Equitable Health Care Task Force Meeting Summary

Meeting information

- March 14, 2025, 9:00-4:00 p.m.
- Urban Research and Outreach-Engagement Center (UROC)
- Plymouth Room 105
- 2001 Plymouth Ave. N.
  Minneapolis, MN 55411

Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Laurelle Myhra, Megan Chao Smith, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members engaged in small group discussions to develop initial recommendations for four overarching buckets.
- Task force members reflected on each other's ideas for recommendations.
- Task force members gave feedback to MDH about the process for continuing recommendation development.
- Task force members shared what they would like to learn from engaging external perspectives on draft recommendations.

Key actions moving forward

- Task force members are invited to a session on March 21 to learn about Tribal health care systems.
- Task force members are invited to help plan engagement of external perspectives (about three 1-hour meetings). If interested, please contact MDH at health.equitablehealthcare@state.mn.us.
- MDH and DeYoung Consulting Services will synthesize notes from discussions about draft recommendations.
- Discussion groups may choose to meet on their own to continue fleshing out their draft recommendations, and groups are encouraged to reach out to MDH for support as needed.

Summary of Meeting Content and Discussion Highlights

Pre-meeting community-building and gallery walk

Task force members arrived, discussed informally, and refamiliarized themselves with content before beginning the meeting.

Welcome

The task force was welcomed with opening remarks by task force members Maria Medina and Yeng Yang who helped plan the retreat.

The agenda was reviewed and the meeting summary from February was shared. It was shared that the purpose of the retreat was to be immersed in recommendation development, and to "connect the dots" between the work completed thus far, today's retreat, and what lies ahead. The following experiential objectives were shared:

- Foster community building
- Ensure inclusive participation
- Ground task force in vision and purpose
- Develop comprehensive draft recommendations
- Create shared understanding of task force
- Plan for next steps

Recommendation Development Fleshing Out

Task force members had the opportunity to develop and discuss recommendations at one or more of the four prepared stations that aligned with broad recommendation buckets:

- Strengthen and Diversify the Workforce
- Bolster Primary and Whole-Person Care
- Meaningful Access
- Ensure System Accountability

Each task force member and station had resource folders that included:

- Handouts of transformative and incremental recommendation ideas culled from previous task force insight,
- The Opportunity Matrix, and
- Promising Policies and Practices resource from the UMN Research Team.

Task force members developed recommendations for two and-a-half hours. The notes they took were organized and are included as an appendix. After small group discussions, each group

reported out highlights of their conversations including draft recommendations. A summary of each group's report-out is below.

Strengthen and Diversify the Workforce station report-out

The Workforce Workgroup convened at this station, and they presented four objectives and shared their understanding of the roles of different stakeholders related to improving workforce equity in the health care system.

The four objectives presented were:

1. Foster workplace inclusion, safety, and wellbeing. This involves creating shared models as well as resources such as guides for organizations to implement inclusive workplace practices.
2. Enhance workforce skills and cultural responsiveness. There is a need for a universal curriculum around health care equity, including definitions of terms and standards. Standards should be supported by incentives and mandates.
3. Address workforce inequities. Rather than piecemeal recommendations, it is essential to develop a comprehensive mental model to tackle inequities. This will provide a big-picture view of the current workforce challenges.
4. Workforce optimization, which aims to diversify care providers to address gaps in the existing system. This diversification will help provide more comprehensive care for everyone and improve the overall delivery of health care services.

The group discussed high-yield recommendations along with sub-recommendations that have been known for a long time. The recommendations were sorted into short-term (i.e., low-hanging fruit), mid-term, and long-term.

The group suggested that MDH advisory bodies be tasked with creating standards and best practices, providing guidelines and accreditation to support those best practices. Health care organizations and community organizations should be responsible for implementing these practices, embedding them into existing systems.

Task force members questioned whether health care organizations would respond to nonbinding recommendations or requirements. Some emphasized the importance of using mandates, regulations, and accreditation.

Bolster Primary and Whole-Person Care station report-out

This group suggested an overall model that would improve equitable access to health care. The benefits of the model include building trust between providers and payers, talent retention, financial guardrails, and incentivizing preventive care. This can evolve from the current health care system without dismantling everything that exists now. The group commented that there is a public perception that 50% of health care spending is allocated to primary care, but it's

actually only 5%. There is room to shift funding and create more balance by investment in primary care.

They identified some fundamental concepts that are needed to make this model truly transformative:

- Primary Care Investment Ratio (PCIR). Require payers to increase the portion of health care resources allocated to primary care.
- Federally Qualified Health Centers (FQHCs) offer an ideal approach to integrated care delivery that includes mental and dental health. Primary care should operate in a highly integrated manner, with partnerships extending to specialty care.
- Value-based, team-based collaborative care model. Various professionals, such as MDs and social workers, should step in as needed and ensure resources are shared appropriately and access to necessary care is provided. The current fee-for-service model is inadequate.
- Calling out institutions that provide specialty care, such as Children's Hospital, to ensure equitable access.
- Cross-payor payout and data sharing across organizations. Enhance provider-to-provider transparency and continuity of care, reducing unnecessary repetition of services. There must be trust between payers and providers. This would, however, likely have unintended consequences like independent clinics being left out. Mitigation strategies include the creation of partnerships.
- Ramping up payments towards primary care and reducing reliance on emergency rooms.
- Simplification of payment processes and decreasing handoffs to enhance wrap-around services.

Task force members discussed the need for accountability, alignment, and partnership. They expressed concern that data sharing has already been in practice and hasn't changed behavior. Minnesota's stringent privacy laws were identified as a potential challenge and the group suggested transforming this into a recommendation. They recognized the need for guidelines and regulations to ensure data security and safeguard targeted populations.

The group acknowledged that primary care is assumed to be an avenue to more equitable health care by improving access and reducing costs. They said trust is a crucial factor for achieving equity, and centering primary care is a way to meet patients where they are.

Task force members suggested there should be a paragraph or explanation in front of all recommendations that bring people along in a change management sense, that explains the why and the mindset.

Meaningful Access station report-out

This group saw overlap with the workforce, primary care, and accountability areas, and their key recommendations included:

- Ensuring that patient and provider conversations remain confidential is crucial, especially as providers face criticism for offering certain types of care.
- Language access should be standard. Documents in patients' native language should be available upon entering.
- One hub for translator services to promote consistency, standardized pay for translators
- Licensing for interpreters
- Avenues for reimbursement: there are opportunities for multiagency collaboration
- Ensure metro-centric solutions are not applied in rural areas
- Partner with existing organizations such as schools to support access
- Use existing services (e.g., school buses for transportation)
- Rely on existing trusting relationships
- Expand existing youth services
- There is overlap with whole-person care, accountability, and workforce
- Data sharing and privacy, patient autonomy especially around mental health
- Providers expand hours to evenings and weekends. Do we require it? Incentivize it?

Ensure System Accountability station report-out

This group emphasized the importance of accountability measures for specific groups and should be integrated into existing frameworks. They stressed that increasing equity for communities that experience the greatest inequities is critical.

- Uphold federal treaty agreements, honor treaty rights, Tribally run insurance, automatic coverage Tribal members and children
- Citizen-based advocacy, accountability group, broader state committee. Address complaints and grievances: Hotline and online forum for patients, workers, community members, a grievance process or agency to build awareness
- Ensure representative community input into health care provider and payer systems and payers at government levels, like an advisory committee that looks at agency policies and has input into the design of evaluations, treatment, and training
- Value-based outcomes could be legislated by linking to financial incentives, reimbursements
- Health care accountability group or leadership council to assess and enforce ongoing
- Grievance board with laws that can be linked to accountability measures
- Office of Patient Protection
- Complaints should be handled in a one-stop shop
- Incentivize rather than mandate things to better support implementation

- Work from existing statutory laws to frame the accountability work
- Disaggregate data from American Indian populations and smaller sample size populations, not lumped in with "other" populations

Reflections

MDH shared that their role moving forward will be to organize the recommendations the task force develops, indicate where more specificity from the task force is needed to make them actionable, and then share them back with the task force. This will happen iteratively until the task force's work concludes.

The task force continued to reflect on the draft recommendations overall. There was a general sense of uncertainty about implementation and accountability. Their comments included:

- MDH has expertise to help understand implementation
- Accountability could be a separate set of recommendations, but metrics are also needed for any or all recommendations
- Need to identify stakeholders and levers such as policy, accreditation, etc.
- Recommendation for a dashboard could be helpful with accountability

Task force members discussed the need to review and comment each other's work. Some station groups said they will take the time to edit their ideas first. Others said they'd like assistance from MDH to understand the actors involved and other information about the feasibility of the recommendations.

Community engagement

The task force discussed how to move forward in engaging external perspectives. Overall, they were concerned with learning how feasible recommendations would be, what implementation would take, and whether recommendation implementation would build trust with communities. Their comments included:

- Test assumptions the task force has about recommendations and the outcomes they would produce. Learn what recommendations would change behavior and build trust, whether it would make things easier for some and alienate others. These may not be the "new" or "innovative" pieces. A lot of times we try to do innovative things, and the community is not necessarily looking for the new, they just want things to work.
- Don't need to reinterrogate longstanding recommendations, but it would be good to ask if these pieces really went into effect, would they build trust
- Some recommendations and models have already been tried, so it would be good to get feedback on why these things are and aren't working
- Learn promising practices

- Connect with groups who are already plugged into health care equity work and have community findings, use existing spaces, reports, and data, draw from the bucket of existing community knowledge (e.g., MDH HEAL Council)
- Learn what we are missing, what needs changing or editing
- Learn from organizations called upon to take action how they would resource it and what it would take to right-size and implement (e.g., health care leaders, board members, employees)
- Learn from regulatory bodies about feasibility of recommendations

The task force was reminded that MDH has contracted with a vendor, Alliant Consulting, to plan, schedule, and conduct engagement activities and share results back with the task force. The task force will provide guidance about who to engage with and how, and what they want engagement on. Task force members were invited to join planning meetings with Alliant and MDH (about three 1-hour meetings between now and May), and Laurelle Myhra and Mary Engels were thanked for already volunteering to be part of community engagement planning efforts.

Close

There was a recap of retreat objectives and how they were met.

Task force members Maria Medina and Yeng Yang shared closing remarks. A meeting summary is to follow. The task force was reminded about the next task force meetings:

- April 10, from 10:00 – 1:00 p.m. In this meeting, task force members should expect to:
  - Refine recommendations developed today and work on anything that's missing
  - Develop a community engagement with Alliant Consulting

March 21, 11:00 a.m. – 12:00 p.m. Virtual session on Tribal Health Care

Contact to follow-up

With questions or comments about the Equitable Health Care Task Force, please reach out to the Health Policy Division at health.equitablehealthcare@state.mn.us.

Meeting summary note

All task force members' comments are represented, identities are intersectional, and discussions reflect barriers and solutions that affect many communities at once.

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03/21/2025

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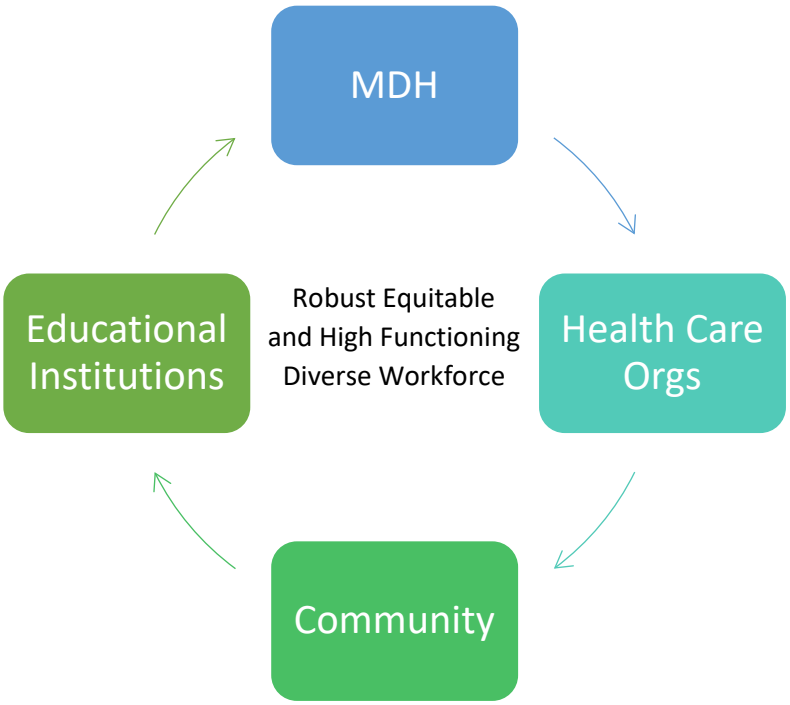
Workforce Work Group Recommendations Guiding Principles

The Workforce Work Group has identified four "high yield recommendations" and a set of sub-recommendations/tactics. Assumptions for these recommendations during implementation:

- MDH will partner with health care organizations to apply rigorous change management practices.
- MDH will connect on implementation with the Minnesota Health Care Workforce Advisory Council.

Group	Role	How
MDH	Create standards and best practices Provide resources	Developing guides, playbooks, and models Provide funding Align MDH accreditation based on action
Health Care Organizations	Implement best practices	Embed into existing structures, processes, and workflows
Community Organizations and Groups	Inform best practices Inform implementation Support implementation	

Leverage the **SHIP Model** as a basis for this approach



Objective 1: Foster workplace inclusion, belonging, safety, and well-being

High Yield Recommendation: Minnesota Department of Health to create a model for inclusion, belonging, safety, and well-being including implementation guidance and resources for health care organizations.

Rationale/Background/Evidence

More than 8 in 10 employees consider psychological safety one of the most valued aspects of the workplace.[1] 9 out of 10 employees want their employer to value their emotional and psychological welfare – and provide relevant support.[2] 60% of employees with low resilience and low psychological safety feel burned out, and 34% are thinking about quitting their job. On the other hand, only 5% of highly resilient employees who feel psychologically safe report feeling burned out, and just 3% are considering quitting.[3]

Employees from underrepresented groups don't feel a sense of belonging in the workplace. ERGs enable organizations to create products and services that resonate with a broader range of customers. This not only enhances organizational reach but also strengthens brand loyalty and reputation.

Sub-Recommendations (Owner)	**Short-Term**	**Mid-Term**	**Long-Term**
1.1 Recommend best practices to enhance the sense of safety, trust and belonging among employees, such as employee resource groups, regular assessments or surveys to measure the employee experience with corresponding action based on this feedback, and a culture of accountability for improved outcomes.	X		
1.2 Recommend leveraging employees and employee resource group members from underrepresented groups in the cocreation of workforce equity strategies designed to meet their needs.		X	
1.3 Recommend strategies to drive leadership accountability for workforce equity outcomes.			X

Engagement Stakeholders

- People leading diversity, equity, and inclusion
- Members of employee resource groups
- Human Resources employees
- Labor unions representing health care employees

[1] Employee Disillusionment Report, Oyster HR, 2023
[2] 2023 Work in America™ Survey, American Psycological Association, 2023
[3] Psychological Safety at Work: The Remote Kids are Alright (Maybe Even Better), meQuilibrium, 2022

Objective 2: Enhance workforce skills and cultural responsiveness

High Yield Recommendation: Minnesota Department of Health to create a mandated/incentivized training for **all** healthcare workers. Accrediting bodies can adapt to their field but need to provide it's the same content. Include content for memb ers of healthcare organization boards of directors.

Rationale/Background/Evidence

TBD

Sub-Recommendations (Owner)	**Short-Term**	**Mid-Term**	**Long-Term**
2.1 Recommend best practices focused on suggested requirements for comprehensive training programs for employees and providers to develop essential soft skills, including cultural responsiveness, mitigation of unconscious bias, effective communication, empathy, and teamwork.	X		
2.2 Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally congruent care.		X	
2.3 Recommend mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally congruent care.			X
2.4 Outline solutions to address the narrowness of specialization, such as cross-training opportunities, mentorship programs, and professional development resources.			X
2.5 Recommend workforce equity core competencies for employees and leaders.	X		
2.6 Recommend workforce equity strategies that are informed by the communities being locally served.	X		
5.4 Recommend educational opportunities to require board members to actively engage in ongoing professional development to acquire the necessary skills to model inclusive leadership and equitable governance.	X		
7.1 Require and implement comprehensive training and continuing education for health care providers (link training to licensure requirements) and other employees (e.g., patient navigators, care coordinators, customer service representatives) to develop essential soft skills including: • Cross-cultural understanding • Cultural competency • Cultural humility • Cultural responsiveness • Culturally appropriate care	X		

• Culturally congruent care • Culturally-specific health needs • Diversity, equity, inclusion, and belonging (DEIB) • Effective communication • Eliminating biases and discrimination • Empathy • Implicit bias • Mitigation of unconscious bias • Patient-centered care • Teamwork • Trauma-informed care • training programs.			
7.2 Cultural Competency Training: Rapidly implement training on eliminating biases and discrimination for health care workers. Partner with local organizations or universities to design culturally appropriate training programs in the short term.	X		
7.3 Use learnings from experiences training providers (such as JAMA article on mandated implicit bias training).	X		
7.4 Partner with local organizations or universities to design culturally appropriate training programs.	X		
7.5 Require trauma-informed, equity training for intrapartum and post-partum care.	X		
7.7 Implement training and education for providers that cultivates better attitudes toward Medicaid patients.	X		
10.2 Create a culture of precepting at systems like Essentia and M Health Fairview.	X		

Engagement Stakeholders

- TBD

Objective 3: Address workforce inequities

High Yield Recommendation: Minnesota Department of Health to outline a framework and model to help healthcare organizations collaborate with stakeholders to examine and address systemic barriers that contribute to healthcare workforce inequities. Include guides and implementation resources.

Rationale/Background/Evidence

TBD

Sub-Recommendations (Owner)	**Short-Term**	**Mid-Term**	**Long-Term**
3.1 Recommend possible solutions to address role inequities, including a pay structure analysis and evaluation of the value, impact and advocacy of care coordinator/community health workers and other similar roles.			X
3.2 Outline a framework, model or resource to help organizations begin to collaborate with key stakeholders to examine and address any systemic biases or barriers that contribute to role inequities.	X		
4.1 Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities we serve, including strategies to support international candidates.		X	
4.2 Recommend best practices for collaborating with educational institutions and community organizations to remove barriers to entering the healthcare workforce.		X	
4.3 Recommend strategies to partner with educational and credentialing institutions to reduce representation gaps that hinder culturally concordant care for historically underrepresented groups in health care positions.		X	
5.2 Identify and remove barriers for students and employees to obtaining scholarships and resources experienced by underrepresented individuals who aspire to pursue careers and leadership positions in healthcare.		X	
5.3 Recommend best practice strategies to provide mentoring and leadership development exposure and expanded opportunities for emerging leaders from underrepresented groups.			X
8.2 Educate K-12 students on medical professional pathways			X
8.3 Expand the development and use of partnerships between K-12 schools and health care providers to sponsor Community Health Worker (CHW) training and increase the pipeline of diverse health care workers (example: WELFIE).			X
8.4 Expand dual-training pipeline programs.			X
8.6 Continue funding the MDH program that supports BIPOC mental health supervisors.	X		

8.7 Track the retention of health care professionals in underserved areas.		X	
9.1 Increase the use of health care loan forgiveness.	X		
9.2 Offer more scholarship funding for potential health care workers to enter the profession.	X		
9.3 Ensure that some NorthStar Promise funding is dedicated to students seeking health care degrees.	X		
9.4 Provide financial aid and funding for Community Health Worker (CHW) training and apprenticeship programs, offering specialization pathways, and expanding the CHW workforce.	X		

Engagement Stakeholders

- TBD

Objective 4: Workforce optimization

High Yield Recommendation: Health Care organizations to diversify who and how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members

Rationale/Background/Evidence

TBD

Additional Recommendations (Owner)	**Short-Term**	**Mid-Term**	**Long-Term**
6.0 Identify workforce gaps and barriers	X		
6.1 Address workforce shortages, especially focused on addressing rural access issues (e.g. dental therapists).		X	
6.2 Expand the dental workforce, particularly dental therapists and hygienists.	X		
6.3 Improve reimbursements and other interventions to support an increased health care workforce.	X		
6.4 Decentralize physicians where evidence supports it.		X	
6.5 Increase the utilization of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.	X		
6.6 Increase the utilization of Health Navigators from underrepresented communities (ex. Hmong Culture Care Connection, Cultural Society of Filipino Americans, SEWA-AIFW).	X		
6.7 Provide legislative authorization to MDH and DHS to develop opportunities to advance and sustain the Community Health Worker (CHW) workforce, and establish a state office to implement CHW policies and coordinate stakeholders.	X		
6.8 Community Health Workers: More resources should be devoted to hiring community health workers, particularly in underserved areas, to act as bridges between health care providers and the community.	X		
7.6 Increase the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.	X		
7.9 Residency Programs in Community Settings: Establish residency and fellowship programs for health professionals to work in underserved, rural, and tribal communities to ensure that they are exposed to the specific needs of these populations.	X		
7.10 Diversity in Health Education: Introduce long-term changes to health professional training programs to ensure they reflect the diversity of the populations they serve. This could include more scholarships for people from underrepresented communities, more	X		

recruitment into health careers from those communities, and ensuring a robust pipeline into health care fields.			
7.11 Support the University of Minnesota and CentraCare expansion of medical training programs for rural physicians.			

Engagement Stakeholders

- Minnesota Health Care Workforce Advisory Council

Primary and Whole-Person Care Station

Marc Gorelick, Bukata Hayes, Tyler Winkelman, Yeng M. Yang

Flipcharts

1. PCIR = Primary Care Investment Ratio

a. Payers set a required proportionary percentage of dollars to be allocated to primary care.

b. Payers decrease the payment proportional to the increase to primary care to more expensive care.

c. This allows health care delivery organization to create/move to a more comprehensive/integrated model to deliver whole person health

Health care payers and providers should

1.2.2 Explore opportunities to increase funding and support integrated behavioral health care and interdisciplinary care systems.

DHS should

1.3.1 Update existing Medicaid reimbursement rates and mechanisms for Health Care Homes (HCH) care coordination services to reflect the true costs of service, implement ongoing annual rate adjustments based on the Medicare Economic Index, and reduce the administrative burden of billing processes for complex, tiered care coordination.

1.3.2 Support more Health Care Homes (HCH) with achieving advanced certification levels, which increase health equity and reduce disparities, by linking advanced HCH certification levels with corresponding enhanced levels of Medicaid reimbursement for care coordination, to better reflect the expanded scope of care coordination practiced by Level 2 and 3 clinics.

1.3.6 Ensure integration of whole-person health into Minnesota Department of Human Services/Medicaid.

d. Link local clinic to public health is fully funded for comprehensive care for whole person health that address whole person care. Special call out on primary care model: Account for segmenting primary care into different populations from healthy and housed to complex high-touch populations. Would need to be built. This would allow different clinics/providers (HP, Allina, Hennepin Health, etc.) vs. the Children's/Mayo/Gillettes of the world to focus on the most impactful care needed.

- Medical health, mental health, dental health
- Access to specialty partners for guidelines/knowledge
- Incorporate culturally responsive care

Minnesota should

1.1.1 Require health care organizations to integrate primary and mental health care, including integrating medical records (e.g., the Institute for Health care Improvement model used by NorthPoint Health and HealthPartners).

1.1.2 Add dental coverage as an essential benefit for adults.

1.1.3 Incorporate funding for Community Health Workers (CHWs) into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure.

1.1.4 Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care providers and payers.

1.1.5 Invest in public health and prevention in communities so health care is more narrowly focused.

2.1.3 Design, implement, and maintain a shared directory of social needs resources.

2.1.8 Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research and maintain public health surveillance and dashboards.

2.1.9 Ensure policies to prevent unnecessary and duplicative medical testing contributing to high cost.

Health care payers and providers should

1.2.1 Invest more resources in primary care services, with a focus on preventive care and culturally appropriate interventions that meet patients where they are.

1.2.3 Integrate oral, mental, behavioral health, and wraparound services into primary care.

1.2.4 Expand the use of alternative approaches to mental health and substance abuse disorder services, such as models (e.g., the Clubhouse approach).

1.2.5 Expand capacity for inpatient mental health care.

1.2.7 Ensure that providers give ample time to each patient and address both physical and mental health needs, especially in primary care.

1.2.8 Improve communication and collaboration between primary care and specialists.

1.2.9 Promote local collaboration between primary care, public health, and other community partners.

1.2.10 Integrate traditional and non-traditional/complementary care.

1.2.11 Integrate cultural wisdom, and health and healing practices.

1.2.12 Ensure complementary care is covered.

1.2.13 Integrating traditional healing practices into clinical education and practice guidelines in a comprehensive way would require long-term partnerships with indigenous and cultural health practitioners.

DHS should

1.3.7 Improve reimbursement to encourage more dentists to participate and increase access to oral care.

1.3.8 *Noted on flipchart, no 1.3.8 in handout, group to update*

e. Providers document the amount invested in primary care.

2. Possible recommendation of collaborative care model to all health care delivery organizations.

a. This allows current payment infrastructure to be used.

3. Accountability

a. Cross-payer metric of success required to ensure providers invest the required amount of money to primary care.

b. Cross-provider acceptance of payment proportion to primary care.

c. Cross provider and payer data sharing creates

- More transparency in patient information
- Less duplication of care - knowledge sharing
- Expertise incentives to not duplicate care
- More continuing in care with better interoperability of electronic health record (EMR).

Minnesota should

2.1.1 Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records.

2.1.2 Modernize the Minnesota Health Records Act to provide clarity and alignment with electronic workflows.

2.1.4 Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community organizations.

2.1.6 Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing.

2.1.7 Identify opportunities for setting interoperability, data governance and quality standards and policies for health care organizations and technology vendors to adhere to that ensure seamless data exchange and communication across all the different electronic health records (EHRs), including the regulation of artificial intelligence (AI) in health care, ensuring health equity as part of quality.

Health care payers and providers should

1.2.14 Support Health Care Homes (HCH) program to improve communication between patients' care managers and coordinators.

Unintended consequences

1. Independent clinics, dental, mental health could feel left out or a M+A environment. – *Group to spell-out "M+A".*

2. To mitigate this issue in #1, the integrated primary care for dental and mental health would take care of primary/routine care for dental and quick assessment crisis stabilization at primary care clinic. The more complicated specialty care can still happen at the dental clinics and mental health clinics.

3. Penalizes

- Standalone high cost organizations
    - Venture capital type disruptors that does one type of care only
    - High end imaging centers
    - Ambulatory surgery centers
    - Standalone specialty care – but could incentivize specialty care to partner with primary care

4. Mitigation tactics for integrated system

- Implement a system to ramp up payment towards primary care and ramp down specialty/high cost services
- Have a tune up process to keep providers whole and financially solvent
- No penalize for performance – *Difficult to read this flipchart text, group to update*

Requirements

1. Trust B/N payers and providers, payers to payers to share data (claims and clinical data).

2. Define risk-adjusted population score to determine a prospective payment model and a tune-up process to make sure providers are paid appropriately for the care/outcomes they produce.

3. Develop financial metrics that provide guardrails to providers to be able to balance

- Talent retention (pay/benefits)
- Patient access
- Quality outcomes – upside incentives for outstanding performance by providers

4. Assessment of care model adoption: Collaborative care team based care model

How this model benefits patient/community

1. Build trust with patients and community with primary care and public health

2. Improve access to primary care

3. Simplifies payment for patients, providers, and payers

4. Better foster health equity

5. Incentivizes/encourage more preventive whole person health

6. Decrease handoffs – helps with system navigation challenges for patients

Special carveouts

1. Centers of excellence for highly specialized care providers (Children's/Gillette/transplant) to maintain viable financial model

Additional feedback/consideration

- Explain the why… change management
  Assumption/Given
  1. More access to trusted primary care, the more equitable care is
  2. We know that only 5% of the health care dollars is spent on primary care now, we want to increase that amount to primary care

Access Station

Elizete Diaz*, ElijahJuan (Eli) Dotts, Marc Gorelick

** = Station Leader*

Flipchart and Other Notes

How do these recommendation ideas fit together?

Interpretation/translation standards

- 1.1.3: Establish a statewide policy for hospitals to buy-into a system of independent contractors for access to interpreter services.
- 1.3.5: Ensure consistency in reimbursement by payers for interpretation and translation services.
- 1.3.6: Immediately provide interpretation services for patients who need this upon arrival at a health care facility
- 1.3.9: Ensure that patient-facing education and materials are vetted with bilingual clinicians to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms
- 2.2.1: Require after-visit summaries to be translated, written in plain language, and include after care and follow-up instructions

Health literacy/education

- 2.1.1: Establish state-wide health literacy and digital literacy education
- 2.3: The Minnesota Department of Health (MDH), health care providers, communities and others should develop partnerships to advance health literacy

Use existing resources to provide services

- For example, schools. We tend to focus on metro solutions and try those in rural areas. Instead of focusing on telehealth we can use existing resources like schools to provide services. If you don't have space, what do you have in your community?
- 1.3.2: Expand school-based health services, including oral health screenings and preventive services
- 1.3.3: Expand primary prevention programs through healthy youth development programs
- 1.1.6: Expand Telehealth and Mobile Health Services especially for rural and underserved areas, implementing technology to provide healthcare access where there are fewer providers can be a low-cost, immediate solution
- 1.4.3 Add continuing support for phone-based telemedicine for Medicare and Medicaid patient
    - This fits with telehealth. There are potential barriers with broadband, wi-fi. Pushback on counties and not all counties have the same funding. Rural areas have less access to consistent internet. How do you do telehealth without addressing that? We need solutions for rural areas first, not applying metro solutions.

Transportation gaps and providing reliable and consistent transportation to health care services

- 1.3.7: Reimburse for transportation services and coordination of transportation services
- 1.3.8 Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment)
- 1.4.2: Expand current non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid
- 1.2.2: Use Community Health Workers to provide transportation services and coordination

Standardize language is at the heart of several recommendations

- Make sure we have statewide interpreters.
- Consistent reimbursement for interpreters, providers have access to one hub for resources that are already translated.
- Should be a standard to have those materials in the languages needed. Services are currently contracted out, and that's where you get the inconsistency.
- We need to get things to state agencies 2 months in advance to get their approval. That's not the case for patient education materials (not needed to get approved). When the translated materials aren't available, the orgs have to pay for it themselves. Providers would be inclined to use those resources. Language access isn't a priority across the organizations.
- If we want to require licensing, there should be support for it. We want interpreters to be licensed and we need to support them. An example of a model to use is childcare workers.

Related to workforce

- 1.2.2: Use Community Health Workers to provide transportation services and coordination
- 1.3.1: Use emerging professions, Community Health Workers, doulas, other care managers and coordinators

Is there any other information or supports from MDH that you need to move this idea forward?

- 1.1.2: Standardize translation services through licensing
    - Due to barriers in licensing and recertification
- DHS, MDH, and MDE coordination – can have some alignment
    - 1.3.7: Reimburse for transportation services and coordination of transportation services
    - If DHS can work out a reimbursement system, e.g. for schools. We see that disparity. It could be a cross-collaboration across agencies. There is a model for it – maybe Head Start.
    - That is a goal but what is the policy recommendation around that?

Additional discussion needed

- 1.1.2: Standardize translation services through licensing
- 1.2.1: Expand use of common referral approaches among cross-sector partnerships (e.g., Blue Cross Blue Shield, Stratis Health, and Collective Action Lab)
    - Not sure what this means

    - My interpretation is, for example, if you have a housing need, we'll send you to an agency that can help with food security, etc. Social service referrals. As a payor, we pay for an MRI over here, and they go to another provider who does an MRI and then we're paying for both, and that could have been avoided. That is taxpayer dollars.
    - Seems related to the lack of information sharing across systems. Some new federal requirements are coming in.
- Context and climate need to be taken into consideration to ensure patient and provider protections
- Multiagency collaboration (DHS, MDH, DOE)
- 1.3.2: Expand school-based health services, including oral health screenings and preventive services
- 1.3.3: Expand primary prevention programs through healthy youth development programs
- 1.1.6: Expand Telehealth and Mobile Health Services especially for rural and underserved areas, implementing technology to provide healthcare access where there are fewer providers can be a low-cost, immediate solution
- 1.1.5: Address rural health care facility closures and workforce shortages
- Space, using existing resources: rural solutions
- Gap in 1.2.2: we're adding responsibility to CHW when they're already overburdened and underpaid. If they sign up as a transportation provider, that is another barrier to jump through just to provide a basic service. People who want to be a CHW, then they're asked to have car insurance because they're transporting people.
- 1.3.4: Require providers to offer flexible hours for evening and weekend appointments
    - Possibly overtime for people – will that in turn make rates even higher? How do you incentivize that? There are positive and negative ways to incentivize. If people can avoid a visit to the ER on the weekend because clinic isn't open but it's mor expensive. If I have to pay $60 to open the clinic, I choose that. Develop plans to incentivize to facilitate more flexible hours.
- 2.1.2: Establish a system for patient-owned electronic records that would facilitate care coordination and shared understanding of patient needs
    - One downfall is if a patient doesn't want a certain provider to have access. If they decide to use that information against the patient, there needs to be guidelines around how to use this information. Flipside: MN has more stringent guidelines than HIPPA and we should look at those to make sure we're getting the right balance. We don't have a great balance right now.
    - The technology is not seamless.
    - Currently in MN you have to provide permission each time you see someone. It's a barrier. That should be addressed. Sometimes it's harder to share information when we need to. And we also want confidentiality.
    - We pull information from claims to fill in information gaps. If it could be easier…
- Some of these recommendations map onto a particular policy concept
    - Health care providers should use CHWs, great but what's the policy? What is the recommendation? We might not know what the policy rec is, maybe MDH does.
    - Some are more outcome-based. E.g., provide immediate interpretation. But what's the recommendation to get to that outcome?
    - We're bucketing these and the recommendations are already in this list.

    - Need to ask what we are asking the department to do. How exactly do we expand services, etc.
    - Recommendation might be "we need a policy that gets to these outcomes."
- Related to funding
    - Where are the barriers that are related to funding? Regulation? When we hear "expand the use of…" some access barriers might be licensing, funding.
    - It goes back to funding. Funding is necessary but not sufficient for access.
    - We have a low uninsured rate in MN. But there are providers who don't take Medicare, etc. So coverage doesn't equate to access. We have focused on coverage so how do we expand that. Reimbursement rates for mental health were even lower than those for physical care. Payors depend on what they get from the state. They can't pay out what they're not getting.
    - We (payor) do take in profit but we reinvest that in the communities, e.g., to combat disparities in American Indian oral health.
    - Do we then look into funding streams other than medicare/aid? Undocumented immigrants aren't eligible but they have gotten coverage so where did that funding come from? Might have come from the surplus.?
    - State and federal put in some money. At Children's we lost $XM in Medicaid. If we want to expand these wraparound services, how do we pay for those?

Areas of overlap

Transportation services

- 1.4.2: Expand current non-emergency medical transportation benefits under Minnesota Department of Human Services (DHS)/Medicaid
- 1.3.8: Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment)
- 1.3.7: Reimburse for transportation services and coordination of transportation services
- 1.2.2: Use Community Health Workers to provide transportation services and coordination

Workforce

- 1.1.4: Create a system for patients that enables patient/provider matching so patients can choose providers they may identify with and/or provide the services they need
- 1.1.5: Address rural health care facility closures and workforce shortages
- 1.2.2: Use Community Health Workers to provide transportation services and coordination
- 1.2.3: Expand the use of Community Health Workers or Patient Navigators to provide wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner
- 1.2.4: Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals

Whole person

- 2.1.2: Establish a system for patient-owned electronic records that would facilitate care coordination and shared understanding of patient needs
- 1.2.4: Secure funding for comprehensive services around care (e.g., housing navigation) and wrap around services at clinics and hospitals

Accountability

- 1.4.1: Require providers to expand acceptance of new patients and patients that receive Medicaid
- 1.3.4: Require providers to offer flexible hours for evening and weekend appointments
    - Positive measures vs. negative ones

Ideal goal – top priority

1.1.1: Establish universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota

Station discussion themes

The group identified the ideal goal as recommendation 1.1.1: Establish universal health care or health care for all to provide baseline comprehensive care for all persons living in Minnesota. In addition, the following themes emerged from their discussion.

Interpretation and translation services

- Statewide policies and standards
- Immediate access
- Cultural context
- Translation of materials
- Standardizing language and services for consistency and access to translated materials
- Licensing and support to ensure licensees have the necessary resources

Transportation services

- Reimbursement and coordination

Utilizing existing resources

- Community-based solutions such as schools, especially in rural areas

Workforce development

- Utilizing CHWs, doulas, and other care managers to expand the healthcare workforce

- Support and training
- Incentivizing providers to offer flexible hours

Policy and coordination

- Standardizing translation services through licensing and expanding common referral approaches
- Facilitate care coordination with electronic medical records while putting guidelines in place

Funding

- Barriers
- Coverage vs. access
- Reimbursement rates, provider participation, and impact on services
- Alternative funding streams
- Reinvestment into communities to address disparities

Structure of our recommendations

- Outcome-based recommendations
- Policy-focused

Accountability Station

Megan Chao Smith, Elizete Diaz, Marc Gorelick, Laurelle Myhra

Flipcharts

4 Measurement and evaluation

- Add #4 – community specific subgroup suggestions (i.e., Tribes, LGBTQ)

1.1.1 Minnesota should uphold federal treaty agreements with Tribes to ensure full health care coverage for Tribal communities with plans that are on par with others (commercial, Medicaid).

- 1.1.1 edit – automatic coverage Tribal members and children

1.1.2 Minnesota should establish and manage a grievance process, including a hotline for patients and health care workers to report issues to the state (e.g., Lieutenant Governor, Attorney General).

- 1.1.2 broad > clinic, provider, hospital, payer

1.1.3 Minnesota should Establish a fund to provide free legal services to patients with grievances about the health care system and ensure compensation is tied to improved health outcomes

- 1.1.3 payment/settlement fund?

1.2.1 Establish an Accountability Group of patients and workers, supported by the Health Equity Advisory and Leadership (HEAL) Council, to handle grievances and oversee health care accountability.

- 1.2.1 citizen/advocacy > expand beyond patient and workier to include those without access Tribe, LGBTQ

1.3.3 Improve Medicaid reimbursement to encourage more dentists to participate and increase access to oral care.

- 1.3.3 + add providers + market rate or higher

3 Community co-leadership of accountability and oversight. Health care providers and payers must customize health care to address each community's unique needs, focusing on social determinants of health (SDOH), encourage collaboration between health care systems and community organizations, and set clear, measurable indicators for success in health outcomes, patient satisfaction, and cultural concordance.

- 3 Increase transparency to community accountability measures, track changes (e.g., hospital needs assessments, increase focus on goals)

payors and health systems increase race data collection no “other” due to small sample size

Station discussion themes

1. **Data Standardization:**
    - Ensure comprehensive data collection that includes race, gender, and ethnicity beyond generic "other" categories.
    - Use REL (Race, Ethnicity, Language) data but explore broader frameworks.
2. **Accountability vs. Punishment:**
    - Focus on motivating compliance through positive incentives rather than punitive measures.
    - Enforce state-mandated health equity training to ensure real impact, not just a requirement with no enforceability.
3. **Grievance and Oversight Processes:**
    - Establish a clear, enforced grievance process.
    - Clarify the authority of key agencies (Department of Human Services, Department of Commerce, Minnesota Department of Health).
    - Evaluate how MDH currently investigates grievances and how recommendations could strengthen the process.
    - Explore a common intake process for different types of grievances (e.g., discrimination, malpractice).
4. **Governance and Transparency:**
    - Include MDH's Health Equity Bureau and HEAL in accountability efforts.
    - Ensure transparency in accountability processes.
    - Engage the public through outreach, publications, and advertisements.
    - Involve advocates and Tribal nations in governance structures.
    - Define responsibilities and identify gaps in current policy that hinder accountability.
    - Establish public oversight mechanisms.
5. **Community and Institutional Role:**
    - Utilize community health needs assessments as part of accountability (linked to IRS tax-exempt status requirements).

Follow-up needed on:

- Maternal mortality review committee charter
- Approach for health-related complaints or grievances in other states (i.e., California State Office of patient protection)

- Equity measure reporting programs

Supplemental resources shared by MDH during discussion

Maternal mortality review committee information and charter:
https://www.health.state.mn.us/people/womeninfants/maternalmort/committee.html

Regarding your interest in a "one-stop shop" or "no wrong door" approach for health-related complaints or grievances—such as a single phone number or website where individuals can seek assistance without determining the responsible agency—no existing model fully covers all health-related complaints. However, the following programs may be relevant to your discussions:

Centralized Health Complaint Systems

Some states have offices that assist with insurance-related issues, particularly denials of coverage, though they do not extend to complaints about health care providers:

- Connecticut Office of the Healthcare Advocate (OHA) – Assists consumers with healthcare coverage issues, including insurance complaints and appeals.
    - More information is available at: Connecticut OHA
    - See attached 'OHA Annual Report 2024'
- California and Massachusetts – Have similar offices that help with coverage denials but do not address concerns related to health care providers.

Additionally, a proposed bill in the Minnesota Legislature (SF 1567) seeks to establish an Office of Patient Protection. This office would assist consumers with access to and quality of healthcare services, aligning with the broader goal of improving accountability and consumer protection: SF 1567 as introduced - 94th Legislature (2025 - 2026)

Health Equity Reporting Programs

You also requested information on health equity reporting requirements in other states. Here are two relevant examples:

- California's Hospital Equity Measures Reporting Program – Requires all hospitals to publicly report equity-related performance measures as a way to improve transparency and accountability.
    - Hospital Equity Measures Reporting Program - HCAI
    - 2022 Hospital Equity Measures Committee Recommendations Report
- Maryland's Proposed Legislation – A bill under consideration would require hospitals to publicly report on disparities and equity measures. While still in development, it could serve as a model for Minnesota in advancing hospital accountability.
    - Bill Resource

DRAFT: Primary and Whole-Person Care Recommendations

Health care equity problem statement:

The health care system in Minnesota does not integrate all aspects of health and public health. Payment models do not support whole-person care, care is largely uncoordinated, and Minnesota underinvests in primary care. The health care system does not effectively share data or leverage health information technology. Health care provider specialists do not effectively communicate with each other or with primary care. As a result, the health care system is difficult for patients to navigate, patients experience interruptions in care at important life stages, they do not experience culturally inclusive and responsive care, and communities impacted by health inequities lack trust in the health care system.

Recommendation 1. Minnesota should implement a strategy that moves toward a primary care-driven model of health care that includes all the cares across life stages and events and phases-out a reliance on episodic and reactive care.

Implementing these recommendations and action steps for primary and whole-person care will foster:

- Effective trust-building among patients, communities, primary care, and public health.
- Improved access to primary care.
- An incentive structure that encourages more preventive, whole-person health.
- A simplification of payment among patients, providers, and payers.
- Easier health care system navigation for patients and a decrease in handoffs.
- A more equitable health care system and health outcomes.

Recommendation 1.1 Minnesota should expand primary care to include the integration and coordination of medical, dental, vision, mental, behavioral, substance use, complementary, and culturally concordant cares.

- Action steps for Minnesota
    - 1.1.1 Require health care organizations to expand primary care
    - 1.1.2 Add dental coverage as an essential benefit for adults
    - 1.1.3 Ensure policies to prevent unnecessary and duplicative medical testing contributing to high cost.
    - 1.1.4 Integrate whole-person health into Medicaid.
- Action steps for payers and providers
    - 1.1.5 Ensure providers give ample time to each patient.
    - 1.1.6 Improve communication and collaboration between primary care and specialists.
    - 1.1.7 Integrate traditional healing practices into clinical education and practice guidelines in a comprehensive way in partnership with indigenous and cultural health practitioners.
    - 1.1.8 Support Health Care Homes (HCH) program to improve communication between patients' care managers and coordinators.
    - 1.1.9 Expand capacity for inpatient mental health care.

Recommendation 1.2 Health care delivery organizations should implement a collaborative care model.

Commented [DM1]: Task force retreat small group and/or task force to define "collaborative care model".

- Action steps for payers and providers
  - 1.2.1 Assess the adoption of the collaborative care, team-based care model.

Recommendation 1.3 Minnesota should invest in community health, public health, and wraparound care services, and support linkages to primary care.

- Action steps for Minnesota
  - 1.3.1 Design, implement, and maintain a shared directory of social needs resources.
  - 1.3.2 Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care providers and payers.
  - 1.3.3 Incorporate funding for Community Health Workers (CHWs) into state initiatives to address social determinants of health/health related social needs, community care hub infrastructure.
- Action steps for payers and providers
  - 1.3.4 Promote local collaboration among community partners, public health, and primary care.

Recommendation 1.4 Minnesota should adopt reimbursement and payment models that will support investments in primary care.

- Action steps for Minnesota
  - 1.4.1 Improve Medicaid reimbursement to encourage more dentists to participate and increase access to oral care.
  - 1.4.2 Update existing Medicaid reimbursement rates and mechanisms for Health Care Homes (HCH) care coordination services to reflect the true costs of service, implement ongoing annual rate adjustments based on the Medicare Economic Index, and reduce the administrative burden of billing processes for complex, tiered care coordination.
  - 1.4.3 Support more Health Care Homes (HCH) with achieving advanced certification levels, which increase health equity and reduce disparities, by linking advanced HCH certification levels with corresponding enhanced levels of Medicaid reimbursement for care coordination, to better reflect the expanded scope of care coordination practiced by Level 2 and 3 clinics.
- Action steps for payers and providers
  - 1.4.4 Explore opportunities to increase funding, resources, support for primary care with a focus on preventive care and culturally appropriate interventions that meet patients where they are.
- Action steps for commercial and public payers
  - 1.4.5 Provide reimbursement for complementary care.

Recommendation 1.5 Commercial and public payers should set a required proportionary percentage of dollars to be allocated to expanded primary care (i.e., Primary Care Investment Ratio) and decrease the payment proportional to the increase to primary care to more expensive care.

- Action steps for providers

    - 1.5.1 Document the amount invested in primary care.
- Action steps for payers and providers
    - 1.5.2 Share claims and clinical data.
    - 1.5.3 Special call out on primary care model: Account for segmenting primary care into different populations from healthy and housed to complex high-touch populations. This would allow different clinics/providers (HP, Allina, Hennepin Health, etc.) vs. the Children's/Mayo/Gillettes of the world to focus on the most impactful care needed.
        - Medical health, mental health, dental health
        - Access to specialty partners for guidelines/knowledge
        - Incorporate culturally responsive care
    - 1.5.4 Implement a cross-payer metric of success to ensure providers invest the required amount of money to primary care.
    - 1.5.5 Implement a system to ramp-up payment towards primary care and ramp-down specialty high-cost services, have a tune-up process to keep providers whole and financially solvent, and do not use performance penalties.
    - 1.5.6 Define risk-adjusted population score to determine a prospective payment model and a tune-up process to make sure providers are paid appropriately for the care/outcomes they produce.
    - 1.5.7 Develop financial metrics that provide guardrails to providers to be able to balance talent retention (pay/benefits), patient access, and quality outcomes (e.g., upside incentives for outstanding performance by providers).
- Assumptions of primary care investment ratio model:
    - Health delivery organization is allowed to create or move to a more comprehensive and integrated model to deliver whole-person health.
    - Link between local clinic and public health is fully funded for comprehensive care for whole person health that address whole person care.
    - Cross payer and provider data sharing creates more transparency in patient information, less duplication of care, more knowledge sharing, and more continuity of care with better information sharing and interoperability of electronic medical records.
- Considerations
    - Independent medical, dental, and mental health clinics could feel left out of a M+A environment. To mitigate this issue, the integrated primary care for dental and mental health should take care of primary and routine care for dental and quick assessment crisis stabilization at primary care clinics. Dental and mental health clinics may manage more complicated specialty care.
    - The primary care investment ratio could penalize standalone high-cost organizations such as:
        - Venture capital type disruptors that do one type of care only
        - High end imaging centers
        - Ambulatory surgery centers
        - Standalone specialty care – but could incentivize specialty care to partner with primary care
    - Special carveouts: Centers of excellence for highly specialized care providers (Children's/Gillette/transplant) to maintain viable financial model

Commented [DM2]: Task force retreat small group to define "M+A".

Recommendation 1.6 Minnesota should develop systems for seamless data sharing among payers, health care providers, community organizations, and patients.

- Action steps for Minnesota
    - 1.6.1 Establish a single, aggregated patient record via one portal that supports the ability for social services/community organizations to collect and add data to patient records.
    - 1.6.2 Modernize the Minnesota Health Records Act to provide clarity and alignment with electronic workflows.
    - 1.6.3 Design, implement, and maintain a shared directory of social needs resources.
    - 1.6.4 Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care, and community organizations.
    - 1.6.5 Incentivize health providers and the state to participate with the Trusted Exchange Framework and Common Agreement (TEFCA) national framework for health information sharing.
    - 1.6.6 Identify opportunities for setting interoperability, data governance and quality standards and policies for health care organizations and technology vendors to adhere to that ensure seamless data exchange and communication across all the different electronic health records (EHRs), including the regulation of artificial intelligence (AI) in health care, ensuring health equity as part of quality.
    - 1.6.7 Support sustained funding for the Minnesota EHR Consortium to conduct evidence-based research and maintain public health surveillance and dashboards.
    - 1.6.8 Ensure policies to prevent unnecessary and duplicative medical testing contributing to high cost.
    - 1.6.9 Require integration of medical records

Omitted station content

Primary and Whole-Person Care

Health care payers and providers should

- Integrate dental care into primary care settings, schools, and community health centers.
- Support care (e.g., obstetrics) where that care is considered a cost center v. a revenue center, to reduce incentives to drop non-profitable care.
- Support and expand emerging and effective models of post-partum care that lead to better outcomes for birthing people (e.g., HealthPartners Healing Circles and the Mom & Baby Center at Abbott Northwestern).
- Provide wrap-around services to new parents and babies, such as public health nurse visits.
- Invest more in mental health, chemical health, and birth justice efforts, with a tailored approach to chronic disease management that respects cultural practices and long-term care.
- Develop best practices around the use of z-codes to document and act on non-disease factors impacting patient health outcomes.
- Ensure that health care delivery systems code for social determinants of health (SDOH) factors to demonstrate the disease burdens of high-risk populations.
- Require that social determinants of health (SDOH) factors count towards complexity risk adjustment.

Minnesota Department of Human Services should

- Extend the use of a tiered structure for advanced certification levels to population-based payments in Medicaid Integrated Health Partnerships (IHPs), which is Minnesota's Medicaid accountable care organization, 80% of whose participants are certified Health Care Homes (HCH).
- Require Health Care Homes (HCH) certification for participation in a Medicaid Integrated Health Partnerships (IHPs), rather than just a recommendation.
- Focus on the development of the social determinants of health (SDOH) waiver application to draw down federal funds and learn from the experiences of other states.

Cross-cutting elements

Payment and reimbursement

Health care payment and reimbursement should reward quality outcomes, focus on value over volume, prioritize equity, and incentivize prevention and wellness.

- Minnesota should
    - Restrict prior authorization requirements for lifesaving and life-sustaining medications.

    - Develop standards and tools for health care, community organizations, and payer engagement that includes operational and financial agreements, as well as options for payment.
- Health care payers and providers should
    - Increase the adoption of value-based payment models.
    - Bridge pay gaps in care and reimbursement for valued care to achieve health equity.
    - Implement reimbursement models that support primary care, preventive care, follow-up care, care coordination, and incentivize wellness.
    - Promote models for value-based purchasing, shared-savings, and cost-sharing contracts.
    - Improve reimbursement for preventive and primary health care (algin with specialty care RVUs).
    - Require reimbursement for follow-up care coordination.
    - Ensure that reimbursements cover community-essential services, such as obstetrics, as well as culturally-specific and supportive care.
    - Mitigate range of reimbursement by type of coverage and health insurance carrier.
    - Increase sustainability through funding and reimbursement for complex care model clinics, which are resource heavy and lack adequate reimbursement currently.
- The Minnesota Department of Human Services (DHS) should
    - Prioritize and invest in equity-focused, community-centered population health.
    - Provide adequate compensation and support for systems that care for high-risk patients.
    - Continue to innovate payments to ensure that the equitable decision is the easy decision.
    - Partner with others on payment policies and rates, Community Health Worker (CHW) services claims tracking, and reports.

Financing and efficiency

Health care must be financed in such a way that it fosters collaboration among patients, providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management while continuing to fund the provision of quality acute and sick care to sustain overall patient and population well-being and prevent the reoccurrence or exacerbation of illnesses. Health care financing should reflect, account for, and cater to the social, cultural, and other needs of each member of the population being served to achieve optimal health.

- Health care payers and providers should
    - Eliminate costly inefficiencies by streamlining processes and communication to remove redundancy in administrative and clinical work (e.g., when patients get repeat care from

different providers, repeat paperwork processing, the seemingly endless back-and-forth between payers and providers on prior authorizations, and other excess administrative overhead costs).

- Eliminate arbitrary health care costs and pricing, including price discrimination.

Cross-Cutting Elements

1. **Affordability**

   Minnesota must eliminate or reduce out-of-pocket patient costs for insurance premiums, health care services, medications, transportation, and other health care supports.

   1.1 Implement policies to reduce or eliminate out-of-pocket expenses for premiums, care, medications, and transportation.

   1.2 Explore and address the root causes of high health care costs (e.g., High U.S. Health Care Spending – Commonwealth Fund).

   1.3 Remove administrative barriers.

2. **Payment and reimbursement**

   Health care payment and reimbursement should reward quality outcomes, focus on value over volume, prioritize equity, and incentivize prevention and wellness.

   2.1 Minnesota should

      2.1.1 Restrict prior authorization requirements for lifesaving and life-sustaining medications.

      2.1.2 Develop standards and tools for health care, community organizations, and payer engagement that includes operational and financial agreements, as well as options for payment.

   2.2 Health care payers and providers should

      2.2.1 Increase the adoption of value-based payment models.

      2.2.2 Bridge pay gaps in care and reimbursement for valued care to achieve health equity.

      2.2.3 Implement reimbursement models that support primary care, preventive care, follow-up care, care coordination, and incentivize wellness.

      2.2.4 Promote models for value-based purchasing, shared-savings, and cost-sharing contracts.

      2.2.5 Improve reimbursement for preventive and primary health care (algin with specialty care RVUs).

      2.2.6 Require reimbursement for follow-up care coordination.

      2.2.7 Ensure that reimbursements cover community-essential services, such as obstetrics, as well as culturally-specific and supportive care.

      2.2.8 Mitigate range of reimbursement by type of coverage and health insurance carrier.

2.2.9 Increase sustainability through funding and reimbursement for complex care model clinics, which are resource heavy and lack adequate reimbursement currently.

2.3 The Minnesota Department of Human Services (DHS) should

2.3.1 Prioritize and invest in equity-focused, community-centered population health.

2.3.2 Provide adequate compensation and support for systems that care for high-risk patients.

2.3.3 Continue to innovate payments to ensure that the equitable decision is the easy decision.

2.3.4 Partner with others on payment policies and rates, Community Health Worker (CHW) services claims tracking, and reports.

3 Financing and efficiency

Health care must be financed in such a way that it fosters collaboration among patients, providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management while continuing to fund the provision of quality acute and sick care to sustain overall patient and population well-being and prevent the reoccurrence or exacerbation of illnesses. Health care financing should reflect, account for, and cater to the social, cultural, and other needs of each member of the population being served to achieve optimal health.

3.1 Health care payers and providers should

3.1.1 Eliminate costly inefficiencies by streamlining processes and communication to remove redundancy in administrative and clinical work (e.g., when patients get repeat care from different providers, repeat paperwork processing, the seemingly endless back-and-forth between payers and providers on prior authorizations, and other excess administrative overhead costs).

3.1.2 Eliminate arbitrary health care costs and pricing, including price discrimination.

Primary care spending targets

A primary care spending target is a goal set by a state used to increase the share of health care spending spent on primary care. In some states, they have been implemented as independent initiatives. In other instances, they are tied to broader health care spending target initiatives that generally aim at constraining (unwelcome or unsustainable) spending growth.

Some states have proposed primary care spending targets, some monitor and report primary care spending, while others are working to increase investment in primary care.

- Altarum Healthcare Value Hub. 2024 Health Care Affordability Snapshot: Dashboard Table, as of July 1, 2024. (filter "Policy Type" by "Health Spending Oversight: Primary Care Spending") https://www.healthcarevaluehub.org/affordability-snapshot
- Primary Care Collaborative website, https://thepcc.org/policy/state-investment-hub/state-initiatives/
- Veltri V., McDowell A. NASHP Blog. Summary of State Legislative Efforts Aimed at Health Care Transformation Reforms. December 8, 2023. https://nashp.org/summary-of-state-legislative-efforts-aimed-at-health-care-transformation-reforms/