DEPARTMENT OF HEALTH

Equitable Health Care Task Force

RECOMMENDATIONS

July 30, 2026

Equitable Health Care Task Force Recommendations

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A Message from the Commissioner

In 2023, when the legislature approved funding for the Equitable Health Care Task Force, I was ecstatic. As someone whose career has focused on systems transformation, and who has been frustrated by the slow uptake (and now in some spaces the quick dismantlement) of health equity as a core principle, I was thrilled by this opportunity to get people from various backgrounds who are all committed to health equity in one room to identify levers to drive us forward in Minnesota. I want to thank each member of the Equitable Health Care Task Force for the experiences, insights, and energy they brought to this work and for wrestling with my call to "be bold" with legitimate—and growing—concerns about pragmatism. The Task Force's collaborative process has produced this report, which will serve as a valuable tool for discussions for years to come.

The recommendations reiterate core domains of health equity strategy—(1) meaningful access to care, (2) primary and whole-person care, (3) workforce diversity, and (4) system accountability—which have been at the center of health equity conversations for decades. The Task Force has called for more support for and investment in key areas, including primary care, telehealth, mobile health, high quality translation and interpreter services, transportation support, community health workers, holistic approaches to school admissions, partnerships to address health-related social needs, and data sharing. I am pleased that they have also called attention to several pain points beyond insurance coverage, including weak integration between mental and behavioral health, primary care, and public health; poor health system literacy, which means people are less prepared to navigate our current system or advocate for its reform; the need to expand access to preventative oral health services in the community rather than solely through dentists' or doctors' offices; and the potential to increase the supply of health care workers by leveraging remote learning modalities in health professional education.

The Task Force's focus on these domains reaffirms how truly critical they are to health equity strategy and to some extent indicts our progress to date. Continuing to point out where our health care system is falling short and leaving people behind is an essential part of the policy dialogue in our state. I also sense a strong desire to move from talk to action, as there are clear calls for policymakers to do more to support health equity and for them to incentivize, mandate, and regulate the health care industry to force greater accountability.

The Task Force's focus on the state as the driver of health system accountability and the central means to address workforce needs perhaps hints at an underlying conviction guiding their approach. Reading the report and noting its focus on the state, I get the sense that health care, writ large, will not make the necessary investments or pivots without state intervention—that if health care, including our educational institutions, were going to take these steps without additional prodding, they would have done so already. This supposition, albeit implicit, is worth a more explicit reckoning with those parties at the table. Certainly, the corporatization, consolidation, and financial strains across the payer and provider landscapes do not bode well for any strategy that leaves advancing health equity primarily up to them. However, because of political polarization and the immense stress on the public sector, it is also true that we are unlikely to see more regulation or the expansion of public policy and programs at this time.

So where does that leave us? My hope is that crisis will force creativity, produce more robust partnerships, and create opportunities for system redesign with and by community members. Community-based organizations, in practice and in this report, are largely positioned alongside

care delivery, as the means for health systems to address patients' social needs. Community organizations should not just be our social safety net; community members are not just sources of feedback on what's broken. Rather we need to turn to them as skilled problem solvers with vision and expertise; the very ones who should be front and center as system architects so that we unlock solutions that are more innovative, equitable, and grounded in real life. I wonder how we might leverage new technology, artificial intelligence, and other advancements in digital health to empower community to address the shortcomings of our current systems, so that the people who use health care are better able to shape and participate in its delivery. While I wholeheartedly agree that we should continue to push health care organizations to do more, making small adjustments at the edges or doing the same things slightly better will not lead to the kind of transformational change we are seeking. If we are skeptical of their ability or willingness to adapt, let us also find those health entrepreneurs who share our vision and are eager to build new models of care right now.

I am so appreciative of the Task Force's work. I hope this letter accurately expresses some of the tensions that I know many of you all feel as you work tirelessly to advance equitable health care. I am grateful for your dedication, your truth-telling, your resilience, and your leadership.

Sincerely,

Brooke Cunningham, MD, PhD

Commissioner

A Word from the Task Force

Dear Commissioner Cunningham:

The Equitable Health Care Task Force (Task Force) is pleased to submit our recommendations to you. We are acutely aware of your personal commitment to health care equity and have appreciated the opportunity to work with you and your team.

Simply put, our health care system doesn't work for many people living in Minnesota. Inequities undermine the health and well-being of many individuals as well as entire communities, including racial and ethnic communities, LGBTQIA+ populations, rural residents, and people with disabilities. **Our definition of Health Care Equity means the ability for every person to achieve and sustain self-defined optimal health outcomes throughout their lives supported by our health care policies, resources, and health care systems. Ultimately, the State of Minnesota is responsible for working with partners and holding all parties accountable to achieve our desired outcomes.** Our vision is that structural and institutional injustices will be addressed, cultural practices will be newly honored, and new modes of health care delivery will be created.

We have organized our recommendations into four broad areas: 1) meaningful access to health care; 2) primary and whole person care; 3) workforce issues; and 4) system accountability. Segmenting many interconnected issues into broader categories was difficult, but ultimately helpful in more clearly organizing our discussions and providing context to explain the basis of our recommendations. Individual components of the recommendations work together to improve health care equity, though they could be implemented through a phased approach.

The road to develop these recommendations has been challenging. Some of us consider ourselves as "outsiders" to Minnesota's health care system and health policy establishment. We brought our lived experience and our communities' voices to the Task Force. Many of us do work in the health care system and these recommendations also reflect the ranges of our professional experience, including caring for people experiencing inequities. Bringing this mix of perspectives together has been both difficult and illuminating. Our process required developing trust and understanding of the ways in which Task Force members could work together and with MDH to support the Task Force's deliberations. Members ultimately supported different recommendations to varying degrees and, in some instances, members may have disagreed with specific recommendations. Nevertheless, all of the recommendations presented here reflect the range of perspectives we—and the communities we represent—hold and believe to be essential to eliminate health inequities.

We put forth these recommendations after 21 months of deliberation, which included seeking input through a public comment process and community engagement sessions (see Appendix E). In those sessions, we sought feedback to understand which of the proposed recommendations would be most likely to have improve health outcomes, access to care, and experience with the health care system. Readers will see the results of that engagement process woven throughout this document. While this report is aimed at an audience of public and private sector leaders with the ability to create change inside our health care and public health systems, the communities we represent and/or serve should remain at the center of this document.

The nation's social and political landscape has shifted substantially since the Task Force was first convened. This evolution impacted the development of our recommendations. From the start (January 2024), there was a tension around whether our recommendations should focus on incremental changes or the wholesale transformation of our health care system. This tension became more pronounced in 2025. We ultimately decided our recommendations should span this continuum. We included recommendations we deemed more feasible in the current environment and those, which some described as "aspirational" right now, that we want hold onto and keep top of mind for our future.

We know this Task Force is not the first to consider these issues or to make similar recommendations to advance health care equity. We know that community members, state agencies, policy makers, and private organizations have made efforts in the four areas that we focus on here. However, in our view, efforts to date have barely moved the needle. This report is intended as an **urgent call to action** to all those who are part of the public health and health care system—policy makers, public health leaders, health care provider executives, physicians, nurses, other care providers, health insurers, community organizations and others—to embrace and implement these recommendations at the scale required to **meaningfully** improve health care equity.

We appreciate MDH's support of this work to date, and we expect MDH to take leadership and accountability for its own role in improving health care equity and in providing transparency on progress made by other public and private sector organizations to do the same. Although this Task Force process has concluded, this work is just beginning. We look forward to MDH keeping us apprised of how MDH is working with policy makers, other state agencies, and private sector organizations to make progress on them. We can't afford to wait any longer.

Executive Summary

The 2023 Minnesota Legislature directed the Commissioner of Health to form an Equitable Health Care Task Force to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies for ensuring that all persons in Minnesotan can receive care and coverage that is respectful and ensures optimal health outcomes.

MDH convened the Task Force in January 2024 with 20 members representing a broad array of communities, perspectives, and subject matter expertise. Members participated in an intensive array of full Task Force meetings, a day-long retreat, learning opportunities with subject matter experts, and working sessions to identify issues contributing to health care inequities and develop recommendations to address them. As part of their deliberations, Task Force members established a working definition of Health Care Equity, meaning **the ability for every person to achieve and sustain self-defined optimal health outcomes throughout their lives supported by our health care policies, resources, and health care systems. Ultimately, the State of Minnesota is responsible for working with partners and holding all parties accountable to achieve our desired outcomes.**

Input gathered through community listening sessions and a public comment period shaped these recommendations. Members were strongly interested in hearing community perspectives about which recommendations, if implemented, would have the strongest positive impact on health care equity and where there might be gaps yet to be addressed.

The Task Force's 26 lead recommendations and more detailed sub-recommendations are organized around four key themes:

- Provide Meaningful Access to Care: These recommendations include strategies to ensure all residents of Minnesota can access health care where and when they need it. They also aim to ensure care is culturally responsive.
- Bolster Primary and Whole Person Care: These recommendations address the need for Minnesota's health care system to move toward a re-envisioned primary care-driven model of health care across life stages and events. While this approach to care would better serve the needs of all Minnesota residents, it is especially needed to improve outcomes for individuals with significant and compounded health-related social needs.
- Strengthen and Diversify the Workforce: These recommendations address the need to enhance diversity of the health care workforce; improve culturally responsive skills among health care workers; address workforce inequities; and optimize the health care workforce.
- Ensure System Accountability: These recommendations aim to ensure the health care system is more accountable to all persons in Minnesota through strategies related to health care coverage; handling patient grievances; community co-leadership and equity-focused oversight in partnership with health care organizations and the State of Minnesota; and measurement of health care equity.

The Task Force's recommendations encompass a spectrum of approaches, ranging from more specific proposals to build on the state's current health care system to broader, more transformational concepts. Many of the Task Force's recommendations would require adoption

of new laws, additional regulatory authorities, and/or budgetary commitments for new or enhanced programs. Virtually all require the active partnership of health care provider organizations and individual health care providers as well as insurers, state and local agencies, and community-based organizations.

Minnesota starts in a relatively strong place with respect to the state's health care and public health system (The Commonwealth Fund, 2025: *2025 Scorecard on state health system performance*). However, the health care ecosystem has significant work to meaningfully address health inequities that are manifest in our state. Our bar is higher for what people should expect from Minnesota's health care system.

The Task Force carried out its work amidst a rapidly evolving and uncertain environment at the federal level. Recent federal policy and budget changes will likely further strain already stressed communities and reduce needed federal funding for Minnesota's publicly funded health care programs. The Task Force is cognizant of these significant changes and the challenges they pose to Minnesota's current health care system— and yet mindful of what is needed to improve health care equity in our state. Public and private leadership, commitment, and strategic investment are urgently needed to help build a more equitable health care system and allow all persons in Minnesota to achieve and sustain optimal health.

Figure 1. Task Force Recommendations Summary

1. Minnesota must ensure all persons in Minnesota have comprehensive health care coverage, timely access to needed health care services, and a basic understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

1.1 Minnesota should implement comprehensive coverage for all persons in Minnesota. This coverage should augment—rather than supplant or replace—the Tribal health systems of the 11 Tribal Nations within Minnesota and the services provided by Indian Health Services. Although comprehensive coverage in itself does not eliminate disparities, it is a component of a more equitable health care system.

1.2 There should at least be comprehensive health care coverage for American Indian communities and Tribal citizens in Minnesota.

1.3 Minnesota should support a health care delivery system that all individuals can access where and when they need it. While these recommendations would benefit all individuals and families, those experiencing health care inequities the most acutely need more flexible access the most due to less flexible work schedules, fewer transportation options, and a greater likelihood of having health-related social needs.

1.4 As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.

1.5 Minnesota should expand inclusive and accessible telehealth by investing in mobile care, phone-based services, and broadband infrastructure to ensure equitable access in rural and underserved communities.

1.6 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

1.7 Minnesota should strengthen patient health literacy related to accessing, navigating, and paying for health care.

1.8 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.

2. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages, events and health conditions to help ensure people of all backgrounds get the care they need.

2.1 A re-envisioned primary care system should integrate and coordinate care for physical health, mental health, substance use, complementary care, and culturally responsive care.

2.2 Minnesota should invest in team-based primary care models that address health-related social needs and coordinate activities with public health and community-based organizations.

2.3 Minnesota should adopt reimbursement and payment models that will support investments in primary and whole-person care.

3. Minnesota should build and nurture an equitable health care workforce to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients, and communities.

3.1 Foster workplace inclusion, belonging, safety, and well-being to encourage equitable retention of current diverse workforce members. Promote diversity at all levels of health care organizations, including senior leadership and boards of directors.

3.2 Enhance workforce skills for cultural responsiveness.

3.3 Increase diversity of the current health care workforce through shorter term strategies.

3.4 Introduce long-term changes to health professional training programs and the broader education system to increase the diversity of the future health care workforce.

3.5 Optimize the health care workforce by making strategic investments to address workforce shortages; to ensure care is more available in underserved areas of Minnesota; and to ensure health care professionals may work at the top of their license to meet basic health care needs.

4. Minnesota should foster an accountable health care system that strengthens patient protections, eliminates discrimination, and ensures fair treatment by integrating community co-leadership, shared data infrastructure, and oversight mechanisms to monitor implementation and promote health care equity through inclusive standards across the health care system.

4.1 Minnesota should strengthen and harmonize its approach to health care patient protection to address health care discrimination and unfair treatment.

4.2 Health care in Minnesota should have community co-leadership and equity-focused oversight.

4.3 Minnesota should strengthen data infrastructure and data support sharing among payers, health care providers, community organizations, researchers, social service providers, and public health.

4.4 Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.

4.5 Health plans and health care provider systems must work towards meaningful improvements in health care equity by following evidence-based best practices and frameworks (for example, the Institute for Health Care Improvement's "A Framework for Improving Health Equity," NCQA's health outcomes accreditation programs, The Joint Commission's Excellent Health Outcomes for All certification, etc.).

4.6 The State should establish a multi-stakeholder "Accountability Group" to serve in an advisory capacity to the Commissioner of Health. The purpose of the group would be to establish an ongoing forum for keeping health care equity issues on the top of MDH's agenda to improve health care equity on a statewide basis.

Introduction

The nation's health care system, including Minnesota's, is rife with inequities impacting many individuals and communities. The Institute of Medicine's landmark 2003 report "Unequal Treatment" documented what many already knew but was not yet acknowledged at that time in the public sphere: that institutional racism is pervasive throughout the health care system and undermines the well-being of many diverse populations and results in worse health outcomes, lower life expectancy, and reduced quality of life (Institute of Medicine, 2023: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care*). The report showed consistent racial and ethnic disparities across a wide range of diseases and procedures, even after accounting for income, insurance coverage, age, and disease severity. These disparities were attributed to structural factors–such as fragmented care, under resourced facilities, and geographic barriers–as well as provider-level bias, stereotyping, and clinical uncertainty. The report also identified longstanding social and economic inequalities, including residential segregation and unequal access to education and employment, as root causes that shape health outcomes and access to care. Other individuals, including residents of rural areas (Thomas et al., 2024: *The nature of the rural-urban mortality gap*), LGBTQIA+ populations (Lampe et al., 2024: *Health disparities among lesbian, gay, bisexual, transgender, and queer older adults: A structural competency approach*), people with disabilities (Okoro et al., 2018: *Prevalence of disabilities and health care access by disability status and type among adults - United States, 2016*) and people with language access barriers also experience inequities in their health outcomes and/or interactions with the health care system. Inequities in the health care system are profound, multi-faceted, and far-reaching, and addressing them requires systematic change across policy, practice and society.

The 2023 Minnesota Legislature directed the Commissioner of Health to form a task force to study issues related to health care inequities. The Equitable Health Care Task Force (Task Force) was created to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies

for ensuring that all persons in Minnesotan can receive care and coverage that is respectful and ensures optimal health outcomes (see Appendix A). When this report uses the term "diverse," it should be noted the Task Force is referring to all of these characteristics plus socioeconomic status and the unique ways in which diverse populations experience inequities.

MDH convened the Task Force in January 2024 to begin its work. The Task Force is comprised of 20 individuals representing various communities, perspectives, and related subject matter expertise (see Appendix B). The Task Force had a broad charge and complex set of interconnected issues to address. Its resulting recommendations—and this report—are organized around four themes:

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

The Task Force developed its preliminary recommendations and subsequently engaged in a community feedback and public comment process about them (see Appendix E). Community feedback included 10 listening sessions with specific communities of interest, including providers, community-based and advocacy organizations, health navigators and care coordinators, local public health, and Tribal health directors, among others. The public comment process yielded 24 comments.

Each section of this report begins with a high-level description of the types of issues and challenges the recommendations are intended to address. It then includes recommendations and a rationale explaining how that category of recommendations relates to improvement of health care equity. Each section concludes with some highlights from public engagement about which of the recommendations are highest priority from a community perspective. The Task Force's recommendations include 26 leading recommendations with more detailed sub-recommendations associated with each. In all, the Task Force has a total of 75 sub-recommendations.

The report also proposes a place to start with respect to implementation of a subset of the recommendations. The appendices include more detailed information, including examples of evidence-based and/or promising strategies to improve health care equity.

Background

The Diversity of Minnesota's Population

Minnesota's population is diverse along a number of dimensions:

- According to the State Demographer's Office, People of Color (those who identify as a race other than White alone, and/or those who are Hispanic or Latino/a) make up 20% of the total population (Minnesota State Demographic Center, 2018: *Age, race, & ethnicity*). Non-Hispanic White individuals represent the remaining 80% of the statewide population. Between 2010 and 2018, Black or African American persons were the fastest growing racial group in Minnesota increasing by 36%. Asian individuals were the second fastest growing

group increasing by 32%, followed by Hispanic or Latino/a individuals increasing by 24%. As we look ahead, Black and Indigenous populations and other Communities of Color are expected to continue to grow at a faster rate than White populations (Minnesota State Demographic Center, 2024: *Our projections*).

- In 2018, nearly 12% of people in Minnesota spoke a language other than English at home (Minnesota State Demographic Center, 2018: *Immigration & language*).
- In 2024, approximately 11% of people in Minnesota identified as LGBTQ+ (Minnesota Compass, 2024: *Picture of LGBTQ Minnesotans, Part 1: What existing data sources can, and can't, tell us*).
- While the poverty rate was 10% for Minnesota in 2018, poverty rates were substantially higher for American Indians (34%), Black individuals (27%), and Hispanic individuals (19%), which were three to four times higher than the rates of non-Hispanic White individuals (Minnesota State Demographic Center, 2018: *Income & poverty*).
- In 2018, 10.4% of individuals ages 35 – 64 had a disability, while 45.1% of individuals 75+ reported having a disability (Minnesota State Demographic Center, 2018: *Health & disability*).

Experiences and Impacts of Discrimination in the Health Care System

Discrimination in the health care system was a key topic of Task Force deliberations. An analysis of the 2024 Minnesota Healthcare Experiences survey found that nearly half of the survey participants (47.2%) reported that they experienced discrimination while seeking health care services (MDH, 2026: *Patient experiences with healthcare discrimination in Minnesota: Findings from the 2024 Minnesota Healthcare Experiences Survey* and MDH, 2026: *Patient Experiences with Healthcare Discrimination in Minnesota–Supplemental Appendices*). Experiences of discrimination were most common among transgender (trans) and nonbinary survey participants; 83.2% reported some type of health care discrimination. Overall, the most common reasons participants cited for discrimination were age- and body weight-related (each around 20% of those reporting some type of discrimination). Discrimination based on race ranked high among participants of color. For Black participants, it was the most reported type (18.9%). BIPOC and Indigenous survey participants also reported higher percentages of race-based discrimination (17.8% and 14.9%, respectively). The most common type of discrimination reported by trans and nonbinary participants was gender, gender expression, or sexual orientation (72.7%). Almost all people who reported experiencing discrimination said that it affected their mental health (95.0%), and nearly as many people believed their health care was negatively affected by their experience with discrimination (86.3%). Roughly one-third of participants who experienced health care discrimination said that it caused them to stop their health care early (37.1%) or avoid seeking health care except in emergencies (33.6%).

In order to position the state well for a healthy, thriving future, Minnesota needs a health care system prepared to serve its diverse population. And all people in Minnesota in rural and urban areas alike deserve a health care system that can meet their health and health-related social needs.

Protecting and Building on Recent Progress

It is important to note that policy makers, state agencies, health care organizations, and community-based organizations have made some significant efforts around some of the issues raised in the Task Force's recommendations. The following are illustrative examples:

- The legislature recently simplified and increased dental care reimbursement rates for MinnesotaCare and Medicaid; restored access to dental benefits for adults enrolled in those programs; and established performance expectations for managed care organizations related to ensuring a target percentage of public program enrollees have at least an annual dental care visit (Minnesota Department of Human Services, 2025: *Oral health*). These were long overdue policy and financing changes to improve access to oral health in Minnesota.
- The Minnesota Department of Human Services (DHS) collaborated with community members to develop its 2022 report, Building Racial Equity into the Walls of Minnesota Medicaid (PDF) with a focus on U.S.-born Black Minnesotans. DHS engaged with health care and human services staff from Tribal nations in Minnesota and leaders from Urban American Indian clinics and organizations to develop its 2024 report, Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota (PDF). These reports examined the impact of Medicaid respectively on Black Minnesotans and American Indians and identified opportunities for meaningful collaboration between DHS and community to address racial equity and improve health outcomes for these populations. The Minnesota Legislature and DHS have acted on recommendations put forth in these reports. For example, persons aged 0-19 have continuous Medicaid coverage, enrollment and renewal processes have been simplified for Medical Assistance and MinnesotaCare, there is increased support for community-based navigator organizations, and there are decreased barriers and improved payments for doulas. Additionally, the Minnesota 2025 legislative session included a bill that directs DHS to pursue a waiver to cover traditional health care practices.
- The unwind of continuous coverage was Minnesota's largest initiative around health insurance since the implementation of the Affordable Care Act (DHS 2024, *Minnesota health care programs renewal equity report: July 2023 – March 2024 renewal cohorts*). DHS and its partners focused funding and attention on decreasing racial and geographic disparities in disenrollment during the unwind and it worked. Disparities in disenrollment for Black and most American Indian enrollees disappeared, and disparities for Hispanic or Latino/a enrollees significantly narrowed. This significant progress was due to collective and multifactorial efforts between DHS and its community partners. For example, much work was taken to increase auto-renewal rates. This process removed administrative barriers to maintaining coverage through utilizing reliable sources to confirm an individual's eligibility and auto-renewal rates nearly tripled.

The Task Force's recommendations seek to ensure Minnesota preserves recently made investments, builds upon other important foundational steps, and improves upon them moving forward.

See Appendix F for additional background information on various strategies underway in Minnesota and elsewhere that address topics included in the Task Force's recommendations. Please note that information in Appendix F is intended as illustrative background information rather than a comprehensive inventory of related efforts.

Recommendations

This section of the report describes each of the four areas of recommendations. The Task Force engaged in a detailed process to develop, review, and refine their evolving recommendations, including identifying where members had concerns about specific recommendations and making modifications to address those issues. Although Task Force members worked diligently to reach consensus on recommendations, it should be noted that members ultimately supported different recommendations to varying degrees and, in some instances, members may have disagreed with specific recommendations. These recommendations reflect a range of perspectives across Task Force Members.

Recommendation Area One: Provide Meaningful Access to Care

What Challenges Do These Recommendations Address?

- Although Minnesota has one of the highest rates of insurance coverage in the nation [State Health Access Data Assistance Center (SHADAC), University of Minnesota, 2024: *Survey data season 2024*], a sizeable proportion of people struggle with access to high quality and comprehensive health care. Almost 4% of people in Minnesota were uninsured in 2023 (MDH, 2024: *Chartbook section 2: Trends and variation in health insurance coverage (PDF)*). Individuals born outside the United States, individuals who are not U.S. citizens, American Indians, people of Hispanic ethnicity, and lower income individuals are more likely to be uninsured.
- Almost 25% of Minnesotans reported forgoing some type of health care (routine medical, specialist, mental health, prescription, or dental) in 2023 due to concerns about the cost of care. Rates of forgone care were highest for Indigenous, Hispanic, and Black Minnesotans, as well as those without insurance (MDH, 2024: *Findings from the 2023 Minnesota Health Access Survey (MNHA) (PDF)*).
- Many individuals lack essential knowledge about how to access and navigate the health care delivery system or how health insurance coverage works. This is especially true among newer immigrants and other individuals who do not have a strong connection to the traditional health care system.
- People in Minnesota face a variety of challenges related to where and when health care services are available. Traditional care models require those in need of care to go to clinics or hospitals that may be outside of their neighborhoods or town, which is especially challenging when those locations are a considerable distance away and/or for families who cannot easily access transportation to get to those care locations. Communities struggle with a lack of access to health care providers due to local closures of clinics and hospitals in both rural and urban areas and due to shortages of health care workers in critical health professions. Individuals and families face challenges in obtaining care when services are not available in the evenings or on weekends, especially for adults with multiple jobs or whose employment may not offer the ability to take paid time off to attend medical appointments.
- Health care provider organizations do not have sufficient capabilities to communicate with patients who speak a language other than spoken English as their preferred language. This detracts from providers' ability to understand the patient's circumstances and the patient's

experience with the care they receive. National Culturally and Linguistically Appropriate Services (CLAS) Standards were first created in 2000 and were an important step forward to promote effective communication with patients (Office of Minority Health, n.d.: *National CLAS Standards: Fact Sheet (PDF)*). There is not a federal requirement to implement CLAS standards, so implementation varies by state and system. A set of federal regulations[1] requiring health care providers (among other entities) to provide meaningful access to language access services for all patients who need them took effect in July 2024 [42 C.F.R. Parts 438, 440, 457, and 460, and 45 C.F.R. Parts 80, 84, 92, 147, 155, and 156 (2024)]. Compliance with the 2024 rules and quality of language access services vary considerably.

- Despite trust and treaty responsibilities, health care coverage and access for American Indian communities and Tribal citizens remains fragmented and incomplete. While the Indian Health Service (IHS), plays a key role in delivering care, it is chronically underfunded and cannot provide sufficient care (DHS, 2024: *Pathways to racial equity in Medicaid: Improving health and opportunity of American Indians in Minnesota (PDF)*). Additionally, IHS is not a form of health insurance coverage (Centers for Medicare & Medicaid Services, 2022: *10 important facts about Indian Health Service and health insurance (PDF)*). Medicaid coverage is essential for American Indians and Tribal citizens to access a broader range of services and to sustain Tribal health systems. American Indians have some of the highest rates of insurance coverage through Medicaid [25% of adults ages 19 to 64, and 54% of children in 2023 [State Health Access Data Assistance Center (SHADAC), University of Minnesota, 2025: *SHADAC analysis of the American Community Survey Public Use Microdata Sample files, State health compare*]. However, Medicaid eligibility rules are complex and maintaining enrollment—especially for adults—requires frequent renewals, which can lead to inconsistent coverage.

Recommendations

Recommendation 1. Minnesota must ensure all persons in Minnesota have comprehensive health care coverage, timely access to needed health care services, and a basic understanding of care delivery and insurance so people may receive the care they need when, where, and how they need it.

Recommendation 1.1 Minnesota should implement comprehensive coverage for all persons in Minnesota. This coverage should augment—rather than supplant or replace—the Tribal health systems of the 11 Tribal Nations within Minnesota and the services provided by Indian Health Services. Although comprehensive coverage in itself does not eliminate disparities, it is a component of a more equitable health care system.

Recommendation 1.2 There should at least be comprehensive health care coverage for American Indian communities and Tribal citizens in Minnesota.

1.2.1 Tribal members and children should be automatically eligible for a health care plan that provides coverage.

[1]Final rule implementing Section 1557 of the Affordable Care Act.

1.2.2 Uphold federal treaty agreements with Tribes to ensure comprehensive health care coverage for Tribal communities.

1.2.3 The State of Minnesota should support Tribal Nations in accessing care for their members and ensuring access to equitable health care.

Recommendation 1.3 Minnesota should support a health care delivery system that all individuals can access where and when they need it. While these recommendations would benefit all individuals and families, those experiencing health care inequities the most acutely need more flexible access the most due to less flexible work schedules, fewer transportation options, and a greater likelihood of having health-related social needs.

1.3.1 Address closures of rural health care facilities by leveraging rural-based solutions and existing community assets, such as schools and mobile care models.

1.3.2 Support providers in offering flexible hours for evening and weekend appointments.

1.3.3 Expand provision of school-based and community-based health services, including oral health screenings and preventive services. Expand primary prevention programs through healthy youth development programs.

1.3.4 Enhance policies for coverage and availability of in-home monitoring systems (for example, blood pressure monitoring and glucose monitoring) that integrate with health care delivery systems.

1.3.5 Expand information in provider directories related to provider demographic information so patients can choose providers with whom they identify.

Recommendation 1.4 As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.

1.4.1 Increase access to multi-lingual providers and staff.

1.4.2 Standardize translation services through licensing of translators to ensure they are knowledgeable about health-related concepts and terminology as well as meet language competency standards.

1.4.3 Establish infrastructure to provide access to independent contractors offering interpreter services and make it available for hospitals and other providers to buy into.

1.4.4 Ensure consistency in reimbursement by payers for interpretation and translation services.

1.4.5 Consistent with federal civil rights regulations and the protections enforced by the Minnesota Department of Human Rights, providers must ensure language access services are available and effective across all points of care. Staff should be trained and systems established so patients are not burdened to report gaps in access; responsibility for ensuring equitable care rests with providers and the health care team. The State of Minnesota should empower patients with meaningful choice of language access services, respecting communication, privacy, cultural, and gender

needs. Beyond regulatory compliance, these actions should affirm Minnesota's commitment to equity, dignity, and person-centered care for people with disabilities and those requiring language access services.

1.4.6 Ensure that translated patient-facing education and materials are vetted with multilingual clinicians or professional translators to ensure cultural context is taken into account for some of the languages that are not easily translatable from English, such as Hmong, Somali, and others with different health paradigms.

1.4.7 Require after-visit summaries to be provided in the patient's preferred format (e.g., written, audio, or video), translated, in plain language, and include after care and follow-up instructions.

1.4.8 Develop a centralized hub for providers to access vetted translated materials in commonly used languages across Minnesota to promote consistency and reduce provider costs.

1.4.9 Require providers to adhere to the National Association for the Deaf's "Minimum Standards for Video Remote Interpreting Services in Medical Settings."

Recommendation 1.5 Minnesota should expand inclusive and accessible telehealth by investing in mobile care, phone-based services, and broadband infrastructure to ensure equitable access in rural and underserved communities.

1.5.1 Expand flexible telehealth-enabled and mobile health services especially for rural and underserved areas. Continue support for audio-only telehealth for people covered by Medicare and Medicaid, especially in rural areas, where reliable internet access is limited and phone-based care may be the most equitable option. The State of Minnesota should update its standard for minimum broadband connectivity speed and continue to update that standard as data-intensive technologies evolve.

Recommendation 1.6 Minnesota should strengthen community transportation infrastructure to ensure all patients can access health care services.

1.6.1 More transportation and transportation coordination options need to be available to all individuals to ensure patients can access health care services. Assess what transportation support is currently available and recommend strategies for scaling up existing infrastructure and filling gaps.

1.6.2 Ensure that transportation services meet all patient needs (e.g., car seats, adaptive equipment).

Recommendation 1.7 Minnesota should strengthen patient health literacy related to accessing, navigating, and paying for health care.

1.7.1 Build upon existing state-wide health literacy initiative related to health care access, navigation, coverage, billing, out-of-pocket costs, and understanding care plans.

1.7.2 Establish digital literacy education to help ensure individuals may access health care services virtually.

1.7.3 Deliver health education in community spaces, such as schools, libraries, and other trusted local venues, particularly in greater Minnesota, to address access gaps and avoid default reliance on telehealth.

Recommendation 1.8 Minnesota should implement funding strategies that improve health care access, support equitable care, and sustain health care services.

1.8.1 Ensure reimbursement rates for mental health and substance use services are equitable with physical health care, thereby improving provider participation and patient access.

1.8.2 Align funding strategies with access goals by addressing regulatory and reimbursement barriers that limit provider participation, particularly for patients enrolled in public programs.

1.8.3 Minnesota should implement policies to eliminate or reduce out-of-pocket patient costs for insurance premiums, health care services, medications, transportation, and other health care supports.

Rationale

Taken together, these recommendations address a core set of inequities impacting individuals and their ability to obtain health care services. Ensuring comprehensive health care coverage for all individuals living in Minnesota is essential to advancing health care equity while recognizing that coverage alone does not eliminate inequities. An equitable health care system requires all individuals to have affordable access; care availability in conveniently accessible locations with some care options available on evenings and weekends; and for all individuals to know how to navigate the health care system.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Comprehensive health care.
- Expanding access and receipt of care when, where, and how patients need it.
- Interpretation and translation services.
- Funding strategies, reimbursement rates, and payment models.

Recommendation Area Two: Bolster Primary and Whole Person Care

What Challenges Do These Recommendations Address?

- Although primary care is foundational to good health, Minnesota's health care system does not adequately support primary and whole person care. Payment models are designed around diagnoses and sick care, rather than investing sufficiently in upstream preventive care, early detection of disease, identification and treatment of mental health and substance use issues. Health care financing should foster collaboration among patients,

providers, and payers where each is appropriately incentivized for preventive care, wellness, and chronic disease management.

- Health care financing does not reflect, account for, or facilitate care that is customized to the social, cultural, and other needs of each member of the population being served to achieve optimal health. Consequently, individuals and families do not experience culturally inclusive and responsive care, which undermines trust in the health care system.
- Minnesota's health care organizations do not effectively share health information across all providers in the state. Most of the large systems can exchange information because they use a common electronic health record (EHR) system. However, many smaller, independent, specialty, rural, and organizations that provide care to underserved communities do not connect electronically to share a patient's health information. This creates disparities in care coordination that disproportionately impact patients who already experience health inequities.
- Minnesota's health care system does not integrate many aspects of health and public health. It is well understood that social determinants of health—access to healthy food, stable housing, and safe recreational spaces, among others—impact an individual's health status to a much greater extent than their interactions with the health care system, and yet, the health care system has only recently begun to address these issues and lacks both the infrastructure and consensus on shared processes needed to effectively do so.

Recommendations

Recommendation 2. Minnesota should implement a strategy that moves toward a primary care-driven model of health care across life stages, events and health conditions to help ensure people of all backgrounds get the care they need.

Recommendation 2.1 A re-envisioned primary care system should integrate and coordinate care for physical health, mental health, substance use, complementary care, and culturally responsive care.

2.1.1 Primary care clinics must provide comprehensive and culturally inclusive care that reflects and respects traditional healing and wellness practices.

2.1.2 Primary care service delivery and reimbursement must integrate mental health and substance use care.

Recommendation 2.2 Minnesota should invest in team-based primary care models that address health-related social needs and coordinate activities with public health and community-based organizations.

2.2.1 To ensure that health-related social needs are addressed, primary care clinics should collaborate with social workers, community health workers (CHW), community health representatives (CHR), community paramedics, licensed alcohol and drug counselors (LADC), and community-based organizations.

2.2.2 Health care provider organizations, payers, and community-based organizations should expand the use of common referral approaches among cross-sector partnerships to ensure health-related social needs are met. Common referral

approaches are a shared strategy to link people with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing. The community care hub model provides an example of how this recommendation may be implemented.

2.2.3 Require managed care organizations to fund staffing for health care provider organizations and community-based organizations to increase capacity for coordinating health-related social needs services.

2.2.4 Expand alternative dental care team models (e.g., dental therapy, dental hygiene collaborative practices) to support more efficient care delivery and increase access to oral care in community settings.

Recommendation 2.3 Minnesota should adopt reimbursement and payment models that will support investments in primary and whole-person care.

2.3.1 To address current and historic underfunding of primary care services and to sustain ongoing investments in primary care, require commercial payers and Minnesota Health Care Programs to increase primary care spending as a percent of total medical expense (e.g., Primary Care Investment Ratio).

2.3.2 Support population health outcomes by promoting and funding coordination between primary care and local public health, comprehensive services around care, and sufficiently reimbursing social workers, community health workers (CHW), community paramedics, and licensed alcohol and drug counselors (LADC) for services.

2.3.3 Incentivize primary care clinic certification as health care homes by updating and simplifying Medicaid reimbursement rates to reflect the true costs of service while reducing administrative burden.

2.3.4 Incentivize the integration of dental services into primary care through improved reimbursement for dental care provided within primary care and through reimbursement for preventive oral health services that can be provided by dental hygiene and primary care clinician teams. Incentivize oral health preventive care by improving Minnesota Health Care Program reimbursement policies and rates.

Rationale

While implementing these recommendations would improve Minnesota's health care system for all individuals and families, they would have an especially helpful impact on those experiencing health care inequities. A more robust system of primary care would offer better opportunities to incorporate culturally responsive practices and traditions into the patient experience and build trust between communities and their health care providers. Those experiencing health care inequities are also more likely to have health-related social needs; implementation of these recommendations would substantially improve how Minnesota's health care system addresses those issues.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Integration and coordination of care for physical health, mental health, substance use, complementary care, and culturally responsive care.
- Reimbursement and payment models that will support investments in primary care.

Recommendation Area Three: Strengthen and Diversify the Health Care Workforce

This category of recommendations addresses the need for a diverse workforce that is representative of and has the skills necessary to provide culturally responsive care to the communities it serves. They encompass strategies to support current members of the health care workforce, especially health care providers from underrepresented communities. This section of the report focuses on the roles of health care provider organizations, institutions of higher education, policy makers, and state agencies in retaining, recruiting, training, and building the size and composition of the health care workforce our state needs in all geographic areas of Minnesota. It is expected that recommendations would be implemented within the limits of applicable state and federal nondiscrimination laws.

What Challenges Do These Recommendations Address?

- Minnesota's health care workforce demographics do not reflect the diversity of the state's populations and communities. For example, in 2018, only 2.6% of Minnesota physicians identified as Black and 1.9% identified as Hispanic or Latino/a (MDH, 2019: *Overview of the physician workforce, 2019 (PDF)*). Representation gaps for historically underrepresented populations among health care providers hinder culturally concordant and culturally responsive care.
- Health care workforce shortages, in combination with other factors, contribute to inequities in access to care both in certain geographic areas of Minnesota and for certain services. For example, it is well established that Minnesota does not have a sufficient dental care workforce (MDH, 2018: *Dental workforce shortage areas*). The available dental workforce is incentivized to serve commercially insured individuals. Historically low reimbursement rates have served as a long-standing barrier for public program enrollees to obtain basic dental care services.
- Historically underrepresented populations face barriers to obtaining the necessary education and training to pursue a career as a health care provider.
- Employees from underrepresented groups don't feel a sense of belonging in the workplace and are therefore at higher risk of leaving their workplace. It is important to retain all health care workers, especially those from underrepresented communities.
- Much of the health care workforce lacks understanding of how patients experience health care inequities. Patients from diverse backgrounds don't experience culturally inclusive and responsive care. People enrolled in Medicaid face discrimination tied to their type of insurance coverage.

- More than eight in 10 employees consider psychological safety one of the most valued aspects of the workplace (Oyster, 2023: *Who gives a shuck?: An Oyster report on employee disillusionment*). Nine out of 10 employees want their employer to value their emotional and psychological welfare – and provide relevant support (American Psychological Association, 2023: *2023 Work in America™ Survey*). Sixty percent of employees with low resilience and low psychological safety feel burned out, and 34% are thinking about quitting their job. On the other hand, only 5% of highly resilient employees who feel psychologically safe report feeling burned out, and just 3% are considering quitting (meQuilibrium, 2022: *Remote and hybrid workers have higher degree of psychological safety at work than on-site employees says new meQuilibrium study*).
- While Minnesota has recognized the important roles community health workers (CHW) play in the health care system, there are opportunities to further support this evolving profession and more effectively leverage the roles played by CHWs, Tribal and urban American Indian organizations' Community Health Representatives (CHR), and care coordinators. These members of the health care workforce bring deep knowledge of community resources, help ensure individuals receive follow up care, and/or assist individuals navigate care and coverage systems. These efforts can inform how to strategically scale up the availability of high quality CHW and patient navigator services in Minnesota.

Recommendations

Recommendation 3. Minnesota should build and nurture an equitable health care workforce to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients, and communities.

Recommendation 3.1 Foster workplace inclusion, belonging, safety, and well-being to encourage equitable retention of current diverse workforce members. Promote diversity at all levels of health care organizations, including senior leadership and boards of directors.

3.1.1 To support current diverse members of the health care workforce, Minnesota should create a model for inclusion, belonging, safety, well-being, and professional development in health care. This framework should include best practices, regular assessment, and strategies for leadership accountability, and leverage insights from underrepresented employees and employee resource groups. This model should also incorporate mentoring and leadership development exposure strategies for emerging leaders from underrepresented groups.

3.1.2 Minnesota should maintain and/or increase funding for programs that support health care professionals, such as those encouraging members of the health care workforce to seek mental health care and substance use disorder services or addressing barriers to and stigma among health care professionals associated with doing so. These are key retention strategies for all health care workers but especially for diverse members of the health care workforce.

Recommendation 3.2 Enhance workforce skills for cultural responsiveness.

3.2.1 Minnesota agencies and relevant entities should collaborate to create a common framework and set of core competencies for training, including health care

organizations' boards of directors and those in leadership roles. This training framework should reflect learnings on training providers on similar content/competencies and adapted to fit specific fields and roles.

3.2.2 To help all members of the health care workforce develop essential soft skills and competencies that advance equitable health care, training should address: cultural humility, cultural responsiveness, cross-cultural understanding, trauma-informed care, elimination of implicit and unconscious bias including attitudes and beliefs regarding patient health insurance status, disability inclusion, empathy, effective communication, teamwork, patient-centered care, and inclusive leadership/governance. Partnerships with local organizations and universities can be leveraged to develop culturally appropriate training.

3.2.3 Recommend certifications and educational opportunities to require employees to actively engage in ongoing professional development and acquire the necessary skills to provide culturally responsive care. Continuing education requirements may include courses on diversity and practice-based cultural concordance models.

3.2.4 Recommend incentive-based mechanisms for provider accountability, such as performance evaluations and feedback systems, to ensure continuous improvement in delivering culturally responsive care.

Recommendation 3.3 Increase diversity of the current health care workforce through shorter term strategies.

3.3.1 Recommend strategies to incorporate into hiring processes to support the hiring of underrepresented candidates and to attract and recruit a workforce that reflects the communities served, including strategies to support international candidates.

3.3.2 Increase the use of international medical graduates (IMGs) and the Conrad-30/J-1 visa waiver program, and educate health systems on the value of hiring IMGs and providers trained outside the U.S.

3.3.3 To increase the number of individuals with disabilities in the health care profession, health care organizations should work to make more roles available to and meaningfully accessible for people with disabilities.

Recommendation 3.4 Introduce long-term changes to health professional training programs and the broader education system to increase the diversity of the future health care workforce.

3.4.1 MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for individuals with socioeconomic disadvantages aspiring to pursue careers and leadership positions in health care. These efforts should incorporate increased funding for grants, scholarships, and loan forgiveness for socioeconomically disadvantaged students and employees. Ensure that some NorthStar Promise funding, which provides scholarships for students from income-eligible families for many Minnesota public colleges and universities, is dedicated to students seeking health care degrees.

3.4.2 Support and expand health care professional training programs focused on providing health care for specific populations, such as American Indians. Establish additional residency and fellowship programs for health professionals to work in underserved, rural, and Tribal communities to ensure that they are exposed to the specific needs of these populations.

3.4.3 Leverage remote learning modalities to grow health-related career and technical education to reach non-traditional learners such as adults considering second careers or residents of greater Minnesota communities who may need different modes of access to higher education.

3.4.4 Expand dual-training pipeline programs, which pairs on-site training with classroom education to provide "earn while you learn" training, thereby reducing cost barriers to education.

3.4.5 Health professional schools should align the numbers of individuals they are training for medical, nursing, pharmacy, dental and other health professions commensurate with state health care workforce needs. Admissions committees should broaden their membership to include individuals with knowledge of state health care workforce needs. Admissions committees should take a holistic approach when screening potential candidates to balance out admission criteria that currently heavily weight admissions on the basis of standardized test scores and grade point averages while not accounting for professional and lived experience.

3.4.6 Use career and college readiness programs in Minnesota's high schools to raise awareness and understanding of medical professional pathways.

Recommendation 3.5 Optimize the health care workforce by making strategic investments to address workforce shortages; to ensure care is more available in underserved areas of Minnesota; and to ensure health care professionals may work at the top of their license to meet basic health care needs.

3.5.1 Health care organizations should identify and implement strategies to restructure how care is delivered to make it more effective, accessible, comprehensive, holistic, and culturally congruent for patients and members. Use a variety of care professionals and paraprofessionals to improve equitably delivered care. Enable all providers to practice at the top of their license to fully leverage training, skills, and experience.

3.5.2 Build on recent investments in oral health care in Minnesota and identify strategies to further expand the dental workforce by training additional dental therapists, hygienists, and assistants. Address workforce shortages by incentivizing newly trained dental professionals to work in rural and underserved urban areas.

3.5.3 Establish an independent (meaning outside of a state agency) Minnesota Health Care Workforce Advisory Group to provide objective health care workforce research and data analysis; identify workforce gaps and barriers; collaborate and coordinate with other entities on health care workforce policies; recommend appropriate

public and private sector policies, programs, and other efforts to address identified health care workforce needs.

3.5.4 Increase reimbursement for lower paid health professions to attract more individuals to train for and work in these health care roles.

3.5.5 Policy makers should augment the range of the MDH-administered loan forgiveness program and other training incentives to include health care professions for which such relief doesn't currently exist. The State should promote both current and new financial relief opportunities as a recruitment incentive to sites that are in health professional shortage areas.

3.5.6 Increase the number and utilization of patient care coordinators in Minnesota through the following strategies:

3.5.6.1 Expand the use of community health workers (CHW) and representatives (CHR), and other patient care coordinators in underserved areas to coordinate wrap-around and follow-up services to ensure patients are getting referrals and next appointments in a timely manner. Ensure these roles are reimbursed for helping patients understand insurance coverage, billing, and out-of-pocket costs.

3.5.6.2 The state should explore and act on opportunities to advance and sustain the CHW and CHR workforce. These efforts should establish a state office to implement CHW policies and coordinate stakeholders.

3.5.6.3 Expand the development and use of partnerships between high schools and health care providers to sponsor CHW training and increase the pipeline of diverse health care workers. Provide financial aid and funding for CHW training and apprenticeship programs and offer specialization pathways to expand the CHW workforce.

3.5.6.4 MDH should assess responsibilities, roles, training requirements, and utilization of CHWs, CHRs, and other care coordinator roles within health care organizations. Examine the value and impact of these roles and any differences in how they are compensated in Minnesota's health care system. Recommend solutions to resolving identified inequities.

3.5.7 Identify strategies for increasing the availability and hiring of culturally diverse mental health providers to ensure language access and address cultural stigma more effectively.

3.5.8 Track the retention of health care professionals in underserved areas to identify gaps and opportunities to improve retention.

Rationale

Implementing these recommendations would improve health care equity through the cultivation of a more diverse workforce over time, which offers greater capacity to build trust between the health care system and all of the communities it serves. These strategies address the need for the health care workforce to work throughout Minnesota, including in underserved rural and urban areas. Finally, training related to cultural responsiveness skills

would help facilitate more respectful and culturally appropriate care for a variety of communities experiencing health inequities.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Support for current members of the health care workforce is critical due to the high stress of the medical profession. It is critical to retain those who have trained for and work in this important profession.
- Need to diversify workforce, including international medical graduates and longer-term strategies to retain existing and recruit additional diverse health care workers.
- Address health care workforce shortage areas.
- Cultural responsiveness training.

Recommendation Area Four: Ensure System Accountability

This category of recommendations addresses the need for Minnesota's health care system to more effectively provide accountability at an individual and system-wide level for fair and equitable access to health care. The recommendations include strategies ranging from how individuals can make complaints to the establishment of infrastructure needed to effectively measure and monitor how Minnesota's health care system makes progress in eliminating health care inequities. It is expected that recommendations would be implemented within the limits of applicable state and federal civil rights laws.

What Challenges Do These Recommendations Address?

- The current system within Minnesota for accepting and investigating consumer complaints is fragmented, confusing, and uncoordinated when issues cross the jurisdiction of multiple agencies and bodies depending on which part of the system the complaint is against (provider, health plan, clinic, etc.; Table 1). Public awareness of how, and ability to, submit grievances, complaints, and appeals about care quality and coverage decisions is limited. It isn't clear where to bring complaints related to discrimination and unfair treatment, as opposed to care coverage, payment, or quality, which contributes significantly to a lack of information about how frequently people in Minnesota experience discrimination.

Table 1. Health Care Complaint Resources

State Agency or Organization	Type of Complaint Addressed
Minnesota Department of Health: Managed Care Systems	Helps consumers resolve health maintenance organization (HMO) complaints and file external appeals from HMOs.
Minnesota Department of Health: Office of Health Facility Complaints	Investigates reports and complaints of health care facilities violating state or federal regulations.
Minnesota Department of Human Services: Equal Opportunity and Access Division	Receives and handles complaints of discrimination by persons working for human services agencies.

State Agency or Organization	Type of Complaint Addressed
Minnesota Department of Human Services: The Office of Ombudsperson for Public Managed Health Care Programs	Explains how to file a health plan grievance, health plan appeal, or state appeal.
Minnesota Board on Aging: Office of Ombudsman for Long-Term Care	Identifies, investigates, and resolves complaints about quality of life and care in long-term care facilities, and outside agencies, services, and individuals.
Minnesota Department of Commerce Consumer Services Center	Receives and investigates complaints to help resolve disputes between consumers and companies, and facilitates external reviews for denied claims from insurance companies and health plans that the department regulates.
Minnesota Department of Human Rights	Receives and investigates reports of discrimination.
Minnesota health licensing boards	Receives and investigates complaints against individuals who are licensed medical professionals.
Office of the Minnesota Attorney General	Receives and reviews complaints from consumers about medical billing and health insurance.

Additionally, the DHS Office of Inspector General executes oversight functions of background studies, licensing, and program integrity for DHS-administered programs, and the DHS Program Integrity Oversight Hotline receives and reviews reports of fraud, waste, and abuse by health care providers working with Minnesota Health Care Programs.

- Patient protection opportunities to make complaints should be more comprehensive, accessible, transparent, and responsive. These systems should be enhanced and coordinated by offering multiple, user-friendly ways for patients to file complaints—such as online platforms, hotlines, and in-person support. This includes ease of navigation to the right resource for the type of issue enrollees are experiencing, transparency about what their rights are, and ensuring language accessibility and confidentiality.
- Minnesota's health care system doesn't encourage sufficient focus on local needs or community-based partnerships. Health care providers and payers must engage local communities to address each community's unique needs, focusing on health-related social needs, and encouraging collaboration between health care systems and community-based organizations.
- Providers and payers need clear, measurable health equity-focused indicators for success in health outcomes, patient satisfaction, and cultural responsiveness. Greater public transparency should be available about these metrics and the health system's progress (or lack thereof) toward achieving them over time.
- Minnesota's health care data infrastructure needs to adequately support patients as they receive care across multiple providers and health care organizations. Further, data on patient social determinants of health need to be collected, safeguarded, and analyzed at de-identified and disaggregated levels. This information is essential to understanding demographic characteristics of patient populations, identifying which populations are experiencing inequities, and improving patient care and outcomes.

Recommendations

Recommendation 4. Minnesota should foster an accountable health care system that strengthens patient protections, eliminates discrimination, and ensures fair treatment by integrating community co-leadership, shared data infrastructure, and oversight mechanisms to monitor implementation and promote health care equity through inclusive standards across the health care system.

Recommendation 4.1 Minnesota should strengthen and harmonize its approach to health care patient protection to address health care discrimination and unfair treatment.

- 4.1.1 Minnesota's system for accepting consumer complaints should ensure a "no wrong door" approach so that individuals are provided appropriate service interventions regardless of where they enter the system. To the extent a consumer complaint crosses jurisdiction of multiple agencies, an agency or office needs to be designated as the lead agency for investigating and following up with consumers about their complaints.
- 4.1.2 Minnesota should establish a consumer-based organization that assists patients with complaints about health care discrimination, access to, and quality of health care services and provides free legal services.

Recommendation 4.2 Health care in Minnesota should have community co-leadership and equity-focused oversight.

- 4.2.1 Strengthen the State's regulatory role in population health expectations, impact, and the accountability of payors, health plans and provider organizations.
- 4.2.2 Health care provider organizations should ensure, within the limits of state and federal civil rights laws, patient and community advisory boards represent underserved members of the community and provide input on addressing inequities in how organizations provide complementary and culturally responsive care.
- 4.2.3 Minnesota should continue to ensure resources are available for local communities to establish healthy environments such as walkable spaces, access to nutritious foods, and other public health services.
- 4.2.4 Minnesota—through authentic community engagement—should strengthen and coordinate its approach to measuring health care quality to identify and ameliorate disparities in health outcomes.

Recommendation 4.3 Minnesota should strengthen data infrastructure and data support sharing among payers, health care providers, community organizations, researchers, social service providers, and public health.

- 4.3.1 MDH should accelerate its implementation of recommendations to standardize data on population characteristics to identify and address health disparities.
- 4.3.2 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and

state data privacy laws, patient consent protocols, and equity considerations in data access and use, including Tribal data sovereignty concerns for data related to Tribal citizens and American Indians. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation.

4.3.3 Minnesota's health care organizations, payers, and community-based organizations (CBO) should collaborate to develop common specifications and workflows for capturing and using information on health-related social needs, including share directories of community-based organizations and electronic closed-loop referral processes.

4.3.4 Minnesota should provide state-level funding to sustain and enhance organizations and collaborations that aggregate electronic health data to inform the public on health equity indicators related to conditions that adversely impact equitable health. These efforts should inform public health, policy makers, health providers, and CBOs to understand health disparities in their communities and design targeted programs and interventions.

Recommendation 4.4 Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.

Recommendation 4.5 Health plans and health care provider systems must work towards meaningful improvements in health care equity by following evidence-based best practices and frameworks (for example the Institute for Health Care Improvement's "A Framework for Improving Health Equity," the National Committee for Quality Assurance's (NCQA) health outcomes accreditation programs, The Joint Commission's Excellent Health Outcomes for All certification, etc.).

Recommendation 4.6 The State should establish a multi-stakeholder "Accountability Group" to serve in an advisory capacity to the Commissioner of Health. The purpose of the group would be to establish an ongoing forum for keeping health care equity issues on the top of MDH's agenda to improve health care equity on a statewide basis. Proposed responsibilities could include the following:

4.6.1 Advising MDH on how to oversee implementation of these recommendations.

4.6.2 Regularly assess how health care equity is being advanced and build on any successes.

4.6.3 Develop and recommend an approach for identifying effective strategies to achieve desired outcomes over time and measuring overall State progress toward health equity goals.

Rationale

Implementation of these recommendations would improve health care equity at both the individual and system level. Individuals experiencing health care inequities need an accessible venue to express concerns related to discrimination and disparate treatment; having an effective investigation and resolution process around these and other types of grievances can lead to meaningful change in health care quality, safety and care experiences for diverse

populations. Streamlining the review process and providing regular updates to complainants can build trust and accountability, while using complaint data to identify and publicly report on systemic issues can drive policy improvements. In addition, the creation of an "Accountability Group" would create public visibility and a standing forum to shine a sustained light on the state's efforts to eliminate health inequities.

Community Feedback

Community engagement and public input supported the following recommendations as priorities:

- Strengthen approach to patient protection.
- Community co-leadership and oversight.
- Data infrastructure for measurement and reporting to hold responsible parties accountable for advancing health equity.
- Data interoperability for the benefit of patients to promote care coordination and quality.

Moving Ahead with Implementation

The Task Force's recommendations include a broad spectrum of strategies, inclusive of both tactics that build on Minnesota's current health care system and others that would fundamentally remake that system. Public feedback suggested the Task Force's recommendations would be strengthened by creating a more actionable plan for which recommendations to move forward with first. This section of the report addresses that feedback by offering guiding criteria that could be used by implementers (e.g., state agencies, health care provider organizations, insurers) and examples of recommendations that meet criteria. The Task Force acknowledged that their recommendations come at a time of constrained resources in health care which will impact how and when responsible parties, including MDH, act on their recommendations.

Criteria

Criteria for selecting recommendations to begin implementing include the following:

- The recommendation is more straightforward to implement and seeks to improve the current health care system rather than require a fundamental restructuring of it.
- Implementation of the recommendation could build on existing efforts or partnerships, which may lend energy and momentum to accomplishing the work.
- Compared with other recommendations, implementation does not require significant policy changes or significant additional financial resources. This is important as we think about current budget challenges and an uncertain policy environment, both of which make it difficult to pursue fully transformational change or invest substantial new resources into the health care system in the short-term.
- Implementation of the recommendation is highly valued by community and/or Task Force members.

Taken as a group, this proposed list of recommendations to initially move forward with is broadly representative of different areas of recommendations.

Table 2. Examples of Recommendations to Initially Move Forward On

Area (#)	Recommendation	Efforts and Partnerships to Build Upon
Access (1.4)	As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.	MDH is convening a Spoken Language Health Care Interpreter Work Group that will make recommendations to support and improve access to the critical health care interpreting services provided across the state.
Access (1.7.1)	Build upon existing state-wide health literacy initiative related to health care access, navigation, coverage, billing, out-of-pocket costs, and understanding care plans.	Interested parties could explore initiatives with the Minnesota Health Literacy Partnership, which is an active network focused on this issue.
Primary care (2.2.2)	Health care provider organizations, payers, and community-based organizations should expand the use of common referral approaches among cross-sector partnerships to ensure health-related social needs are met. Common referral approaches are a shared strategy to link people with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing. The community care hub model provides an example of how this recommendation may be implemented.	Build upon the efforts of providers, payers, and other organizations to streamline community-based organization referral processes, such as collaborating on directories, administrative processes, and developing electronic workflows.
Primary care (2.3.1)	To address current and historic underfunding of primary care services and to sustain ongoing investments in primary care, require commercial payers and Minnesota Health Care Programs to increase primary care spending as a percent of total medical expense (e.g., Primary Care Investment Ratio).	Work through MDH's Center for Health Care Affordability to learn about what other states' experiences have been in implementing a similar policy. Explore how this could be designed and what steps would be needed to establish a requirement for Minnesota's health care system to spend a set percentage of health care spending on primary care.
Workforce (3.2)	Enhance workforce skills for cultural responsiveness.	The Healthy Minnesota Partnership is launching an Equitable Access and Care workgroup whose goal is to increase culturally competent and trauma-informed training, care, supports, services, and policies across the state.
Workforce (3.4.1)	MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for individuals with socioeconomic disadvantages aspiring to pursue careers and leadership positions in health care. These efforts should incorporate increased funding for grants, scholarships, and loan forgiveness for socioeconomically disadvantaged students and employees. Ensure that some NorthStar Promise funding, which provides scholarships for students from income-eligible families for many Minnesota public colleges and universities, is dedicated to students seeking health care degrees.	MDH can convene agencies and health organizations to explore the scope and deliverables, and determine resources needed for full implementation.

Area (#)	Recommendation	Efforts and Partnerships to Build Upon
Workforce (3.5.6.2)	The state should explore and act on opportunities to advance and sustain the CHW and CHR workforce. These efforts should establish a state office to implement CHW policies and coordinate stakeholders.	DHS should clarify training and billing criteria for CHWs and CHRs, and seek parity between the two, as appropriate.
Workforce (3.5.6.4)	MDH should assess responsibilities, roles, training requirements, and utilization of CHWs, CHRs, and other care coordinator roles within health care organizations. Examine the value and impact of these roles and any differences in how they are compensated in Minnesota's health care system. Recommend solutions to resolving identified inequities.	MDH could explore the methods, scope, and budgetary needs to conduct this assessment in order to recommend a legislative funding proposal.
Accountability (4.3.1)	MDH should accelerate its implementation of recommendations to standardize data on population characteristics to identify and address health disparities.	MDH could look into implementation barriers.
Accountability (4.3.4)	Minnesota should provide state-level funding to sustain and enhance organizations and collaborations that aggregate electronic health data to inform the public on health equity indicators related to conditions that adversely impact equitable health. These efforts should inform public health, policy makers, health providers, and community-based organizations to understand health disparities in their communities and design targeted programs and interventions.	Interested parties could convene community conversations to inform an approach to use health care data for population health, health care quality measurement, and other initiatives with the goal of addressing disparities in health outcomes.
Accountability (4.4)	Encourage the use of Culturally and Linguistically Appropriate Services (CLAS) standards as a framework to improve and ensure inclusive practices in health care organizations.	These are existing standards health care organizations should use to learn and improve their practices related to cultural responsiveness and language access.

Task Force members stressed the importance of making clear that this subset of example recommendations is not the full extent of the work ahead. While they can help serve as a starting point, the Task Force also acknowledges that systemic changes are essential to achieving an equitable health care system. Maintaining focus on both the immediate and the long-range vision presented throughout all of the recommendations in the report will be critical to addressing health inequities.

Conclusion

This report identifies myriad fundamental flaws in Minnesota's health care system related to lack of health care access, insufficient focus on whole person care, workforce issues, and a need for stronger accountability mechanisms at the individual and system levels. While some of these problems affect all people in Minnesota, they especially impact those from diverse racial and ethnic communities, American Indians, people with disabilities, rural residents, people with socioeconomic disadvantages, and LGBTQIA+ populations. These populations struggle to access the health care system or obtain care that is designed to meet their specific needs. Our recommendations propose numerous strategies to provide all persons in Minnesota with the care they need to achieve and sustain optimal health as well as mechanisms to monitor the extent to which our state makes substantial inroads to improve health care equity.

As Minnesota looks ahead to future changes in its health care system, it will be important to creatively and intentionally leverage technology as a tool to reduce health care inequities – and equally important to guard against the possibility of its use in ways that exacerbate the issues raised in this report. Emerging tools can support better access to care with application-based services to support transportation, translation, scheduling, and navigating the system. The health care system must look for opportunities to leverage existing and emerging technologies to provide better care in more efficient ways and also support the workforce to perform at the top of their license. This will involve integrating innovative, accessible service delivery models alongside more traditional ones, using data in better ways, rethinking how information is communicated, and how to optimize community-based resources. Within this context Minnesota's health care organizations must ensure that patient privacy and consent preferences are honored, that their data are protected from cybersecurity threats, and artificial intelligence machine learning tools are applied judiciously.

As members of the Health Care Equity Task Force, we recognize Minnesota is at an important crossroads with some fundamental aspects of our state's health care system. We are concerned about what recent federal funding and policy changes will mean for health care coverage and access in our state and how these changes may impact communities already experiencing deep health inequities. We urge Minnesota policy makers to center improving health care equity as a cornerstone of their deliberations in moving forward to address these new challenges.

We urge Minnesota policy makers, state agencies, health care provider organizations, payers, institutions of higher education, and community-based organizations to take our recommendations seriously and see their role in implementing them. Addressing the scope and scale of concerns raised in this report will take concerted effort, resources, and our collective will.

Appendices

Appendix A: Legislative Authorizing Language

Minnesota Session Laws 2023, Chapter 70, art. 4, sec. 105.

Sec. 105. EQUITABLE HEALTH CARE TASK FORCE.

Subdivision 1. Establishment; composition of task force. The equitable health care task force consists of up to 20 members appointed by the commissioner of health from both metropolitan and greater Minnesota. Members must include representatives of:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x/ communities;

(4) American Indian communities and Tribal Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+) communities;

(7) organizations that advocate for the rights of individuals using the health care system;

(8) health care providers of primary care and specialty care; and

(9) organizations that provide health coverage in Minnesota.

Subd. 2. Organization and meetings. The task force shall be organized and administered under Minnesota Statutes, section 15.059. The commissioner of health must convene meetings of the task force at least quarterly. Subcommittees or work groups may be established as necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task force shall expire on June 30, 2025.

Subd. 3. Duties of task force. The task force shall examine inequities in how people access and receive health care based on race or ethnicity, religion, culture, sexual orientation, gender identity, age, or disability and identify strategies to ensure that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes, to include:

(1) identifying inequities experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age, or disability status;

(2) conducting community engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care;

(3) identifying promising practices to improve the experience of care and health outcomes for individuals in these population groups; and

(4) making recommendations to the commissioner of health and to the chairs and ranking minority members of the legislative with primary jurisdiction over health policy and finance for changes in health care system practices or health insurance regulations that would address identified issues.

Appendix B: Equitable Health Care Task Force Membership Roster

- **Sara Bolnick**, Representing: Advocacy Organizations
- **Elizete Diaz**, Representing: Latina/o/x communities
- **Elijahjuan (Eli) Dotts,** Representing: General member
- **Mary Engels**, MS, RD, PCC, Representing: General member
- **Marc Gorelick**, MD, Representing: General member
- **Bukata Hayes,** Representing: General member
- **Joy Marsh,** Representing: African American communities
- **Maria Medina,** Representing: General member
- **Vayong Moua,** Representing: Health Coverage Organizations
- **Mumtaz (Taj) Mustapha**, MD, Representing: General member
- **Laurelle Myhra**, PhD, LMFT, Representing: American Indian communities
- **Cybill Oragwu**, MD, FAAFP, Representing: Health Care Providers
- **Miamon Queeglay,** Representing: African Heritage communities
- **Nneka Sederstrom**, PhD, MPH, MA, FCCP, FCCM, Representing: General member
- **Megan Chao Smith**, BSN, PHN, RN, Representing: LGBTQIA+ communities
- **Patrick Simon S. Soria**, DNP, MAN, MHA(c), RN, Representing: Asian American and Pacific Islander communities
- **Sonny Wasilowski,** Representing: Disability communities
- **Erin Westfall**, DO, Representing: General member
- **Tyler Winkelman**, MD, MSc, Representing: General member
- **Yeng M. Yang**, MD, MBA, Representing: General member

Appendix C: Acronyms and Glossary of Terms

Acronyms

- CBO – Community-Based Organization
- CHR – Community Health Representative
- CHW – Community Health Worker
- CLAS – Culturally and Linguistically Appropriate Services
- DHS – Department of Human Services
- EHR – Electronic Health Records
- IHS – Indian Health Service
- IMG – International Medical Graduate
- LADC – Licensed Alcohol and Drug Counselor
- LGBTQIA+ – Lesbian, gay, bisexual, transgender, queer, intersex, and asexual. The additional '+' stands for other identities like pansexual, agender, nonbinary, and gender fluid, as well as allies of the community.
- MDH – Minnesota Department of Health
- NCQA – National Committee for Quality Assurance
- TEFCA – Trusted Exchange Framework and Common Agreement

Glossary of Terms

Community transportation refers to all transportation resources in a community that are available to help meet community mobility needs. These include both public and private services, such as shuttles for seniors, vans that churches or community organizations own and operate, and other services (Massachusetts Department of Transportation, 2025: *Community transportation terminology*).

Culturally congruent or concordant care is a process of effective interaction between the provider and client levels. The model is based on the idea that cultural competence is ever-evolving; providers must continue to improve their quality of communication, leading to improved quality of care. However, care offered is not always equal to care received. Patients and families bring their own values, perceptions, and expectations to health care encounters which also influence the creation or destruction of cultural congruence (Schim, S.M., et al., 2010: *A three-dimensional model of cultural congruence: framework for intervention*).

Culturally responsive care is access to care, services, and programs that are culturally-specific honoring and appropriate (Minnesota Department of Health, 2019: *Culturally responsive care: Access to care, services, and programs that are culturally-specific, honoring and appropriate (PDF)*).

Health-related social needs are "social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse

health outcomes and increased health care use. Health-related social needs refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation," (Centers for Medicare & Medicaid Services, 2025: *Social drivers of health and health-related social needs*).

Social determinants of health "are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, n.d.: *Social determinants of health*).

Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care (World Health Organization, 2025: *Universal health coverage*).

Appendix D: Description of Task Force Process

In 2023, the Minnesota Legislature established the Equitable Health Care Task Force (Task Force). The Task Force's purpose was to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age, and disability, and identify strategies for ensuring that all persons in Minnesota receive care and coverage that is respectful and ensures optimal health outcomes.

The enacting legislation set the membership parameters of up to 20 members that represented various communities and the health care sector (see Appendix A). Interested members of the public applied for a seat through the Office of the Minnesota Secretary of State Boards and Commissions Open Positions process. The application period opened on August 21, 2023, and closed on November 21, with the official appointment of members by the Commissioner of Health.

The Task Force met 18 times between January 2024 and September 2025. Originally, the Task Force had expected to conclude their work by June 2025 but extended their timeline into September to allow more time for recommendation development and community engagement. Task Force meetings were facilitated by DeYoung Consulting Services with support from MDH staff. MDH provided administrative support and coordinated meeting space and logistics. Meetings were held in a hybrid format with in-person and remote participation options for members. Meetings were open to the public and members of the public were invited to provide comment in advance of meetings.

During meetings and supplemental small group working sessions, the Task Force learned about health care equity strategies from each other and invited speakers, and undertook work to articulate problem statements, objectives, and opportunities to frame their recommendations.

A team from the University of Minnesota School of Public Health Division of Health Policy and Management undertook a rapid evidence review of priority topics identified by the Task Force, reviewed individual studies and grey literature on these topics, and conducted web-based searches to identify state-based policy and practice innovations aligned to the priority topics. From this research, the team developed a resource guide and provided it to the Task Force (University of Minnesota School of Public Health, Division of Health Policy and Management, 2025: *Resource Guide for Minnesota's Equitable Health Care Task Force (PDF)*).

The Task Force invited comment on their draft recommendations through community listening sessions facilitated by Alliant Consulting, Inc. and a written public comment period (see Appendix E). The Task Force sought input on which recommendations would have the strongest positive impact on health care equity, whether there were gaps to be addressed, and considerations for recommendation implementation. The Task Force took feedback themes into account as they finalized their recommendations.

MDH staff and Katie Burns 10,000 Lakes Consulting assisted the Task Force in drafting, revising, and finalizing their recommendations and report to the Commissioner of Health. The Task Force engaged in a detailed process to develop, review, and refine their recommendations, including identifying where members had concerns about specific recommendations and making modifications to address those issues. Members ultimately supported different recommendations to varying degrees and, in some instances, members may have disagreed

with specific recommendations. The recommendations reflect a range of perspectives across Task Force members. The Task Force also held four supplemental report writing work sessions. The Task Force finalized their recommendations and the report in September 2025.

Appendix E: Community Engagement Process

The Equitable Health Care Task Force (Task Force) prioritized conducting meaningful community engagement to inform their recommendations (Minnesota Department of Health, 2025). Alliant Consulting, Inc. and MDH staff worked with the Task Force to identify feedback objectives, desired community perspectives, and methods of obtaining input.

The Task Force invited community input on their draft recommendations and specifically sought comment on which recommendations would have the strongest positive impact on health care equity, whether there were gaps to be addressed, and considerations for recommendation implementation. The Task Force determined that a series of listening sessions and a written public comment period could provide meaningful feedback. The Task Force prioritized the following perspectives from around the state:

- Cultural, LGBTQIA+, and disability communities
- American Indian communities and Tribal Nations
- Local public health professionals
- Tribal health directors
- Community and advocacy groups
- Health care coordinators and navigators
- Health care providers serving communities impacted by disparities
- Health insurers

Ten virtual listening sessions—including one for the general public—were held between June 11 and August 21, 2025. These sessions were facilitated by a combination of Alliant Consulting, Inc. staff, MDH staff, and the MDH Tribal Liaison MDH opened a written public comment period between June 14 and July 23, 2025, and 24 comments were submitted. Over 100 people from more than 50 organizations e.g., health care and Tribal health organizations, state and local agencies, health care professional associations, and advocacy organizations) were represented across all engagement methods.

- Overall themes across all contributors included:
- Equity and inclusion for underserved populations.
- Concerns about funding and feasibility requiring prioritization and a considered phased approach to implementing recommendations.
- Support for universal and meaningful access to health care.
- Rural health infrastructure including transportation, digital, mobile, telehealth solutions.
- A focus on community health workers and community health representatives, a need for culturally and linguistically diverse providers, concerns about barriers to enter into health professions and the importance of funding, career pathways and education to strengthen and diversify the workforce.

- Centralized complaint and support offices and holding insurers, providers and health systems accountable plus the importance of transparent data, better metrics and community co-leadership.
- Support for primary care that integrates mental health, substance use and complementary care plus care coordination and wraparound services for whole-person and integrated care.
- Concern about the quality and availability of interpretation and translation services, alongside support for health literacy initiatives.

Although broader engagement had been hoped for, the engagement efforts still resulted in rich feedback on the draft recommendations for Task Force consideration. Because it took more time than initially anticipated to develop draft recommendations, the number of engagement activities were adjusted so they could be held before the Task Force concluded its work. Numerous factors likely contributed to participation levels. The timing of the availability of the draft recommendations affected the planning window for engagement events and shaped the types of engagement activities that could be implemented within the available timeframe. Listening sessions were held virtually, during the day and evening—some invitees may have preferred in-person events or had conflicts during the scheduled dates and times. The Task Force members understood these limitations and still found immense value in the feedback provided.

A wrap-up virtual community engagement event was held on October 27, 2025, for people who were invited to and/or participated in the listening sessions and submitted written public comments. The purpose of this session was to share how community feedback informed the Task Force's recommendations and report and provide an update on the timeline for issuing the Task Force's final recommendations and report. Thirty-one people representing at least 15 different organizations attended.

Appendix F: Illustrative Examples of Implementing Recommendations

During meetings and supplemental small group working sessions, the Equitable Health Care Task Force (Task Force) learned about health care equity strategies from each other and invited speakers. The table in this appendix includes health care equity initiatives that resonated with the Task Force as illustrative examples that could guide or inform implementation of their recommendations. Information in this appendix is intended as illustrative background information rather than a comprehensive inventory of related efforts underway in Minnesota and elsewhere. Other examples are also included in the University of Minnesota School of Public Health Division of Health Policy and Management's, "Resource Guide for Minnesota's Equitable Health Care Task Force."

Table 3. Health Care Equity Illustrative Examples

Theme	Program/ Initiative	Description	Recommendation to Which It Is Related
Access	Comprehensive coverage	The Minnesota Health Plan bill sets provisions to establish health care availability and affordability for all persons. Senate File Number 2740 House File Number 2798	1.1 Minnesota should implement comprehensive coverage for all persons in Minnesota. This coverage should augment—rather than supplant or replace—the Tribal health systems of the 11 Tribal Nations within Minnesota and the services provided by Indian Health Services. Although comprehensive coverage in itself does not eliminate disparities, it is a component of a more equitable health care system.
Access	Minnesota School-based Health Center Grant Program	Grant program to support new or existing school-based health centers. School-Based Health Centers in Minnesota	1.3.3 Expand provision of school-based and community-based health services, including oral health screenings and preventive services. Expand primary prevention programs through healthy youth development programs.
Access	Mechanism for hospitals to buy into a system of independent contractors for access to interpreter services	Emergency Statewide Sign Language Interpreter Advocacy and Training Project and partners created a business model to address the delivery of interpreting services for emergent requests. Hospitals decided to join together as a "consortium" to share the costs of a 24/7 ASL interpretation referral service. Consortium of Minnesota Hospitals Enters Agreement	1.4 As part of its efforts to provide culturally responsive care, Minnesota should identify opportunities to build on federal requirements related to language access to ensure high quality, timely, consistent, and culturally appropriate interpretation and translation services in health care.
Primary and Whole Person Care	Co-creating a social needs common referral approach in Minnesota	Exploration of a shared approach for connecting people in Minnesota to needed and culturally responsive resources to health care and health-related social needs such as food, transportation, and housing. Co-creating a Social Needs Common Referral Approach in Minnesota	2.2.2 Health care provider organizations, payers, and community-based organizations should expand the use of common referral approaches among cross-sector partnerships to ensure health-related social needs are met. Common referral approaches are a shared strategy to link people with essential and culturally appropriate health care services and health-related social needs like food, transportation, and housing. The community care hub model

Theme	Program/ Initiative	Description	Recommendation to Which It Is Related
			provides an example of how this recommendation may be implemented.
Workforce	Minnesota Health Care Workforce Advisory Council	Recommended duties for a new Minnesota Health Care Workforce Advisory Council include: providing objective health care workforce research and data analysis; collaborating and coordinating with other entities on health care workforce policies; reviewing, commenting and advising the legislature and other stakeholders on relevant workforce legislation as it relates to health professions education, training, retention, diversity and demographics, changes in health care delivery, practice, and financing; and recommending appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs. Recommendations for the Minnesota Health Care Workforce Advisory Council (PDF)	3 Minnesota should build and nurture an equitable health care workforce to foster workplaces where every individual feels valued, empowered, and equipped to deliver exceptional care to members, patients, and communities.
Workforce	Mental Health Grant for Health Care Professionals	This grant to health care entities for the purpose of establishing or expanding evidence-based or evidence-informed programs focused on improving the mental health of health care professionals. Mental Health Grant for Health Care Professionals	3.1.2 Minnesota should maintain and/or increase funding for programs that support health care professionals, such as those encouraging members of the health care workforce to seek mental health care and substance use disorder services or addressing barriers to and stigma among health care professionals associated with doing so. These are key retention strategies for all health care workers but especially for diverse members of the health care workforce.
Workforce	Create a culture of precepting at systems	Essentia Health M Health Fairview	3.2 Enhance workforce skills for cultural responsiveness.
Workforce	NorthStar Promise	North Star Promise provides free college tuition for students from income-eligible families for many Minnesota public colleges and universities, and Tribal colleges. North Star Promise	3.4.1. MDH should facilitate collaborations with educational institutions, credentialing entities, and community organizations to identify and remove barriers for individuals with socioeconomic disadvantages aspiring to pursue careers and leadership positions in health care. These efforts should incorporate increased funding for grants, scholarships, and loan forgiveness for socioeconomically disadvantaged students and employees. Ensure that some NorthStar Promise funding, which provides scholarships for students from income-eligible families for many Minnesota public colleges and universities, is dedicated to students seeking health care degrees.
Workforce	Native Americans into	Native Americans into Medicine program is a summer enrichment program for college	3.4.2 Support and expand health care professional training programs focused

Theme	Program/ Initiative	Description	Recommendation to Which It Is Related
	Medicine program, Center of American Indian and Minority Health, Medical School, University of Minnesota	students interested in pursuing health careers. Native Americans into Medicine	on providing health care for specific populations, such as American Indians. Establish additional residency and fellowship programs for health professionals to work in underserved, rural, and Tribal communities to ensure that they are exposed to the specific needs of these populations.
Workforce	CentraCare Regional Campus in St. Cloud	To address health care workforce shortages in rural Minnesota, CentraCare and the State of Minnesota provided funding to the University of Minnesota Medical School to establish the CentraCare Regional Campus in St. Cloud. This program is a community-based educational experience for third-year medical students who live and train in rural communities. CentraCare Regional Campus St. Cloud Medical School campus in St. Cloud will improve healthcare workforce in rural Minnesota	3.4.2 Support and expand health care professional training programs focused on providing health care for specific populations, such as American Indians. Establish additional residency and fellowship programs for health professionals to work in underserved, rural, and Tribal communities to ensure that they are exposed to the specific needs of these populations.
Workforce	Youth Force	Platform that helps: young people earn a certificate, get credentialed, and begin a career in health care; students, schools and community-based organizations; apprentices and training centers; and health care professionals and employers. Youth Force	3.5.6.3 Expand the development and use of partnerships between high schools and health care providers to sponsor CHW training and increase the pipeline of diverse health care workers. Provide financial aid and funding for CHW training and apprenticeship programs and offer specialization pathways to expand the CHW workforce.
Accountability	Office of Patient Protection	The Office of Patient Protection bill sets provisions to assist consumers with access to and quality of health care services. Senate File Number 1567 House File Number 1072	4.1.1 Minnesota's system for accepting consumer complaints should ensure a "no wrong door" approach so that individuals are provided appropriate service interventions regardless of where they enter the system. To the extent a consumer complaint crosses jurisdiction of multiple agencies, an agency or office needs to be designated as the lead agency for investigating and following up with consumers about their complaints.
Accountability	Cedars-Sinai Community Connect Program	Strategic Partnerships and Innovative Grantmaking This program helps address non-medical factors that impact patient health to help ensure that patients receive comprehensive support for a healthier life. Its approach to centralized grantmaking, screening, and intervention efforts under one team helps foster a comprehensive, nonsiloed approach that enhances coordination and maximizes impact. Community Connect	4.2 Health care in Minnesota should have community co-leadership and equity-focused oversight.

Theme	Program/ Initiative	Description	Recommendation to Which It Is Related
		The Cedars-Sinai Community Connect Program: Strategic Partnerships and Innovative Grantmaking	
Accountability	Minnesota Health Records Act	The Minnesota Health Records Act could be updated to provide clarity and alignment with electronic workflows. Minnesota Health Records Act	4.3.2 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and state data privacy laws, patient consent protocols, and equity considerations in data access and use. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation.
Accountability	Trusted Exchange Framework and Common Agreement (TEFCA)	TEFCA provides a nationwide framework for health information sharing. TEFCA	4.3.2 Minnesota should implement comprehensive, forward-looking policies, sustainability plans, and implementation strategies that advance health data interoperability, governance, and secure information exchange across all electronic health record (EHR) systems in Minnesota. These recommendations should align with national interoperability standards and ensure compliance with federal and state data privacy laws, patient consent protocols, and equity considerations in data access and use. Emphasis should be placed on identifying funding mechanisms and assistance needed to support successful implementation.
Accountability	Minnesota Electronic Health Record (EHR) Consortium	This consortium provides robust information on health equity indicators related to COVID-19, substance use disorders, and other chronic conditions such as cardiovascular disease and hypertension. It is a partnership between Minnesota health systems and public health agencies to provide timely and granular data to inform the real-time actions of policymakers, health system leaders, and researchers. MN EHR Consortium	4.3.4 Minnesota should provide state-level funding to sustain and enhance organizations and collaborations that aggregate electronic health data to inform the public on health equity indicators related to conditions that adversely impact equitable health. These efforts should inform public health, policy makers, health providers, and community-based organizations to understand health disparities in their communities and design targeted programs and interventions.

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Table 3 Links

- Senate File Number 2740 (https://www.revisor.mn.gov/bills/93/2023/0/SF/2740/?body=senate)
- House File Number 2798 (https://www.revisor.mn.gov/bills/bill.php?f=HF2798&y=2023&ssn=0&b=house)
- School-Based Health Centers in Minnesota (https://www.health.state.mn.us/people/childrenyouth/schoolhealth/healthctrs.html)
- Consortium of Minnesota Hospitals Enters Agreement (https://accesspress.org/consortium-of-minnesota-hospitals-enters-agreement/)
- Co-creating a Social Needs Common Referral Approach in Minnesota (https://stratishealth.org/initiative/co-creating-a-social-needs%E2%80%AFcommon-referral-approach-in-minnesota/)
- Recommendations for the Minnesota Health Care Workforce Advisory Council (PDF) (https://www.health.state.mn.us/facilities/ruralhealth/docs/wfcrecrprt25.pdf)
- Mental Health Grant for Health Care Professionals (https://www.health.state.mn.us/facilities/ruralhealth/funding/grants#mhcccet)
- Essentia Health (https://www.essentiahealth.org/about/essentia-health-newsroom/essentia-health-recognized-as-clinical-training-site-of-excellence)

- M Health Fairview (https://www.fairview.org/for-medical-professionals/medical-education-and-learners)
- North Star Promise (https://ohe.mn.gov/northstarpromise)
- Native Americans into Medicine (https://med.umn.edu/caimh/college-premed)
- CentraCare Regional Campus St. Cloud, (https://med.umn.edu/CentraCare-Regional-Campus)
- Medical School campus in St. Cloud will improve healthcare workforce in rural Minnesota (https://brief.umn.edu/feature/medical-school-campus-st-cloud-will-improve-healthcare-workforce-rural-minnesota)
- Youth Force (https://www.youthforce.health/)
- Senate File Number 1567 (https://www.revisor.mn.gov/bills/bill.php?b=senate&f=SF1567&ssn=0&y=2025)
- House File Number 1072 (https://www.revisor.mn.gov/bills/bill.php?f=HF1072&y=2025&ssn=0&b=house)
- Community Connect (https://www.cedars-sinai.org/health-equity/social-needs-of-patients.html)
- The Cedars-Sinai Community Connect Program: Strategic Partnerships and Innovative Grantmaking (https://catalyst.nejm.org/doi/full/10.1056/CAT.24.0123)
- Minnesota Health Records Act (https://www.revisor.mn.gov/statutes/cite/144.291)
- TEFCA (https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca)
- MN EHR Consortium (https://mnehrconsortium.org/)