Medicaid Services Advisory Committee Meeting

Public Meeting

Tuesday, February 9, 2021

12:30 – 2:30 pm

- This meeting is open to the public
- Please mute your line to reduce background noise
- Public comment will be taken at the end of the meeting or can be submitted in writing to krista.oconnor@state.mn.us

Medicaid Services Advisory Committee

February 9, 2021

Krista O’Connor I Strategic Development Director

Welcome

Housekeeping items

- WebEx Meeting
- Meeting is public
- Please mute your line when not speaking
- Committee members can use the chat to provide comment or ask questions
- Public members can provide public comment today by putting “public comment: your name, and your organization” in chat
- Written public comment is also welcomed and encouraged. Please submit to krista.oconnor@state.mn.us
- State conflicts of interest prior to providing comment

Health Care Administration Vision:

The Health Care Administration builds and operates affordable and efficient health care programs that improve the health of Minnesotans.

Purpose & duties

Purpose

- Provides guidance on key initiatives brought forward by DHS that affect Medicaid program administration, policy or Medicaid funded services
- Represent community groups and professional stakeholder organizations, Medicaid beneficiaries and caregivers, and various health care and long term services and supports professionals that influence the health and covered services of Medicaid populations
- Serves to advise DHS and is not a governing board.

Duties

- Provide guidance on specific policies, initiatives, and proposed program changes brought forward by DHS
- Act as liaisons back to individuals, organizations, and institutions that receive, facilitate, or provide Medicaid services

Agenda

- New member introduction
- Updates
- IHP's equity interventions – COVID impact
- Racial equity in MN Medicaid
- Topics for 2021
- Request for feedback: External committee processes
- Public comment
- Next meeting & adjourn

DEPARTMENT OF HUMAN SERVICES

MSAC Members

Medicaid Services Advisory Committee

Committee Members

Beneficiary/Caregiver

George Klauser

Robert Marcum

Kate Quale

Bradford Teslow

Open seat (Tribal)

Physicians/Providers

Abdirahman Ahmed, DDS

Dr. Jean Balestrery

Dr. Micah Niermann

Lynette Tahtinen

Dr. John Wust

Non profit/Human Service

Megan Ellingson

Hodan Guled

Elizabeth McMullen

Samuel Moose

Stephanie Schwartz

Jovon Perry, Director, Economic Assistance & Employment Support Division
Children and Family Services, DHS

DEPARTMENT OF HUMAN SERVICES

Updates

Krista O’Connor, Strategic Development Director

Medicaid Services Advisory Committee

HCA Updates

- Federal PH emergency
- Walz budget: https://mn.gov/mmb/budget/current-budget/governors-budget-recommendations/
- Special enrollment period: https://www.mnsure.org/news-room/news/index.jsp#/detail/appId/1/id/467109
- Deep poverty report: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG
- MN Encounter Alerting System (EAS): https://mneas.org/

Integrated Health Partnerships

Mat Spaan, Manager Care Delivery and Payment Reform

Medicaid Services Advisory Committee

IHPs Equity Interventions

- Overview
- 2020 Experience – Impact of COVID to date
- Potential future priority areas (survey responses)
- Discussion

DEPARTMENT OF HUMAN SERVICES

Thank You!

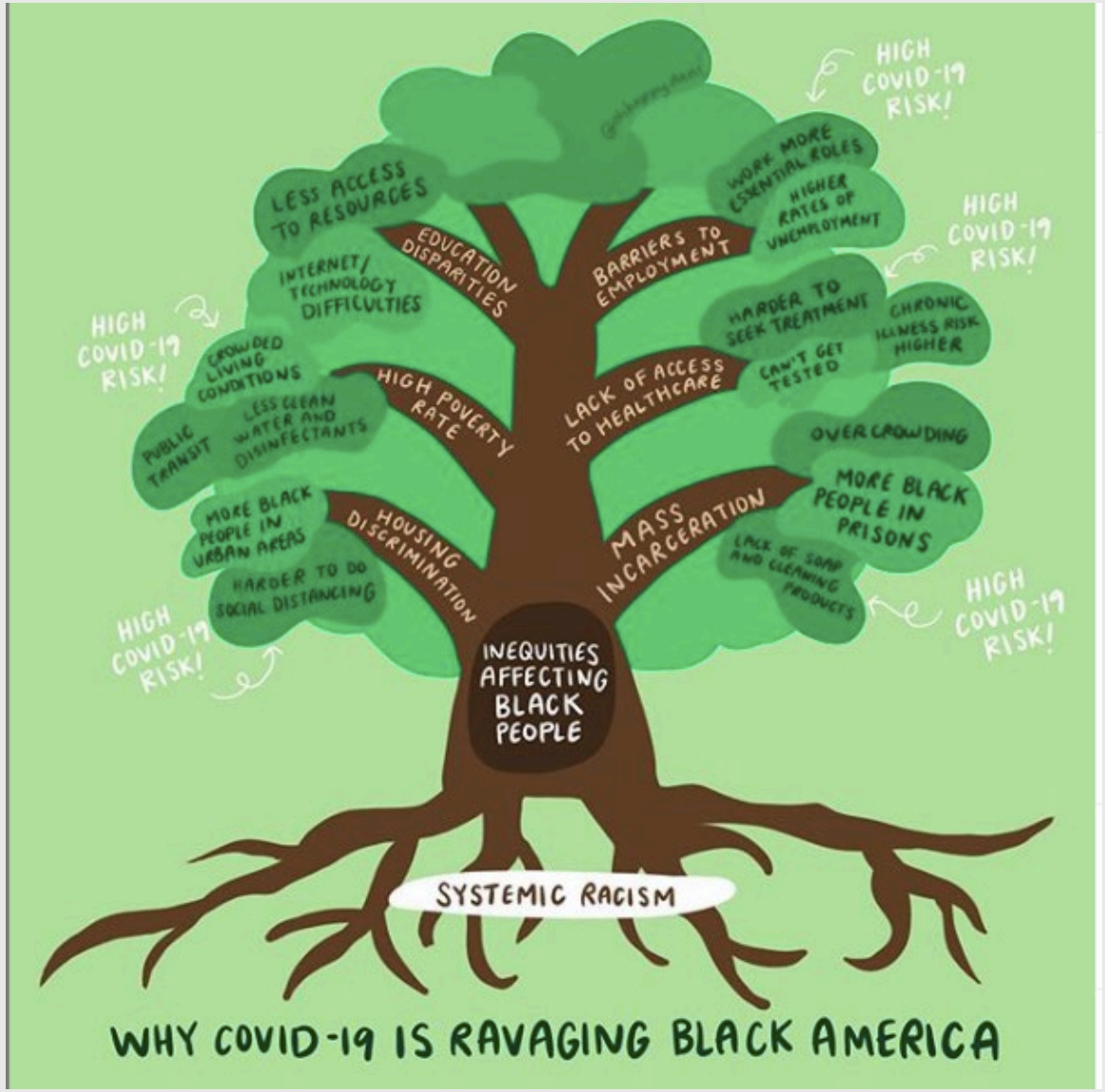
Mat Spaan

mathew.spaan@state.mn.us

Racial Equity in the Walls of Minnesota Medicaid: Improving the Health and Opportunity of Black Minnesotans

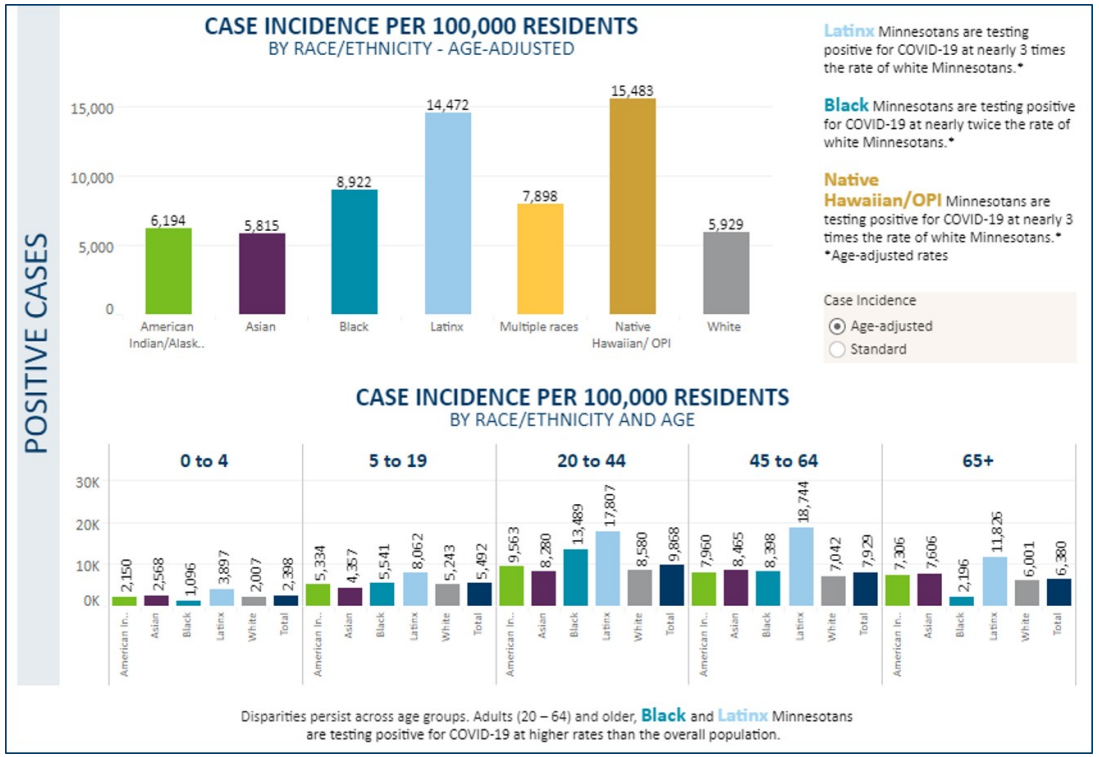
Nathan Chomilo, M.D. FAAP| Medical Director

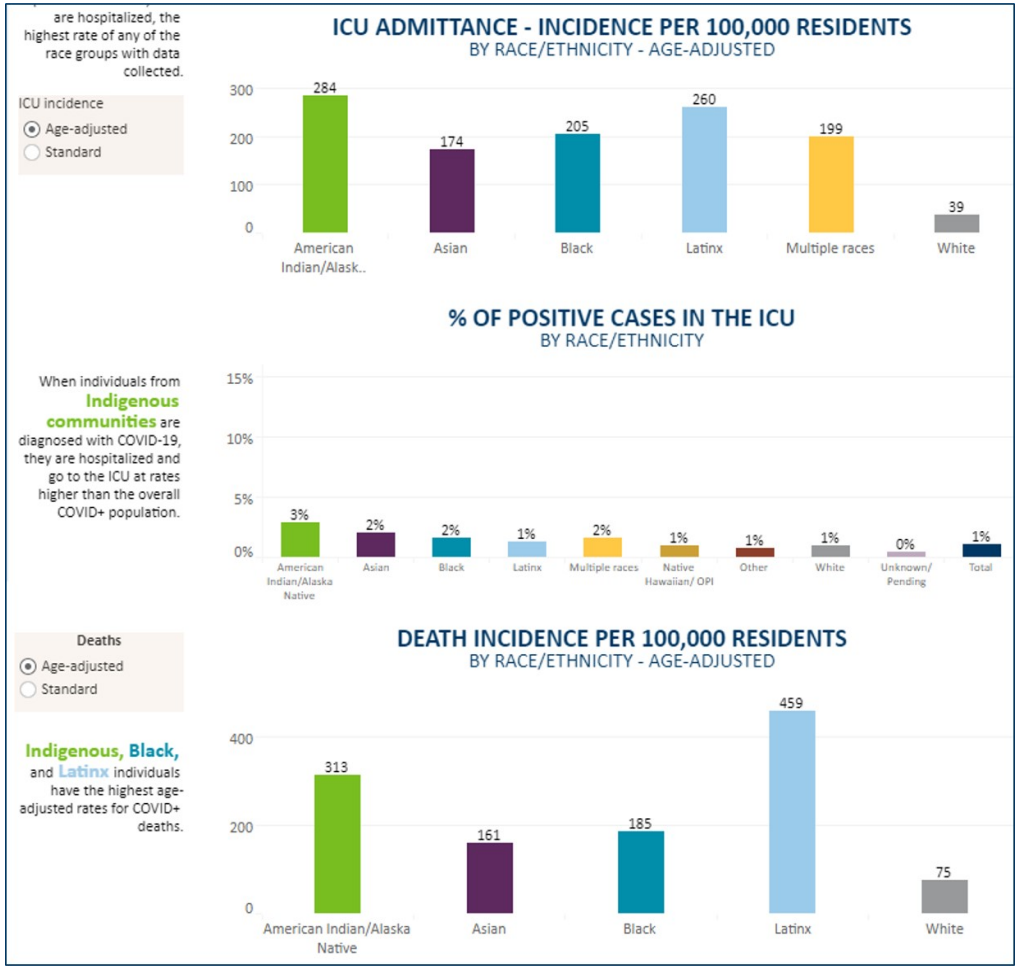
What COVID19 is showing us about the health and opportunity of Black Minnesotans



Art by Danielle Coke

What COVID19 is showing us about the health and opportunity of Black Minnesotans (1/4)

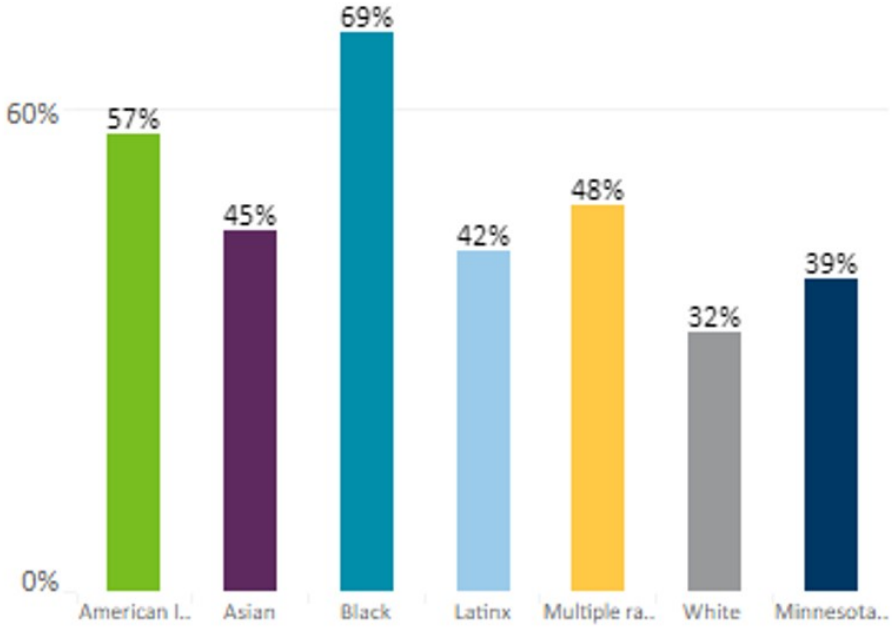




What COVID19 is showing us about the health and opportunity of Black Minnesotans (2/4)

% OF LABOR FORCE FILING FOR NEW/REACTIVATED UI BENEFITS

CUMULATIVE SINCE MARCH | BY RACE/ETHNICITY



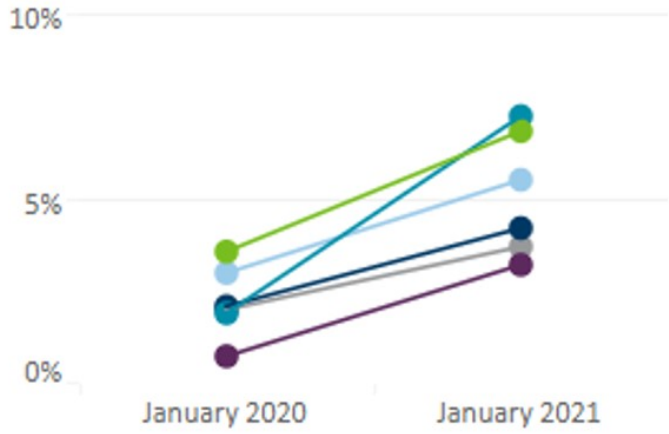
Communities of color have applied for unemployment benefits and continue to need those benefits at higher rates than white Minnesotans.

During the summer more than 1 in 4 **Black** workers were filing for multple weeks of claims; by December the number is nearly 1 in 10 for **Black** workers; just 4 percent of **white** workers filed continued claim in early January.

Through the course of the pandemic, over 60 percent of **Black** workers and over 50 percent of **Indigenous** workers have filed for UI benefits.

% OF LABOR FORCE FILING FOR CONTINUED CLAIMS

JANUARY 2020 AND JANUARY 2021 BY RACE/ETHNICITY

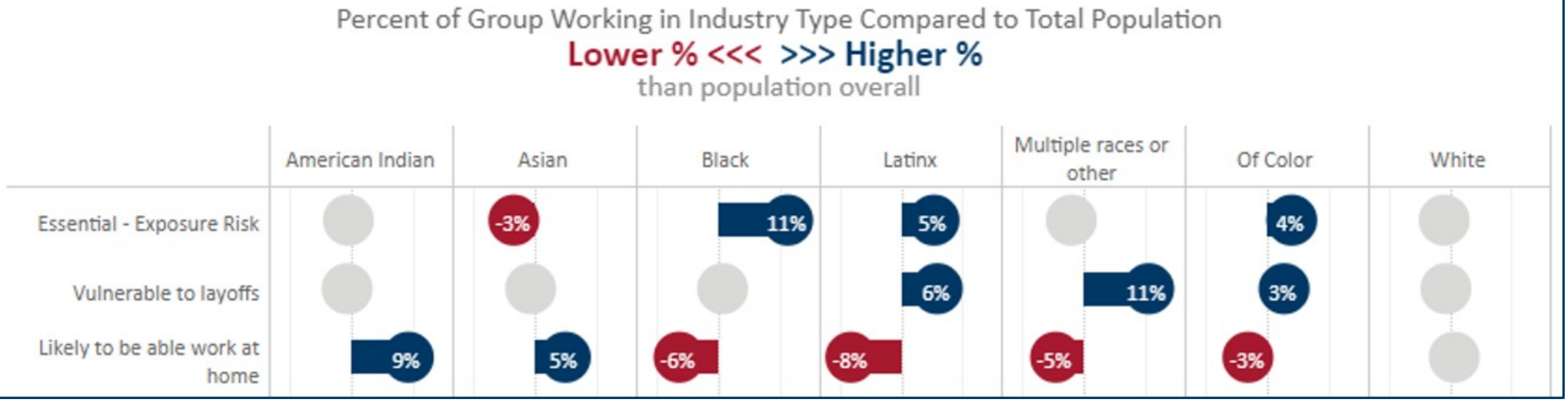


All groups have seen declines in the number of new UI claims since a peak in April and fewer continued weekly claims since the end of May.

What COVID19 is showing us about the health and opportunity of Black Minnesotans (3/4)

Black Minnesotans have the higher exposure to COVID-19 because they are more likely to workworking in industries considered essential and are less likely to be in jobs that allow them to work from home. This higher exposure is due nearly exclusively to the engagement in the Health Care industry.

Latinx Minnesotans also have a high exposure because they are working in essential industries, especially food production and restaurants. Latinx Minnesotans are also less likely to be in jobs that allow them to work from home. Latinx and **multiracial** Minnesotans are more vulnerable to layoffs.

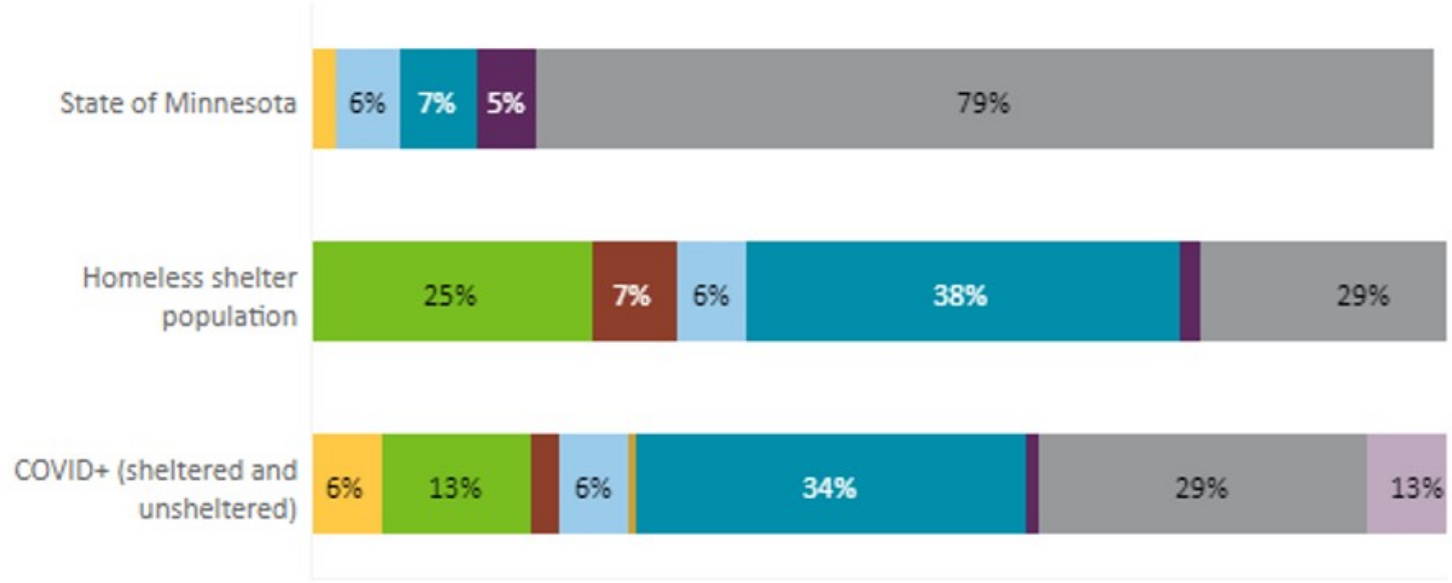


What COVID19 is showing us about the health and opportunity of Black Minnesotans (4/4)

COVID+ CASES OF INDIVIDUALS EXPERIENCING HOMELESSNESS (662)

AMERICAN INDIAN/ALASKA NATIVE | ASIAN | BLACK
LATINX | MULTIPLE | WHITE | UNKNOWN | OTHER

State of Minnesota and statewide homeless population demographics displayed for comparison

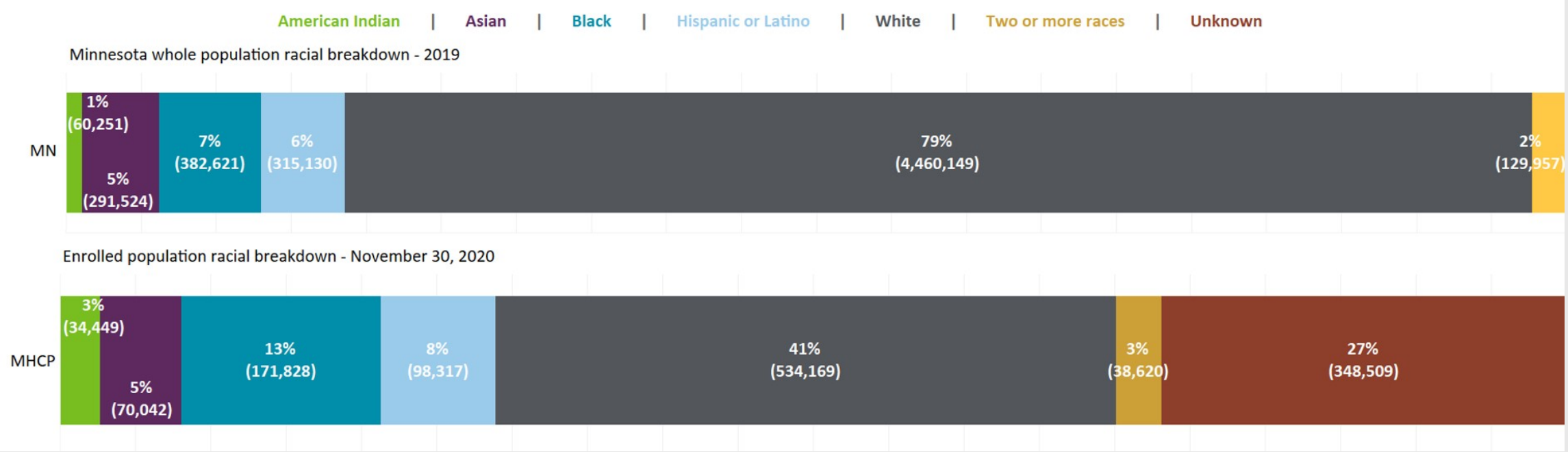


There have been more than 600 COVID+ cases among the homeless population in Minnesota.
In Minnesota, People of Color and Indigenous Minnesotans are disproportionately represented in the state's homeless population.
For example, while less than 2 percent of the state's population is **Indigenous**, nearly 1 in 4 individuals experiecing homelessness are **Indigenous**.

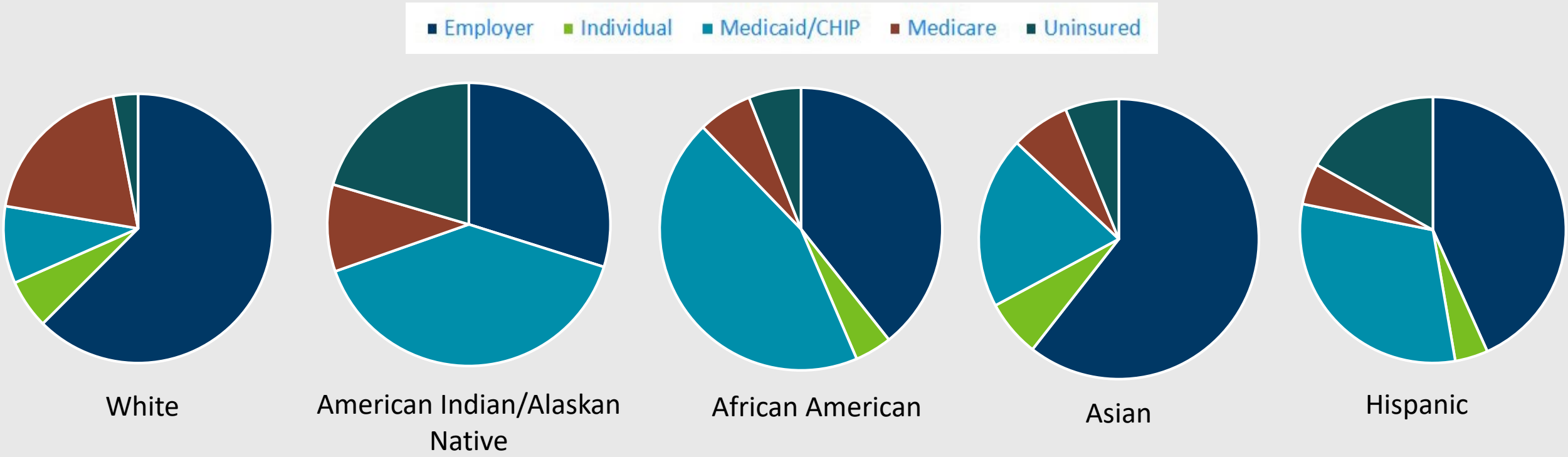
Similarly, **Black** individuals make up less than 1 in 10 of Minnesota's population statewide, but represent nearly 40 percent of individuals experiecing homelessness.

It is difficult to evaluate the disproportionality of COVID+ cases compared to the state's homeless population because such a large share of cases in homeless shelters has a race/ethnicity that is unknown.

Why focus on racial equity?



Why focus on racial equity? (1/2)



Medicaid/MNCare/CHIP is the source of health care coverage for:

- 44% of Black/African American Minnesotans
- 39% of American Indian/Alaskan Native Minnesotans
- 31% of Hispanic Minnesotans
- 20% of Asian Minnesotans
- 9% White Minnesotans
- 24% of “Other” Minnesotans

Why focus on racial equity? (2/2)

Medicaid/CHIP is the source of health care coverage in Minnesota for:

- 64% of Black/African American children
- 54% of American Indian/Alaskan Native children
- 52% of Hispanic children
- 31% of Asian children
- 17% of White children
- 28% of “Other” children

What do MN's MHCP outcomes look like for Black Minnesotans?

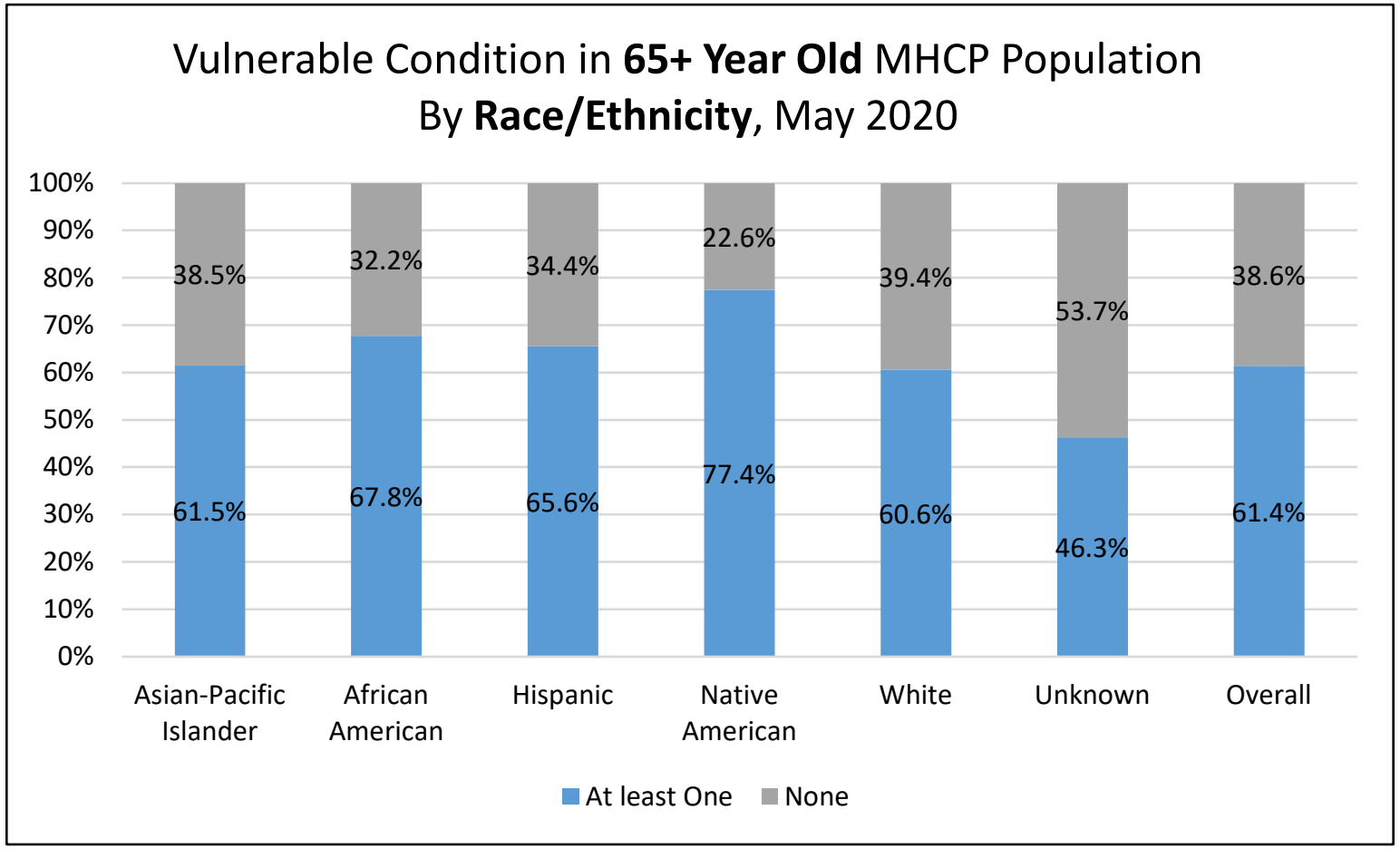
Minnesota Community Measurement: 2019 MINNESOTA HEALTH CARE DISPARITIES by Insurance Type

DDS MEASURE	2019 MHCP Managed Care Statewide Rate*	RACE									ETHNICITY		
		American Indian/ Alaskan Native	Native Hawaiian/ Other Pacific Islander	Black/ African American	Asian	White	Multi-Racial	Some Other Race	Unknown Race	Chose Not to Disclose/ Declined	Hispanic	Not Hispanic	Unknown Ethnicity
Colorectal Cancer Screening	56.4%	▼	▼	▼	●	▲	▼	●	▼	▼	●	●	▼
Optimal Diabetes Care	46.0%	▼	●	▼	▲	●	●	▲	▲	●	▲	●	●
Optimal Vascular Care	33.8%	▼	●	▼	▲	●	▼	▲	●	▲	▲	●	▼
Optimal Asthma Control - Adults	43.6%	▼	●	▼	●	▲	●	▼	●	●	●	●	●
Optimal Asthma Control - Children	54.0%	▼	●	●	●	●	●	●	●	●	●	●	●
Adolescent Mental Health and/or Depression Screening	86.2%	▼	●	●	●	▲	●	▼	▼	●	▼	▲	▲
Adult Depression: Remission at Six Months	4.9%	●	●	▼	●	▲	●	●	●	●	●	●	●

▲ Significantly above MHCP Managed Care statewide rate ● Average ▼ Significantly below MHCP Managed Care statewide rate

* Statewide rate in tables 3 and 4 were re-calculated for those with race/ethnicity information available

MHCP Enrollees & High Risk for COVID-19



Underlying Health conditions - at least one of the following:

- Diabetes
- Cancer treatment
- HIV
- Chronic liver or kidney conditions
- Severe heart diseases
- COPD
- Asthma
- ILD
- MS
- Severe obesity
- Tobacco smoking

Source: DHS MHCP claims, and Medicare data of dual enrollees

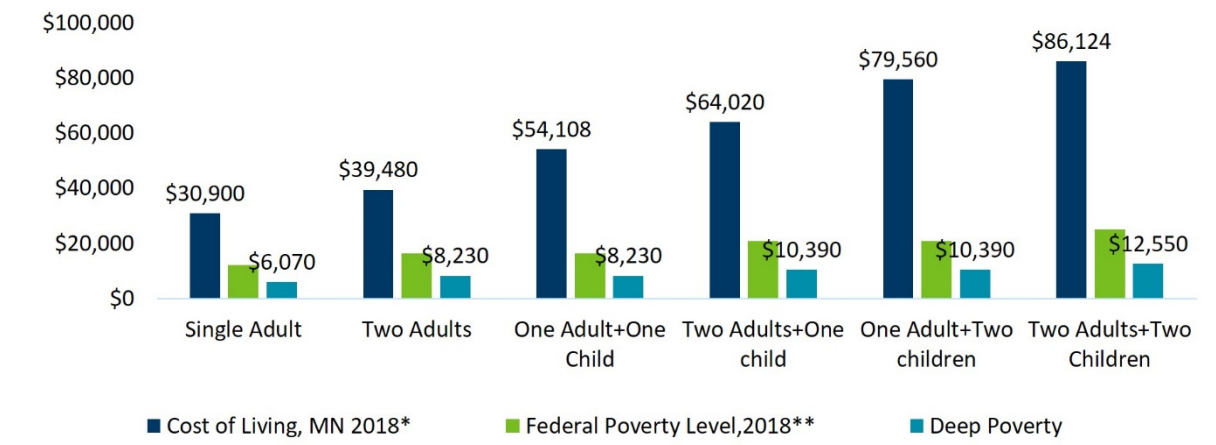
Social Drivers of Health

4. Social determinants indicators in Minnesota, by race/ethnicity, 2017

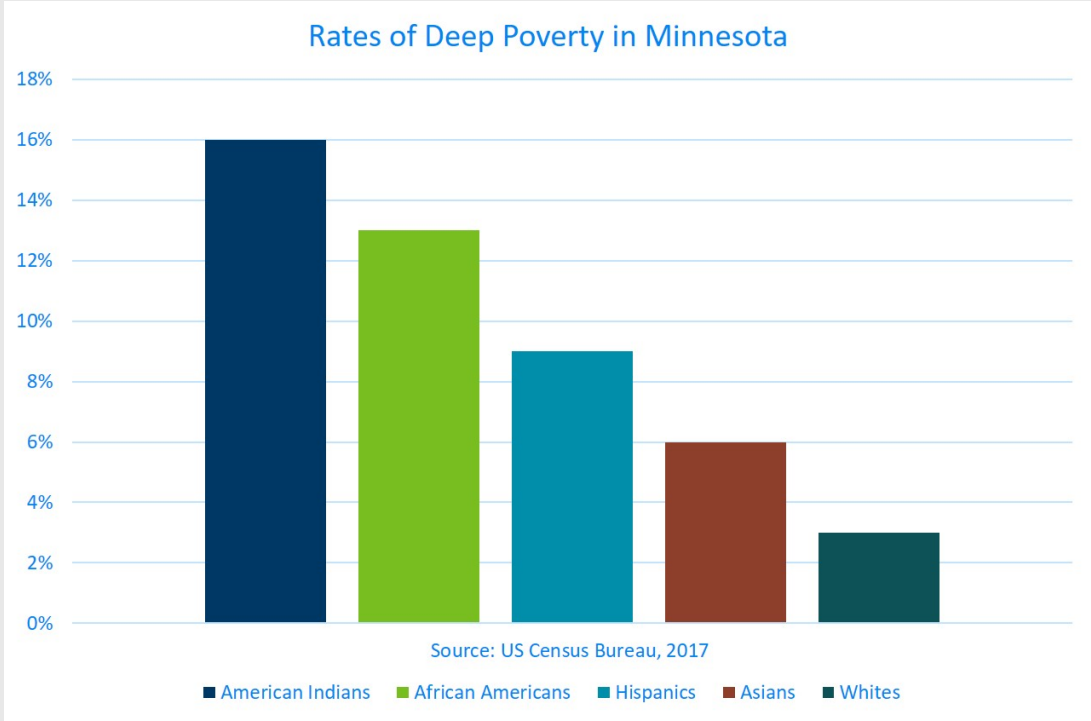
	American Indian	Asian	Black	Hispanic	More than one race	Another race	White	All Minnesotans
Persons (under age 65) without health insurance	18%	4%	7%	18%	7%	24%	4%	5%
Students graduating high school on time	51%	86%	54%	66%	71%	**	88%	83%
Adults (age 25+) with a bachelor's degree or higher	13%	44%	22%	17%	31%	12%	37%	36%
Proportion of adults (age 16-64) working	51%	72%	70%	75%	72%	75%	81%	79%
Individuals living below the poverty level	29%	12%	28%	19%	16%	21%	7%	10%
Homeownership rate	40%	56%	24%	46%	52%	40%	77%	72%

Sources. U.S. Census Bureau, American Community Survey; Retrieved from Minnesota Compass. (n.d.).
Note. Not all social determinants have data disaggregated at a state level by race/ethnicity.

Social Drivers of Health measures: Deep Poverty (1/2)



*https://mn.gov/deed/data/data-tools/col/ (housing, transportation, food, health care, child care, taxes, and other necessities (e.g., clothing, personal care products)
**https://aspe.hhs.gov/poverty-guidelines



Social Drivers of Health measures: Deep Poverty (2/2)

	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.

MHCP Enrollee Experience

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.

Items Within Each Domain

PATIENT-LEVEL FACTORS	PROVIDER-LEVEL FACTORS	SYSTEM-LEVEL FACTORS
Family/work barriers • Family or work responsibilities • Availability of childcare	**Provider-related barriers** • Providers do not speak language • Providers do not understand culture • Providers do not understand religious beliefs • Providers are not trustworthy • Provider office is not welcoming **Perceived discrimination** • Unfair treatment due to gender • Unfair treatment due to ability to pay • Unfair treatment due to being enrolled in MCHP • Unfair treatment due to race/ethnicity/nationality	**Coverage barriers** • Not sure if dropped from MHCP program • Do not know what health plan covers • Do not know where to go for questions **Financial barriers** • Worry pay more than expect • Worry pay more than can afford • Worry insurance won't cover care • Worry medication will cost too much **Access barriers** • Cannot get appointment • Do not know where to go • Transportation problems • Cannot see preferred provider • Inconvenient office hours

The opportunity we have to lead with racial equity (1/2)

HEALTH AFFAIRS BLOG

RELATED TOPICS:
COVID-19 | HEALTH DISPARITIES | RACISM | RESEARCHERS | PUBLIC HEALTH | HEALTH EQUITY

Building Racial Equity Into The Walls Of Health Policy

Nathan T. Chomilo

DECEMBER 1, 2020 10.1377/hblog20201119.508776

- Co-create with community leaders' involvement
- Conduct a racial equity assessment over identified areas of opportunity
- Continue this iterative process with community → provide a roadmap for those within MN DHS, legislators, other elected officials, health care leaders, clinicians and the communities we serve

The opportunity we have to lead with racial equity (2/2)

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.

Opportunity to lead with Equity: Community Strengths + Medicaid Levers

4 Medicaid “buckets”

- Eligibility/Enrollment
- Access
- Quality
- Early Opportunities

Opportunity to lead with Equity: Eligibility/Enrollment (1/2)

MHCP Enrollment Process

- Application may be made online via the MNsure website at www.mnsure.org or with a paper application and returned to the county, tribal agency or DHS by mail, fax or in person
- Application help is available from county or tribal agencies, DHS, the MNsure Contact Center, a navigator, or broker
- Once eligibility is determined, applicants receive a notice of the eligibility result
- If eligible, new members receive a welcome packet and Minnesota Health Care Programs ID card and select a managed care plan

Opportunity to lead with Equity: Eligibility/Enrollment (2/2)

- Official 2018 DHS average application processing times for Medical Assistance for families with children was 6 days for an online application and 25 days for a paper application.

- ***Recommendation: DHS should engage with county and tribal human service agencies to identify best practices and fully understand the challenges they face in facilitating the eligibility and enrollment processes across both MHCP and MFIP or SNAP.***

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.

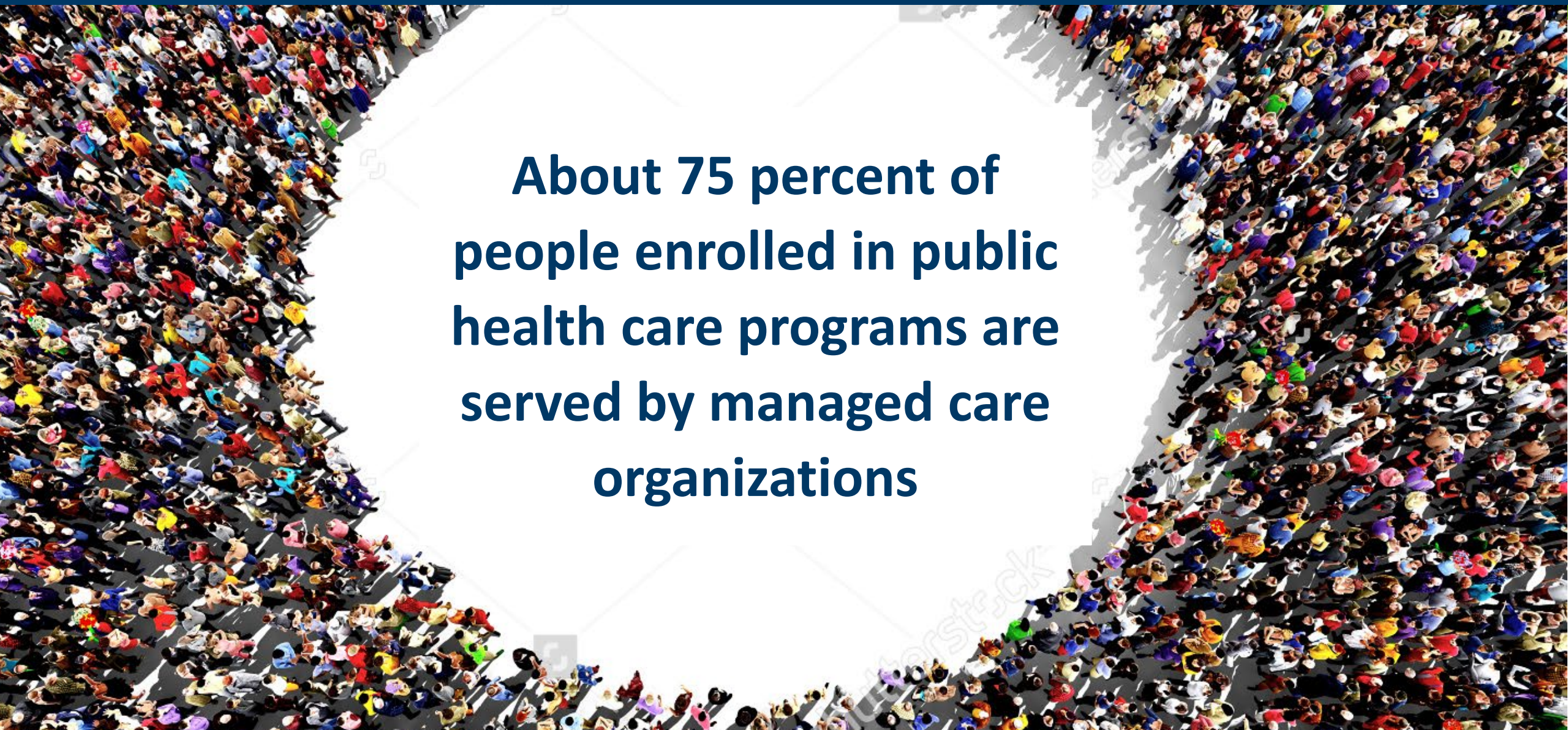
MHCP eligibility considerations

- Pregnant Women
- Postpartum Women
- Newborns
- Infants through age 2
- Ages 2-18
- Ages 19 & 20
- Impact of Continuous Enrollment during COVID19 public health emergency

Opportunity to lead with Equity: Access

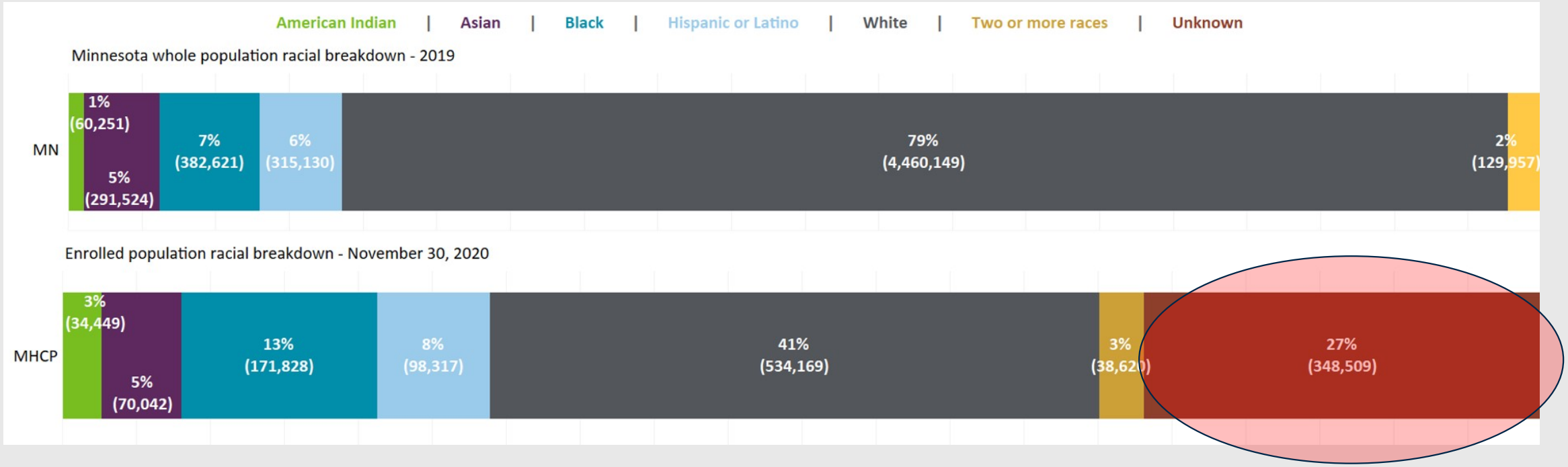
- You have a MHCP ID card, can you access the care you need?
  - Finding a primary care provider
  - Transportation
  - Telehealth
  - Access to mental health, dental care & specialists
  - Access to Community Health Workers, Doulas and other paraprofessionals
  - Access to culturally acceptable care

Managed Care Enrollment



About 75 percent of people enrolled in public health care programs are served by managed care organizations

Opportunity to lead with Equity: Quality (1/3)



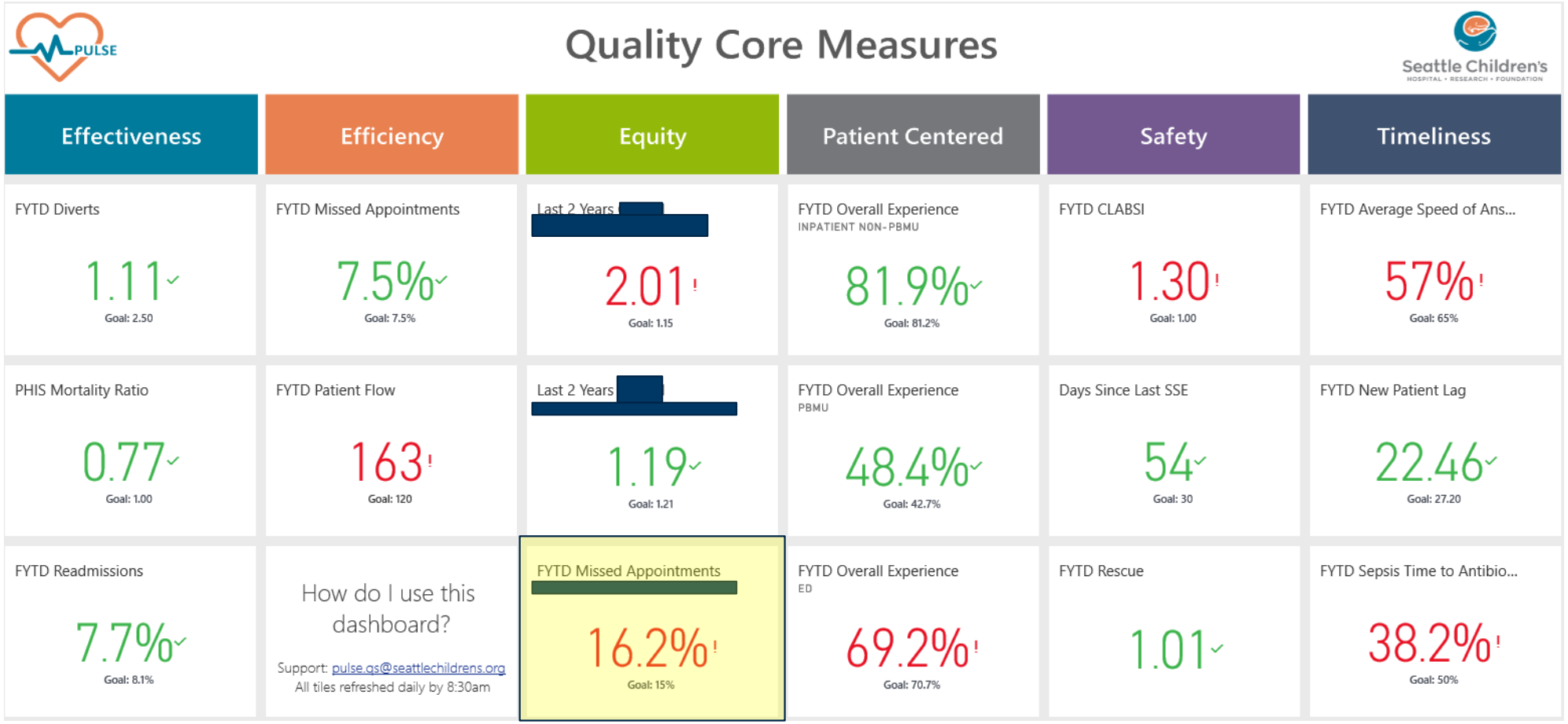
Opportunity to lead with Equity: Quality (2/3)

- **Opportunities to Improve Racial Demographic Data**
  - **Engage Enrollees**
  - **Engage Navigators**
  - **Modify the Enrollment/Renewal Interface**
  - **Explore Alternative Data Sources**

Lukanen, E., & Zylla, E. (2020, October 1). Exploring Strategies to Fill Gaps in Medicaid Race, Ethnicity, and Language Data. Retrieved October 05, 2020, from https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/

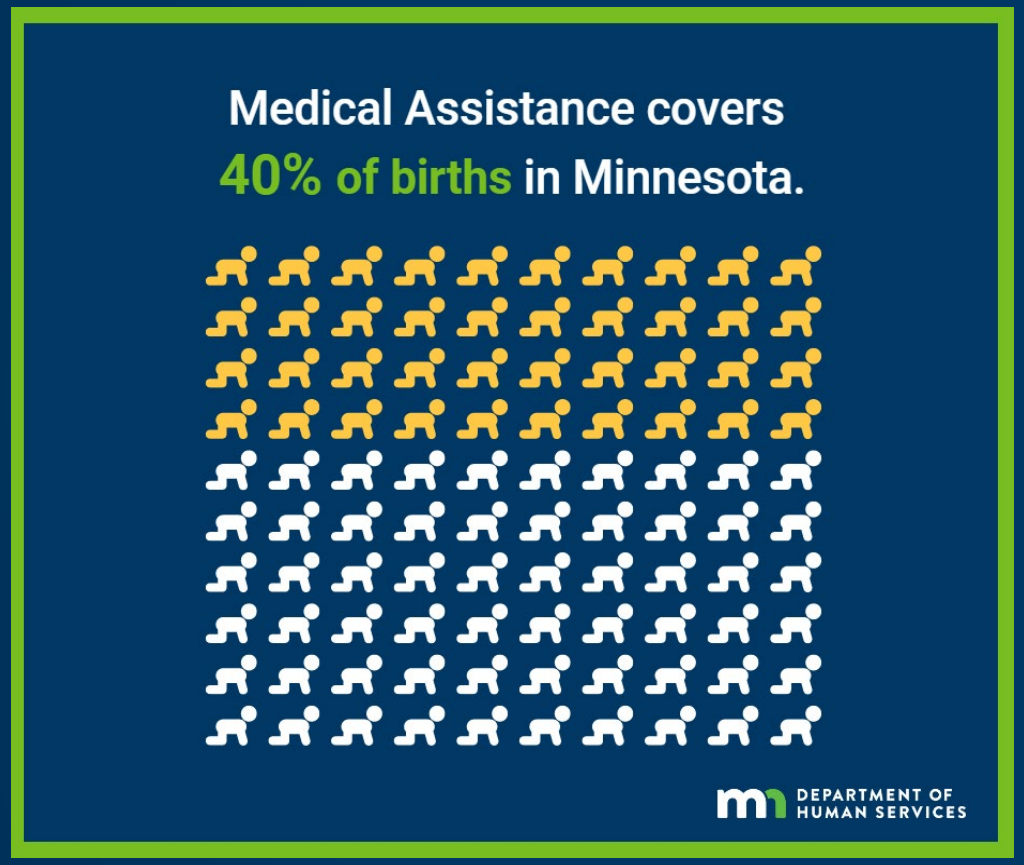
Taylor S, Currans-Henry R, Thielke A, King V. Collecting race and ethnicity data in Medicaid. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2020

Opportunity to lead with Equity: Quality (3/3)

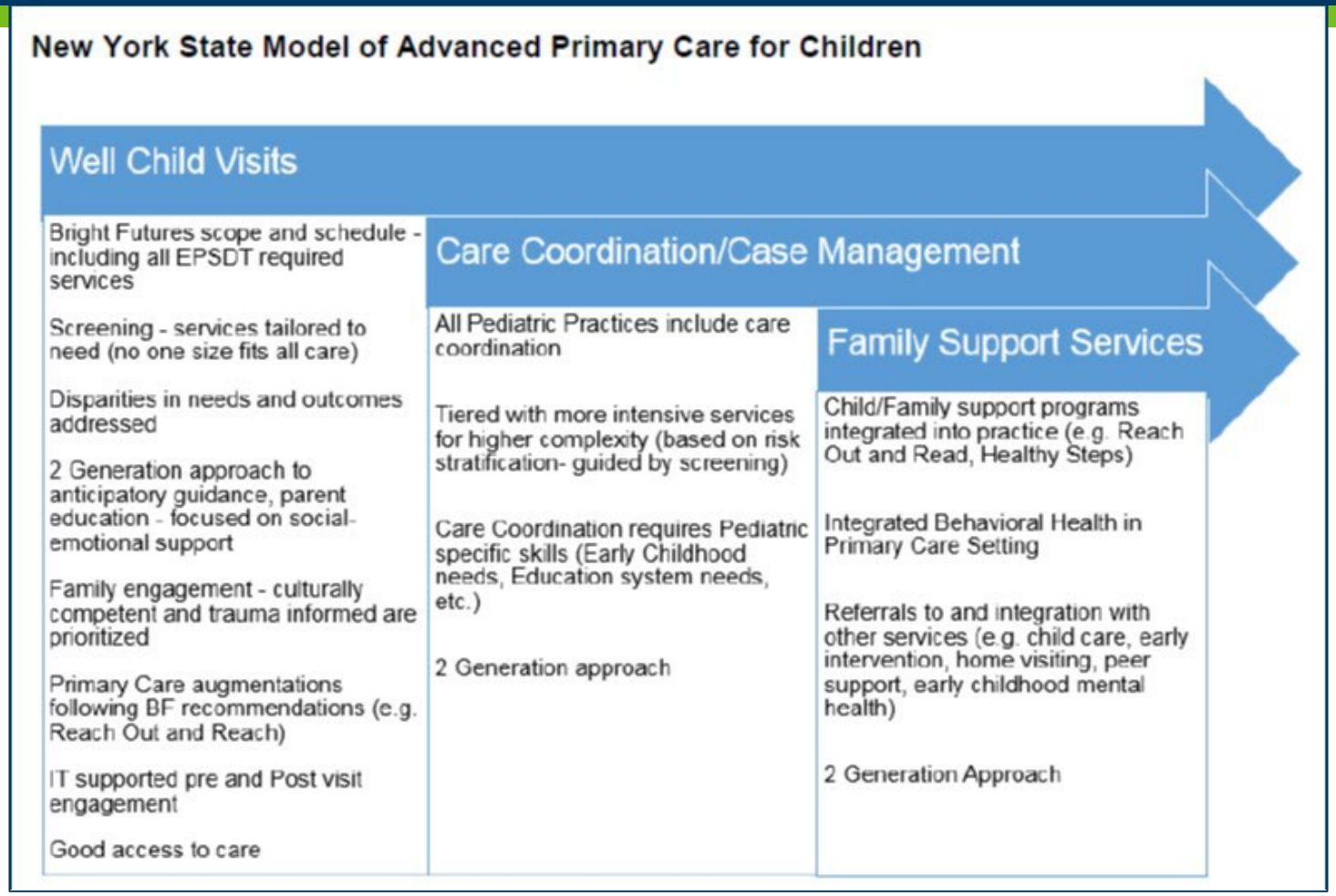


Slide Credit: Shaquita Bell, MD (Seattle, WA), presenting at the American Academy of Pediatrics 2020 Virtual National Conference and Exhibition, Council on Quality Improvement and Patient Safety Program: *Utilizing Quality Improvement to Drive Health Equity in Pediatrics*

Opportunity to lead with Equity: Early Opportunities (1/2)



Opportunity to lead with Equity: Early Opportunities (2/2)



New York State Department of Health (2019). New York State 1st 1000 Days on Medicaid Final Report of the Preventive Pediatric Care Clinical Advisory Group. Retrieved February 04, 2020, from https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2019-10-01_final_report.htm

Questions and next steps

- Questions? Thoughts on buckets?
- Ideas for community leader outreach?
- So far have reached out to:
  - Council of Minnesotans of African Heritage (CMAH)
  - MDH's Health Equity Advisory and Leadership (HEAL) council
  - MN DHS' Cultural and Ethnic Communities Leadership Council (CECLC)
  - Voices for Racial Justice
  - MN NAACP
  - Twin Cities Urban League
  - AALF
  - Center for Economic Inclusion
  - Northpoint

Impact of this report's framework for potential future reports:

Indigenous Minnesotans
Hispanic Minnesotans
Asian Minnesotans
New Minnesotans
Gender/Sexuality
Citizenship
Disability

"If there's a book that you want to read, but it hasn't been written yet, then you must write it" – Toni Morrison

DEPARTMENT OF HUMAN SERVICES

Thank You

Nathan Chomilo, M.D. FAAP

Medical Director for Medicaid and MinnesotaCare

DEPARTMENT OF HUMAN SERVICES

Approach for 2021

Krista O’Connor, Strategic Development Director

Medicaid Services Advisory Committee

Areas of Interest

Areas of Interest: Previously Discussed

- Case Management Redesign
- Medicaid Quality Measures
- Minnesota Medicaid Managed Care Comprehensive Quality Strategy
- Managed Care procurement and contracting
- Medicaid Matters data dashboard
- Integrated Health Partnerships
- Blue Ribbon Commission

Areas of Interest: Newly Identified

- Maternal and Child Health: priorities and expectations of health plans
- Beneficiary experience: improving eligibility, enrollment, access
- Duplicate PMIs
- Quality strategy for new behavioral health initiatives

External Committee and Boards Process

Krista O’Connor, Strategic Development Director

Medicaid Services Advisory Committee

Feedback Requested

- Seven Statutorily mandated external committees and boards in HCA
- Goal is to standardize a general set of criteria across all committees
  - Solicitation of open seats/appointment process
  - Bylaws/Chairs/Co-Chairs
  - Member Expectations/compensation
  - Meeting structure/public comment/conflict of interest/materials
  - Communications/list serv/webpages
- Request will be sent to MSAC members via email for follow up

DEPARTMENT OF HUMAN SERVICES

Public Comment

Krista O’Connor, Strategic Development Director

Medicaid Services Advisory Committee

Public comment

- Please state your name, organization (if relevant) and any conflicts of interest
- Please limit comments to approximately 2 minutes
- Written comments can be submitted to:

  krista.oconnor@state.mn.us

Next meeting

Tuesday, May 11, 2021

12:30 – 2:30 pm

Virtual, WebEx

DEPARTMENT OF HUMAN SERVICES

Questions & Thank You

Krista O'Connor

krista.oconnor@state.mn.us

651-431-7297