way that Black patients do. He suggested the strategy of "being communal in how we care for each other," building true partnerships between providers and patients. Medicaid and providers should be learning from how "we [the Black community] have conversations amongst each other."

DHS Medicaid colleagues agreed that there had been little-to-no engagement specific to U.S.-born Black communities to date. Indeed, most agreed that there had been insufficient community engagement across the board, regardless of specific racial or ethnic focus.

Engaging the communities and families Medicaid serves: What is Medicaid doing to address this?

Some parts of the agency have sought enrollee input directly, with one example being listening sessions with U.S.-born Black Minnesotans and Black providers to hear what has been going on in response to multiple high-profile police murders of Black men in Minnesota. However, some parts of the agency have mostly relied on insight from staff members from the U.S.-born Black community.

Some of the people interviewed were familiar with DHS' Integrated Care for High Risk Pregnancies (ICHRP) program, a grant-supported program administered by DHS in full partnership with African American community leaders and clinicians in the Twin Cities. (ICHRP also includes a parallel initiative in partnership with Native American communities and tribes.) Interviewees spoke of the need for more of these types of power-sharing arrangements to address health disparities beyond birth outcomes.

Important features of ICHRP include:

- Leadership by a community-based advisory council, whose work is facilitated and coordinated by African American consultants under a contract administered by DHS. As of this writing, the council has just become incorporated as an independent nonprofit corporation.

- Fiscal support for community infrastructure. Appropriations within the state's base budget currently fund ICHRP. The new nonprofit corporation will soon be positioned to seek other forms of programmatic and philanthropic funding.

- Embrace of an evidence-based model specific to the psychosocial risks that are heightened among many minoritized groups. In ICHRP, this model centers on community-based, culturally specific paraprofessionals who reach out to potential clients, identify psychosocial needs and navigate to appropriate services. In some cases, health care providers refer pregnant Black people to ICHRP for the assessment and navigation; in other cases, the paraprofessionals work in reverse, helping expectant mothers and fathers who are not yet obtaining prenatal care connect to a local clinic.

- Paraprofessional services, to the extent permitted by federal and state Medicaid policy, should be covered by Medicaid directly, in order to free up programmatic funds to support the infrastructure.

DHS staff pointed to some other success stories around the agency. For example, as part of their efforts to understand and prevent child abuse and neglect, the Children and Families Services Administration uses federal funding to support an intensive training program for parents who have been involved with child protection. Parents learn about legislative and agency advisory councils and become effective members of such bodies. Similarly, staff have learned important principles, such as the importance of having more than one parent voice on any advisory body, so that parents participate on an equal footing with the many other stakeholders present.

In 2015, DHS obtained a philanthropic grant from the Bush Foundation to increase the agency's capacity to engage communities. An advisory council comprising community experts and DHS staff oversaw DHS' grant-supported activities, and approximately 25 staff members from all corners of the agency received training on facilitation methods and real-time opportunities to conduct engagement. Unfortunately, many employees who participated in the Bush-supported work have since left the agency, and there have been no initiatives of similar scale to sustain the work.

Many DHS staff expressed a strong desire to do more to engage enrollees, but felt disempowered due to insufficient resources, lack of staff and lack of training. No one questioned the value of community engagement, only the will within the agency to get it done.

Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives that community the opportunity to "start a journey of trusting larger agencies that provide resources and services." As noted above, this must be intentional. Organizations asked DHS to adopt a co-design model for health care policy and programs, creating *with* the community, not *for*. They stressed that relationship building is key, and that power should be shared. The challenge is for DHS to do it better by doing it differently. DHS employees were able to easily identify the organization's own role in perpetuating certain aspects of systemic racial health inequity in Minnesota. Concerted, reliable and consistent efforts must occur to earn back the trust of the Black community in Minnesota. Internally, DHS divisions stressed that relationship building with the community cannot be a one-time or sporadic event. To be meaningful, engagement must be dedicated, intentional and iterative.

Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into routine policy, budget and administrative activities.** Minnesotans who receive the services are the ones best positioned to inform what needs to be done differently in order to move the needle on health disparities. Indeed, the agency should have standing contracts with respected community partners who can engage enrollees with and for DHS. This will allow community members to share their experiences and needs and improve DHS'

ability to share what resources are currently available and how people can navigate them. Contractors are often better positioned to host these conversations, and contracting with a community facilitator makes it easier to ensure that participants can be compensated for their time and reimbursed for expenses, such as travel and child care.

> **What will accountability to U.S.-born Black Minnesotans look like for Medicaid in engagement?**
>
> - Creating a mechanism and expectation that community will be consulted early about current policy and budgets and future proposals that impact them.
> - Developing more models of care that are community co-created and led with true power sharing.
>
> Outcome: Sufficient funding for longitudinal, authentic community conversations.

Cultural Wellness Center CEO Elder Atum Azzahir offered the example of their "Year of Learning" approach to connecting with community members in an intentional, longitudinal process of growth both for both DHS and the community. Participating members commit to conversations that happen regularly over 12 months, receive compensation for their time and get support from community navigators and Elders who connect them to resources as needs arise. This model also centers on bi-directional learning and unlearning that places all participants in the role of both student and teacher to create transformational knowledge-sharing. A longitudinal, community-centered approach to engagement allows staff from Medicaid and other DHS programs to be in ongoing conversation. Seeing community as true partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way toward repairing the trust that has been broken.

V. Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from conversations that warrant discussion. There is a clear sense of urgency. The interviews and data that comprise this report confirm the indisputable fact that Minnesota has a staggering racial health equity problem. While Minnesota's racial health disparities have been known to those in the field for decades, the murder of George Floyd and the COVID-19 pandemic pushed the issue straight to the forefront of the public's awareness. These historic events made Minnesota's health and racial disparities international news and finally impossible to ignore. Because the general populace and their representative governments are now willing to acknowledge that racial health disparities do exist exorbitantly in Minnesota, there is an urgency for DHS to act quickly on the current momentum and commitment of many leaders and partners to substantive change.

Throughout these conversations there was a shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Organizations and staff alike have been down this road before and are all too familiar with well-intended efforts losing steam. Yet, despite the weariness, there is a willingness to try again.

All agreed that leadership, at the highest level, must play a critical role in DHS' ability to improve racial health disparities for U.S.-born Black Minnesotans; they called for prioritization, agency-wide alignment and resource allocation. Finally, and most importantly, there was a plea to keep the conversation going, because ignoring the stain of institutional racism in Minnesota has not made it go away.

VI. Conclusion

On his first full day in office, President Biden issued Executive Order 13995, establishing the Presidential COVID-19 Health Equity Task Force. He charged the task force with recommending actions against long-standing and emerging health inequities exacerbated by the COVID-19 pandemic. Ten months later, after hundreds of working sessions, extensive literature reviews, meeting with more than 100 subject-matter experts and eight public meetings, the Task Force submitted its final report (U.S. Department of Health and Human Services, 2021). The report includes 55 recommendations with five actions proposed as overarching priorities:

1. Invest in community-led solutions to address health equity.
2. Enforce a data ecosystem that promotes equity-driven decision making.
3. Increase accountability for health equity outcomes.
4. Invest in a representative health care workforce, and increase equitable access to quality health care for all.
5. Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House.

Given the incredibly broad scope of the task force, it is notable that all five of the proposed priorities are reflected in some way in this report's Calls to Action to build racial equity into the walls of Medicaid for U.S.-born Black Minnesotans. This gives further credence to the belief that choosing to focus on a historically under-resourced community is vital to authentically addressing racial health inequities. One example of how this approach has taken hold throughout Minnesota is the [Minnesota Business Coalition for Racial Equity](#), which comprises leaders from 80 organizations including most of Minnesota's Fortune 500 companies. Their purpose: "coming together to build an equitable, inclusive and prosperous state with and for Black residents." This is not a zero sum tactic; it instead improves policies and programs for all, getting the state closer to an overall goal where, "all Minnesotans are provided the opportunity to lead healthy, fulfilled lives," as detailed in Governor Tim Walz' very first executive order: [19-01 Establishing the One Minnesota Council on Diversity, Inclusion and Equity](#).

The Calls to Action detailed and justified in this report serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid. They also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action also aim to set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

What may surprise readers of this report most is that these are not revolutionary ideas and approaches to the work of population health. More than 100 years ago, sociologist and civil rights activist W.E.B. Du Bois was pointing out the impact of structural racism and how social drivers of health impacted the opportunity of Black Americans. The solutions he proposed then echo throughout this report. In 1906, he wrote in *The Health and Physique of the American Negro*, "The Conference recommends the

formation of local health leagues among colored people for the dissemination of better knowledge of sanitation and preventive medicine. The general organizations throughout the country for bettering health ought to make special effort to reach the colored people. The health of the whole country depends in no little degree upon the health of Negroes."

Some 116 years later, Americans are still striving to create a system that has racial equity built into the walls instead of being simply seen as optional wallpaper. To meet this moment, it's time to heed another piece of advice Du Bois shared, this time in his book, *The Souls of Black Folk*:

"Now is the accepted time, not tomorrow, not some more convenient season. It is today that our best work can be done and not some future day or future year."

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