SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF MINNESOTA

Resource Guide for Minnesota's Equitable Health Care Task Force

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EXECUTIVE SUMMARY

This resource guide has been developed to support the Minnesota Equitable Health Care Task Force in its mission to examine inequities in how people experience health care and to identify strategies and recommendations that promote a more equitable system of coverage, care delivery, and health outcomes for Minnesotans.

The University of Minnesota (UMN) team was asked by the Minnesota Department of Health (MDH) to review documented, promising health care practices and public policy supports that promote equity in coverage, care, and health outcomes for population segments that have experienced significant disparities in access, quality, and outcomes, resulting from structural, institutional, or other barriers. In our review, we prioritized population segments that have experienced significant disparities, including persons who identify as Black, Indigenous, or Persons of Color (BIPOC), persons who identify as Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+), persons with disabilities, and persons residing in rural geographic locations.

Development of this resource guide occurred in two phases. In the first phase, the UMN team undertook a rapid evidence review of priority topics identified by Task Force members to generate a timely synthesis of research literature. Priority topics included integration of health care and public health, whole-person health, culturally appropriate care, and value-based payment models. During the December 2024 Task Force meeting, the UMN team presented its initial findings and received feedback.

In the second phase of resource guide development, the UMN team expanded the literature review to include individual studies and relevant grey literature corresponding to each priority topic. Team members also conducted web-based searches to identify state-based policy and practice innovations aligned to the priority topics. This exercise revealed two important findings. First, while several innovations demonstrate promise for equity promotion, the scholarly literature evaluating interventions to reduce health and health care disparities among priority population segments is still emerging. Second, our research identified several examples of current investments by the State of Minnesota aligned to the priority topics. We have included references to these investments in the resource guide as they may be useful for policy recommendation development.

During late 2024, MDH introduced an organizing framework for recommendation development based on the following four categories:

- Primary Care and Whole-Person Health
- System Accountability
- Strengthening and Diversifying the Workforce
- Meaningful Access

To support the next phase of work by the Task Force and MDH, the UMN team has mapped each of the 32 policy and practice innovations identified in our research to one or more of these categories. These are summarized in Executive Summary Tables 1-3. Specifically, we report 29 innovations corresponding to primary care and whole-person health; 7 innovations for system accountability; 6 innovations for strengthening and diversifying the workforce; and 22 innovations to create meaningful access. This document also includes additional resources and references to assist Task Force members and MDH in recommendation development and drafting.

Executive Summary Table 1: Policy or Practice Innovation Mapping to Recommendation Categorical Framework for ***Priority Topic Area: Integration of Health Care and Public Health***

Policy or Practice Innovation	Primary Care and Whole-Person Health	System Accountability	Strengthening & Diversifying the Workforce	Meaningful Access
Standardization of Health-Related Social Needs (HRSN) Screening Tool	X	-	-	-
Development of Networks of Community Based Organizations for Addressing HRSN	X	-	-	X
Provide Support for HRSN Infrastructure with Community Based Organizations	X	-	X	X
Community Based Partnership Staffing Requirements for Managed Care Organizations	X	X	X	X
Direct Provision of Nutrition Support for Individuals Experiencing Food Insecurity	X	-	-	-
Medicaid HRSN Social Bond Program	X	-	-	-
Reimbursement of Non-Medical Transportation for Addressing HRSN	X	-	-	X
Expanded Options for Non-Emergency Medical Transportation	X	-	-	X

Executive Summary Table 2: Policy or Practice Innovation Mapping to Recommendation Categorical Framework for ***Priority Topic Area: Whole-Person Health***

Policy or Practice Innovation	Primary Care and Whole-Person Health	System Accountability	Strengthening & Diversifying the Workforce	Meaningful Access
Primary Care Behavioral Health Model in Patient-Centered Medical Homes (PCMH)	X	-	-	X
State Policies for Certification of PCMH to Promote Primary Care and Behavioral Health Integration	X	X	-	-
Trauma-Informed Collaborative Care Model Implemented in Federally Qualified Health Centers and Rural Health Clinics	X	-	-	-
Co-location of Dental Care and Primary Care Services in Patient-Centered Medical Homes, Federally Qualified Health Care Centers, and Rural Health Clinics	X	-	-	X
Encourage or Require Dental Care Services within Medicaid Accountable Care Organization (ACO) Arrangements	X	-	-	X
Expand DT and ADT Workforce Capacity Through Training and Scope of Practice	X	-	X	X
Environmental Scan and Evaluation of Community-Based Navigation Service Utilization	-	-	X	X
Local Evaluation to Build Evidence of Disparities Reduction Associated with Patient Navigation Service Use	-	-	-	X

Policy or Practice Innovation	Primary Care and Whole-Person Health	System Accountability	Strengthening & Diversifying the Workforce	Meaningful Access
Specialization Pathway Development for Serving Needs of Priority Populations and/or Populations That Are Medically Complex	X	-	X	X
Insurance Coverage Mandate for Patient Navigation Services	X	X	-	X
Promote Financial Sustainability of Patient Navigation Services Through Use of Primary Care Population-Based Payment Models	X	-	-	X
Regulate Payers' and Providers' Community Benefit Resources to Be Directed Toward Specific Equity-Promoting Workforce Investments	-	X	X	X
Private Insurance Coverage Mandates for Complementary Health Approaches	X	X	-	X
Medicaid Waivers or Demonstration Projects for Complementary Health Approaches	X	-	-	-
Federal and State Grants to Support Complementary Health-Focused Programming	X	-	-	-

Executive Summary Table 3: Policy or Practice Innovation Mapping to Recommendation Categorical Framework for ***Priority Topic Area: Culturally Appropriate Care***

Policy or Practice Innovation	Primary Care and Whole-Person Health	System Accountability	Strengthening & Diversifying the Workforce	Meaningful Access
Creation of a Statewide "Doula Hub"	X	-	-	X
Creation of a Doula Advisory Committee	X	-	-	X
Creation of a Maternity Bundle	X	-	-	X
Use of 1115 Waivers to Create Culturally Tailored Substance Use Demonstration Projects	X	-	-	
Growth and Sustainability of Tele-Consultation Services Such as the Pediatric Mental Health Care Access Program	X	-	-	X
Reimbursement by the State's Medical Assistance Program of Health Care Homes and Behavioral Health Homes for Interpretive Services	X	-	-	
Include Computer and Website Access to Multilingual Materials in the Preferred Drug List Through Medicaid Fee-for-Service Programs	X	X	-	X
Establishing Competency Requirements for Interpreters	X	-	-	-
Mandate Meaningful Access to Language Interpreter Services for Individuals with Limited English Proficiency When Receiving Medicaid-Funded Health Services–At No Cost to the Individual	X	X	-	X

1. INTRODUCTION

This resource guide has been developed to support the Minnesota Equitable Health Care Task Force in its mission to examine inequities in how people experience health care and to identify strategies and recommendations that promote a more equitable system of coverage, care delivery, and health outcomes for Minnesotans.

This guide is one of several resources designed to inform the Task Force's deliberations and recommendations; it is meant to complement other information sources, including the personal and professional experiences of Task Force members, insights derived from work group activities, and learnings from related innovations that are currently being implemented in Minnesota—spanning public, nonprofit, and private sectors—as well as examples from across the country. This guide is proposed to serve as an appendix to the final recommendations submitted to the Commissioner. By providing a summary of evidence and identifying gaps, this guide aims to assist Task Force members to create informed and actionable strategies that align with their vision for a more equitable health care system.

2. SCOPE OF WORK

The University of Minnesota (UMN) team was asked by the Minnesota Department of Health (MDH) to review documented, promising health care practices and public policy supports that promote equity in coverage, care, and health outcomes for population segments that have experienced significant disparities in access, outcomes, and quality resulting from structural, institutional, or other barriers. Specific priority population segments include:

- Individuals who identify as Black, Indigenous, or Persons of Color (BIPOC)
- Persons who identify as Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+)
- Individuals with disabilities
- Persons residing in rural geographic locations

In consultation with MDH, the UMN team was asked to identify and summarize recent evidence (and gaps in evidence), including from both peer-reviewed and grey literature, on the effects of selected health care delivery and payment innovations on equity-focused outcomes corresponding to the following priority topic areas:

1. **Integration of Health Care and Public Health:** Strategies that bridge the gap between health care services and public health efforts to address systemic disparities and health-related social needs (HRSNs). Specifically:
    - Health-related screening, referral, and unmet HRSNs
    - Addressing transportation-related needs
2. **Whole-Person Health:** Approaches that prioritize holistic care, addressing physical, mental, and social health needs. Specifically:
    - Primary care and behavioral health integration
    - Primary care and oral health integration
    - Patient navigation
    - Complementary health approaches
3. **Culturally Appropriate Care:** Innovations that honor and integrate diverse cultural practices into health care delivery. Specifically:
    - Doula care workforce and sustainable payment models
    - Culturally sensitive mental health and substance use interventions
    - Language interpretation services

These areas were identified based on Task Force member input regarding challenges experienced by Minnesotans in the health system and potential opportunities for improvement.

3. APPROACH

Resource guide development occurred in two phases. In the first phase during the fall of 2024, the UMN team consulted with MDH on the set of key challenges and opportunities identified by Task Force members. In November 2024, the UMN team undertook a rapid evidence review on four distinct priority topics (integration of health care and public health; value-based payment models; whole-person health; and culturally appropriate care) to generate a timely synthesis of research literature. Following these initial background searches, team members worked collaboratively with the Research Librarian from the Minnesota Evidence-Based Practice Center to conduct scholarly literature searches to identify evidence corresponding to effectiveness of policy or practice interventions with particular attention on disparities reduction or equity promotion among our priority populations.

For this rapid evidence review, we prioritized existing literature reviews and other pre-synthesized materials published between 2014-2024. And, for each priority topic area, we identified systematic reviews and developed summaries of the evidence, opportunities, and gaps along with recommendations for prioritizing issues based on evidence of impact and potential actionability via state policy. During the December 9, 2024 Task Force meeting, the UMN team responded to questions and asked for feedback from Task Force members to guide the next steps in preparation for the creation of the resource guide.

During the second phase of resource guide development (December 2024-February 2025), UMN team members expanded the literature reviews to include individual studies and relevant grey literature corresponding to each specific issue. For each issue, team members also conducted web-based searches to identify state-based policy and practice innovations aligned with each issue. Throughout this process, the team has been mindful of potential biases that may exist in published literature. For example, data limitations for certain populations could affect published results, or the ability to publish on certain topics and communities entirely. Those historically (and presently) underrepresented in academia and STEM work, would likely also be underrepresented in published literature, thus missing key viewpoints and perspectives. As we conducted our reviews, we were also intentional about identifying innovations that have the potential to address structural and/or institutional barriers that contribute to health care and health inequities.

In response to feedback from MDH and the Task Force, we summarize findings on three of the priority topic areas and subtopic areas: integration of health care and public health, whole-person health, and culturally appropriate care. Each of these sections begins with a brief description of the problem(s), including key definitions. We then summarize findings from our evidence review, including gaps and opportunities. Next, we provide a set of policy and practice innovations to address the problem(s), including examples of where this innovation has been adopted while also highlighting potential financial considerations. Because value-based payment is a financing consideration that cuts across several topics, we conclude with a section on value-based purchasing and other financing mechanisms that may be leveraged to facilitate the diffusion of specific care delivery innovations.

4. FINDINGS BY PRIORITY TOPIC AREA

A. INTEGRATION OF HEALTH CARE AND PUBLIC HEALTH

Despite the fact that key societal and public health forces can (and do) impact individuals' health, well-being, and access to care alongside health care services, health care providers and facilities are typically only paid for health care services *provided* to patients. Encouragingly, during the past decade, policymakers, payers, health care delivery organizations, and community-based organizations (CBOs) have increasingly recognized the importance of identifying and responding to these health-related social needs of individuals to improve health and well-being in ways beyond providing health care services.

Health-related social needs (HRSN) are social and economic needs experienced by individuals that affect their ability to maintain health and well-being, putting individuals at risk for poorer health outcomes and increased health care utilization. These are individual factors, such as lack of access to transportation, healthy food, affordable housing and utilities, and health care (CMS 2024).

The topic "Integration of Health Care and Public Health" is focused on how to identify and address HRSN, from screening in health care settings to referrals and connections to CBOs, with the goal of improving health and/or mitigating additional health impacts in the long-term. To date, many health care providers are not equipped (or compensated) to systematically screen and refer patients to resources to address health-related social needs, especially in rural or underserved areas; there is also a need for greater coordination and information sharing across medical and community-based resources to address health and health-related social needs in all communities (Dauner et al. 2021; Trochez et al. 2023).

Nationally, the Centers for Medicare and Medicaid Services (CMS) has started requiring facilities to screen for and track health-related social needs for hospital quality reporting programs (QualityNet 2024), and, as of 2024, Medicare reimburses providers for risk assessments that identify HRSNs (HHS 2023a).

Other CMS innovation models, including the Accountable Health Communities model, in which Minnesota's Allina Health participated (CMS 2022), have incentivized addressing HRSN; the new Making Care Primary model, also operating at several locations in Minnesota, includes additional efforts in this area as well (CMS nd). Additionally, the Joint Commission and health insurers have increased their focus on HRSN (Joint Commission 2022; AHIP 2023), while other organizations such as the National Committee for Quality Assurance (NCQA) provide accreditation in health equity for health care organizations (NCQA 2024).

This section includes two areas of focus identified based on feedback from MDH and the Task Force within the Integration of Health Care and Public Health topic:

- HRSN screening, referral, and addressing unmet needs
- Addressing unmet transportation needs

The areas of focus are described below and include a summary of the innovations for each area (see Tables 1 and 2) and case examples (see Examples 1 and 2). We also include a section specific to Minnesota's relevant innovations.

1) HEALTH-RELATED SOCIAL NEEDS SCREENING, REFERRAL, AND ADDRESSING UNMET NEEDS

Health care providers are increasingly screening patients for HRSNs, though there is limited evidence for outcomes of interventions integrating HRSN screening and referral. Outcomes have included minor to modest improvements in health outcomes (e.g., improved blood pressure, medication adherence, HbA1c levels), improvement in unmet social needs, and minor to modest improvements in health care utilization (e.g., emergency department visits, re-admissions, immunizations). Additionally, there is some evidence about referral processes indicating that referrals that are more involved (e.g., direct referrals connecting patients vs. indirect referrals providing information) lead to greater effects, either in number, outcomes, or strength of improvement (Yan et al. 2022; Escobar et al. 2021; Jackson et al. 2023).

Barriers to integrating screening and referral programs include concerns about relationships with CBOs for closed-loop referrals, as well as the current capacity of CBOs, particularly in areas with greater need for services or areas lacking easy access (e.g., rural communities). Innovations to address this barrier can include statewide or regional initiatives to develop networks of CBOs and/or increase capacity of CBOs across a state to be better prepared to provide services for individuals with unmet HRSN.

New York's Social Care networks, for example, established a network of CBO providers for Medicaid MCOs to contract for HRSN services (NY Department of Health 2024). Additionally, providing support for the development of infrastructure for CBOs is another innovation with goals to improve the capacity for addressing HRSN (Crumley et al. 2023). Other innovations include requirements for MCOs related to staffing and/or planning for addressing HRSN and working with CBOs (Crumley et al. 2023).

Task Force members indicated interest in innovations integrating standardized HRSN screening tools and data collection, an idea supported in the literature as well (Craven et al. 2024) This has been implemented in some innovative models, including through North Carolina's Medicaid 1115 waiver (NC DHHS 2018) (see Example 1 below) and CMS' Accountable Health Communities model (Billioux et al. 2017). Financing for each of these innovations has been achieved mainly through adjustments to state Medicaid policy, but innovations could be expanded to other populations through policy action.

Remaining gaps in this area are related to a lack of innovations (or evaluation) focused on the specific priority populations identified by the Task Force as well as a lack of information on achievement of outcomes addressing health equity through these interventions. This may be due to a lack of data for disaggregating priority populations in evaluative work, or simply due to the more recent focus on addressing HRSNs.

Health-Related Social Needs Actions in Minnesota

The State of Minnesota also has taken steps related to addressing HRSN. Most notably, the Minnesota Legislature has commissioned a report from the Department of Human Services (DHS) to provide recommendations and a strategy to address HRSNs by March 1, 2025 (MN Session Laws 2024a). Additionally, recent legislation provided the Minnesota Department of Health with funding for a Community Care Hub Planning Grant, to plan a hub that would operate as a 'one-stop shop' to connect people to health and HRSN resources (MN Session Laws 2024b).

Minnesota's Integrated Health Partnerships model also provides payment for care coordination for Medicaid beneficiaries that can help address HRSN (MN DHS 2024a). The Medicaid program in Minnesota also accounts for social risk factors through quarterly population-based payments to Integrated Health Partnership (IHP) organizations and includes questions about social drivers of health and health equity in Managed Care Organizations (MCO) requests for proposals (Bailit 2022).

To date, integration of innovative practices to address HRSNs at the state level has been mainly focused on the Medicaid population through several policy levers available to state Medicaid programs, including the use of Medicaid Section 1115 demonstration waivers to provide reimbursement for non-traditional Medicaid services, and incentives or requirements for Medicaid MCOs targeted to improve HRSNs in patient populations. While many states have tested these innovations in recent years, there is still little evidence related to the effects of these practices on disparities reduction.

TABLE 1: HEALTH-RELATED SOCIAL NEEDS INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
A.1.1 – Standardization of HRSN Screening Tool	Organizations develop a standardized HRSN screening tool for use by all health care providers, to standardize screening practices as well as HRSN data collection and referral practices.	• Aim to improve screening practices and efficacy, as well as HRSN data collection and utility	NC, Nationally via CMMI Accountable Health Communities model
A.1.2 – Development of Networks of CBOs for Addressing HRSN	Creation and management of networks of social service organizations able to provide HRSN services to patients upon referral.	• Aim to increase the ability for patients to be connected with services and providers, and receive HRSN assistance upon positive screening for HRSN	NC, NY
A.1.3 – Provide Support for HRSN Infrastructure with Community Based Organizations	Funding provided to improve CBO capacity through technology, workforce development, outreach and convening of stakeholders, and development of operations practices.	• Aim to increase capacity of CBO to be able to better address HRSN	AR, AZ, MA, OR
A.1.4 – Community Based Partnership Staffing Requirements for Managed Care Organizations	State Medicaid programs require Managed Care Organizations to have a staff member dedicated to coordinating with CBOs to address HRSN (e.g., housing coordinator).	• Aim to increase MCO direct capacity for coordinating HRSN services	AZ, NJ
A.1.5 – Direct Provision of Nutrition Support for Individuals Experiencing Food Insecurity	Medicaid program provision of meals or food prescriptions and/or food bundles to enrollees meeting certain criteria.	• Aim to directly address food insecurity of Medicaid enrollees	CA, HI, IL, MI
A.1.6 – Medicaid HRSN Social Bond Program	State-level, social bonding program to promote private investment in resources to address HRSNs	• Aim to raise capital to address HRSNs, coordinate and scale investments, mitigate risk for Medicaid MCOs given greater variability in enrollee population over time	Not yet implemented

EXAMPLE 1: HEALTH-RELATED SOCIAL NEEDS INNOVATIONS IN NORTH CAROLINA

Name - Healthy Opportunities Pilots

State - North Carolina

Policy - North Carolina Medicaid Reform - Medicaid Section 1115 Waiver

Timeframe - Began in January 2019, recently extended through December 2029

Financing - Medicaid state and federal funding

Description - The Healthy Opportunities Pilots initiative began delivering services in 2022, where health plans were required to provide services to address HRSN for select Medicaid beneficiaries. The initiative includes the use of standardized screening questions, as well as regional networks of CBOs for referral services, to provide services in areas of food insecurity, housing instability, transportation insecurity, and interpersonal violence.

Priority Population - Medicaid beneficiaries in the NC Medicaid Direct population (including dual eligibles, medically needy, children in foster care, older adults in PACE, and others)

Equity Goals/Effects - Preliminary results have shown successful achievement of establishing multi-sector collaboration across the state, CBOs, and health care systems, as well as both increased screening and decreased HRSN among participants. It is too early to identify health or utilization outcomes, but interim cost of care analyses indicated lower health care expenditures for pilot participants compared to what would have occurred in the absence of the initiative.

Sources: NC Healthy Opportunities Pilots: Interim Evaluation Report; A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots

2) ADDRESSING UNMET TRANSPORTATION NEEDS

Each year, millions of Americans miss medical appointments due to transportation issues; those individuals are more likely to be poorer, people of color, people with chronic illnesses or disabilities, and Medicaid recipients (Wolfe et al. 2020). The same transportation barriers for health care appointments are likely to be barriers for individuals accessing other essential needs, including HRSNs (e.g., getting to the grocery store to access healthy food). Additionally, transportation barriers are particularly evident in rural communities, where there is often less access to public transportation options as well as longer distances and/or travel times to access services compared to urban residents (Lam et al. 2018).

Evidence for interventions related to addressing transportation as an HRSN is limited. Some outcomes from previous studies include fewer missed appointments, though there was evidence of low utilization of the transportation benefits, dependent on mode of benefit (e.g., voucher, rideshare) and population (Solomon et al. 2020). Innovations to address HRSN may need to consider geography along with patient preference for transportation benefit type to be able to best address unmet needs.

Two types of transportation interventions are commonly used to address unmet transportation needs:

1. non-emergency medical transportation (NEMT) and,
2. *non-medical* transportation.

NEMT is provided through Medicaid, though each state may have different processes and eligibility rules. While not typically covered in traditional Medicare, Medicare Accountable Care Organizations and Medicare Advantage plans may also provide NEMT. Nationally, use of NEMT in Medicaid has been higher among rural beneficiaries compared to their urban counterparts (HHS 2023b). Evidence for NEMT interventions indicates provision of NEMT may lead to fewer missed appointments, but evidence for effects on health outcomes and outcomes associated with cost or further utilization are lacking (Shekelle et al. 2022).

Non-medical transportation is a newer benefit, often used to provide individuals with transportation to address other HRSN and has more recently been integrated into some Medicaid programs through 1115 waivers. To date, evidence on non-medical transportation has not been readily available due to the relative novelty of these initiatives.

Barriers to achieving equitable access to transportation may depend on populations involved in these initiatives, as well as processes developed to provide services for these populations. For instance, transportation innovations in rural communities where rideshare and other potential solutions may not be feasible due to a lack of availability or capacity may be more challenging compared to urban areas. Integration of community feedback regarding processes for establishing such programs is still limited.

Information gaps for both NEMT and non-medical transportation innovations are similar to the previous section, with limited data related to Task Force priority populations (outside of rural NEMT utilization findings above). While NEMT has been studied and shown to be moderately effective overall, there is limited information assessing how equitable NEMT may be across populations.

Transportation Actions in Minnesota

Through this review, there were not particularly innovative transportation actions currently underway in Minnesota. While Medicaid in Minnesota provides NEMT, they do not currently provide non-medical transportation services as a benefit for addressing HRSN (MN DHS 2024b).

TABLE 2: TRANSPORTATION INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
A.2.1 – Reimbursement of Non-Medical Transportation for Addressing HRSN	Transportation services for addressing non-medical HRSN (e.g., travel to housing appointments, nutrition classes, picking up groceries) are covered through Medicaid benefits	• Aim to provide access to HRSN service providers and other locations to meet HRSN	NC, NY
A.2.2 – Expanded Options for Non-Emergency Medical Transportation (NEMT)	Provision of additional NEMT services for Medicaid enrollees, including additional modes (e.g., transportation network companies, such as Uber or Lyft), destinations, or populations	• Aim to provide additional availability and/or capacity for NEMT services to address medical-related needs	CA, CO, OR

EXAMPLE 2: TRANSPORTATION INNOVATION IN NEW YORK

Name - Non-Medical Transportation

State - New York

Policy - New York Health Equity Reform (NYHER) 1115 Waiver Program

Timeframe - January 1, 2024 - March 31, 2027

Financing - Medicaid state and federal funding

Description - Non-medical transportation is a component of New York's Health Equity Reform program, and service provision for this program began in August 2024. Social Care Networks will build networks of CBOs to provide HRSN services and coordinate with health care providers, and pay CBOs for services provided, including transportation services for accessing HRSN services.

Priority Population - Subset of Medicaid beneficiaries, including children and individuals with complex and/or chronic health conditions

Equity Goals/Effects - There are no preliminary results of this model to date, though the initiative aims to improve health and reduce health disparities through reduction of barriers for beneficiaries to access HRSN services.

Sources: New York Health Equity Reform (NYHER) 1115 Waiver Program; CMS Approval Letter for NY 1115 Waiver

B. WHOLE-PERSON HEALTH

Whole-person health refers to a care delivery approach that considers multiple interconnected factors that promote either health or disease, including biological, behavioral, social, and environmental factors. The overarching question is whether greater integration of care (i.e., centering whole-person health), including navigation supports, may improve accessibility, quality, and health outcomes for all served.

Task Force members identified a few key problems within the scope of this topic to focus on. Firstly, the current health system is not designed to deliver or pay for whole-person care – there is too much focus on fixing problems versus preventing problems. Secondly, accessing the right care at the right time and place is challenging for most individuals. And, thirdly, there are complementary health approaches that may be beneficial to individuals' health outcomes but are not necessarily encouraged for use.

With these key problems identified, we moved forward with evidence and literature reviews on the following *specific* issues:

- Primary care and behavioral health integration
- Primary care and oral health integration
- Patient navigation
- Complementary health approaches

1) PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

Integration of primary care and behavioral health involves a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population (Kinman et al. 2015). Efforts to integrate behavioral health and primary care are rooted in recognition that individuals, families, and communities are better cared for by systems that address physical and behavioral care together. Integrated primary and behavioral health care delivery models exist on a continuum, ranging from consultation and co-location of services to team-based, collaborative care models.

Several strategies to integrate behavioral health with primary care have been shown to be effective (Asarnow et al. 2015; Lee et al. 2024; Meisnere et al. 2023; Possemato et al. 2018). The most common components of these published strategies include co-location of primary care and behavioral health providers, systematic screening for behavioral health needs, shared care plans, team meetings between behavioral health and primary care providers, alternative staff training (i.e., training non-psychiatric care providers and staff to provide mental health services such as depression screening by primary care providers), and a process for referring patients with serious mental illnesses to advanced psychiatric specialty care.

The successful implementation of integrated care models requires extensive and effective communication among providers, time to plan, train, and develop shared vision and workflows, and sustained support for multi-disciplinary teams (Asarnow et al. 2015; Lee et al. 2024; Possemato et al. 2018). Professional hierarchies, different care terminology and treatment approaches, and insufficient electronic health record (EHR) systems get in the way of success. Integration is often supported by time-limited grant funding; sustainable funding models are needed for prolonged viability of integrated care models (Lee et al. 2024).

Two well-known models include:

1. The primary care behavioral health (PCBH) model and,
2. The collaborative care model (CoCM).

The PCBH model entails systematic mental health screening, basic interventions (e.g. individual therapy sessions, brief counseling for common mental health concerns like anxiety and depression, stress management techniques, medication management consultation, behavioral activation strategies, psychoeducation), and need-based referral to specialty behavioral health providers for patients requiring psychiatric treatment by specialists. In the PCBH model, a licensed mental health clinician, such as a psychologist or clinical social worker, is embedded in the primary care team to provide brief assessment and intervention (e.g., psychotherapy) for a wide range of mental health, substance use, and health behavior concerns.

CoCM typically involves nurse care managers providing education and psychosocial support around the use of medications for specific behavioral health concerns (e.g., depression) in consultation with the primary care provider as well as a supervising psychiatrist. The support provided in CoCM is protocol-driven and guided by algorithms for stepping care up or down based on the patient's progress over time.

The PCBH model can be implemented as part of a patient-centered medical home (PCMH). The Department of Defense (DoD) has successfully used the PCBH model to integrate behavioral health for improving patient, provider, and care utilization outcomes, including cost savings (MHS 2025). While not the PCBH model specifically, national PCMH recognition institutions such as the National Committee for Quality Assurance (NCQA) require basic behavioral services such as depression screening for PCMH recognition, which signals support for integration. For example, Connecticut's PCMH program offers financial incentives as well as no cost support and guidance from a Clinical Practice Transformation Specialist to assist with the accreditation process (HUSKY Health Connecticut nd).

Operational barriers, such as structural barriers due to historically siloed systems for behavioral health and primary care and workforce shortages, need to be addressed (ICSI 2021). Telehealth may help overcome some of these barriers and be a valuable addition to implementing CoCM (ICSI 2021).

People with minoritized racial/ethnic identities have lower levels of engagement with integrated behavioral and primary care services compared to others, potentially due to factors such as communication barriers, cultural misalignment in care plans, and low confidence in or mistrust of the health care system (Cos et al. 2022; Petts et al. 2022; Saab et al. 2022). Adding a trauma-informed component to the CoCM model promotes culturally sensitive care for marginalized populations who may have trauma from multiple sources such as discrimination and adverse social determinants of health (Bills et al. 2023; Menschner & Maul 2016; Meredith et al. 2022). For example, in one clinical trial at a Federally Qualified Health Center (FQHC) in Louisiana, a trauma-informed CoCM for Black patients with post-traumatic stress disorder resulted in significantly greater clinical benefits compared to the usual treatment (Meredith et al. 2022). A systematic review focused on the First Nations people reported that interventions that additionally integrated culturally relevant health beliefs and practices experienced the largest gains in health outcomes (Lewis & Myhra 2017).

PCBH and CoCM Model Actions in Minnesota

Minnesota's PCMH program, known as Health Care Homes (HCH), has its own tiered certification process and does not mandate primary care and behavioral health integration at the foundational level, as stated in its Certification/recertification Operations Manual Providing Application Submission Supports (called COMPASS) (MDH n.d.). This leaves room for opportunities to make regulatory policy changes for HCH certification/recertification, such as requiring behavioral health screenings or other elements of integrating behavioral health services or creating financial incentives specifically for behavioral health integration (MDH 2024).

There is evidence that CoCMs have been implemented successfully in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). However, there is a lack of standardized implementation across these provider organizations, which creates an opportunity for developing state policies that set a minimum standard for all clinics to integrate behavioral health with primary care services.

Minnesota residents with depression and anxiety struggle to access timely care, particularly those on Medical Assistance, but the CoCM has proven to improve access, clinical outcomes (such as increased treatment response and reduced risk of acute crisis and ED visits), patient and provider satisfaction, and cost-effectiveness by integrating behavioral health care with primary care, especially by leveraging a behavioral health care manager (Archer et al. 2012; State Advisory Council On Mental Health and Subcommittee On Children's Mental Health 2022).

In Minnesota, the Mayo Clinic's experience when implementing the CoCM model for treating depression showed significantly better response to treatment, remission, and absenteeism at three and six months compared to usual practice (Shippee et al. 2013). Another study using simulation methods estimated that for every $1 spent on care delivered in the Collaborative Care Model there may be a $6.50 return on investment in improved health and productivity (State Advisory Council On Mental Health and Subcommittee On Children's Mental Health 2022).

A State of Minnesota legislative report (State Advisory Council On Mental Health and Subcommittee On Children's Mental Health 2022) recommended: (1) to have Minnesota Medical Assistance and MinnesotaCare pay for the suite of collaborative care codes (CMS 2024) at sustainable rates, (2) broadly publicize this payment plan and the details of the sustainable rate, and (3) for all future DHS requests for proposals for managed care organization contracts for the Prepaid Medical Assistance Program (PMAP) to include that the health plans cover the full suite of collaborative care service codes and monitor utilization of such services during the contract.

In Minnesota, some behavioral health services already implement a trauma-informed approach. However, a culturally sensitive trauma-informed approach is not required or intentionally promoted in CoCM or other integrated behavioral health care strategies at any FQHCs/RHCs.

This gap provides opportunities for state policies and measures to promote trauma-informed CoCM for behavioral health integration in FQHCs/RHCs in Minnesota. Some examples of behavioral health integration interventions can be found in Minnesota Integrated Health Partnerships (IHP) program to reduce health inequities (MN DHS 2023). Additionally, published case studies for special populations, including children with special needs, people with serious mental illness, refugees, and deaf populations, highlight opportunities for intentionally promoting accessibility measures in behavioral health integration strategies (Pollard et al. 2014).

See Table 3 and Example 3 for a summary of the innovations discussed above as well as a case example.

TABLE 3: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
B.1.1 – Primary Care Behavioral Health (PCBH) Model in Patient-Centered Medical Homes (PCMH)	The PCBH model involves professionals such as licensed therapists and psychologists, and entails systematic mental health screening, basic (and brief, clinician-judgment based) interventions, and need-based referral to specialty behavioral health providers for patients requiring psychiatric treatment by advanced providers.	• Increased access to behavioral health screening, earlier diagnosis, and treatment • Reduced stigma associated with seeking mental health treatment • Mitigate gaps in care or under-treatment • Reduce costs for patients	Nationwide DoD PCMHs
B.1.2 – State Policies for Certification of PCMH to Promote Primary Care and Behavioral Health Integration	Requires elements of integrating behavioral health for certification and recertification of PCMH as well as creates financial incentives/ reimbursements specific to integrated behavioral health care services.	• To promote adoption of PCBH model in PCMH	CT
B.1.3 – Trauma-Informed Collaborative Care Model (CoCM) Implemented in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)	Trauma-informed components of CoCM promote culturally sensitive care for marginalized populations who may have trauma from multiple sources such as discrimination and adverse social determinants of health.	• Increases access to need-based specialty psychiatric and behavioral health care • Improves patient health outcomes • Improves patient satisfaction and experience • Improves provider outcomes (such as satisfaction/experience, competency, and performance outcomes) • Reduces costs	Several states, including LA and MA (but at varying levels; not standardized in all settings at the same level within the state)

EXAMPLE 3: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION IN FQHCS

Name - Transforming and Expanding Access to Mental Health Care in Urban Pediatrics (TEAM UP) Model

State - Massachusetts

Practice Innovation - TEAM UP promotes positive child health and well-being through innovative and consistent delivery of trauma-informed, culturally responsive, integrated behavioral health care from birth to young adulthood.

Timeframe - Implemented in mid-2016

Financing - Non-profit foundations and Medicaid

Description - TEAM UP actively works to transform the way care is delivered within the pediatric medical home with an emphasis on strengthening families through strength-based parenting interventions; enhancing screening by implementing evidence-based multidimensional screening processes; ensuring access through a stepped care approach to ensure prompt access to services based on acuity level; and bridging connections through clear referral pathways to external resources and specialists.

Priority Population - Pediatric Medicaid population at Massachusetts-based federally qualified health centers (FQHCs)

Equity Goals/Effects - A study using electronic medical records at TEAM UP FQHCs documented high rates of screening, effective use of warm hand-offs (i.e., in-person transfer of care between two clinicians) to connect children to care, reductions in polypharmacy, and increases in diagnosis and treatment for attention-deficit/hyperactivity disorder. Another study using claims data, which included the same six comparison sites as the first study mentioned, indicated that after 1.5 years of implementation, TEAM UP was associated with increases in all-cause primary care visits, especially among children with baseline mental health (MH) conditions, with no changes in avoidable utilization. A third large-scale study analyzed data from 20,170 Medicaid-enrolled children aged 3 to 17 years served by FQHCs. After 1.5 implementation years, children receiving care at FQHCs with MH integration, compared with nonintervention FQHCs, had relative increases in primary care visits with MH diagnoses, MH service use, and decreases in psychotropic medication use.

Sources: Association of Integrating Mental Health Into Pediatric Primary Care at Federally Qualified Health Centers with Utilization and Follow-Up Care; TEAM UP for Children. TEAM UP for Children Transformation Model

2) PRIMARY CARE AND ORAL HEALTH INTEGRATION

Integration of oral health care into primary care has been proposed as one approach that could potentially improve access to care, increase operating efficiencies, and reduce health care costs (Christian et al. 2023). Sharing information, providing basic diagnostic services, and consulting systematically support a patient-centered model of care, enabling early detection of disease precursors and underlying conditions (Grantmakers in Health 2012). Such integration also raises awareness of oral health's importance and encourages timely use of dental services.

Key advantages coming from this integration include enhanced prevention of disease, reducing preventable dental conditions often treated in emergency rooms (Pew Center on the States 2012); improved chronic disease management and prevention; expanded access to oral health care for at-risk and underserved populations (IOM 2011; IOM and NRC 2011); use of interdisciplinary methods to address barriers like dental anxiety (Munger 2012); and significant cost savings by mitigating shared risk factors for dental and chronic diseases, such as diabetes (Ide et al. 2007; Cigna 2010; Fierce Healthcare 2011).

In a systematic review of 49 studies, 96% of studies reported that integration of oral health in primary care resulted in favorable outcomes (Christian et al. 2023). The studies included in this review implemented a wide range of integration strategies such as co-location of medical and oral health services, creation of electronic referral pathways and financial support to build necessary information technology infrastructure (e.g. interoperable electronic health records systems), training non-dental providers such as primary care physicians, medical students, and community health workers to provide oral health care services, policy changes including the extension of scope of practice for non-dental primary care professionals, and expansion of health insurance benefits to include coverage for oral health and to reimburse non-dental primary care professionals for oral health services.

Favorable outcomes of oral health and primary care integration strategies include improvements in referral pathways, documentation processes, operating efficiencies, the number of available health staff, increased number of visits for oral health issues, increased proportion of children receiving fluoride varnish applications/other preventive treatment, and increased proportion of visits to an oral health professional.

A promising strategy to increase access to integrated oral health and primary care is to promote co-location of services, i.e., oral health care and primary care provided in the same setting. This can be achieved in different ways.

Previous reports of integration of oral health care services with primary care via co-location in FQHCs, RHCs, and PCMH have shown favorable results (Crall et al. 2016; Gupta et al. 2022; Wood et al. 2020). FQHCs/RHCs serve a large proportion of underserved and marginalized populations. PCMH is designed to deliver whole-person care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. These settings are poised for delivery of integrated oral health and primary care services.

However, in practice, implementation of such integrated oral health and primary care service delivery varies widely. Indeed, FQHCs are mandated to provide only basic preventive oral health services. Yet successful case studies show the potential of these settings to expand access to oral health care services for the underserved and most vulnerable populations (Crall et al. 2016; Gupta et al. 2022; Wood et al. 2020). For example, by integrating oral health into primary care at FQHCs, Crall et al. (2016) demonstrated a threefold increase in the number of children that received preventive treatment, such as fluoride varnish applications.

Another opportunity for improving access to integrated oral health and primary care is to motivate Accountable Care Organizations (ACOs) to integrate oral health care with overall medical services. The majority of ACOs are not responsible for dental care as part of their ACO contract (Colla et al. 2016). Despite its known benefits to patients, oral health care remains largely separate from primary care services, even within ACOs focused on improving population health.

While integrating oral health care could enhance accountability for overall health, ACOs currently have little incentive to prioritize access to these services (Colla et al. 2016). However, a few promising case studies suggest that innovative policies expanding insurance and creating financial incentives or cost-savings can promote buy-in from ACOs to integrate oral health care with their overall health care services (The ADA Health Policy Institute 2015).

The most common barriers to integration of primary and oral health care reported in the literature are time constraints, staffing shortages, resource limitations, and lack of organizational support (Christian et al. 2023). This has given rise to several strategies for alternative staffing i.e. a non-dentist providing oral health care services.

One promising strategy in which the Task Force indicated interest is the Dental Therapists (DTs) and Advanced Dental Therapists (ADTs). Dental therapists are licensed oral health practitioners who can provide evaluative, preventive, restorative, and minor surgical dental care under the direction of a licensed dentist through use of a collaborative management agreement (Office of Rural Health and Primary Care 2019). While the evidence for barriers and facilitators of DT/ADT is sparse (Mertz et al. 2021), this strategy holds potential for expanding dental workforce capacity. The Alaska Native Tribal Health Consortium has partnered with some states (not including Minnesota) to offer a certified DT/ADT training program which is sufficient to fulfill the needs of Alaskan Native communities (see Example 4B).

Primary Care and Oral Health Integration Actions in Minnesota

Improving access to oral health care services is a priority for Minnesota. Low-income Minnesotans enrolled in Medical Assistance and MinnesotaCare experience higher rates of dental disease and greater difficulty accessing oral health care services than privately insured residents (MN DHS nd). This gap spurred the recently passed dental legislation establishing minimum performance standards for Medicaid MCOs related to annual dental visit rates (Minnesota Statute 256B.0371 2024; MN DHS nd). Additionally, as of January 2024, adults enrolled in Medicaid and MinnesotaCare have access to comprehensive dental benefits that had been previously reduced in 2008, given budgetary constraints (MN DHS nd).

When Hennepin Health's ACO and its partner organizations, including NorthPoint, implemented integrated oral health and primary care, increases in its annual dental visit rate (a quality measure tied to reimbursement) and decreases in emergency care utilization due to dental pain were both observed. These results led to both cost savings and to reducing risks associated with the use of prescription painkillers in populations with elevated risk of mental illness and chemical dependency (The ADA Health Policy Institute 2015).

Minnesota is one of several states that provides certification for Dental Therapists (DTs) and Advanced Dental Therapists (ADTs), allowing them to provide a wide range of oral health care services (Mertz et al. 2021). DTs and ADTs are reported to have favorable outcomes including patient satisfaction with care (Mertz et al. 2021). DTs and ADTs also tend to be more diverse than the remaining dental professional workforce (Mertz et al. 2021).

In Minnesota, DTs and ADTs account for less than 10% of the dental workforce. Current information suggests that DT/ADT training programs in Minnesota are small (between 8-12 students per program cohort at degree-granting institutions). Degree program costs also vary considerably (Minnesota State University - Mankato nd; University of Minnesota School of Dentistry). Furthermore, restrictions in scope of practice as well as restrictions on practice locations may diminish the appeal of this career path.

See Table 4 for a summary of innovations and Examples 4a and 4b for how they have been tested in the States of Ohio and Alaska.

TABLE 4: PRIMARY CARE AND ORAL HEALTH INTEGRATION INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
B.2.1 – Co-location of Dental Care and Primary Care Services in Patient-Centered Medical Homes (PCMH), Federally Qualified Health Care Centers, and Rural Health Clinics (FQHCs/RHCs)	Apply policy and regulatory changes to expand and integrate oral health care across all FQHC/RHC in several states, and PCMH in MN	• Increase access to and reduce costs for patients seeking dental services • Develop oral health workforce competency • Adoption of evidence-based oral health screening tools • Information sharing and coordination between dental and medical providers	Several states (including in Health Care Homes in MN), but it is not standardized across all centers/clinics
B.2.2 – Encourage or Require Dental Care Services within Medicaid Accountable Care Organization (ACO) Arrangements	State policy to expand ACO arrangements to include dental care within scope of services; create financial incentives to motivate ACOs to integrate oral health care with overall health care.	• Aims to increase access (measured by annual dental visit rate) • Aims to reduce ED visits for dental issues and related costs • Aims to improve patient experience	IA, MN (Hennepin Health and NorthPoint partnership), OH, OR, WA
B.2.3 – Expand DT and ADT Workforce Capacity through Training and Scope of Practice	State policy to expand alternative dental provider capacity, i.e., DTs and ADTs, who deliver a wide range of preventive and routine dental care services with favorable performance (clinical outcomes and patient satisfaction) and tend to be more diverse (from under-represented backgrounds) compared to other dental providers.	• Improve access to preventive and restorative oral health services in underserved areas • Increase awareness of and access to DT and ADT professional career development opportunities, particularly among underserved groups and communities with staffing shortages	AK, MN, and WA have training programs

EXAMPLE 4A: PRIMARY CARE AND ORAL HEALTH INTEGRATION IN OHIO

Name – Partners for Kids (a large Medicaid-serving pediatric ACO) Serving Children with Disabilities

State – Ohio

Policy – Opportunity for a Pediatric ACO that covers dental care services to serve all needs of children with disabilities after a state policy change requiring most Medicaid eligible children with disabilities to move from fee for service to capitated Medicaid managed care plans.

Timeframe – Policy implemented in 2013

Financing – Medicaid state and federal funding

Description – Partners for Kids receives a capitated fee to care for more than 300,000 pediatric beneficiaries, which includes oral health care services. The 2013 state policy change effectively resulted in most Medicaid-eligible children with disabilities becoming part of this ACO in 34 of 88 counties in Ohio.

Priority Population – Children with disabilities enrolled in Medicaid in Ohio

Equity Goals/Effects – Partners for Kids emphasizes oral health prevention and care coordination. They reported an 11% increase in the rate of preventive dental visits among children with disabilities in the ACO compared to the non-ACO. Partners for Kids maintains an oral health project and is currently experimenting with embedding dental hygienists in select FQHCs.

Sources: Dental Care in Accountable Care Organizations: Insights from 5 Case Studies (American Dental Association Health Policy Institute); The Effect of an Accountable Care Organization on Dental Care for Children with Disabilities

EXAMPLE 4B: PRIMARY CARE AND ORAL HEALTH INTEGRATION IN ALASKA

Name – Dental Health Aide Therapists (DHATs)

State – Alaska

Practice Innovation – DHATs are trained and licensed to provide preventive and restorative care (e.g. filling, extractions) to expand the dental workforce in Alaska's Yukon-Kuskokwim Delta (with an emphasis on including First Nations people).

Timeframe – 2006-Present

Financing – Federal and non-federal (non-profit) funding organizations

Description – The Alaska Dental Therapy Educational Program (ADTEP) is two years in length, followed by at least three months of preceptorship with a supervising dentist. Successful completion of these requirements is needed prior to certification by the Alaska Community Health Aide Program Certification Board. A DHAT's education provides them with the skills to meet most basic dental care needs in rural Alaska Native communities.

Priority Population – First Nations people

Equity Goals/Effects – A review article reported that 78% of practicing dental therapists in Alaska practiced in their own village or region of origin, and 87% are of AI/AN descent, with a retention rate for dental therapists in Alaska over 11 years to be 81% (Llaneza et al. 2024). DHATs were also associated with delivering more preventive care and fewer extractions (Chi et al., 2018). State-level policies should consider dental therapists as part of a comprehensive solution to meet the dental care needs of individuals in underserved communities and help achieve health equity and social justice.

Sources: Oral Health Workforce and American Indian and Alaska Native Communities: A Systematic Review; Dental Therapists Linked to Improved Dental Outcomes for Alaska Native Communities in the Yukon-Kuskokwim Delta

3) PATIENT NAVIGATION

The U.S. health care delivery system is complex and challenging for many Americans to navigate effectively. Patient navigation is a patient-centric, care delivery intervention designed to support individuals as they seek timely diagnosis and treatment of medical conditions, including cancer as well as other chronic illnesses (Freeman & Rodriguez 2011).

Patient navigators have a broad set of responsibilities. They provide health education and outreach (e.g., disease self-management, health promotion, preventive care), care coordination (e.g., medical appointment scheduling), coordination of health-related social needs (HRSNs) and connection to social services, and coordination of end-of-life care. Many patient navigation programs serve populations with specific diagnoses (e.g., cancer, HIV), persons considered 'medically complex', individuals facing transitions of care, and persons facing significant barriers to health care access for socioeconomic and other reasons (e.g., individuals without insurance, limited English proficiency, limited health literacy, unhoused) (Budde et al. 2021, Predmore et al. 2023). Patient navigation services may be offered by health care delivery or insurance organizations (where 'care coordination' or 'care management' is more common terminology) or services may be in community-based settings.

Individuals who provide patient navigation have heterogeneous educational backgrounds, skill sets, and responsibilities. Individuals who provide patient navigation may be licensed health professionals (e.g., nurses, social workers), where some or their entire set of position responsibilities are focused on patient navigation. Community-based patient navigators are often community health workers (CHWs). The American Public Health Association defines a CHW as a "frontline public health worker who is a trusted member and/or has an unusually close understanding of the community served."

Other terms for lay person navigators are community health representatives, promotores de salud, community health advisers, and lay health educators (Budde et al. 2022; Perez and Martinez 2008; Indian Health Service nd). Since many community-based navigators have shared cultural, language, and life experiences with their clients, they are important advocates and voices for addressing barriers and health inequities at multiple levels (APHA 2009; Office of Rural Health and Primary Care 2016).

The evidence base for measuring the impact of patient navigation services has been summarized in numerous systematic reviews. Patient navigation programs are associated with improvements in care-seeking behavior, such as cancer screenings and follow-up care receipt (Chen et al. 2024). These findings are demonstrated in diverse patient populations, including those served by FQHCs (Roland et al. 2017).

Other systematic reviews find evidence positively relating navigation to medication adherence and reduced waiting times (Bush et al. 2018). Evidence also finds improvements with respect to diabetes and cardiovascular-related intermediate clinical outcomes among persons who identify as immigrants or ethnic minorities and receive patient navigation (Shommu et al. 2016). Other documented effects relate to pediatric asthma management as well as pregnancy and perinatal outcomes (e.g., low birthweight births) (Budde et al. 2021; Knowles et al. 2023).

There is a growing literature base documenting the effects of navigation on utilization and spending. A randomized clinical trial by Kangovi et al. (2018) examined the impact of the evidence-based CHW intervention (known as the IMPaCT program) for patients who were uninsured or publicly insured and had at least two chronic diseases. The authors documented lower odds of repeat hospitalizations including 30-day readmissions (Kangovi et al. 2018) A companion study estimated that for each dollar invested in the IMPaCT intervention, the return was $2.47 to an average Medicaid payer in a fiscal year (Kangovi et al. 2020). Finally, a recent systematic review by Mistry et al. (2021) reports mixed evidence in terms of the influence of patient navigation on patient experience and satisfaction.

Critiques of the evidence related to patient navigation suggest four key limitations.

First, many earlier studies utilize weaker study designs in terms of being able to draw causal inferences of impact (e.g., pre-post with no comparison or control groups). More recent studies have employed either randomized controlled trial designs or more sophisticated modeling techniques to account for potential selection bias.

Second, many patient navigation programs are heterogeneous in their design, implementation, populations served, and outcomes studied. This renders comparisons across studies difficult (Knowles et al. 2023).

Third, there are few studies that have attempted to estimate a return-on-investment of patient navigator programs (particularly CHW program interventions). This information may be particularly important to key stakeholders considering future investments or policy action.

Fourth, while many patient navigation programs are targeted for socially disadvantaged population segments, there is very little direct published evidence to date demonstrating patient navigation programs' impact on reducing disparities in specific outcomes across population segments.

Patient Navigation Actions in Minnesota

Provider-, insurer-, and community-based patient navigation services are all offered in Minnesota. Investments in developing Minnesota's CHW workforce have been significant and influenced by a number of state and federal policies, awarded grants, and more. Key milestones include:

- **2005:** CHW certificate program with standardized curriculum first established in Minnesota
- **2009:** Using a State Plan Amendment, Minnesota Health Care Programs (Medicaid) is the first in the nation to establish Medicaid payment for services delivered by community health workers (NASHP, 2025)
- **2010:** Passage of the Affordable Care Act allowed reimbursement of non-licensed providers; supported use of CHWs through focus on patient-centered medical homes (Health Care Homes)
- **2013-2017:** Minnesota State Innovation Model (SIM) grant, which included focus on population-based payment models and emerging professions (e.g., community health workers)
- **2016:** CHW Toolkit for Employers developed by the Office of Rural Health and Primary Care in the Minnesota Department of Health. This toolkit provides valuable resources for CHW program design, implementation, and financing decision-making
- **2022:** Minnesota Department of Health receives a $3 million Community Health Worker Training grant award from the Health Resources and Services Administration (HRSA) to support workforce development (e.g., scholarships, apprenticeships)
- **2024:** Centers for Medicare and Medicaid Services implements health equity focused billing codes, including principal illness navigation (PIN) services (Medicare Learning Network, 2024)

There is still opportunity for additional policy innovations to promote access to patient navigation services among priority population segments. Noted barriers to further diffusion and sustainability of patient navigation services include role clarity, scalability, and financial sustainability. Opportunities exist for policy and practice innovations (see Table 5 below) to address one or more of these barriers. The State of Maine, among other states, is promoting the financial sustainability of CHWs by testing a primary care-based alternative payment model (APM) for its Medicaid population using population-based payment as described in Example 5.

TABLE 5: PATIENT NAVIGATION INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
B.3.1 – Environmental Scan and Evaluation of Community-Based Navigation Service Utilization	Policy development related to navigation workforce development investments and financing models would benefit from analyses using the Minnesota All Payer Claims Database (APCD) to understand rates of patient navigation service utilization in Medicaid and Medicare (as of 2024), including variation by patient attributes, provider types, payers, geographies, and over time. Need for more comprehensive understanding of patient navigation service capacity and employment by providers, payers, and state government, with particular focus on community-based navigators focused on priority population segments	• Quantify utilization of patient navigation services to evaluate degree of alignment between capacity/supply and potential needs	No additional states identified regarding use of APCD for this context.
B.3.2 – Local Evaluation to Build Evidence of Disparities Reduction Associated with Patient Navigation Service Use	Purchasers and provider organizations seek evidence that patient navigation service delivery models are effective at reducing disparities for particular priority populations and clinical contexts	• Aim to use findings from the Minnesota measurement and evaluation plan to inform care delivery and financing investments • Aim to leverage existing data infrastructure and research capacity (Minnesota Electronic Health Records Consortium; Learning Health Systems; Minnesota APCD)	RI, MA, NY, OR
B.3.3 – Specialization Pathway Development for Serving Needs of Priority Populations and/or Populations That Are Medically Complex	Services and provider types supporting 'patient navigation' functions are very broad. Create opportunities for specialized training or programs to serve particular population segments	• Aim to differentiate training and competency levels (and potentially payment) • Aim to develop patient navigation programs and delivery modalities for specific patient populations (e.g., rural, LGBTQ+)	Private payer and provider organization innovations (e.g., BCBS of MN Gender Services Team; Avera eCare)
B.3.4 – Insurance Coverage Mandate for Patient Navigation Services	Mandate coverage for patient navigation services for individual market or fully insured employer group plans	• Aim to expand access to patient navigation services	No states identified
B.3.5 – Promote Financial Sustainability of Patient Navigation Services Through Use of Primary Care Population-Based Payment Models	Pursue options to promote financial sustainability of patient navigation through Medicaid rate refinement. Expand use of alternative payment models which include greater flexibility for adoption of patient navigation services	• Proposals to shift Medicaid primary care funding to capitation per member per month (PMPM) system for all primary care providers or FQHCs only to enhance flexibility of care delivery, including navigation	CA, ME, NC, VT
B.3.6 – Regulate Payers' and Providers' Community Benefit Resources to Be Directed Toward Specific Equity-Promoting Workforce Investments	Consider tying community benefit dollars from providers or payers into workforce development (e.g., training, apprenticeships)	• Identify a new funding resource to promote CHW or other related workforce development	MI (not workforce specific; but prospective use of % of MCO profits)

EXAMPLE 5: PROMOTING FINANCIAL SUSTAINABILITY OF CHWS THROUGH POPULATION-BASED PAYMENT MODEL IN MAINE

Name - Primary Care Plus (PC Plus) Program

State - Maine

Policy - Innovative primary care-based alternative payment model (APM) for Medicaid population using population-based payment including per member per month (PMPM) rate for services within a 'whole-person care' approach; aligned with CMMI Primary Care First (multi-payer advanced primary care initiative)

Timeframe - 2022-Present

Financing - Medicaid funding through State Plan Amendment (SPA)

Description - Tiered, primary care population-based alternative payment model that requires practices to: use electronic health records (EHR) in Tier 1; provide services including medication for addiction treatment services, telehealth, care coordination and transition, and monitoring social needs and conducting an environmental scan to assess CHW resource needs and integrate community health workers into primary care practices directly or through contractual relationships in Tier 2; participate in Maine's Accountable Communities (AC) program in Tier 3. Reimbursement potential increases with each tier and advancements must be approved by CMS. PMPM payments are adjusted quarterly for performance on 10 quality measures.

Priority Population - Children; adults; persons who are aged, blind, or disabled; and dual eligible

Equity Goals/Effects - Promote sustainable CHW resources within primary care

Sources: Office of MaineCare Services (OMS) Primary Care Plus (PC Plus); Primary Care Plus Orientation; Q&A: Using an Alternative Payment Model to Support Community Health Worker Sustainability in Maine's Primary Care Plus Program

4) COMPLEMENTARY HEALTH APPROACHES

Complementary health approaches (CHA) encompass a diverse range of practices that are used alongside conventional medical treatments. According to the National Center for Complementary and Integrative Health (NCCIH), complementary health approaches may include dietary supplements, vitamins and minerals; exercise and mind-body practices, such as yoga, meditation, mindfulness-based stress reduction, and tai chi; other psychological therapies, such as guided imagery; and manipulative and body-based practices such as chiropractic care, acupuncture, and massage therapy (NCCIH 2021). Here we focus on service or activity-based complementary health approaches and exclude from consideration dietary supplements, vitamins, and minerals.

Two of the most common clinical contexts for which complementary health approaches are used are chronic pain (e.g., low back pain, headache, fibromyalgia) and mental health (e.g., depression and anxiety). Utilization rates of complementary health approaches vary by specific service, setting, and over time.

Using the National Health Interview Survey, Nahin et al. (2024) documents changes in the prevalence of use for seven complementary health approaches from 2002-2022. In 2022, 15.8% of adults report engaging in yoga, 17.3% in meditation, and 2.2% in acupuncture (although such activities are not necessarily directly linked to clinical care). Of individuals using complementary health approaches, approximately one-half reported doing so for the purpose of pain management.

Our review included examining pre-synthesized literature on acupuncture for adult health conditions (Allen et al. 2022), massage therapy for pain (Mak et al. 2024), mindfulness-based stress reduction for low-back pain (Anheyer et al. 2017), a 2018 AHRQ comparative effectiveness review focused on nonpharmacological treatments for chronic pain (Skelly et al. 2018), and a 2023 AHRQ Evidence-based Practice Center focused on research gaps in pain management (Carr et al. 2023). We also searched for individual studies focused on the use of CHA for mental health treatment, including postpartum depression (McCloskey and Reno 2018).

High level findings are summarized below by approach:

- **Acupuncture (for pain):** There was a large set of systematic reviews; approximately 30% of reviews rated certainty or strength of evidence; the strongest evidence related to use of acupuncture was for fibromyalgia, shoulder pain, and stroke; most literature did not compare acupuncture against other active therapies (Allen et al. 2022).
- **Chiropractic/spinal manipulation (for pain):** Evidence was rated low strength; this approach had slightly greater effects in short-term function than sham or usual care (Skelly et al. 2018).
- **Massage therapy (for pain):** There were a large number of randomized clinical trials; a minority of conclusions were rated as moderate-certainty evidence; very few moderate-certainty studies find a positive association between massage therapy and pain; this approach had slightly greater effects in short-term function than sham or usual care (Mak et al. 2024; Skelly et al. 2018).
- **Mindfulness-based stress reduction (MBSR) (for mental health and pain):** MBSR had slightly greater effects than usual care on short-term pain; no evidence of differences between MBSR and usual care on short-, medium-, or long-term function (Skelly et al. 2018); Maglione et al. 2016)
- **Yoga (for mental health; cancer-related symptoms):** For women diagnosed with breast cancer, yoga was more effective than no therapy for reducing fatigue, sleep disturbances, and for improving quality of life vs. psychosocial or educational interventions; limited evidence of benefits for those with major depressive disorder (Cramer et al. 2017a; Cramer et al. 2017b)

There are several potential barriers to the adoption of complementary health approaches. Potential barriers include:

1. Limited insurance coverage for complementary health approaches, given limited or weak evidence of specific clinical impact;
2. Lack of awareness and education by individuals or providers regarding potential benefits; and,
3. Cultural or religious barriers that are in conflict with certain complementary health approaches.

Just as there are potential barriers, we also identified several potential facilitators. These facilitators may include:

1. Increased interest in primary prevention through non-pharmacological approaches;
2. Integration with conventional medical services (e.g., massage as part of physical therapy program) or care delivery models;
3. New evidence on ‘use cases’ and evidence translation (e.g., National Center for Complementary and Integrative Health); and,
4. Digital health advances that may increase accessibility to certain types of complementary health approaches (e.g., meditation, online exercise programming).

Access to complementary health approaches is influenced by several factors, including whether or not specific services are covered by health insurance and associated cost-sharing; availability of integrative medicine providers and/or the support of CHA by clinical providers more generally; resource availability for community-based provision of services and/or evaluation of programming to test the impact of CHA on health-related outcomes, particularly for priority population segments.

Complementary Health Approaches in Minnesota

A preliminary review of Minnesota's insurance regulations suggests that Medicaid provides coverage for chiropractic services with quantity limits (MN DHS 2022). The state also covers acupuncture services for the Medicaid population for several conditions, including pain- and mental health-related conditions (MN DHS 2023). Chiropractic services also appear to be a mandated benefit for persons with individual and small group market coverage, though cost sharing may apply (CMS nd1). Acupuncture and massage therapy do not appear to be mandated benefits for individuals with private insurance in Minnesota. For Medicare beneficiaries, Part B includes coverage for spinal manipulation by a chiropractor as well as a limited benefit for acupuncture for chronic low back pain (CMS nd2; CMS nd3).

There are other distinct examples of CHA-related policy innovations in Minnesota. First, there is a designated office within the Minnesota Department of Health that oversees complementary and alternative health care practice. Second, the state has engaged in making grants for research to understand the effectiveness of CHA in the context of pain management and mitigating opioid use (MDH 2022).

One unique practice innovation is the opening of the Integrative Clinic of Minnesota at Oshun Center in 2022. This clinic is a partnership model among Northwestern Health Sciences University, the University of Minnesota medical school, and the Oshun Center for Intercultural Healing, and provides holistic therapies (NWHSU nd).

See Table 6 for a summary of CHA innovations and Example 6 for how Colorado has used a Medicaid waiver process to expand access to CHA.

TABLE 6: COMPLEMENTARY HEALTH APPROACHES INNOVATIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
B.4.1 – Private Insurance Coverage Mandates	Establish state-based coverage mandate for specific types of CHAs and clinical contexts. Applies to private insurance policies where the state maintains regulatory authority.	• Increase financial access to specific types of CHAs	OR, WA (not exhaustive list of states)
B.4.2 – Medicaid Waivers or Demonstration Projects	Use waiver process to obtain resources to evaluate CHA effectiveness in Medicaid populations	• Expand access to CHA services and evaluate effectiveness of CHA for health-related outcomes	CO
B.4.3 – Federal and State Grants to Support CHA Programming (e.g., Yoga, Meditation, Mindfulness-Based Stress Reduction, etc.)	Every Student Succeeds Act (Title IV, Part A);	• Expand access to subset of CHAs via schools or other community-based programming to support well-being	Federal sources

EXAMPLE 6: USING A HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER TO EXPAND ACCESS TO CHA IN COLORADO

Name - Complementary and Integrative Health Waiver

State - Colorado

Policy - Medicaid Home and Community Based Services Waiver program (Section 1915c of Social Security Act)

Timeframe - 2022-Present

Financing - State and Federal Medicaid funding

Description - Expansion of Medicaid HCBS benefits to include coverage for chiropractic, acupuncture, and massage therapy for individuals with spinal cord injury or nervous system conditions which inhibit mobility.

Priority Population - Adult Medicaid enrollees (age 18+) who have spinal cord injuries or other nervous system conditions and who are without the physical ability to be independently mobile

Equity Goals/Effects - Expand access to complementary health approaches for individuals with disabling conditions.

Sources: Colorado Department of Health Care Policy and Financing, Complementary and Integrative Health Waiver; Evaluation of Complementary and Integrative Health Services (CIHS) in Health First Colorado

C. CULTURALLY APPROPRIATE CARE

Culturally appropriate care refers to the provision of care services that recognize, respect, and center the unique cultural needs of diverse patient populations. The provision of this care includes, but is not limited to, the practice of cultural humility by providers. Task Force members have identified the provision of culturally appropriate services as a promising pathway through which the state can diversify its workforce and reduce persistent health inequities.

The provision of this type of care can be very broad and conceptualized in a myriad of ways. To offer constructive examples we focused on policies and innovations that centered payment and reimbursement.

Within this priority topic, the UMN team focused on three specific issues:

- Doula care workforce and sustainable payment models
- Culturally sensitive mental health and substance use interventions
- Language interpretation services

1) DOULA CARE WORKFORCE AND SUSTAINABLE PAYMENT MODELS

As additional attention is paid to the persistent maternal mortality crisis in the United States, alternative care models and support staff have been identified as potential tools to better support birthing people in the United States. A well-established body of literature has shown that for racially and ethnically minoritized individuals, as well as those who are from lower income backgrounds, the use of doulas–non-medically trained care professionals who offer physical, emotional, and educational support to pregnant individuals and their families throughout pregnancy and into the postpartum period–is significantly associated with improved maternal and infant health outcomes (Safon et al. 2021).

Nationally, insurance coverage of doula services is often inconsistent across states and payer types. To date, few insurers cover these services, and private payers often rely on retroactive reimbursement for services. Two states, Minnesota and Oregon, have been early adopters in providing Medicaid coverage for doula services. In both states, doulas are required to register with state health agencies in order to be eligible for Medicaid reimbursement, obtain specific forms of certification or licensure that is recognized by the state, and meet other state-specific requirements like background checks (Chen 2018).

The creation of a state registry of doulas in both states has been seen as one way to increase access to these services, but others suggest that by requiring individual doula organizations to register rather than listing larger doula organizations in the state's registry, an additional barrier has been created. Critics of the state-based registry also note that this may also make contracting with payers more difficult (Kozhimannil, Vogelsang, and Hardeman 2015).

Several options exist when thinking about how to create sustainable reimbursement pathways for doula services. Generally, most states who have attempted to support doula services have done so using the Affordable Care Act (ACA) mandate that all health plans must cover certain preventive services without cost sharing. Under this mandate, several options for payment and reimbursement exist that can be used to leverage Medicaid managed care plans, Medicaid value-based payment models (VBP), and Medicaid delivery system reform incentive payment (DSRIP) waivers. For example, if a state establishes that doula services meet the preventive service stipulations laid out in the ACA, managed care plans in the state can cover doula services and receive reimbursement for these services.

Another option for managed care plans is to categorize doulas as a “value-added service” that can utilize capitation payments. VBP models allow states to include doula services as part of their global budgets and package of services associated with pregnancy and birth. While this is an option, it may require doulas to negotiate with individual agencies, which presents another potential barrier to reimbursement and sustainability.

An example of such a program is Connecticut's Husky Maternity Care Bundle developed by the state’s Department of Social Services (CT DSS 2024). This program explicitly identifies doula services as value-added services within the state’s maternity care bundle. Including doula services in this bundled payment model rather than in a traditional fee-for-service model aims to increase physician recommendation of doula services to eligible or interested patients (Chen 2024).

DSRIP waivers, which allowed states to support innovative care models, were another funding option for doula services. However, because these waivers are often tied to performance measures, doulas would be required to provide specific performance measures in order to qualify for funding–a requirement that may be difficult for independent providers to verify or sustainably report given their limited administrative capacity. (Most of the DSRIP waiver programs ended in 2020.)

Despite all of the aforementioned mechanisms for funding and reimbursement, doula care advocates often note glaring inequities in reimbursement rates as a major barrier to expansion of the doula care workforce, especially among populations that could benefit from these services the most. Over the past decade alone (2015-2024) there has been a considerable amount of variation in doula reimbursement rates (Ogonwole et al. 2022).

Some states have established doula services advisory committees to ensure that both the certification requirements and reimbursement rates within the state reflect appropriate certification and reimbursement rates. These committees, composed of doulas, health policy experts, and health care professionals, are required to provide the legislature with a report on the aforementioned topic areas within 18 months of convening that outline clear recommendations and next steps (TN DoH n.d.). Although evidence is limited, these committees are designed to reduce health disparities by creating clear and practical incentives that grow a state’s doula care workforce while establishing reimbursement rates that encourage more individuals from historically underserved communities to become certified doulas (Network for Public Health Law 2024).

Although existing studies have looked at variations in health outcomes associated with doula care, to date no study has specifically examined whether the reimbursement mechanism utilized by states influence patient outcomes.

Doula Care Workforce and Sustainable Payment Models Actions in Minnesota

Within Minnesota, the importance of doulas and the doula care workforce has been enshrined by Minnesota State Statute 144.1461, the “Dignity in Pregnancy and Childbirth Act” that explicitly dedicates resources to the identification of access barriers, development of strategies to improve barriers, and explicit diversification of the doula workforce. And, as previously referenced, Minnesota was an early adopter of providing Medicaid coverage for doula services. Additionally, to be eligible for Medicaid reimbursement, doulas in MN are required to register with state health agencies, obtain specific certifications/licensure, and meet other specific requirements (see critiques of registry in section “Doula Care Workforce and Sustainable Payment Models”).

See Table 7 for a summary of innovations related to sustainable doula care, including Minnesota’s ‘Doula Hub’, and Example 7 for one way Minnesota is already on the path to providing resources to help doulas.

TABLE 7: INNOVATIONS TO PROMOTE DOULA SERVICES AND SUSTAINABLE PAYMENT MODELS

Policy or Practice Innovation	Description	• Goals/Effects (Overall or Equity Specific)	Where This is Happening
C.1.1 – Creation of a Statewide "Doula Hub"	This legislative action resulted in the creation of specific funds that were allocated for the creation of a "Doula Hub" that was managed through the state to provide resources to help doulas receive timely reimbursement and to allow prospective families to more easily identify providers.	• Creates supports for doulas in navigating the Medicaid billing system • Establishes a referral system for Washington State Medicaid families which allows families to find doula support more easily	MN, WA
C.1.2 – Creation of a Doula Advisory Committee	Doula services advisory committees, which are usually established through formal statutes or regulations, are designed to identify initiatives that expand access to doula services, create standards for doula services, develop core competencies for the doula care workforce, and propose reimbursement rates for Medicaid and incentive-based payments. Many of these programs are still in their infancy and have yet to be evaluated for their efficacy.	• Allows continual evaluation and updating of appropriate reimbursement rates for doula services • Convenes an interdisciplinary group of doulas and practitioners to contribute to the co-creation of state-specific policies specifically designed to reduce racial inequities in maternal and infant health outcomes	CA, TN, MI
C.1.3 – Creation of a Maternity Bundle	This program incorporates doula services into the state's bundled payment program and allows doula services to be rendered and reimbursed under the supervision of the medical provider.	• Includes high value services–like doula services–that have not historically been included in payment models that may bridge equity gaps • Medical providers can include doula services as part of a patient's complete care plan	CT

EXAMPLE 7: DOULA PATHWAY TOOLKIT FOR AFRICAN AMERICAN AND AMERICAN INDIAN PEOPLE IN MINNESOTA

Name - Birth Justice Collaborative Doula Pathway Toolkit

State - Minnesota

Policy - Creation of a statewide doula resource

Timeframe - 2023-Present

Financing - State grant; Hennepin County partnership

Description - This toolkit, developed by the BJC, is designed to increase the training, recruitment, and timely reimbursement of African American and American Indian Doulas–a workforce that has been shown to be significantly associated with improved perinatal and infant health outcomes for the populations they serve. In Washington state, the creation of these materials was mandated by the state's legislature and funded through appropriations.

Priority Population - African American and American Indian

Equity Goals/Effects - Allows doulas from lower income backgrounds, who are disproportionately people of color, to receive timely reimbursement from payers. Additionally, timely payments also help publicly insured patients seem more attractive to potential doulas.

Source: Doula Pathway Toolkit

2) CULTURALLY SENSITIVE MENTAL HEALTH AND SUBSTANCE USE TREATMENT INTERVENTIONS

A growing body of evidence suggests that although prevalence rates of substance use are lower than their non-Hispanic white counterparts, individuals from minoritized racial and ethnic backgrounds bear a greater burden of disease and adverse health outcomes while also having lower access, initiation, and retention rates within substance use treatment programs (Hai 2021). NIAAA (2017) identified cultural adaptation of substance use programs as one potential way to increase access and retention for minoritized populations in substance use programs.

Preliminary research suggests that cultural adaptations make treatments more accessible and relevant to communities of color. As with other culturally tailored services, research on cultural adaptation of substance use services has been shown to increase utilization.

Several systematic reviews exist that have examined the impact of culturally adapted substance use interventions among adolescent and adult populations. Among youth of color, reviews have found small, yet positive treatment effects for improving substance use outcomes (Hernandez Robles et al. 2018). Other studies have found larger reductions in substance use among racially and ethnically diverse youth attributable to culturally adapted interventions (Hodge et al. 2012). This evidence, as well as more recent systematic reviews, demonstrates the potential efficacy of culturally tailored substance use programs, and therefore it is valuable to policies, practices, or innovative approaches to support such programing.

One community that has been very intentional about the creation and utilization of culturally adapted substance use programming has been American Indian and Alaska Native (AI/AN) populations. The National Council of Urban Indian Health recently published a report outlining the diverse array of traditional health programs provided by Urban Indian Organizations (UIO) and how third-party billing can support the continued integration of traditional healing practices within this community (National Council of Urban Indian Health 2023).

Within this report, they identified several forms of traditional healing that vary across tribes and include, but are not limited to, talking circles, arts, sweat lodges, spiritual guidance, dancing, native language lessons and groups, culturally based elder program, smudging, and the use of traditional plants to support substance use treatment. These indigenized approaches to sobriety, which mirror existing 12-step programs like Narcotics Anonymous and Alcoholics Anonymous, aim to address historical trauma and experiences unique to AI/AN people.

To support the utilization of these traditional healing practices, UIO rely heavily on Medicaid reimbursement for services, primarily through Section 1915(c) waivers or Section 1115 demonstrations. Such initiatives allow Medicaid and CHIP programs to cover traditional healing services. Section 1115(a) demonstration waivers have been used in several states to cover traditional healing services with the explicit declaration that these demonstration projects seek to address the social determinants of health and inequities facing AI/AN communities. Under this waiver category, UIO have been able to create programs that allow providers to leverage non-clinical services or provide medical services in alternative settings that may support the reduction of health inequities. At the time of the report, four states (Arizona, California, Oregon, and New Mexico) had leveraged 1115(a) waivers to cover traditional healing and culturally adapted substance use treatment services. Through these programs, traditional healers can be reimbursed for their services. In the specific case of New Mexico's managed care program, enrolled AI/AN individuals gained access to $500 annually that they could use to access traditional healing services (CMS 2024).

Another growing area that has been shown to be amenable to culturally sensitive interventions has been mental health services. With increasing adverse pediatric mental health outcomes (DASH 2023), it is becoming abundantly clear that the provision and coverage of pediatric mental health services for minoritized populations must be a federal and state-level priority (Youth Mental Health and Substance Use Task Force 2025). Providers and public policy advocates alike have identified the expansion of primary care and behavioral health services in pediatric services as one way to increase access to mental health services and reduce health inequities.

One program that has demonstrated success and that advocates believe should be expanded to reduce inequities is the Pediatric Mental Health Care Access Program (PMHCA). PMHCA is a HRSA-funded program that helps pediatric health professionals provide mental health services during routine physical health visits. Continued federal support of this program allows racially, ethnically, and geographically marginalized pediatric patient populations to have increased access to behavioral health screening. For example, an evaluation of PMHCA and similar programs found that 12.3% of children with access to this funding received behavioral health services compared to only 9.5% of children in states without these services (Stein 2019). A recent study documenting implementation of PMHCA funds in Arkansas showed increased access to telehealth behavioral consultants and reimbursement for such services led insurers to save nearly $200, on average, per patient.

A potential barrier to the widespread implementation of similar telehealth consultation programs is the large initial startup costs. At a state-level, there are many ways to support PMHCA (Berk et al. 2024). For example, Massachusetts has passed legislation requiring PMHCA services to be funded by commercial and Medicaid plans (Massachusetts Department of Mental Health 2024).

Culturally Sensitive Mental Health and Substance Use Treatment Intervention Innovations in Minnesota

The delivery system for mental health and substance use treatment in Minnesota spans public, non-profit, and private sectors, and is delivered in a variety of settings using different care models.. As noted in the whole-person health section above, there is room for improvement as it relates to policies and programs that support the integration of primary care and behavioral health (mental health and substance use treatment), including trauma-informed approaches. The Minnesota Department of Human Services (DHS) administers several behavioral health programs in the areas of adult mental health, children's mental health, and alcohol, drug, and other addictions. In 2020, DHS received approval from CMS to implement a Section 1115 Demonstration Substance Use Disorder waiver, which aims to strengthen the behavioral health care system in the state. Although a required evaluation is underway, it is unclear if proposed measures address cultural sensitivity. Additionally, the DHS Behavioral Health Administration supports programs and policies for Tribal Nations through its American Indian Team.

While a deep dive into the extent to which existing mental health and substance use providers and models in the state are delivering culturally sensitive interventions was outside the scope of this review, the UMN team did identify a long-standing DHS program specifically focused on addressing health inequities in mental health and substance use disorder known as the Culture and Ethnic Minority Infrastructure Grant (CEMIG) program. The CEMIG program, which began in 2008, was initially implemented to reduce disparities in access to mental health services by improving the representativeness of the mental health workforce in Minnesota. After a decade, the program expanded to provide culturally-specific, trauma-informed mental health and substance use disorder supports and services as well as activities to increase the supply of health professionals and peer support specialists from specific ethnic and cultural minority communities (MN DHS 2020). A least one state advisory body (State Advisory Council On Mental Health and Subcommittee On Children's Mental Health 2022) recommended expansion of CEMIG.

A case study of CEMIG's early years reported mixed results. The program was well-liked by agency staff and shown to remove barriers to health professional advancement. However, turnover of program administrators was high and visibility of the program was low (Aby and Gonzalez Benson 2021). A more recent report by the Minnesota Office of the Legislative Auditor, evaluating state programs supporting Minnesotans on the basis of their racial or ethnic identity, noted that the 2018 – 2022 CEMIG grant cycle was the first to administer children mental health, adult mental health, and substance use disorder grants under one award process. However, data were insufficient to assess whether the program was serving the intended communities (OLA 2023). According to the DHS website, another evaluation of the CEMIG program is underway.

See Table 8 for a summary of innovations to promote culturally sensitive mental health and substance use care and Example 8 for a description of work in New Mexico covering traditional healing services for Native American Medicaid beneficiaries.

TABLE 8: INNOVATIONS TO PROMOTE CULTURALLY SENSITIVE MENTAL HEALTH AND SUBSTANCE USE INTERVENTIONS

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
C.2.1 – Use of 1115 Waivers to Create Culturally Tailored Substance Use Demonstration Projects	1115 waivers can be used to demonstrate the effectiveness of traditional healing services and later expanded and offered as a care option to all beneficiaries.	• Allows Medicaid reimbursement of traditional healing practices. The equity specific impact is that AI/AN enrolled in managed care have allocated funds that they can use for traditional healing services	AZ, CA, OR, NM
C.2.2 – Growth and Sustainability of Tele-Consultation Services Such as the Pediatric Mental Health Care Access Program	This HRSA funded program seeks to improve children's behavioral health needs by providing pediatric health professionals with mental health training, consultation, resources, and referrals that allow providers to add mental health screening and treatment to routine health check-ups.	• Goal of this program is to increase pediatric mental health care access and improve equity related to racial, ethnic, and geographic disparities in access to care	Over 8,880 primary care providers in 50 states, tribes, and territories participated in a statewide or regional PMHCA program

EXAMPLE 8: TRADITIONAL HEALTH SERVICE PROVISION UNDER MEDICAID IN NEW MEXICO

Name - Turquoise Care

State - New Mexico

Policy - Medicaid 1115 waiver that covers traditional healing services for Native American Medicaid beneficiaries.

Timeframe - Several iterations of this program beginning in 2018, this specific program name began in July 2024

Financing - State and federal Medicaid funding

Description - American Indian and Alaska Native beneficiaries enrolled in New Mexico's managed care plan will be provided with $500 annually for traditional health services provided by traditional healers. Value added services, which are eligible for reimbursement include: "prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and use of meaningful symbols of healing 'like the medicine wheel.'"

Priority Population - Native Americans

Equity Goals/Effects - Allows AI/AN enrollees to access traditional healing methods that have been shown to effectively support substance use treatment.

Source: Turquoise Care Section 1115 Medicaid Demonstration Waiver Renewal Request (formerly Centennial Care 2.0)

3) LANGUAGE INTERPRETATION SERVICES

As the U.S. population becomes more diverse, language interpretation services are particularly important in the context of health care delivery. Two decades ago, the National Health Law Program and the Kaiser Commission on Medicaid and the Uninsured published a groundbreaking report outlining the legal rights and responsibilities that made linguistic access within health care settings a health equity issue (Perkins 2003). Since then, every state and the District of Columbia has enacted multiple laws that address language access issues. More recently, the National Committee for Quality Assurance requires access to and availability of language interpretation for its health equity accreditation.

Four primary federal laws require language access in health care settings–Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; Hill-Burton Act; and Emergency Medical Treatment and Active Labor Act. States have also enacted different policies, practices, and innovations to support language access (Youdelman 2019).

Language access innovations currently focus on addressing the role of private insurers, marketplaces, outlining interpreter competencies, and requiring cultural competency training for health professionals. The lack of comprehensive language access policies presents a major barrier to reducing health inequities. To date, the language access regulatory landscape across states includes mandates and/or policies that focus on specific health care providers, services, payers, or patient groups.

Within the scholarly and grey literature, there is some evidence to suggest significant associations between use of professional medical interpretation services and patient outcomes related to quality, safety, resource use, and patient experience (including communication) in both inpatient and outpatient settings (Karliner et al. 2007; Flores et al. 2012; Karliner et al. 2017; Laher et al. 2018). For example, a study by Jacobs et al. (2001) reported reduced disparities in preventive care rates and office visit rates by those with limited English proficiency (LEP) who obtained professional interpretation services versus those who did not.

Bernstein et al. (2002) found positive effects of interpretation services for mitigating ED return rate risk. Karliner et al. 2017 evaluated 24-hour access to telephonic interpretation among older LEP patients in an academic medical center inpatient setting and found a significant decrease in 30-day readmission rates. The use of interpretation services (versus no use) is associated with more time spent with the provider with additional variation by modality of interpretation type (in-person, video, telephonic) (Gany et al. 2007; Jacobs et al. 2012). Individuals' experience with providers is also linked to receipt of interpretation services during patient encounters. For example, a study by Eytan et al. found interpreter use to result in higher reporting of psychological symptoms. Another study by Jimenez et al. 2014 found that postoperative pain management in pediatric patients was better when interpreter services were available versus not. The strongest evidence of impact of interpretation services demonstrates that use of uncertified interpreters or family members can contribute to clinically significant errors relative to professional interpreters (Flores et al. 2012).

Language Interpretation Actions in Minnesota

Availability and quality of language interpretation services in health care settings has been an active policy issue in Minnesota.

In 2009, the state established a voluntary roster for its spoken language interpreters, charging a $50 annual roster fee to seeking to be listed. In 2010, MDH issued a report to the Minnesota State Legislature entitled, "Health Care Interpreter Services Quality Initiative: Report of Plans for a Registry and Certification." This report included additional minimum requirements for interpreters as well as discussion of fees needed to cover the costs of establishing and maintaining the roster. Beginning in January 2011, interpreters providing services to Minnesota Health Care Program members were required to be listed on the roster to be eligible for reimbursement.

In 2015, MDH issued a report entitled, “Interpreting in Health Care Settings: Recommendations for a Tiered Registry.” This report provided a summary of evidence and recommended the establishment of tiers within the registry, designed to distinguish interpreters with different levels of training and/or certification. No action appears to have been taken on these specific recommendations.

More broadly, the financing mechanisms available to providers to cover language interpretation service costs are not transparent. One exception is that Minnesota explicitly reimburses interpretation services delivered in outpatient settings for its Medicaid and CHIP enrollees (directly by the state or by MCOs whose costs are built into capitation contracts) (National Health Law Program, 2024). Within Medicaid, for other types of services (e.g., hospital inpatient services) or providers (e.g., FQHCs), such costs are embedded into existing payment methods. Payment for interpretation services for other insured population segments is unclear.

Within Minnesota, there are several statutes that attempt to establish guidelines regarding the provision of language interpreter services, many of which call on insurers to develop risk adjustment systems that reflect the unique needs of populations with limited English proficiency. However, one area of potential improvement in Minnesota would be the development of an advisory group that is specifically charged with the development of competency requirements for interpreters; similar innovations have been undertaken in other states like Oregon. By establishing clear certification and competency standards, the state can ensure that only qualified interpreters are used.

See Table 9 for a summary of innovations to promote language interpretation services and Example 9 for an example from the State of Washington.

TABLE 9: INNOVATIONS TO PROMOTE LANGUAGE INTERPRETATION SERVICES

Policy or Practice Innovation	Description	Goals/Effects	Where This is Happening
C.3.1 – Reimbursement By the State's Medical Assistance Program Of Health Care Homes and Behavioral Health Homes for Interpretive Services	This state statute allows the Oregon Medicaid program to provide reimbursement to health care homes that utilize interpretive services. This statute allows these providers to more easily care for diverse patient populations and address the needs of patients with limited English language proficiency.	• Make interpreter services more accessible to primary care and behavioral health care homes • Normalize and routinize the use of interpreter services when treating patients with limited English language proficiency	OR
C.3.2 – Include Computer and Website Access to Multilingual Materials in the Preferred Drug List Through Medicaid Fee-For-Service Programs	This legislative mandate requires all fee-for-service plans to increase language access for individuals with limited LEP by making materials available in multiple languages online	• Increases access for LEP populations	VA
C.3.3 – Establishing Competency Requirements for Interpreters	This statute creates a council on health care interpreters which is charged with training, assessment, qualification and certification standards for medical interpreters	• Ensuring the use of qualified or certified health interpreters may result in improved patient outcomes and reduced risk of language related medical errors	OR
C.3.4 – Mandate Meaningful Access to Language Interpreter Services for Individuals With Limited English Proficiency When Receiving Medicaid-Funded Health Services–At No Cost to the Individual	Consistent with federal and state requirements, this mandate requires that health care settings provide access to interpreter services at no cost to the patient.	• Increases access for LEP populations	WA

EXAMPLE 9: MEANINGFUL ACCESS TO LANGUAGE INTERPRETER SERVICES IN WASHINGTON STATE

Name - Sustained interpreter use in Seattle Children's Emergency Department

State - Washington

Policy - Increasing interpreter use in pediatric emergency department through staff education, data feedback, and reductions in barriers to interpreter use

Timeframe - 2017-2021

Financing - Medicaid

Description - Individuals receiving Medicaid-funded services have the right to be provided a qualified interpreter and translated materials at no cost to the individual, and the right to receive any languages offered other than English of providers in a managed care organization.

Priority Population - Limited English proficiency pediatric populations seeking emergency medical care

Equity Goals/Effects - Increases access for populations with limited English language proficiency

Source: Improving And Sustaining Interpreter Use Over 5 Years In A Pediatric Emergency Department

5. PAYMENT MODELS TO SUPPORT EQUITY PERFORMANCE OUTCOMES

Value-based payment (VBP) models seek to address misaligned financial incentives between payers and providers under traditional fee-for-service (FFS) payment systems by tying payment to financial and quality performance and encouraging greater coordination in care delivery across the continuum. These models can also be referred to as value-based purchasing or alternative payment models (APMs). Some view VBP as necessary on the path toward achieving the quintuple aim for health care improvement (lower per capita costs, better individual care experience, better population health, support for the well-being of the health care workforce, and advancing health equity) (Nundy 2022).

Value-based payment model designs vary along three key dimensions: scope of services, financial risk and reward, and performance criteria. Common examples include pay-for-performance, shared savings and risk arrangements, bundled or episodic payments, and population-based payments. The most well-known framework for categorizing VBP models is by the Health Care Payment Learning & Action Network (HCP-LAN), which emerged in 2015.

Evidence from identified systematic reviews suggests that VBP program effects on spending and quality have rarely been negative, but mostly mixed (null or positive). One systematic review examined 69 unique publications summarizing 24 VBP programs by measure and model type. Measures of processes of care and quality appeared to show positive effects as did models involving risk-sharing (Pandey 2023).

According to one systematic review that examined eight different models and stratified effects by different racial and ethnic groups, promising outcomes were identified for capitation (fixed per member per month) in terms of reduced disparities in hospital admission rates for ambulatory care sensitive conditions, having a regular source of care, visiting any doctor in the last year, or using emergency room services in the last year across multiple racial and ethnic groups. However, patient satisfaction measures were not as positive.

Pay-for-performance models also showed positive effects related to screening and preventive care for most racial and ethnic groups (Tao 2016). Gaps in evidence evaluating the effects of value-based payment models include limited subpopulation analyses, suggesting that unsuccessful findings may not always be published, and high-level systematic reviews often blurred the association between process of care and clinical or health outcomes.

A deeper dive into the effects of VBP on equitable outcomes suggested that some pay-for-performance programs were unintentionally penalizing providers caring for a higher proportion of Black patients (Kyalwazi 2024; Aggarwal et al 2021). Additionally, some provider types were reluctant to participate in population-based payment models (e.g., ACO or total cost of care arrangements) due to limiting design features or insufficient capacity to meet information technology and data analytics requirements (Ortiz 2015).

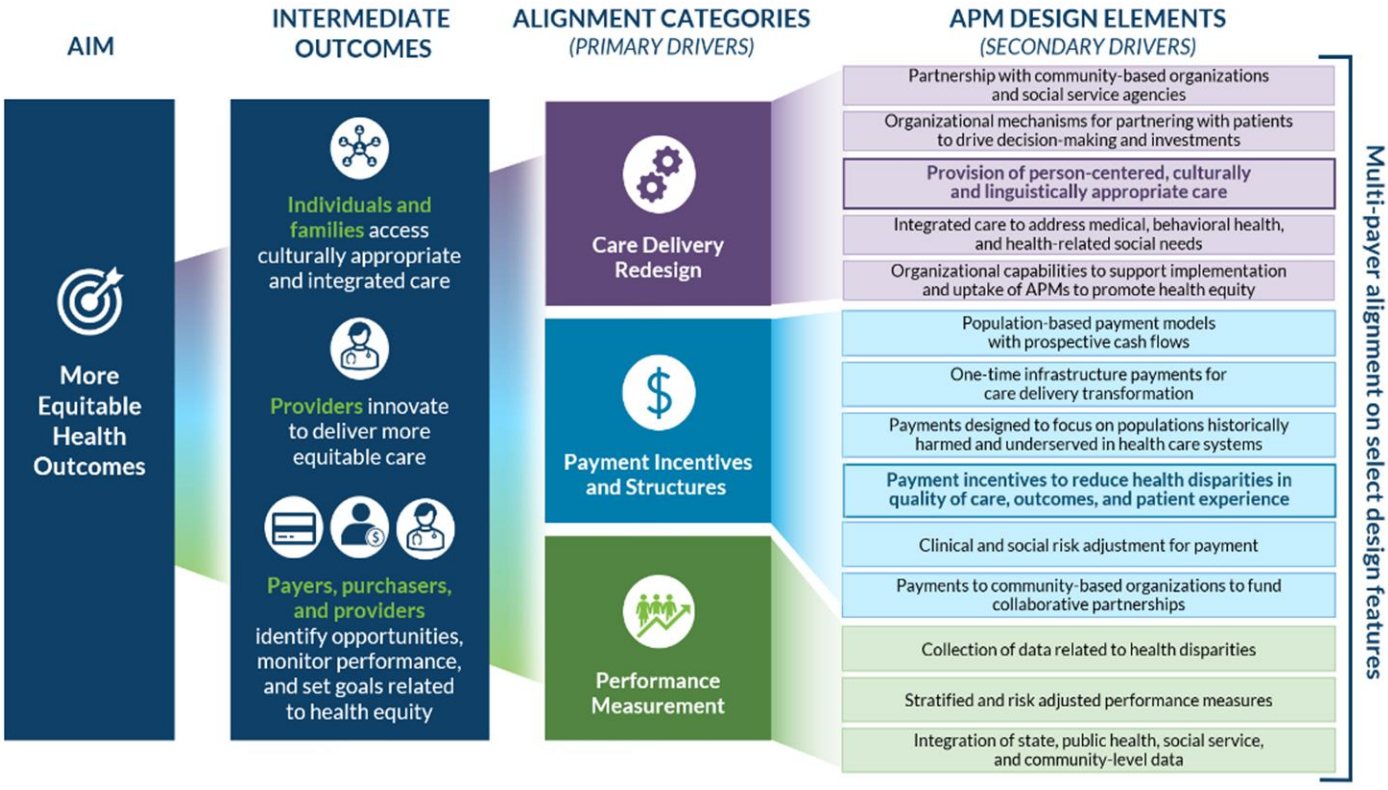
In some instances, implementing social risk adjustment stratification within performance measures was found to reduce payment discrepancies and penalties for participating providers, with mixed results in outcome measures (Conway 2022; Park 2018) while other studies pointed to the idea that the predictive spending practices used in social risk adjustment could further entrench inequitable outcomes rather than responding to population needs (McWilliams 2023).

Qualitative interviews with stakeholders serving as part of the Medicare Hospital Readmissions Reduction Program (HRRP) revealed two key suggestions for advancing equity - protecting providers from penalties while serving more vulnerable populations and improved patient-level data collection regarding social risk factors (Rogstad 2022).

Additionally, stakeholders (including those in Minnesota) reported that linking payment to current quality measures can perpetuate health inequities because measures were not aligned with how patients and clinicians define quality health care and systems do not account for providers serving communities that have been historically marginalized (Culhane-Pera 2018). To date, equitable health care outcomes were not the priority in the design of most bundled payment reforms, although that is evolving, as noted in the maternity bundle innovation discussed previously in this resource guide.

Only recently (with a few exceptions) have VBP models emphasized embedding equity performance into model design and performance measurement. In 2021, the HCP-LAN introduced a health equity framework (see Graphic 1) that describes equity-promoting strategies and tactics within the context of value-based purchasing models (referenced as APMs). The framework identifies broad opportunities for alignment between payers and providers, including investments in care delivery transformation, articulation of specific design elements in VBP arrangements that support disparities reduction/equity promotion efforts, and data infrastructure investments to permit measurement of processes and outcomes that are equity focused. Each of these primary drivers in advancing health equity have the potential to realize a collective, not just an individual, return on investment (HCP-LAN 2024).

GRAPHIC 1: HCP - LAN HEALTH EQUITY ADVISORY TEAM (HEAT) THEORY OF CHANGE FOR HOW APMS ADVANCE HEALTH EQUITY



Source: Advancing Health Equity Through APMs

Payment Models to Support Equity Performance Outcomes in Minnesota

Minnesota has a long history of care delivery and financing reforms, spanning Medicaid managed care, its 2008 health reform law, and expansion in 2013 of DHS IHPs, MDH HCHs, data analytics and e-health work, community care teams (which evolved into Accountable Communities for Health - ACHs), and standardized quality measurement under the Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) initiative.

SIM in Minnesota was a cooperative agreement between the Minnesota Departments of Human Services and Health and CMMI. Efforts under SIM to align ACO performance measurement across public and private payers were not as successful (SHADAC 2017). Since SIM ended in 2017, the IHP program remains strong with 25 participants, continued cost savings, and an improved design that enhances its focus on health equity (Gowlovech 2024). Building from and upon the IHP program is one important idea for the Task Force.

Another potential consideration for the Task Force is getting a better understanding of how equity performance is or will be incorporated in other VBP arrangements. For example, three Minnesota provider organizations are participating in another CMMI initiative known as ACO REACH - Accountable Care Organization Realizing Equity, Access, and Community Health. ACO REACH is an initiative with participants in 30 states that aims to improve care quality and outcomes for Medicare beneficiaries while advancing health equity. Features include risk-sharing mechanisms, enhanced data sharing, and simplified quality reporting to encourage participation from diverse providers, including those serving high-needs populations and safety-net communities.

Additionally, Minnesota Department of Human Services was just announced as a Transforming Maternal Health (TMaH) Model awardee by CMMI. This is a 10-year initiative (three of which are pre-implementation planning) that includes provider infrastructure payments, quality and performance incentive payments, and implementation of a value-based payment model to incentivize whole-person care that improves maternal health outcomes and reduces disparities while maintaining or reducing Medicaid and CHIP program expenditures (CMS 2025).

A. POPULATION-BASED PAYMENT MODELS

Population-based payment models (as highlighted in Graphic 1) that center health equity in design, implementation, and evaluation are promising delivery system and payment reforms that have the potential to produce equitable health care outcomes. Examples 10 through 12 below highlight two states (Oregon and Massachusetts) implementing or expanding population-based payment models for their Medicaid populations that embed equity into model design and incorporate direct equity performance evaluation.

Example 4A and Example 5, highlighted previously in this resource guide, also demonstrate how value-based payment with risk sharing arrangements and population-based models also allow for greater investment in integrated care, accounting for social risk factors, and sustaining support services such as patient navigation or language interpretation.

Population-based contracts occur when a health plan or purchaser contracts with a medical group or integrated delivery system to assume responsibility for the total cost of care for a designated patient population and a specific scope of services. A contracted provider organization receives prospective payments that cover a defined scope of services for a defined attributed population over a specified time period with financial risks (full or partial accountability lies with the provider, depending on model design) and rewards (incentives based on quality of care and patient experience) incorporated into the arrangement (Shartzer et al 2021).

Population-based payment models offer many benefits, encouraging more investment in identifying and treating upstream health factors such as health-related social needs, preventative care, and care coordination. However, adoption of population-based payment models requires provider buy-in, which may be difficult if models do not effectively account for clinical and social risks within the designated population (risk adjustment) or have adequate data infrastructure to support mature analytics.

One prevalent type of organization that enters into population-based APM arrangements are the Medicaid and Medicare based Accountable Care Organizations (ACOs), which emerged from the Affordable Care Act (ACA). ACOs agree to assume financial responsibility for the cost and quality outcomes of a defined population. A greater share of ACOs have typically been hospital-led, but over time have become increasingly physician-led (Muhlestein et al. 2020).

ACO contracts with an insurer or self-insured employer often stipulate responsibility for the full range of covered services over a designated time period and for a designated population. ACOs enter into risk-based arrangements with payers that span varying degrees of potential for financial loss or financial gains. However, researchers have cautioned that better evaluations of ACO metrics of success, both patient and quality outcomes and financial savings, are needed to ensure that equity is present in the design, implementation, and practices of this type of population-based payment model (Webb 2019).

EXAMPLE 10: MONITORING VALUE-BASED PAYMENT AND EQUITY IN OREGON

Name – Coordinated Care Organizations 2.0 – Monitoring VBP and Equity – Work in Progress

State - Oregon

Policy - Section 1115 Waiver Authority (including 2 renewals), which included levers such as measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, equity components of the CCO Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

Timeframe – 2020-Present (CCOs began in 2012)

Financing – Medicaid

Payment Model – CCO Version 2.0 was based on Oregon's 2019 CCO Value Based Payment (VBP) Roadmap that set specific, progressive targets for CCOs to meet, in terms of the level of Medicaid payments that were in the form of qualifying value-based arrangements. CCOs were always required to expand the use of payments based on value; however, at the outset, specific approaches varied and experience with linking payment to quality and reporting on VBP activities was limited. Individual CCOs determine the types of VBP arrangements to implement with their contracted providers including both pay-for-performance and risk-sharing models (considered a less prescriptive approach). (Targets for arrangements with provider downside risk began in 2023).

Description – Oregon's CCOs, launched over a decade ago by the Oregon Health Authority (OHA), are partnerships of payers, providers, and community organizations to provide coordinated medical, behavioral, and oral health care for children and adult Oregon Health Plan enrollees. They operate similar to Medicaid accountable care organizations and include Patient Centered Primary Care Home (PCPCH) payment structures and models in five care delivery areas (behavioral health, hospital care, maternity care, children's health, and oral health). (The PCPCH program in Oregon predated CCOs.) FQHCs may participate as providers within CCOs. Oregon is a state that made elimination of health disparities a priority for its Medicaid CCOs. Early in implementation, CCOs were required to document and implement activities related to disparity reductions including adopting standards for culturally and linguistically appropriate care, hiring and training practices, and stratifying data. Oregon stood up regional health equity coalitions to support CCOs, invested in community health workers (traditional health workers), and required quality improvement plans.

Priority Population – Low-income, vulnerable Oregonians enrolled in Medicaid

Equity Goals/Effects – A 2018 study reported that CCOs saw a reduction by 2014 in disparities between Black patients and white patients in primary care visits and in access to care. More recently, a 2023 interim evaluation report of CCOs VBP program and equity found: Most of the 16 CCOs were on track to meet value-based payment targets, however, variability in implementation made outcome measurement more difficult. Some providers were reluctant to enter downside risk arrangements having experienced staff losses and financial challenges post-public health emergency, and rural CCOs experienced turnover among oral and behavioral health providers. There was little evidence that CCOs were monitoring for possible disparities from VBP models due to missing or incomplete race ethnicity language and disability (REALD) data. There was evidence of equity monitoring by some CCOs outside of VBP monitoring (by population health teams). CCOs were using clinical risk adjustment to protect individuals with complex care needs and exploring social risk adjustment. VBP models afforded CCOs opportunities to promote health equity in terms, but not limited to, paying for non-covered Medicaid services and use of meaningful equity measures.

Sources: Oregon's Emphasis on Equity Shows Signs of Early Success for Black and American Indian Enrollees; Value-based Payment Roadmap for Coordinated Care Organizations; Oregon's Value-based Payment Roadmap for Coordinated Care Organizations (Baseline Evaluation Report); Value-based Payment Roadmap for Coordinated Care Organizations (Third Annual Progress Report)

EXAMPLE 11: BLUE CROSS BLUE SHIELD OF MASSACHUSETTS "PAY FOR EQUITY" PROGRAM

Name - Blue Cross Blue Shield of Massachusetts (BCBS MA) Alternative Quality Contract - "Pay for Equity"

State - Massachusetts

Policy - Multi-payer value based payment model - pay-for-equity incentives

Timeframe - 2009 through present; Health equity incentive grant cycle began in 2023

Financing - Combination of a fixed, per-patient payment with performance and equity incentive payments

Description - Through the Alternative Quality Contract model, BCBS MA - in partnership with the Institute for Healthcare Improvement (IHI) - award five-year contracts to providers and partner organizations to help them develop necessary infrastructure to launch and/or implement programs and initiatives designed to address health disparities for historically underserved populations, replacing fee-for-service systems or creating new services previously not offered. Providers/partners can also receive additional funding when they achieve equity goals, such as improving quality, patient experience, and total cost-of-care measures.

Beginning in 2023, BCBSMA introduced pay-for-equity incentives within the AQC to reward participating providers/organizations who make advancements in health equity in several areas including colorectal cancer screenings, blood pressure control, and diabetes care in addition to overall improvements in quality. Currently, 12 systems are funded through the regular AQC model, and 5 participants are part of the newer pay-for-equity model.

Priority Population - Racial and ethnic minority groups (more specifically Black and Latino/a Residents); but plans to roadmap current population-specific equity metric targets to other groups: persons who identify as LGBTQ+, persons with disabilities, persons with a preferred language other than English, and persons of other national origins.

Equity Goals/Effects - The "Pay for Equity" model within the AQC focuses on greater financial rewards for larger reductions in racial and ethnic inequities from several identified clinical areas and provides maximum payment when inequities are eliminated completely. Future plans include expansion of applicable race and ethnicity populations included, and expansion to address other populations such as persons who speak/prefer a language other than English, persons who identify as a different sexual orientation or gender, persons of a different national origin, and persons with disabilities.

Qualitative research on implementation of this model revealed four key learnings that underpin efforts to pay for equity: 1) Equity performance measurement approaches must be carefully designed to encourage improvement without creating unintended consequences. This is essential for physician buy-in. 2) Organizations need to have mature quality management systems and data infrastructure to effectively measure differences across population segments. 3) Programs must be able to effectively account for social risk factors within patient populations served by provider organizations in such arrangements. 4) Alignment across payer organizations is important to achieve greater scale to justify additional investments by provider organizations as well as to reduce administrative burden.

Sources: Payer Strategies for Advancing Health Equity Through Value-Based Care; Blue Cross Blue Shield of Massachusetts: The Alternative Quality Contract; Blue Cross Blue Shield of Massachusetts Pay-for-Equity Technical Methods; Launching Financial Incentives for Physician Groups to Improve Equity of Care by Patient Race and Ethnicity

EXAMPLE 12: QUALITY AND EQUITY INCENTIVE PROGRAMS IN MASSACHUSETTS

Name - MassHealth Quality and Equity Initiative Program (MQEIP)

State - Massachusetts

Policy - Section 1115 waiver demonstration extension

Timeframe - 2023-2027

Financing - Hospital Equity Incentive Program: $500 million divided into separate incentive pools for: 1) Private acute care hospitals ($400 million) and 2) Cambridge Health Alliance, a non-state-owned public hospital ($90 million); additional $139 million in incentive-based revenue for ACOs, MCOs, and the Massachusetts Behavioral Health Partnership (MBHP)

Description - Under CMS approval, MassHealth established the Hospital Quality and Equity Initiative to improve quality of care and advance health equity through two separate but related accountability programs. The first is aimed at hospitals, and the second at ACOs, MCOs, and MBHP. Organizations are held accountable for progress made across a set of metrics under a broader health equity domain framework. The three domains are: 1) Demographic data collection and health-related social needs screening (example metric: Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness [EOHHS]); 2 Equitable quality and access (example metric: Disability Accommodation Needs Met [EOHHS]); and 3) Capacity and collaboration (example metric: Achievement of External Standards for Health Equity [EOHHS]).

Priority Population - Multiple underserved populations enrolled in Medicaid, with a particular focus on persons with disabilities, persons with a preferred language other than English, and persons who identify as LGBTQ+

Equity Goals/Effects - Both equity incentive programs (hospitals and ACOs, MCOs, and MBHP) will make equity a pillar of value-based care alongside such domains as quality and cost. Participating hospitals will earn significant incentive-based payments if they are able to demonstrate measurable progress in meeting health equity targets such as: data collection requirements; reducing disparities in quality and access; achieving high standards for delivery of equitable care, enhancing cultural competency, and building cross-system and cross-sectoral partnerships around equity. All participants are required to submit an annual “Health Quality and Equity Strategic Plan” at the beginning of the contract year and an end-of-the-year report measuring success in achieving set goals.

Sources: State Spotlight: Massachusetts’ Cutting Edge Health Equity Initiatives; MassHealth Quality and Equity Initiative Program for ACOs; MCOs; Hospitals; Behavioral Health Centers

6. RESOURCES

This section provides resources that may be of interest to Task Force members. Topics are organized by priority area (alphabetized by title), with an additional section describing more structural changes in health care. The last section of the resource guide is a list of references used to summarize recent evidence and gaps by topic area.

A. INTEGRATION OF HEALTH CARE AND PUBLIC HEALTH

A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots

Addressing Health-Related Social Needs in Section 1115 Demonstrations

Incorporating Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations

Medicaid Authorities and Options to Address Social Determinants of Health

New York Health Equity Reform (NYHER) 1115 Waiver Program

NC Healthy Opportunities Pilots: Interim Evaluation Report

Screening, Referral, and Community Alignment to Address HRSNs: Early Lessons from the Accountable Health Communities Model

Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina

B. WHOLE-PERSON HEALTH

1) PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

Advancing Primary Care Innovation in Medicaid Managed Care Conceptualizing and Designing Core Functions

Association of Integrating Mental Health into Pediatric Primary Care at Federally Qualified Health Centers with Utilization and Follow-Up Care

Health Equity Interventions Summary for the Minnesota Integrated Health Partnerships (IHP) Program

Integrated Care with Indigenous Populations: A Systematic Review of the Literature

Integrating Behavioral Health and Primary Care- Better Care and Health for the Whole Person: Case Studies on Health Plan & ACO Partnerships

Integrating Primary Care and Behavioral Health with Four Special Populations: Children with Special Needs, People with Serious Mental Illness, Refugees, and Deaf People

Primary Care Behavioral Health in the Department of Defense

TEAM UP Model

2) PRIMARY CARE AND ORAL HEALTH INTEGRATION

A Focus on Prevention

Dental Care in Accountable Care Organizations: Insights from 5 Case Studies

Dental Therapists in the United States Health Equity, Advancing

Dental Therapy Advocacy: Community Engagement Guide

Dental Therapy Toolkit - A Resource for Potential Employers

Oral Health Toolkit for Primary Care

3) PATIENT NAVIGATION

Care Coordination in Primary Care: Mapping the Territory

Community Health Worker

Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States

Community Health Workers Program

Enhancing Patient Navigation with Technology to Improve Equity in Cancer Care

Health Equity Services in the 2024 Physician Fee Schedule Final Rule

Primary Care Plus Orientation

Primary Care Plus (PC Plus)

Q&A: Using an Alternative Payment Model to Support Community Health Worker Sustainability in Maine's Primary Care Plus Program

State Approaches to Community Health Worker Financing through State Plan Amendments

Understanding Billing for CHW Services in MN - Medicare and Medicaid & Part II: Understanding Billing for CHW Services in MN

What Are Patient Navigators and How Can They Improve Integration of Care?

4) COMPLEMENTARY HEALTH APPROACHES

Complementary and Integrative Health Waiver

Evaluation of Complementary and Integrative Health Services (CIHS) in Health First Colorado

Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update

Use of Complementary Health Approaches Overall and for Pain Management by US Adults.

What Does NCCIH Do?

C. CULTURALLY APPROPRIATE CARE

1) DOULA CARE WORKFORCE AND SUSTAINABLE PAYMENT MODELS

Birth Doula in MN

2) CULTURALLY-SENSITIVE MENTAL HEALTH AND SUBSTANCE USE INTERVENTIONS

Is Culturally Based Prevention Effective? Results from a 3-year Tribal Substance Use Prevention Program

3) LANGUAGE INTERPRETATION SERVICES

Improving and Sustaining Interpreter Use Over 5 Years in a Pediatric Emergency Department

Interpreting in Health Care Settings: Recommendations for a Tiered Registry

Language Testing and Certification (LTC) Program

Medicaid and CHIP Reimbursement Models for Language Services: 2024 Update

D. POPULATION-BASED OR OTHER VALUE BASED PAYMENT MODELS

Developing Primary Care Population-Based Models in Medicaid: A Primer for States

Federally Qualified Health Centers and Performance of Medicare Accountable Care Organizations

Launching Financial Incentives for Physician Groups to Improve Equity of Care by Patient Race and Ethnicity

Measuring Health Disparities in a Commercially Insured Population: The First Step to Incorporate Equity into Value Transformation

Paying for Health and Value Health Care Authority's Long-term Value-based Purchasing Roadmap 2023-2027

Provider Strategies for Advancing Health Equity Through Value-Based Care

Risk Adjustment and Promoting Health Equity in Population-Based Payment: Concepts And Evidence

Senior-Focused Primary Care Organizations Increase Access for Medicare Advantage Members, Especially Underserved Groups

Value-Based Payment Models in the Commercial Insurance Sector: A Systematic Review

Value-Based Purchasing Design and Effect: A Systematic Review and Analysis

Value of Health Care Redefined: Social Return on Investment Understanding the Landscape and Opportunities for Applying Social Return on Investment to Health Care

E. ROOT CAUSES OF HEALTH INEQUITIES AND SOLUTIONS FOR DISMANTLING THEM

A Conceptual Map of Structural Racism in Health Care

Achieving a Racially and Ethnically Equitable Health Care Delivery System in Massachusetts: A Vision and Proposed Action Plan

Annotated Bibliography: Underlying Factors of Medicaid Inequities

Barriers to Care for Patients with Diabetes in Durham, North Carolina, Why Are We Withholding Life-sustaining Medications from the Patients Who Need Them the Most?

Health Equity Action Plan Toolkit

How Hospitals Are Addressing the Effects of Racism: A Mixed-methods Study of Hospital Equity Officers

Instruments for Racial Health Equity: A Scoping Review of Structural Racism Measurement, 2019-2021

Making the Invisible Visible: How Better Data, More Access, and Community-based Solutions Can Drive Health Equity

Mitigating Racial and Ethnic Bias and Advancing Health Equity in Clinical Algorithms: A Scoping Review

Proposing a Racism-Conscious Approach to Policy Making and Health Care Practices

Targeted Universalism Policy and Practice

The C2DREAM Framework: Investigating the Structural Mechanisms Undergirding Racial Health Inequities

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B. WHOLE-PERSON HEALTH

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