DRAFT Agenda: Equitable Health Care Task Force

Date: 12/09/2024

Opening, 12:00 – 12:10 p.m.

Overview of meeting agenda and objectives, and October meeting summary review.

Welcome from MDH, 12:10 – 12:20 p.m.

Welcome from the Minnesota Department of Health (MDH).

Recommendation and report development, 12:20 – 1:40 p.m.

The Task Force and MDH will walk through and refine the recommendation development process for January through June 2025, including engagement with interested parties and the public.

Break, 1:40 – 1:50 p.m.

Preliminary findings from the UMN Research Team, 1:50 – 2:55 p.m.

The University of Minnesota (UMN) Research Team will share preliminary findings on their scan of promising health care equity practices and policies.

Closing and action items, 2:55 – 3:00 p.m.

We will review our accomplishments and share upcoming next steps.

Minnesota Department of Health
Health Policy Division
625 Robert St. N.
PO Box 64975
St. Paul, MN 55164-0975
651-201-4520
health.EquitableHealthCare@state.mn.us
www.health.state.mn.us/communities/equitablehc

11/26/24

To obtain this information in a different format, call: 651-201-4520

DRAFT Equitable Health Care Task Force Meeting Summary

Meeting information

- October 24, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, ElijahJuan (Eli) Dotts, Mary Engels, Bukata Hayes, Joy Marsh, Maria Medina, Vayong Moua, Laurelle Myra, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Yeng M. Yang

Key meeting outcomes

- Task force members learned from and engaged with the University of Minnesota (UMN) research team about the landscape of health care financing.
- Task force members learned from and engaged with panelists who discussed NCQA Health Equity Accreditation.
- MDH proposed an approach for a process to develop recommendations, and task force members provided feedback on that approach

Key actions moving forward

- Task force members are encouraged to continue to add opportunities to the Opportunity Matrix.docx that will inform the development of recommendations.
- Task force members are encouraged to follow up on the discussion with the UMN research team about health care finance by either contacting health.equitablehealthcare@state.mn.us or posting in MDH_ Equitable Health Care Task Force | Discussion and Information Sharing | Microsoft Teams.

Summary of meeting content and discussion highlights

Meeting Objectives

The following objectives were shared:

- Increase a shared understanding of health care financing
- Build understanding of NCQA Health Equity Accreditation

- Discuss the opportunity matrix and recommendation development process

Opening, welcome, and public comment

Task force members were welcomed, and the agenda was reviewed. The meeting summary from September was reviewed and discussed.

One public comment was received, and highlights were shared with the task force. The comment was primarily about insurance costs and coverage, particularly with respect to MNsure. Task force members wondered about the term "people-powered health plans." MDH responded that it wasn't clear and could go back to the person who submitted the comment to clarify.

Health care financing

The UMN research team was welcomed. The research team includes faculty, staff, and students from the Division of Health Policy and Management at the School of Public Health and the State Health Access Data Assistance Center (SHADAC). They have officially joined this project to support the task force in its learning and development of recommendations for an equitable health care system in Minnesota.

Dr. Jean Abraham, Head of the Division of Health Policy and Management at the School of Public Health, presented an overview of health care financing. She was joined by Elizabeth Lukanen, Deputy Director of SHADAC.

The UMN research team covered the following in their presentation:

- Minnesota insurance landscape
- Introduction to provider payment models and equity implications
- Potential interactions of equity-promoting financial models and current Minnesota-specific initiatives

The research team ended their presentation by noting:

- The health care financing and delivery landscape is complex, evolving, and is influenced by many factors including public policy.
- The design of payment systems and benefits influence the behavior of individuals, providers, and insurers with important tradeoffs to consider.
- Value-based purchasing models are not new, but explicit consideration of equity-focused outcomes is recent.
- Policy recommendations should leverage existing Minnesota investments.

Discussion

A task force member asked about the Tribal Health payment structure. The research team responded that this is an important, complex area to understand and more research is needed.

It is worth looking into given the need to think creatively about what the resources are to address critical needs of the state's populations.

A concern was expressed about the availability of disaggregated data, specifically for African Americans, Asian Americans, and immigrants. The research team observed that even in a data-rich state like Minnesota, we cannot always get to the level of granularity we want. The team will push the data as hard as they can. They agreed to take another look to see what information was available on immigrant populations.

A question was asked about data illustrating health insurance affordability and communities that face the greatest struggles. The research team said the Minnesota Health Access Survey as one source for this information and they will look into it.

There was some discussion about the administrative burden across all models that insurance companies account for, along with some skepticism around value-based purchasing (VBP). Insurance companies account for a substantial amount of costs by virtue of their intermediary role and there may not be clear value for this role. These administrative costs are then born by providers and the more complex value-based purchasing models are, the harder it is to put them into play. Reducing administrative burden could offer opportunities to better use health care talents and dollars directly on patient care and quality. The idea of standardizing value-based purchasing suggests parties could be driven to common places where agreement can be reached, administrative simplification is achieved, and benefits could be far-reaching.

Task force members lifted-up Minnesota and other data and assets, including:

- The Federally Qualified Urban Health Network (FUHN) as a virtual Medicaid ACO of 10 metro federally qualified health centers (FQHC),
- Health Care Payment Learning & Action Network (LAN) working on publishing some guidance on social return on investment to further encourage and embed health equity into alternative payment models and methodologies,
- Federal guidance around measurement and best practices,
- Blue Cross Blue Shield of Massachusetts as a national leader in building equity explicitly into incentive structures—this organization prioritizes equity data collection adhering to the notion that they cannot improve what they do not measure.

Task force members commented that gathering complete data is key to creating a strong foundation for the task force's work and addressing gaps and providing incentives for organizations collecting race, ethnicity, and language (REaL), and sexual orientation and gender identity (SOGI) data should be considered.

Learning and solutioning: NCQA Health Equity Accreditation

As part of the One Minnesota cross-agency work, MDH shared that there are discussions about health equity accreditation as a strategy to bring change to health insurers and health systems around equity. The accreditation process can serve as a catalyst to bring organizations together, dedicate resources, and secure leadership commitment for meaningful change. One Minnesota

is thinking about accreditation requirements and state levers such as insurance procurement processes at the Department of Human Services (DHS) for the Medicaid population and the State Employee Group Insurance Program for the state's workforce.

MDH presented background information on NCQA Health Equity Accreditation.

The five panelists were introduced and welcomed:

- Bukata Hayes, Vice President and Chief Equity Officer, Center for Racial and Health Equity, Blue Cross Blue Shield of Minnesota
- Pleasant Radford, Jr., Health Equity Officer, UCare
- Ross Owen, Director of Improvement and Integration, HealthPartners
- Angelique Harbin, Project Manager, Portfolio and Project Management, Hennepin Healthcare
- Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM, Chief Health Equity Officer, Hennepin Healthcare

The panelists were asked about their experience and learnings from the accreditation process, and the value of accreditation. Below are high-level takeaways.

Success factors

- Buy-in is needed from leadership at the top.
- Champions are needed across business lines.

Learnings

- Accreditation provided an external force and perspective that set standards and helped create a more accessible plan for all, addressing systemic failures.
- The process helped with intentionality, identifying gaps, improving data, and making cultural competence a foundational part of their work, with next steps focused on expanding these efforts to pursue Health Equity Plus accreditation.
- The gap analysis provides a reality check in terms of identifying shortcomings and what is missing from an organization's equity efforts.
- Equity was a top-level goal without a clear framework, so we developed a cohesive approach using guiding principles and a community-driven model to operationalize health equity. More internal structure was built with dedicated roles.
- Our process was a pilot for NCQA and it revealed challenges in adapting the model from payer systems to hospitals, as hospitals have different needs and structures.

Value

- Health inequities drive-up health care costs that are born by patients, members, health systems, and tax payers—addressing equity reduces system costs.
- The accreditation process was a catalyst to advance equity efforts.

- The accreditation set the baseline for a robust approach to equity moving forward.
- The process required authentic engagement and power-sharing with communities.
- One organization gave special focus to disability identity and justice.
- Accreditation requires more robust collection and use of member/patient and provider data.
- One organization tackled intersectionality due to data improvements.
- Accreditation bakes-in equity into the organization through the documentation and implementation of policies and processes.
- There are real improvements in how accredited organizations are caring for members/patients.

Discussion

The task force engaged in discussion with the panelists.

There was a question about the difference between the NCQA Health Equity Accreditation and the Joint Commission's Health Equity Certification. It was clarified that their goals are the same. NCQA focuses on policy, partnerships, and community impact. The Joint Commission is folding it into its typical accreditation process.

There was a question about how organizations that go through the process are seeing improved outcomes and panelists provided examples.

- Established improved, centralized access to language services for members.
- New resources to community partners to implement health equity efforts and ability to tangibly measure outcomes.

There was a question about lessons learned for unaccredited organizations to take steps toward accreditation.

- Organizations should do what they can to align equity strategies across the entire business to meet various external regulatory requirements in a coordinated manner to better assure efficiency and effectiveness.
- It is important to find champions and ensure leadership buy-in.
- Conduct the gap analysis using NCQA guidance as a reality check. Determine what is involved, who needs to be involved, and the timeframe to do the application work.
- Organizations will likely find that employees want to participate in health equity work even if it's not in their job title.
- NCQA helps organizations through the accreditation process and organizations should contact NCQA throughout the process with questions and concerns.

- Accreditation is a heavy lift, but the more accredited bodies there are, the better overall. Encourage your organization to go forward because the ultimate outcomes are improved outcomes for members/patients and improvements in how we take care of people.

The panelists offered additional takeaway suggestions to the task force.

- Stay committed to the accreditation process and keep the focus on addressing inequities rather than just achieving accreditation. Use it as leverage to push the health care system to act on inequities. Stay on the path accreditation put your organization on.
- Consider how to leverage other accreditations in this space.
- How MDH and DHS do things has incredible influence over organizations—the more they center health equity and eliminating health inequities, the more it drives us to show-up and do the work. External pressure such as state Medicaid mandates can be beneficial in terms of organizations participating in equity accreditation efforts.
- It's important to ensure that equity remains at the forefront. Health inequities burden members, patients, communities, and the health care system. The accreditation model is a consistent framework that's being applied that has shared goals, outcomes, understanding, and a certain degree of accountability. External forces can be applied in a good way to move all of us toward advancing health equity.
- Short-, mid-, and long-term goals came from the accreditation process and data analysis. We have a multi-pronged approach and policy is a lever we use. Policy impacts not only members but communities as well. How can we come together to advocate for policy, for a similar framework for all to use so we are moving larger levers in the same direction?
- Improved data collection has led to better understanding and targeting of disparities, especially in the area of intersectional identities and demographic categories. The NCQA accreditation does not compel an organization to think about that complexity.
- The "plus" accreditation and collaboration with community partners are key opportunities for improving care and reducing duplication.
- There are mid- and long-term implications for how we can collectively operate as an industry in terms of data standards, frameworks, and understanding of community resources. There is duplication of effort if we do this separately. Through collective action, we can save on costs and turn those savings over to communities.
- Need to have grace in this process. It is easy to say it will cost too much and then not do it. Give people the resources they need to make this happen. Take the challenge with enthusiasm—many are doing equity work well and we can expand the work even more.

Opportunity matrix and recommendations

MDH reminded the task force of the working document "Opportunity Matrix," which is being used to form the development of recommendations. They proposed an overall process for developing recommendations, including the following roles:

- Task force's role: Identify and highlight health care equity opportunities within the Opportunity Matrix. Provide input and advice on draft recommendations.
- MDH project team, UMN research team, and subject matter expert (SME) support: Provide technical support and help craft recommendations based on task force's discussions and inputs.
- Iterative development: MDH, with UMN research team and SMEs, will draft recommendations using task force input and ongoing matrix updates. Continuous feedback loops with task force and community input to refine recommendations.

MDH assured that they will take all the inputs from the task force, as well as from the UMN research team and subject matter experts to draft recommendations. MDH is proposing they lead the drafting process due to task force members' busy schedules and capacity. This does not preclude any task force members from stepping in to collaboratively lead efforts. MDH proposed starting the drafting process and continuing to get task force feedback and community input. Recommendations must be completed by June 2025.

It was requested that the task force provide additional input in the Opportunity Matrix document to ensure that MDH staff have thorough input as they move forward in their supportive role to assist with recommendation drafting.

The following key questions were shared as framing the process of informing a structured recommendation and prioritization process:

- What specific health care equity issues are we addressing? How significant is the impact?
- What policies, training, technology, or financing are needed?
- How do we ensure accountability (e.g., incentives or regulations)?
- Who needs to act, and when (short-term, mid-term, long-term)?
- What impact or results do we envision? How will we measure success and monitor outcomes?
- What community members should provide input?

Some task force members asked about involving outside perspectives, including how SMEs will be identified and brought into the process, and how Tribes will be represented in the recommendations. MDH responded that SMEs include the UMN research team, program staff at MDH and DHS, and they can include SMEs brought forward by the task force and public. MDH is consulting with Tribal Health Directors.

MDH asked whether it is helpful for them to bring forth draft recommendations to react to, rather than having the task force start with a blank slate. The task force had the following questions, considerations, and ideas.

- Suggest conducting a crosswalk with the small groups to find commonalities among what's already been discussed.
- Where are the recommendations coming from? Do they exist somewhere already? It's important to access the institutional knowledge other groups have already put forth. Task

force recommendations can be informed by the recommendations from other equity groups across MDH and DHS.

- Happy to support MDH bringing forward recommendations based on what they see in the opportunity matrix but want to know how deeply rooted those recommendations are in community voice.
- What is an alternative to this approach?
- Suggest conducting a literature review around the recommendation areas.
- This approach has benefits but it is important to discuss the right questions to focus recommendation development. There should be a high level of agreement on the key domains.
- Have the workgroups see the draft recommendations before they come to the large group. Important to include community input to make sure we're not making any assumptions.
- Proceed with this route. When small workgroups bring their recommendations forward, everyone wants to have input and this is less efficient.

MDH recorded the questions raised by members and responded to a few explaining that recommendations are coming from insight from the task force, including from small group conversations and from presentations like NCQA today. The next step is for the task force to reflect on what they heard today. Given that not everyone has time, MDH is trying to cull information from task force meetings and small group discussions in the form of these draft recommendations. The task force and MDH can pilot the approach and if it doesn't work, try something else.

Closing and action items

Some task force members have volunteered to organize a community-building gathering on December 9. More information will come from Joy Marsh and Megan Chao Smith.

The task force was thanked and reminded of the next meeting on December 9, 12:00 – 3:00 p.m. A meeting summary is to follow.

Contact to follow up

With questions or comments about Equitable Healthcare 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.

Health Policy Division
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