DEPARTMENT OF HUMAN SERVICES

Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans

Nathan Chomilo, M.D. FAAP| Medical Director, Medicaid and MinnesotaCare

Gender pronouns: he/him/his

Recognition of past trauma and abuse

The state of Minnesota and the Department of Human Services recognize the trauma, medical abuse, and discrimination that have happened to our Black, Indigenous, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and social service providers.

The work of equity and antiracism requires that we are all actively committed to rebuilding trust with communities and bringing community members' voices to the table.

Definitions

Racism: “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.” [Jones]

Antiracism: A personal and collective identity which embraces the intentional dismantling of our racialized society and proactively builds racial peace [McKinney and Essenburg]

Antiracist policy: Any measure that produces or sustains racial equity between racial groups [Kendi]

Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardeners tale. *American Journal of Public Health*, *90*(8), 1212–1215. doi: 10.2105/ajph.90.8.1212

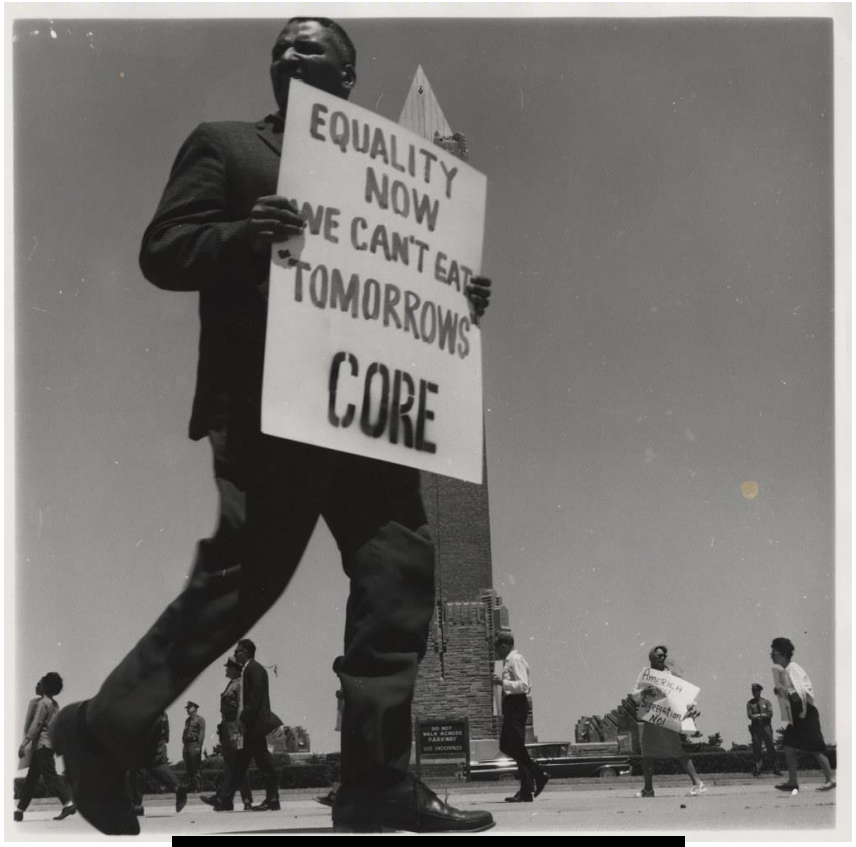
"Reconciliation in a Racialized Society" Karen McKinney & Tim Essenburg. Bethel University.

How to Be an Antiracist. New York: One World. Kendi, Ibram X. 2019.

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."

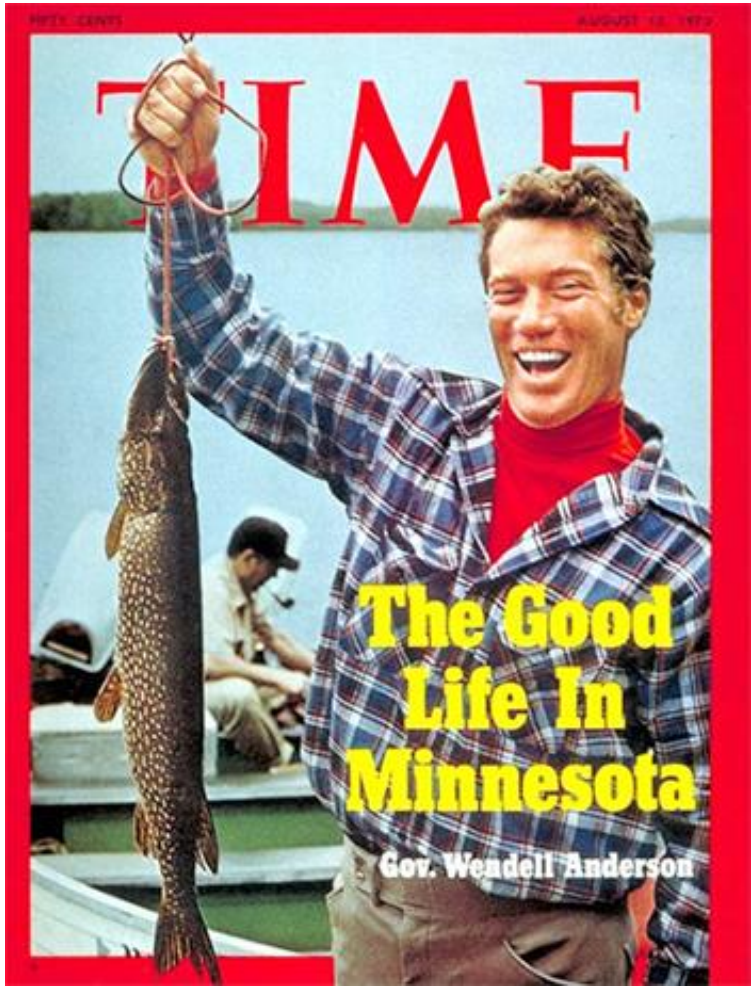
- Evelynn Hammonds, historian of science at Harvard University



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

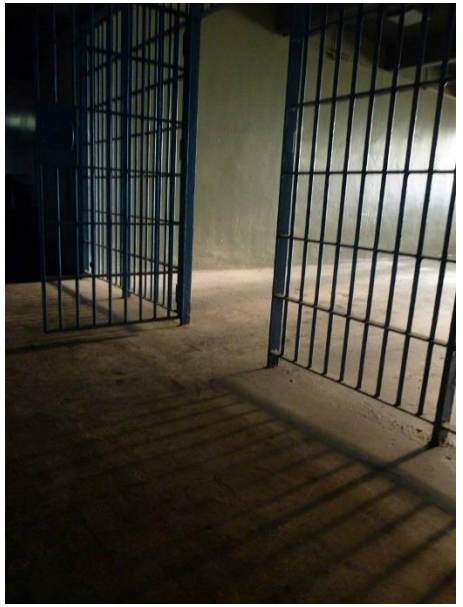
Interlandi, J. (2019, August 14). Why Doesn't America Have Universal Health Care? One Word: Race. Retrieved from https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html?smid=nytcore-ios-share

The Minnesota Paradox



Myers, S. L. (2020). *The Minnesota paradox*. Hubert H. Humphrey School of Public Affairs. Retrieved January 10, 2022, from https://www.hhh.umn.edu/research-centers/roy-wilkins-center-human-relations-and-social-justice/minnesota-paradox

Inequities in Opportunity for Black Minnesotans



Disparities in Health for Black Minnesotans

- Black Minnesotan adults have increased rates of:
  - Diabetes
  - Asthma
  - HIV
  - High Blood Pressure
  - Cardiovascular Disease
  - Substance Use Disorder
  - PTSD
- Black Minnesotan children have increased rates of:
  - Preterm Birth
  - Low Birth Weight
  - Asthma
  - Obesity
  - Anxiety
  - Suicidal Ideation

Breslin, E., Heaphy, D., Dreyfus, T., Lambertino, A., & Schiff, J. (2021, January). *Minnesota offers lessons on Advancing Health Justice using Medicaid Data*. AcademyHealth. Retrieved January 14, 2022, from https://academyhealth.org/publications/2021-01/minnesota-offers-lessons-advancinghealth-justice-using-medicaid-data

Racial INEQUITIES lead to Racial Disparities

- Inequity - an instance of injustice or unfairness

- Disparity - noticeable and usually significant difference or dissimilarity

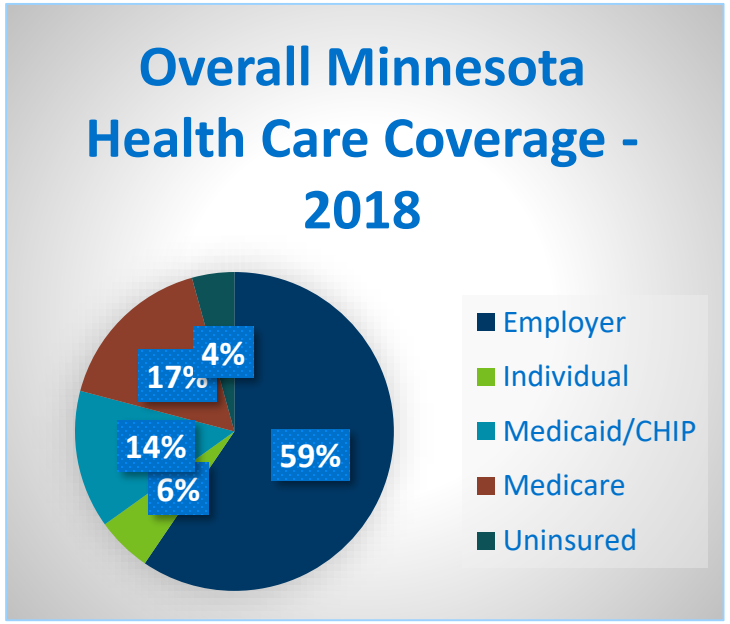
Structural racism is therefore THE inequity that leads to racial disparities

"Inequity." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/inequity. Accessed 20 Feb. 2021.
"Disparity." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/disparity. Accessed 20 Feb. 2021.

Minnesota Medicaid's Role in Addressing Structural Racism & Health Disparities

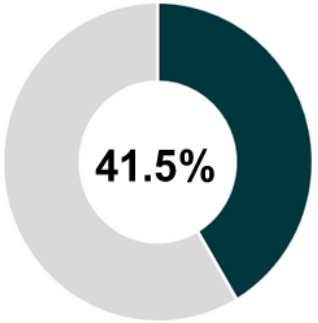
- MN DHS' Equity Policy was enacted in 2017
- "Health in All Policies" approach
- Compels that communities experiencing inequities be consulted when programs are designed, implemented, and evaluated
- MN Medicaid has adapted and operationalized GARE's racial equity assessment

Minnesota Medicaid's Role in Addressing Structural Racism & Health Disparities

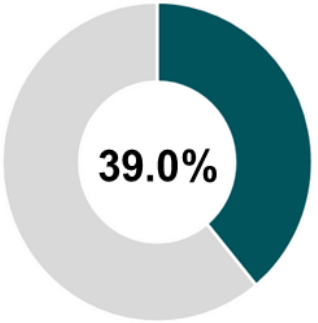


Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

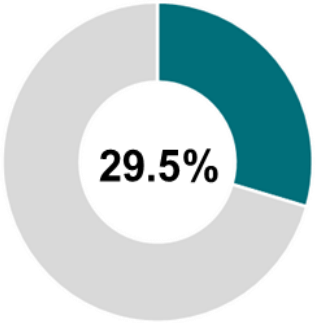
In 2019 Medicaid was the source of health care coverage for:



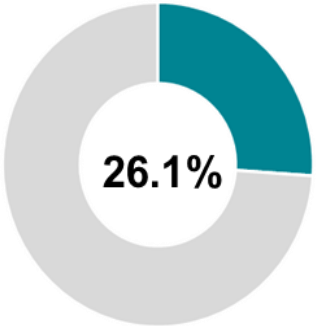
of Black Minnesotans



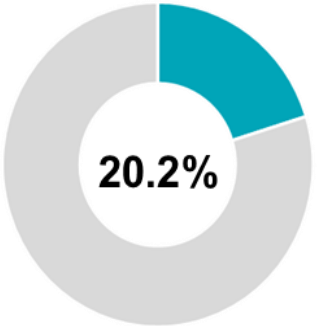
of American Indian/ Alaskan Native Minnesotans



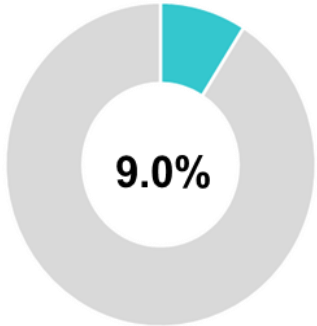
of Hispanic/Latino Minnesotans



of Other/Multiple Race Minnesotans



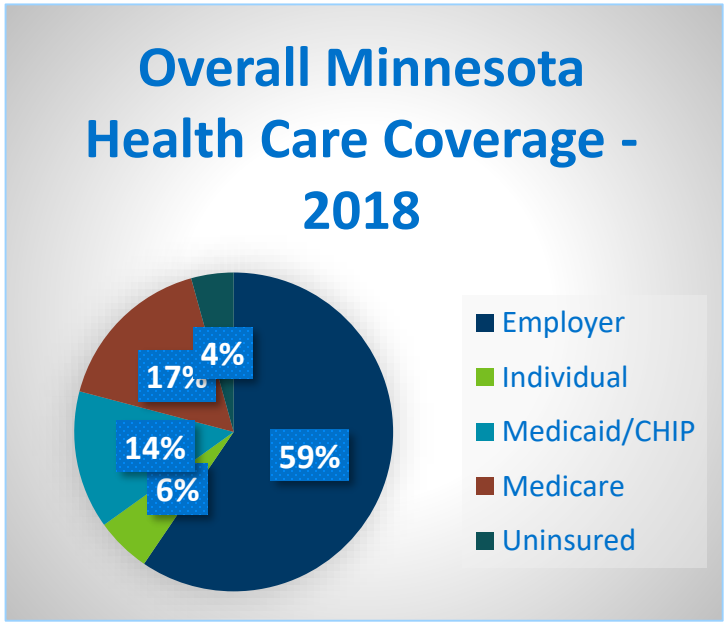
of Asian Minnesotans



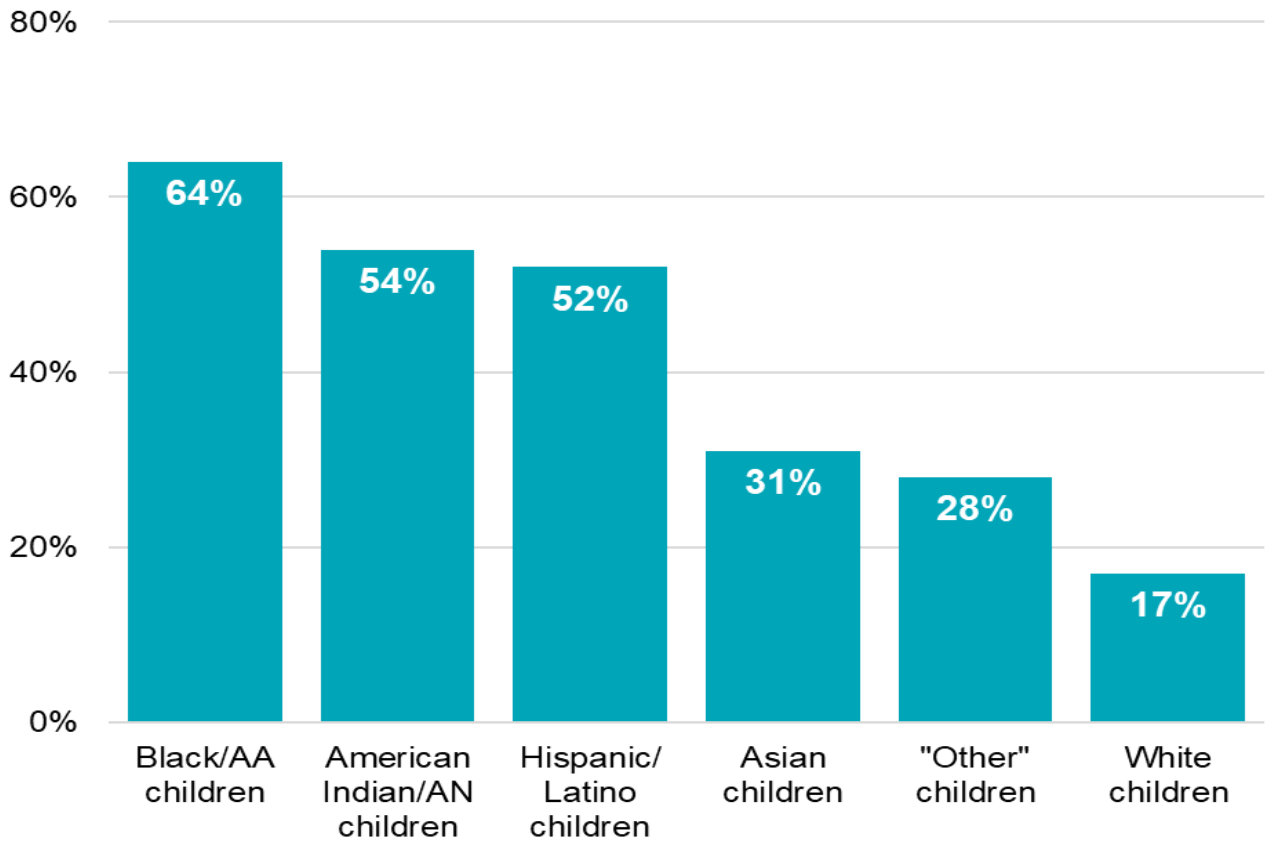
of White Minnesotans

Minnesota Medicaid's Role in Addressing Structural Racism & Health Disparities

Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018



Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.



Why focus specifically on Black Minnesotans?

MN has some of the WORST racial inequities

MN has some of the WORST racial HEALTH disparities

Black Minnesotans are disproportionately covered by MN Medicaid

MN Medicaid MUST focus on racial equity

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

	Enrollees who were born in the U.S.						Enrollees who immigrated to the U.S.					
Mortality and Morbidity	**American Indians***	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Others/ Unknown**	**African Americans**	**Whites**	**Hispanics**	**Asians**	**Other/ Unknown**	**All MA Enrollees**
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

Minnesota Department of Human Services report "Improving the health of people living in deep poverty." December. 2020 Retrieved at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG.

The opportunity we have to lead with racial equity

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.

Leading with Racial Equity: Community Strengths + Medicaid Levers

4 Medicaid "Levers"

- Eligibility/Enrollment
- Access
- Quality
- Early Opportunities

Cultural and Ethnic Communities Leadership Council (CECLC)

VOICES FOR RACIAL JUSTICE

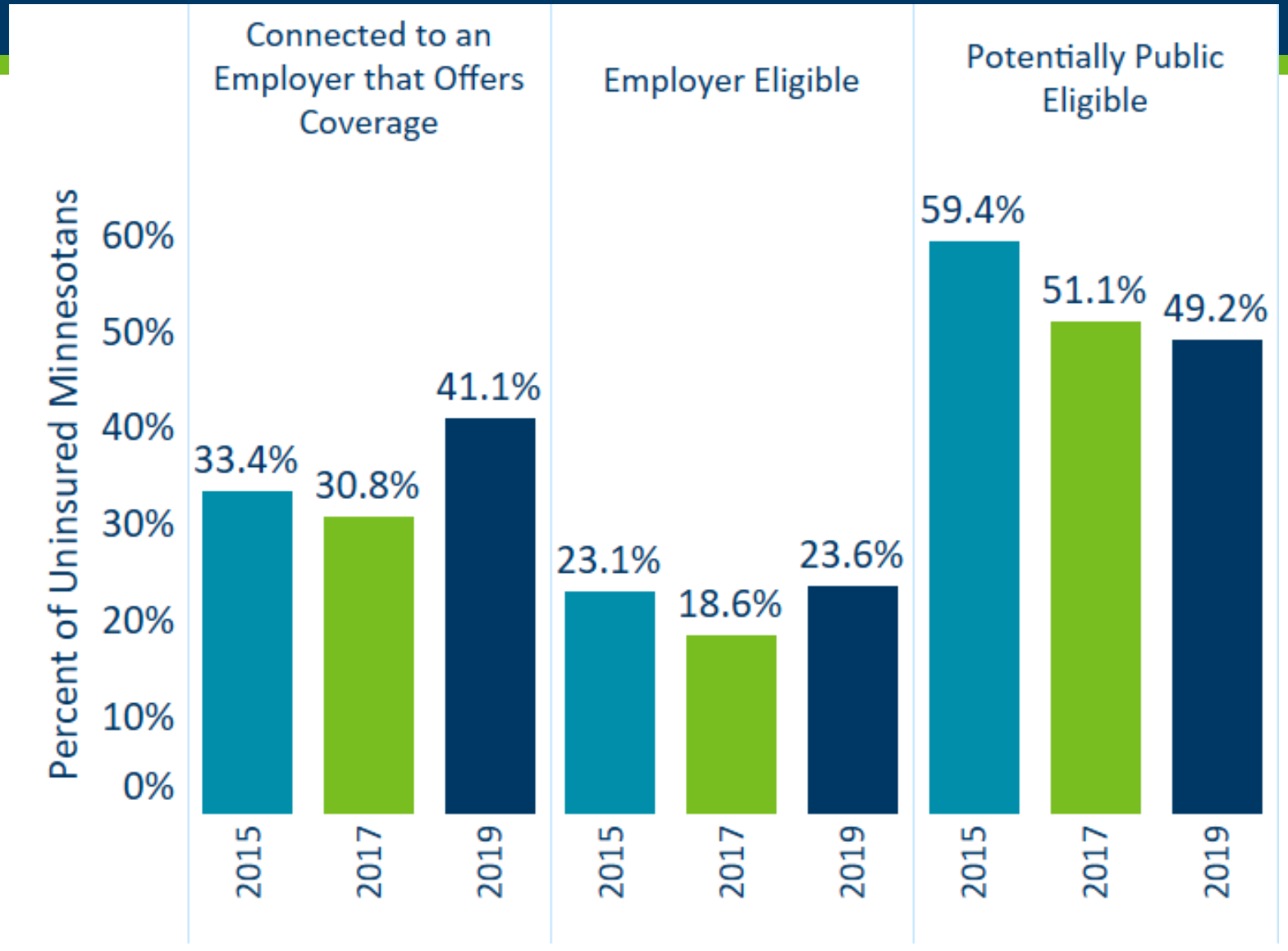
Cultural Wellness Center
Health · Heritage · Harmony

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

Medicaid Levers: Eligibility & Enrollment

Potential Access to Coverage for the Uninsured, 2015 to 2017[1]



Source: Minnesota Health Access Surveys, 2015 to 2019

* Indicates statistically different from previous year at 95% level.

Medicaid Levers: Eligibility & Enrollment

Income volatility

45% Hispanic households

38% of Black households

32% of white households

Churn

Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months

=

less likely to have a regular source of care

more likely to forego health care for financial reasons

more likely to report problems paying medical bills

Sugar S, Peters C, DeLew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021

Goold, S., Tipirneni, R., Ayanian, J., Beathard, E., Chang, T., Haggins, A., Kieffer, E., Kirch, M., Kullgren, J. T., Lee, S., Lewallen, M., Patel, M., Rowe, Z., Solway, E., & Clark, S. J. (2020). Patterns of enrollment churn in Medicaid expansion, subsequent insurance coverage, and access to care: A longitudinal study. *Health Services Research*, *55*(S1), 39–39. https://doi.org/10.1111/1475-6773.13379

Medicaid Levers: Access

Based on data from a 2008 survey of adults in the Minnesota Health Care Program (MHCP) population, results showed the following barriers to care and utilization:

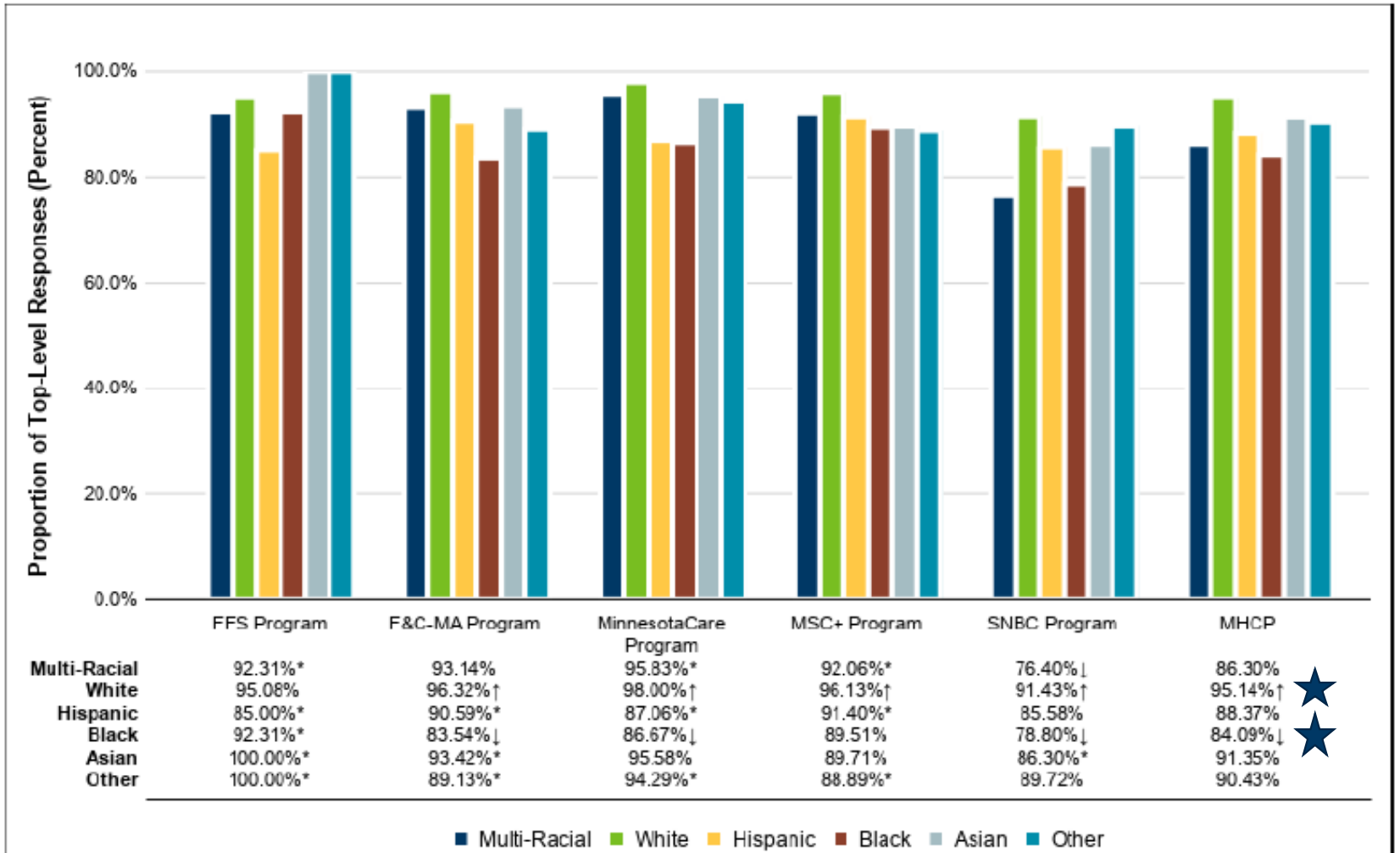
- 65% reported financial barriers
- **55% reported access barriers**
- 30% reported provider-related barriers
- **49% reported provider discrimination**
- 33% reported family/work barriers

Source: Allen, E., K Call, T Beebe, D McAlpine, and P Johnson. "Barriers to Care and Healthcare Utilization among the Publicly Insured." Med. Care. 2017 Mar; 55(3): 207–214. Retrieved at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309146/#idm139981065771824aff-info.

Medicaid Levers: Access

Figure 3-70—Race and Ethnicity Comparisons: Percentage of Respondents Who Were Never Told They Showed Up Too Late to an Appointment to Still be Seen

Q41a. In the last 6 months, how often were you informed you showed up too late to an appointment to still be seen?

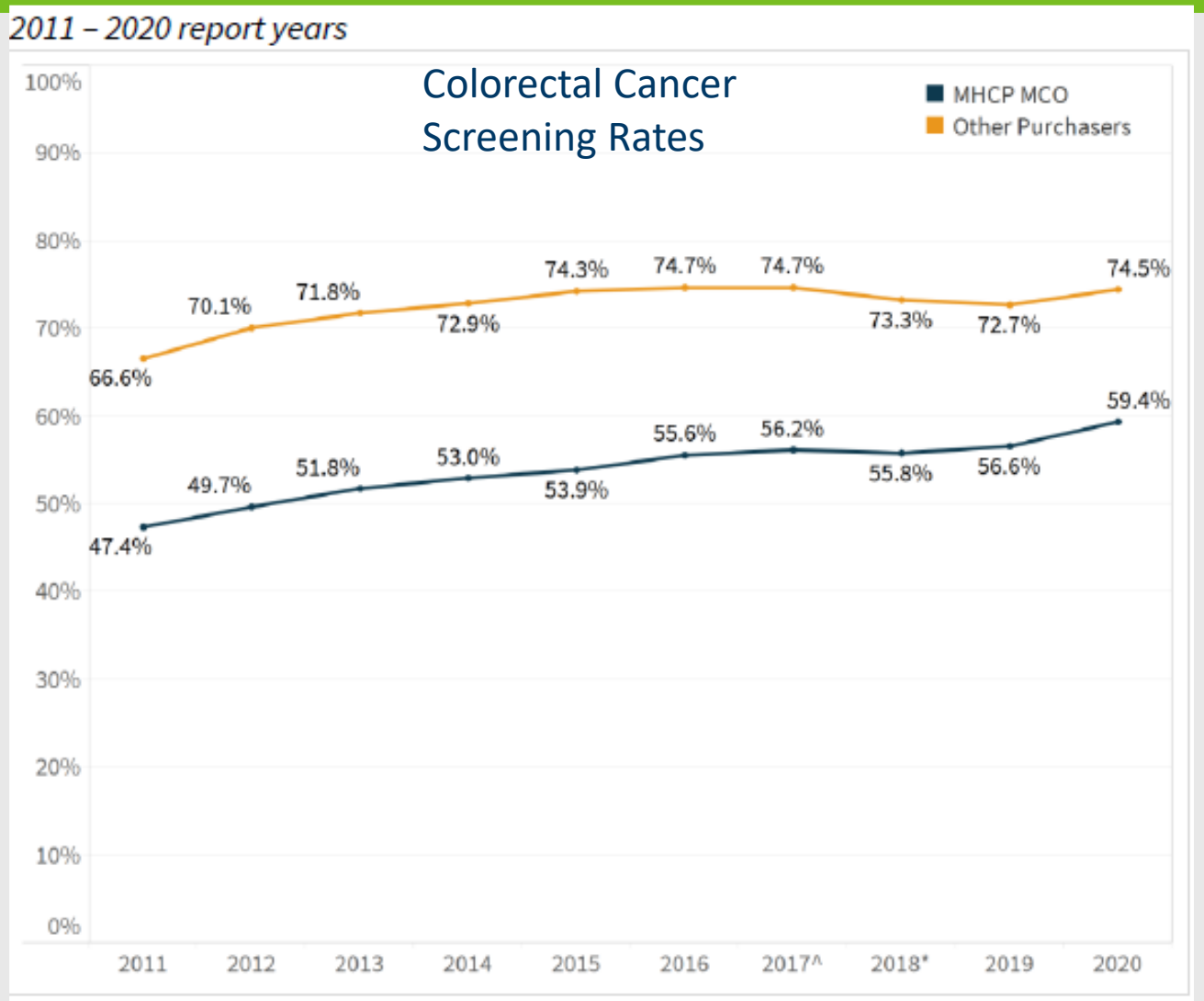



About 80 percent of people enrolled in public health care programs are served by managed care organizations

Medicaid Levers: Quality

MNCM 2020 Annual MN Health Care Disparities by Insurance Type Report

2011 – 2020 report years

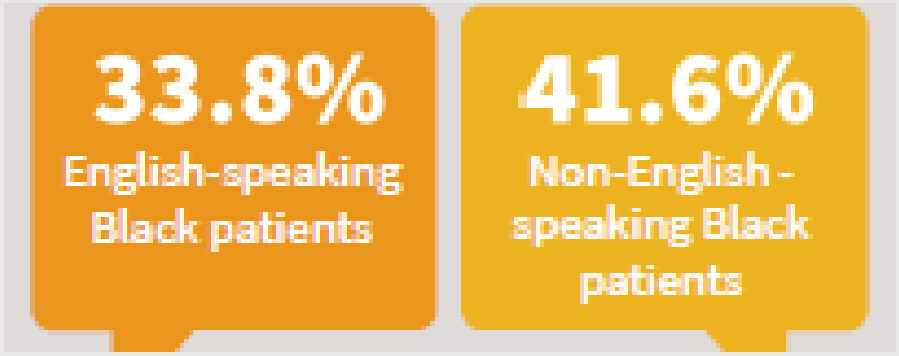


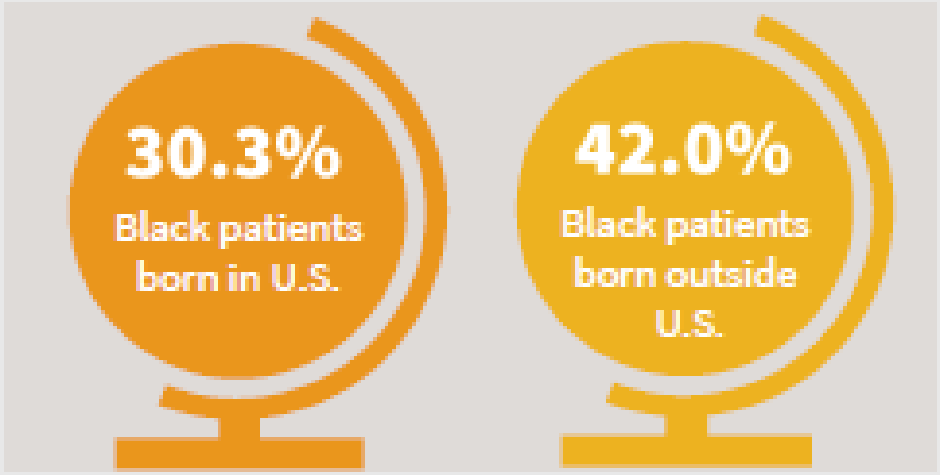
Medicaid Levers: Quality

MNCM 2020 Annual MN Health Care Disparities by Insurance Type Report

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%	●	●	●

Medicaid Levers: Quality



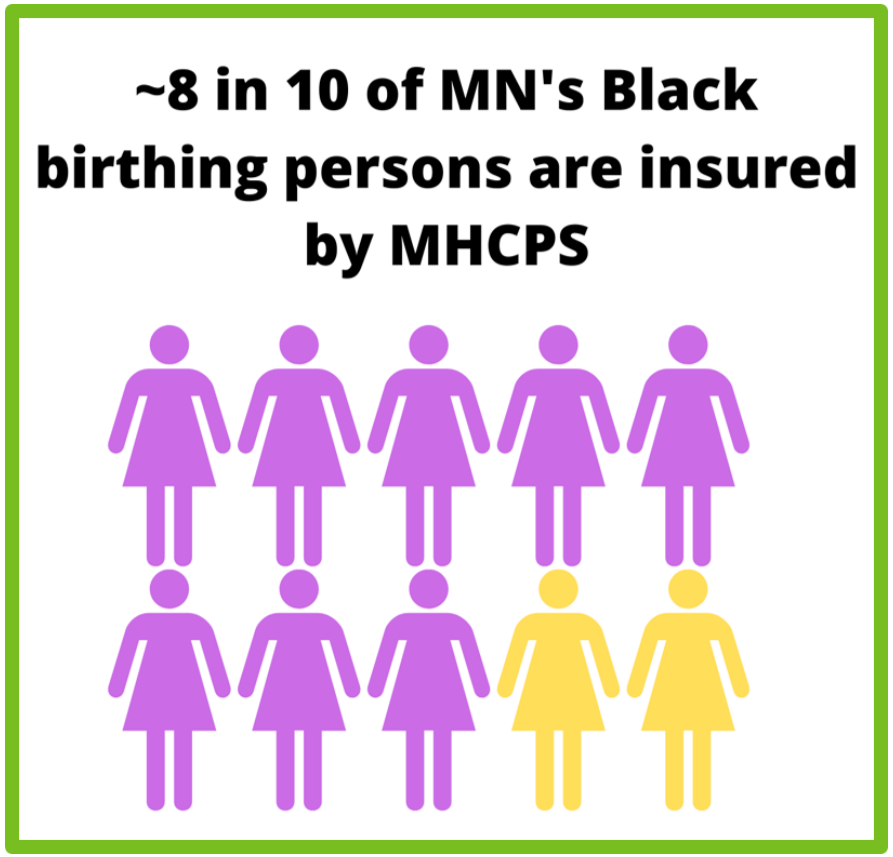


Black patients whose preferred language is English have **significantly lower rates** of optimal:

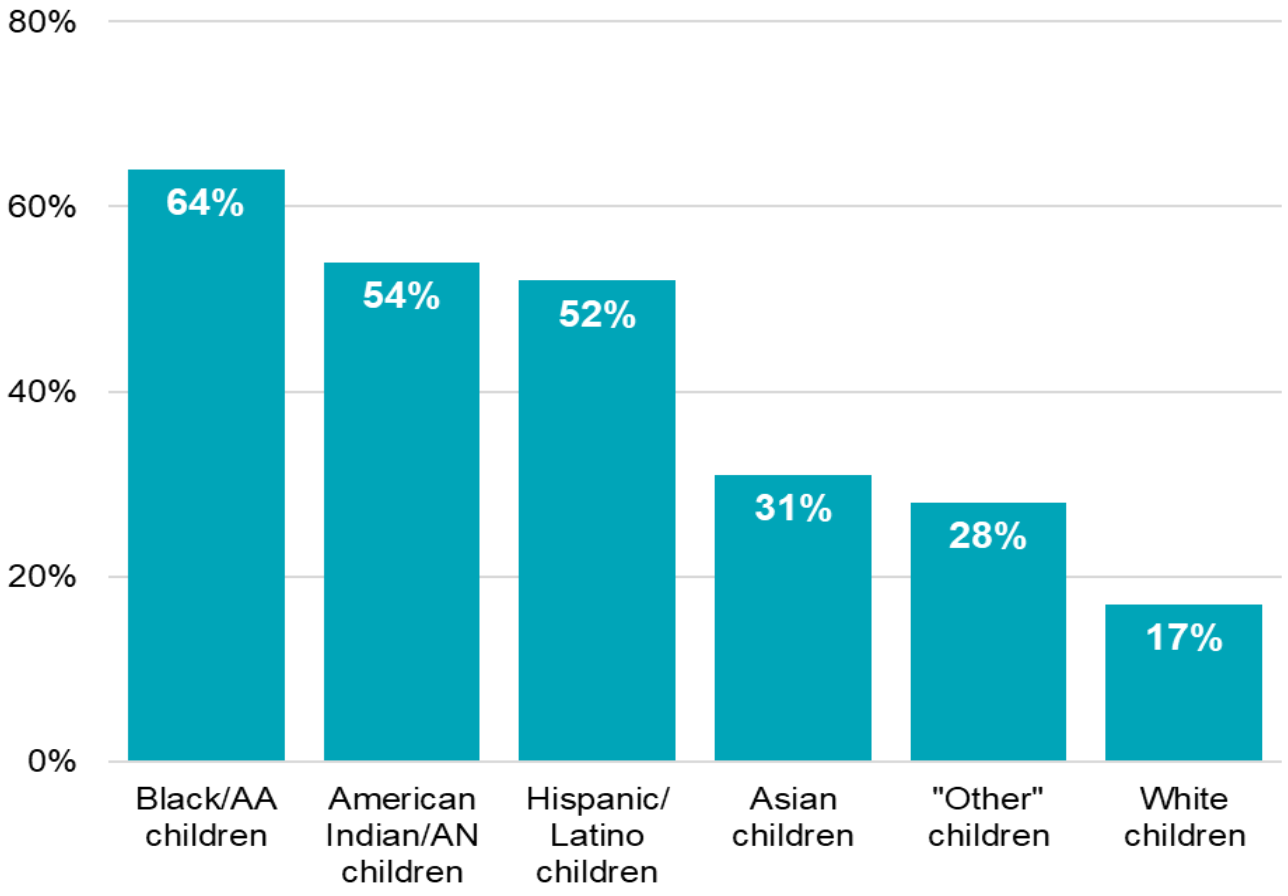
- diabetes care
- optimal vascular care
- depression remission at six months

compared to Black patients whose primary language is not English

Medicaid Levers: Early Opportunities

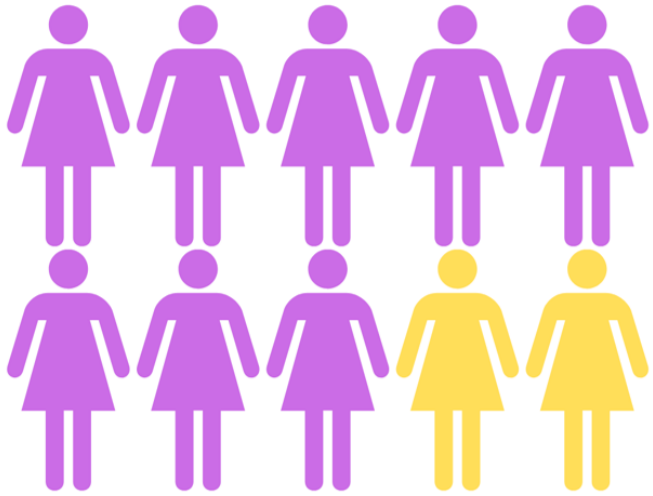


Medicaid Levers: Early Opportunities



Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

~8 in 10 of MN's Black birthing persons are insured by MHCPS



Leading with Racial Equity: Community Strengths + Medicaid Levers

4 Medicaid "Levers"

- Eligibility/Enrollment
- Access
- Quality
- Early Opportunities

Cultural and Ethnic Communities Leadership Council (CECLC)

VOICES FOR RACIAL JUSTICE

Cultural Wellness Center
Health · Heritage · Harmony

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

Importantly, since Medicaid service eligibility cannot 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.

1st Call to Action: Simplify and support enrollment and renewal

- **Who is eligible for Medicaid in MN & how do they get enrolled**
- **Historically "Churn" a big issue**
- **Examples of what MN DHS has done:**
  - Support for Navigators
  - Planning for MN Benefits
  - Maintain enrollment during incarceration

1st Call to Action: Eligibility & Enrollment

- **What community members shared:**
  - Process is confusing/complicated
  - Communication on status is poor
  - How can we keep people enrolled who are eligible

- *"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*

"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

1st Call to Action: Eligibility, Enrollment & Renewal

MN DHS should improve racial equity in Eligibility, Enrollment & Renewal by:

1. Pursue continuous eligibility policies

- Implementing ***12 month Continuous Eligibility for those 0-19 years old***
- 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**

1st Call to Action: Eligibility, Enrollment & Renewal

MN DHS should improve racial equity in Eligibility/Enrollment by:

2. Support navigators and simplify the enrollment and renewal process

- Develop and implement **a plan to ensure eligible Black Minnesotans gain and/or maintain Medicaid coverage** throughout the year but in particular as the federal public health emergency ends

1st Call to Action: Eligibility, Enrollment & Renewal

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.

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.

2nd Call to Action: Access to Culturally Relevant Care

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

Historically there are increased barriers to access faced by Black community members

- A significant amount of literature demonstrates that both Black adults and children are the recipients of unequal care.
- 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.

2nd Call to Action: Access to Culturally Relevant Care

- **Examples of what MN DHS has done:**
  - Supported non-licensed provider benefits (ex. Doula, Community Health Workers)
  - Integrated Care for High Risk Pregnancies (ICHRP) program
- **What community members shared:**
  - **"Culture is missing"**
  - Access to care that honors culture remains difficult.
  - 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.

2nd Call to Action: Access to Culturally Relevant Care

MN DHS should improve racial equity in Access to Culturally Relevant Care by:

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

2nd Call to Action: Access to Culturally Relevant Care

MN DHS should improve racial equity in Access to Culturally Relevant Care by:

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

2nd Call to Action: Access to Culturally Relevant Care

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 organizations that provide culturally relevant training to Medicaid providers

Outcome: Increase in number of and utilization of culturally specific providers

3rd Call to Action: Engaging the communities and families Medicaid serves

- **In all our discussions with community members and DHS staff there was a shared desire for meaningful engagement and co-creation**
- **Historically engagement has been with enrollees from multiple groups**
- **Examples of what MN DHS has done:**
  - Office of Community Engagement
  - Specific conversations in response to George Floyd and police violence
- **What community members shared:**
  - Need for community consultation in general and for culturally specific consultation
  - Need ongoing, longitudinal engagement. Where can power be shared?

3rd Call to Action: Engaging the communities and families Medicaid serves

MN DHS should improve racial equity in MN Medicaid by:

- ***Funding community conversations with U.S.-born Black Minnesotans on Medicaid***
  - 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

3rd Call to Action: Engaging the communities and families Medicaid serves

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.

Capturing the moment for change

2021 Presidential COVID-19 Health Equity Task Force overarching priorities:

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

Capturing the moment for change

Impact of this report's process and framework for potential future MN Medicaid reports:

- Native & Indigenous Minnesotans
- Hispanic/Latinx Minnesotans
- Asian-Pacific Islander Minnesotans
- New Minnesotans
- Minnesotans who are LGBTQ+
- Minnesotans living with disabilities
- Unhoused Minnesotans
- Incarcerated Minnesotans

"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." – W.E.B. Du Bois

BIG thanks!!!

MN DHS BREW report co-authors

- Ellie Garrett
- Justine Nelson
- Diego Diaz-Rivero
- Jessica Hultgren

BREW report technical assistance

- Mehgan Lee
- Abhiraman Rajagopal

Community Collaborators

- Council of Minnesotans of African Heritage leadership
- MDH HEAL council leadership
- DHS Cultural & Ethnic Communities Leadership Council
- Voices for Racial Justice
- African American Leadership Forum
- Cultural Wellness Center
- Center for Economic Inclusion
- Former State Senator Jeff Hayden

Community Conversation team

- De Anna Conover
- Rebeca Sedarski
- Cathlyn Dymit
- LaDonna Morrison
- Dr. Karen McKinney
- Verona Mitchell
- Debra Anthony
- Jovon Perry
- Shaneen Moore

Thank You!!

You can find the report here: **Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)**

Questions? Feedback? Want to help us Build Racial Equity into the Walls?

Reach out here: **BREWMedicaid.DHS@state.mn.us**