DEPARTMENT OF HUMAN SERVICES

Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota

2024

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"Like water through a canyon, as long as it takes, we need to make changes."

– Community Conversation participant, Duluth

What Medicaid can do now to continue to address racial health equity with American Indian community members

The growing recognition of current and longstanding health disparities between American Indian/Alaskan Native (AI/AN) populations and other U.S. groups necessitate an urgent shift to center Indigenous perspectives and wisdom in how our health care systems define health, wellbeing and the evidence generated by health care research to make decisions about how we pay for health care services. Through a Western biomedical model, the outlook for the health of American Indians is bleak. The individual-focused and disease-specific valuation of health, when paired with a colonial and capitalist-based system of health care, narrows both the options, and imagination, for what is possible. This report seeks to lift up the pressing need to recognize the importance of not only supporting Indigenous self-determination through words but also finding concrete ways to ensure Medicaid, and our health care system broadly, appreciates the value of, and pays for, Indigenous-centered, holistic health practices. It captures numerous reflections from community members and leaders about what is working well and what isn't when it comes to Minnesota Medicaid meeting the needs of American Indians, Tribal Nation staff and Urban American Indian organization leaders. It links Minnesota Department of Human Services' (DHS') data with outcomes of interest provided by the reports Co-creators as well as innovations from other state Medicaid agencies and best practices seen in the literature. The report is one tool in an overall effort to drive equity-centered, community-led change within DHS' Medicaid agency and model that process for others within state government and the health care system. To drive change requires more than observing data and listening to those most impacted by inequity. It requires a commitment to action and accountability, specifically, investing in Traditional Healing, reframing what defines health and wellness and the evidence used to make decisions, and creating pathways to an American Indian and Tribal Health Integration Team at DHS.

A Community-informed, iteratively developed report

Understanding what defines well-being in any community is crucial to authentic co-creation and partnership towards improving health. In DHS' 2022 "Building Racial Equity into the Walls of MN Medicaid" report DHS acknowledged that, "Communities impacted the most by structural racism and inequity need to be engaged early and provided accountability, as Minnesota strives to dismantle systems of harm and build systems that support the health of all."[1] As part of the iterative process of creating this report and implementing its actions we aimed to meet a level of "Involve" in our community co-creation as defined by the International Association for Public Participation's (IAP2)

spectrum (Figure 3). In our commitment to push the work of DHS further along the IAP2 spectrum for this report we strived to meet the level of "Collaborate," learning from areas of success and missed opportunity experienced during the 2022 report process. Our proposed process of engagement sought to provide health care and human services staff from every sovereign tribal nation in Minnesota, as well as leaders from Urban American Indian clinics and organizations, the opportunity to participate as much or as little as they had the bandwidth and interest. **The intent shared in these, and subsequent, meetings was to receive guidance on co-creating a report focused on answering 2 primary questions: What policies or structural changes should be prioritized in order to improve the health and opportunity of American Indians on Minnesota Health Care Programs (Medicaid/MA and MinnesotaCare)? And how can MN Medicaid more truly add value and support what Tribal Nations and American Indian communities are already doing to help members realize their full health and potential?** Like our 2022 report, after our initial meetings with community leaders and Tribal Health and Human Service staff, our report team met with specific DHS divisions involved in the stewardship of policy areas that were consistently prioritized. Those conversations further informed the "Calls to Action" selected for this report and contributed to the background about what Minnesota DHS has, and has not, historically done to advance health and opportunity for American Indian Medicaid members. From there three new strategies were employed to build upon what DHS learned in the process of the 2022 report and continue moving towards "Collaborate" on the IAP2 Spectrum: working alongside Co-creators, convening a data guidance panel, and contracting with a facilitator for community conversations.

Call to Action: Invest in Traditional Healing

The desire, need and evidence for expanding American Indian community members access to Traditional Healing services is apparent. DHS can take several concrete steps towards this Call to Action by:

- Continuing to engage Tribal Nations, Urban American Indian clinics and organizations, and CMS in finding paths to cover Traditional Healing through Medicaid funding. As noted above, that can involve conversations and ultimately applying for a Section 1115 waiver, continuing to pilot coverage through In-Lieu of Services (ILOS) agreements with Managed Care Organizations (MCOs) and/or incorporating Traditional Healing services into efforts to address Social Drivers of Health (SDoH) and primary care innovation.
- Seek American Indian community guidance on establishing a Tribal-Based Practice Review Panel. The goal would be to co-create community standards and consensus around Traditional Healing practices as well as identify initial steps to addressing questions around implementation like:
    - Are Tribal traditional healers in the community willing to assign or negotiate a monetary value for their healing services? If not, what are other appropriate, acceptable options?
    - Would traditional healers be willing to participate in the claim process?
    - How does an individual become a traditional healer and what, if anything, is the licensing or certification process for Traditional Healing practitioners? Is a licensing or certification process appropriate in the determined context?
    - How will Tribal data sovereignty be upheld?

- Implement lessons learned from the DHS Behavioral Health Administrations' Mental Health Tribal Healing grant program and consider a statewide grant program for integrated Tribal Healing services.

Call to Action: Reframe What Defines Health and Wellbeing and the Evidence Used to Make Decisions

This report seeks to lift up the pressing need to recognize the importance of not only supporting Indigenous self-determination through words but also finding concrete ways to ensure Medicaid and our health care system broadly appreciates the value of, and pays for, Indigenous-centered, holistic health practices. To reframe how we define health and wellbeing, and the evidence used to make policy and resource decisions, DHS should:

- Work with Tribal Nations and Urban American Indian communities to develop a shared definition of health and wellbeing for American Indian community members.
- Continue to work with federal partners to support interpretations of Medicaid rules and regulations that are aligned with the 2022 White House Council on Environmental Quality and Office of Science and Technology Policy guidance around Indigenous Knowledge through available levers like Medicaid State Plan Amendments, Waivers and Demonstration applications.
- Continue to co -create, -propose, -implement, and -evaluate state-funded models of care and payment that center an American Indian community-defined approach to health and well-being.

Call to Action: Create a Pathways to American Indian and Tribal Health Integration team at DHS

To achieve broader integration and assist in reframing health as not isolated to one diagnosis or part of the body, DHS should create, appropriately resource, and position a Pathways to American Indian and Tribal Health Integration (PATH) team. Initial tasks for the PATH team could include:

- Ongoing Community Engagement to listen and inform other DHS staff on community priorities.
- Ongoing Community Engagement to share knowledge about available Medicaid resources.
- Work across DHS administrations, state, and local governments (ex. MN Department of Health, MN Department of Children Youth and Families, county human service agencies), with Tribal Nations, Indian Health Services and Urban American Indian health care systems to improve integration of whole person and cultural approaches to health and share opportunities for Medicaid to lead or participate in systems integration.

Levers that Medicaid has to address racial health equity with American Indian community members

Eligibility and Enrollment

Medicaid eligibility and enrollment policies and procedures remain a key lever in forging a path towards greater racial and health equity. Prior to the pandemic there were known racial disparities in who experienced procedural disenrollment. The COVID-19 Public Health Emergency (PHE) provided Medicaid enrollees with continuous eligibility for 3 years. Nationally the "unwind" of these PHE policies has led to millions of people losing health care coverage. In Minnesota, DHS has been working on improving racial equity in eligibility and enrollment policies through community-centered collaborations and community-guided systems changes. This has contributed to most disparities in disenrollment for American Indian enrollees during DHS' unwind campaign being eliminated. Analysis of churn data (data related to the constant exit and re-entry of beneficiaries and their eligibility changes) done in collaboration with Co-creators and our Data Guidance panel illustrates the impact of multi-year continuous enrollment policies as a way to address racial equity in how DHS administers Medicaid. Further evaluation and refinement of policies that impact eligibility, like the Tribal General Welfare Exclusion Act,[2] were also identified as opportunities to advance equity. However, to fully eliminate disparities in churn, and the resultant health disparities due to gaps in coverage, will require further refinement of data, support, and accountability for administering partners and continued investment in enrollment navigators and community-led outreach and supports. The Call to Action to create a Pathways to American Indian and Tribal Health Integration team would provide DHS with the infrastructure to ensure MN Medicaid is able to apply the eligibility and enrollment lever toward racial and health equity.

Eligibility and enrollment

- Who is eligible for Medicaid? What is the process for enrollment? For re-enrollment? How does someone get and keep their Medicaid insurance in the first place?

Access

- Once someone has Medicaid, can they access the care they need? Do they have access to primary care? Dental or behavioral health services? Do they have access to culturally relevant care or care from a provider who shares their cultural background? Do they have transportation or interpreter services?

Quality

- If they have access to care, are they getting quality care? Do the metrics Medicaid uses to determine quality care meet the community's definition of quality care?

Early opportunities

- Medicaid disproportionately covers pregnant people and children. Knowing the long-term impact of the first years of a child's life, how can Medicaid ensure health and racial equity from the very start?

Intersection with Indian Health Services

- The Indian Health Service (IHS) is the principal federal agency charged with fulfilling the U.S. government's responsibility to provide health care services to American Indians and Alaska Natives. However, IHS is chronically underfunded, and a significant number of AI/AN members are on Medicaid, making Medicaid one of the biggest sources of funding for IHS. How does the administration of Medicaid therefore support, or impede, the health care services owed to AI/AN communities?

Access

In examining the impact and potential of the access "lever" within Medicaid to address health equity for American Indian communities we note both broad and specific, successes and struggles. Pending federal decisions like the CMS' four walls policy and Medicaid telehealth guidance could either bolster or undermine commitments to health equity for American Indian communities. Other state Medicaid agencies have explored and implemented innovative approaches to workforce development, managed care, and benefit administration to support improved access for their American Indian members. And as American Indian Medicaid members in Minnesota have shared repeatedly, addressing access means improving affordability and availability of both transportation to care, and care that is culturally specific and responsive. Minnesota DHS is utilizing the access lever to improve racial equity both broadly

through federal advocacy in partnership with Tribal Nations, participation in federal pilot programs like the Money Follows the Person - Tribal Initiative, resourcing teams focused on American Indian member access to perinatal, substance use and mental health care and disability services and implementing policies like eliminating or reducing cost-sharing and bolstering the Non-Emergency Medical Transportation (NEMT) benefits. Conversations with Co-creators and Data Guidance Group members about DHS' data on where the most common providers of primary care, mental health and dental care were located in relation to where American Indian MHCP members live identified an ongoing need to support workforce development and retention in rural areas of the state. DHS can also better evaluate the impact on access of policies like the Restricted Recipient Program that may appear neutral as written but given known implicit and explicit biases among health care systems and providers, exacerbate inequities in access to the care American Indian members deserve. The Call to Action to Invest in Traditional Healing would provide DHS a framework to expand access to culturally specific services for American Indian members and continue learning how access more broadly can be improved to address long standing health disparities.

Quality

To fully activate the "Quality lever" in Medicaid and advance racial health equity will require bolstering our current system and redefining "quality." Improving the data Medicaid collects on race/ethnicity and geography through disaggregation and partnership with Tribal Nations and American Indian communities while respecting Tribal data sovereignty is vital. MN DHS' conversations with Co-creators and community members around quality health care led to this report's Call to Action: Reframe What Defines Health and Wellbeing and the Evidence Used to Make Decisions, where we note creating a definition of health, wellbeing, and quality, that more fully captures what American Indian communities value, and using that to determine what their owed portion of health care funding pays for, is essential. Once this is accomplished, other tools like Managed Care Contracting and In-Lieu of Services, 1115 Demonstration waivers, Quality measurement and reporting can better align to elevate the priorities of Tribes and American Indian communities, pay providers and health systems who provide high quality care appropriately and foster a trust not yet experienced between our health care system, sovereign Tribal Nations, and Urban American Indian communities.

Early Opportunities

To seize the "Early Opportunity" lever MN DHS must continue to participate in and lead recent national efforts to expand postpartum coverage, extend multiyear continuous eligibility during childhood, offer culturally specific services during the perinatal period, and continue testing innovative ways to pay for better and more equitable outcomes in pregnancy and early childhood. Despite Minnesota's leadership and innovation in developing maternal health benefits for Medicaid members it continues to see disparities in outcomes for American Indian mothers and birthing persons, most notably among cesarean section rates and infants born prematurely or with a low birth weight or admitted to the Neonatal Intensive Care Unit. MN DHS' conversations with Co-creators and community members around early opportunities highlighted that American Indian community members' experiences with both the physical health care system and the mental/behavioral health and child protection systems, impact their trust in systems overall and ultimately their ability to get the support they deserve. The iterative

community conversations and examination of published literature make clear that American Indian members deserve better awareness of what benefits are available, say in which perinatal and early childhood efforts should be prioritized, and consistent engagement to rebuild trust so every child in Minnesota has what they need to thrive and reach their full potential. The Call to Action to create a Pathways to American Indian and Tribal Health Integration team would be a step towards that vision for a more equitable start for our youngest community members.

Intersection with Indian Health Services (IHS)

Despite glaring structural inequities, IHS/Tribal 638/Urban Indian Organization (I/T/U) facilities and programs are not only finding ways to meet their community's health needs but leading in innovative approaches to care delivery and financing that are inspiring more equitable outcomes around the country and world. More Medicaid-specific data on the experience of members within the I/T/U system will be helpful to identify areas of strength and opportunities for increased support and collaboration. MN DHS' conversations with Co-creators and community members about the intersections between IHS and Medicaid highlighted the impact of inequitable funding streams, particularly on the greater restrictions UIOs (Urban Indian Organizations) face to meet their community members' needs. All participants noted the financial and member-experience benefit in having on-site enrollment navigators. Therefore, finding ways to extend periods of eligibility for Medicaid members and improving enrollment supports at I/T/U organizations and other organizations (ex. Federally Qualified Health Centers or FQHCs) serving a high proportion of AI/AN Medicaid enrollees will be important steps to support the intersection of IHS and Medicaid. The Call to Action to Reframe What Defines Health and Wellbeing and the Evidence Used to Make Decision will support openness to the needed innovation in payment and service delivery I/T/U facilities have long delivered and the Call to Action to Create a Pathways to an American Indian and Tribal Health Integration team at DHS can provide DHS the internal infrastructure to propose, implement, evaluate and scale community co-created solutions in partnership with I/T/U organizations.

Answering the Call

As DHS strives to be an organization that not only administers publicly funded health insurance but helps support the conditions where Minnesotans thrive in community and live their healthiest and fullest lives, it needs to lay out a vision and approach to addressing population health. While systems of oppression have been leveraged similarly across racially marginalized communities to devastating effect, Tribes are governmental and political entities, not racial groups.[3] It is therefore incumbent upon policymakers to be aware of this history, Tribes' sovereign status, and the levers that can and should be utilized to achieve health through reconciliation, repair and ultimately, justice. As DHS seeks to develop, implement, and iteratively evaluate an integrated population health strategy to eliminate health disparities and meet our commitments to health and racial equity, there remains much DHS can learn from, and create together with, American Indian communities and Tribal Nations.

Part 1 - What Medicaid can do now to address racial and health equity with American Indians in MN

"Our traditional world views were taken away from us, we now have to re-learn these views and practices which takes community, time, resources." Bemidji Community Conversation participant

This report is one tool in an overall effort to drive equity-centered, community-led change within the Minnesota Department of Human Services' (DHS) Medicaid agency and model that process for others within state government and the health care system. To drive change requires more than observing data and listening to those most impacted by inequity. It requires a commitment to action and accountability. It also requires an approach that recognizes there are many ways for necessary change to happen and for us to reach our shared goals of greater health, equity, and opportunity for Minnesotans. We therefore present three "Calls to Action" based on our iterative approach to evaluation of data, engagement with American Indian community members, Tribal Nation staff and Urban American Indian organizations, consultation with our DHS policy subject matter experts and guidance from our Co-creators. Within each Call to Action, we will address the questions: Why does the problem exist? What has Medicaid done to address it? We then put forth steps DHS and other partners can take to drive the necessary action. Each Call to Action also features an accountability box that addresses the question: What will accountability to American Indian Minnesotans look like?

What will accountability to American Indian Minnesotans look like for Medicaid?

Recognizing that changes in Medicaid policy can require state or federal legislative authority or funding, accountability for the Calls to Action covered below can be difficult to place. These call outs intend to present broad outcomes that the Medicaid agency within DHS can be accountable to with the American Indian community in Minnesota. The aim of that accountability is to be Medicaid-focused and on the outcome of racial equity and not just the process. The Calls to Action are some of the ways proposed to improve racial equity with American Indian Minnesotans based on the iterative process involving community members and DHS staff. However, many actions can realize racial equity. The process is important, but accountability ultimately comes from a change in outcomes.

Importantly, since Medicaid service eligibility cannot currently be dependent on an individual's racial background, none of these calls to action seek to create Medicaid-funded services that are racially exclusive. However, according to research conducted by the Public Health Law Center, "Racial equity is important and necessary for a just and healthy society; however, the federal government's trust responsibility is not based on racial equity goals. Its foundation is the relationship between sovereigns and the treaty obligations the federal government owes to Tribes and Tribal citizens. Further, Tribes are governmental and political entities, not racial groups.[4] This foundational principle was most recently

recognized by the U.S. Supreme Court in *Haaland v. Brackeen*, in which the Court reaffirmed that Native Americans are a political class and not a racial group.[5]"

Definitions of Descriptive Population Terms used in this report:

Minnesota DHS recognizes that many identifiers have and are used across communities and forced through oppressive methods to silence, box-in, and diminish generations of culture and history. This continues to impact the health and well-being of individuals and communities and contributes to health disparities. Current terminology of "Indigenous," "Native American," "American Indian" and other terms are not unanimously shared between groups at a local or global scale and may be imprecise. Which terms individuals identify with may also not be applicable to large groups and populations when defined in the aggregate (ex. many community members can claim more than one racial identity). As this report seeks to identify structural and policy changes to improve health for populations, we use population-level terms. **American Indian Co-creators of this report expressed, "American Indian," as the preferred primary option and identifier for populations to support consistency within this Pathways report.** We at times will refer to other terms and, with our Co-creators' guidance, define them as such:

- **Indigenous**: We use the term Indigenous to refer to the Native people of North America (United States and Canada; otherwise known as First Nations, Native American, Alaskan Native and Native Hawaiian). The word Indigenous will be capitalized to indicate that it represents a population group.
- **American Indian**: We use the term American Indian to refer to Indigenous populations from the United States. However, we understand the political and cultural complexities of labeling and have no intention of reifying oppressive colonial language.
- **Native American**: We use this term, which generally signifies Indigenous peoples Native to the lands now known as the United States of America, when it is the term used by data sources or research that we cite.

Therefore, the Calls to Action both recognize the long overdue need to ensure policies, programs, and the administration of each are done with awareness and action toward racial equity, while also incorporating concepts of Tribal Sovereignty and self-determination. With that frame as a guide, focusing the agency's efforts on changes, and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for American Indian communities.

Collective work integrated throughout this report:

- This report is the product of collective work led by the Minnesota Department of Human Services (DHS) in collaboration with American Indican community Co-creators, the Public Health Law Center and Marnita's Table.
- The Public Health Law Center (PHLC) provided 4 legal memoranda pertaining to health policy and Tribal public health in support of our team's community-guided evaluation of ways that Medicaid could be used to address health inequities experienced by American Indians and caused by structural racism. Excerpts from the PHLC memoranda have been integrated throughout. The full legal memoranda are available in this report's Appendix.
- DHS contracted with Marnita's Table, Inc (MTI) to conduct 5 events, called community conversations, with American Indian community members about how to improve our Medicaid program. MTI prepared a report summarizing what was learned in that process. Excerpts from this report has been integrated throughout and cited when used. The full MTI report is available in this report's Appendix.
- Further details on this community-guided process can be found in Part 2 of the report.
- Additionally, in 2022 DHS conducted a representative survey of working-age adults specifically enrolled in Medicaid (Medical Assistance or MA). A methodology was selected that allowed reporting of what members said overall, as well as separately for American Indian Americans and five other racial/ethnic groups. 532 people indicated on the survey that they are American Indian and data from that survey is referred to as the "MA Enrollee Survey."

Call to Action: Invest in Traditional Healing Services

What is the problem?

"Cultural practices are preventative care practices!" – Minneapolis Community Conversation participant

Traditional Healing seeks to restore balance in an individual between the multiple dimensions of health.[6] It is this imbalance that contributes to illness and traditional healers assist in restoring balance and maintaining cultural knowledge of health.[7] Traditional Healing offers more holistic health care that connects the patient to their cultural healing ways which have been practiced for millennia. Traditional Healing does not replace the knowledge Western medicine has generated but enhances it. From diabetes prevention[8] to substance use disorder and mental health treatment[9,10], Traditional Healing has demonstrated positive impacts on health and wellbeing even by Western medicine standards. **In 2023 the National Council of Urban Indian Health published a report about Traditional Healing programs that included a meta-analysis of the impact of Traditional Healing on health outcomes and found,**

"using the quantitative benchmarks set by Western medicine, Traditional Healing should be considered generally effective for health outcomes, and especially effective for mental health outcomes."[11] Traditional Healing for American Indians has outcomes equivalent to interventions in other populations[12] and should be a core component of the health care system for AI/AN people. Ensuring coverage for these services would also assist in reversing the stigmatization that was deliberately created by the federal government and the states, who prohibited and punished American Indians who tried to maintain these traditions for much of U.S. history. This horrific policy was not formally addressed until 1978 and continues to affect American Indian people's lives today.[13] The Indian Health Care Improvement Act (IHCIA) contains sections reflecting acceptance of Traditional Healing services and promoting them.[14] However, Medicaid does not currently cover Traditional Healing services as part of AI/AN health care coverage and so fails to provide culturally specific services to AI/AN enrollees.

States should collaborate with Tribal Nations about if, and then how, to provide reimbursement for Traditional Healing services through Medicaid or other mechanisms. Important considerations include:

- Traditional Healing practices vary widely across Tribal Nations.
- Are Tribal traditional healers in the community willing to assign or negotiate a monetary value for their healing services? If not, what are other appropriate, acceptable options?
- Would traditional healers be willing to participate in the claim submission process?
- How does an individual become a traditional healer and what, if anything, is the licensing or certification process for Traditional Healing practitioners? Is a licensing or certification process even appropriate in this context?
- How will Tribal data sovereignty be upheld? Traditional Healing practices are often considered private, sacred practices, and may not lend themselves to processes designed to track patient use or outcomes.

Opportunities and strengths identified by community

MA Enrollee Survey: Traditional Healing Services

In the spring of 2022, DHS conducted a representative survey of working-age adults enrolled in Medical Assistance (MA). We chose a methodology that allows us to report back what members said overall, as well as separately for American Indians and five other racial/ethnic groups. 532 people indicated on the survey that they are American Indian. Among those, 319 indicated that they are Ojibwe and 67 that they are Dakota (including 15 who are both). There were an additional 43 who specified a different

Tribe that was part of their identity[i], and 132 who said they are American Indian, but did not specify a Tribe.

For about half of American Indians on MA, Traditional Healing practices are important to their health, they participated in at least one practice (often many more) in the past year, and they want to participate in more. Traditional Healing practices may be a powerful set of tools to support the health of these members.

More American Indian MA members reported that cultural and Traditional Healing practices are important to their health than do other MA enrollees. For example, over half of American Indian members said these practices are moderately or very important to their health. As seen in Table 1, only about 31% of non-American Indians said this.

Table 1. Importance of cultural and Traditional Healing practices. ***

How important are cultural and Traditional Healing practices (e.g. cultural healing ceremonies, spiritual rituals) to your health?	American Indian members			Non-American Indian members
	Statewide	Metro	Greater MN	Statewide
Not important	17%	12%	22%	23%
A little important	14%	16%	13%	12%
Moderately important	23%	22%	24%	13%
Very important	31%	37%	25%	18%
I do not use cultural or Traditional Healing practices.	15%	13%	16%	34%

***Differences between the last three columns were statistically significant at $p<0.001$.

In CMS' Proposed Framework for Traditional Health Care Practices in Section 1115 Demonstrations, they have initially put forth policies that provide coverage of Traditional Healing services at Indian Health Service (IHS) and Tribal facilities, but not at Urban Indian Organizations (UIOs). This potential gap in coverage for urban community members is a significant problem for American Indian MA members as half of them (48%) live in urban areas[ii]. In addition, these practices appear to be more important to American Indian MA members who live in the metro than those in Greater Minnesota. For example,

[i] The other tribal identities, grouped, are the following: Cherokee (11), Blackfoot (6), Lakota (5), Iroquois (3), Chocktaw (3), Cree (2), Ho-Chunk (2), Aztec (2), Northern Cheyenne (2), Menominee (2), and the following Tribes that had one person each: Apache, Navajo, Crow, the Mandan, Hidatsa and Arikara Nation, Salinian, and Seminole. This double counts a few people and represents only 43 people in total.

[ii] DHS analysis of MA enrollees who were enrolled as of June 2024. "Urban" is defined for our purposes as the seven-county metro area, Duluth, Bemidji, or Brainerd. In all other analyses in this report, "Metro" refers to the seven-county metro area and all other counties are considered "Greater MN".

thirty-seven percent of American Indian MA members in the metro area indicated that cultural and traditional health practices were '*very important'* to their health, compared to 25% in Greater Minnesota. In a positive development, in the approval letters for the four state waivers approved on October 16, 2024, CMS stated that "states may choose to include urban Indian organizations in these demonstrations."[15]

As shown in Table 2, half of American Indian MA members participated in at least one cultural practice in the past year. An impressive nine percent participated in ten or more in the past year. Those who live in the metro have participated in more of these practices than those in Greater Minnesota. For example, 39% of American Indians in the metro said they went at least twice in the past year, compared to 28% of American Indians in Greater Minnesota.

Table 2. Participation in cultural and Traditional Healing practices***

In the past year, how often have you participated in cultural and Traditional Healing practices like cultural healing ceremonies or spiritual rituals?	American Indian members			Non-American Indian members
	Statewide	Metro	Greater MN	Statewide
Never	53%	43%	62%	81%
1 time	13%	17%	10%	7%
2-5 times	19%	22%	16%	7%
6-9 times	6%	6%	6%	2%
10+ times	9%	11%	6%	3%

***Differences between the last three columns were statistically significant at $p < 0.001$.

Note: Everyone who said they 'don't use' cultural and Traditional Healing practices in the previous question were coded as 'never' in this question.

Table 3 illustrates that just over half of American Indians enrolled in MA want to participate in more cultural and traditional health practices. This rate was higher in the metro than in Greater Minnesota. [iii]

Table 3. Desire for more Traditional Healing practices (*Statistical significance of $p \leq 0.001$ is denoted with ****)

Would you prefer more opportunities to take part in cultural and traditional health practices in your community?	American Indian members			Non-American Indian members	
	Statewide	Metro	Greater MN	Statewide	
Yes	56%	60%	53%	32%	***
No	44%	40%	47%	68%	***
Not asked	17%	16%	18%	36%	

[iii] This question was skipped if someone said that they do not use Traditional Healing practices. The "not asked" rate is quite high. It is possible that some people do not use these practices, but would like to, but they are not included in the overall rate who said "yes."

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

In every initial guidance meeting and Community Conversation the one topic that was always a shared priority was Traditional Healing. Co-creators, Tribal staff and community members alike shared how Traditional Healing takes a whole health lens and helps in processing the causes and effects of inter-generational trauma, promotes self-esteem, serves as a coping skill, aids in connecting community members (such as children and Elders) together and promotes positive community presence.

A range of significant ceremonies and medicines was shared by various participants including sweat lodges, smudging, powwows, music and the arts, visits with traditional healers and medicine men, beading classes, tent ceremonies, naming ceremonies, funerary practices, morning offerings, prayers, use of traditional foods and herbs (cedar, sage, tobacco, sweetgrass, broths and soups, etc.), and traditional seasonal activities with family and community. Accessibility of traditional medicines, ceremonies and other health practices included not only the right and ability to practice, but also dedicated spaces and sufficient resources, and the elimination of pressure to justify or explain the significance of their use by Western medical providers or social workers.

"[When it comes to] traditional healers [we] need to know who they are and how to access them (two participants [of our small discussion group in Bemidji] use traditional healers)." Bemidji Community Conversation participant

One of the main barriers to accessing Traditional Healing services was that frequently participants found that there were not enough traditional healers available. Additional barriers related to transportation support for those who must travel to visit a traditional healer, lack of money to provide adequate compensation for healers, and concerns around licensing/certifications/"vetting" as a barrier to accessing healers or knowing if they were actually traditional healers.

There was also significant interest in community education and youth training programs for those interested in learning about Traditional Healing practices and becoming traditional healers themselves.

"[We] need community teaching/education around traditional healers."

"Fund young people to go to camps to learn traditional healing practices."

Bemidji Community Conversation participants

What is Medicaid doing to address this?

As noted in "Medicaid Levers: Quality" below, several states have obtained permission from CMS or exploring a Medicaid Section 1115 waiver to support reimbursement for Traditional Healing practices. States such as Arizona have also successfully integrated Traditional Healing as a value-added service, using innovative approaches like residential bed day codes to partially cover services such as sweat lodge treatment under Managed Care Organizations (MCOs).[16] However, challenges persist, including the need for further development of diagnostic codes to adequately reimburse these services along with administrative complexities that hinder broader implementation. The World Health Organization found during their August 2023 Traditional Medicine Global Summit that an ability to accurately document and

code Traditional Healing in health information systems is an important component of making these service more mainstream and billable. There is precedent with the Healthcare Common Procedural Coding System (HCPCS) Level II codes for utilization of other nontraditional healing codes such as S9900, *Services by a journal-listed Christian science practitioner for the purpose of healing, per diem*.[17] Other potential reimbursement mechanisms include standard encounter fees such as the IHS All Inclusive Rate, member allowances, and Medicaid 1115 waivers.

In Minnesota, DHS has supported MCOs in exploring In-Lieu of Services (ILOS) to address Traditional Healing. ILOS are allowable services or settings that are substitutes for services or settings covered under the state plan, based on cost-effectiveness and medical necessity. One example of Traditional Healing being made available to Minnesotans on Medicaid is the ILOS offered through Blue Plus' MN Medicaid MCO. Blue Plus worked with the Native American Community Clinic, a Federally Qualified Health Center that primarily serves the Urban American Indian community in Minneapolis, to develop the benefit. Blue Plus provides up to $500/member/year to members that can be used for Traditional Healing services through in-network providers[18] and since April 2024 has utilized a new CMS HCPCS Level II code (H0051) for Traditional Healing Services.[19]

DHS has also sought to address Traditional Healing through grant funded programs. In 2020, DHS, in collaboration with the Minnesota American Indian Mental Health Advisory Council and the Opioid Epidemic Response Advisory Council along with Tribal Nations and UIOs, contracted with 10 Tribal Nations and 5 UIOs to provide funding for Traditional Healing. These grants were appropriated at $2 million per year to address behavioral health needs for Tribal members.[20]

Call to Action: Invest in Traditional Healing Services

Access to Traditional Healing Services is a clear priority for American Indian communities and Tribal Nations. CMS and many states are exploring how to meet this need through the levers currently available to State Medicaid Agencies (SMA). Each has potential advantages and challenges. Pursuing Traditional Healing through In-Lieu of Services (ILOS) may be the most straightforward way for SMAs as it can be negotiated directly with Managed Care Organizations. However, only 42 SMAs currently utilize a MCO model and not all their Medicaid members are enrolled in MCOs, particularly American Indian members who have the right to opt out of MCO enrollment. Further, while this may be relatively more straightforward for SMAs it will likely cause added complexity for members as each MCO may have differences in their what their Traditional Healing benefit covers, how and how much is paid, and which Traditional Healers are "in network" and therefore accessible to MCO enrollees.

Similarly, while CMS is working to provide more clarity around how SMAs can utilize 1115 demonstration waivers to cover Traditional Healing services, pursuing an 1115 waiver for this culturally specific practice will continue to have a variety of challenges. There are signs of progress. The recent approval on October 16, 2024 of four states' (Arizona, California, New Mexico, and Oregon[21]) 1115 waivers to provide coverage for Traditional Healing practices after years of delay is a step in the right direction. Notably, as reviewed in "Medicaid Levers: Quality" below, is a current interpretation by CMS that non-tribal affiliated Urban American Indian clinics will not be eligible for participation in Traditional Healing services under an 1115 waiver and therefore won't be eligible for federal Medicaid funding for

Traditional Healing. However, the approved waivers for California,[22] New Mexico,[23] and Oregon[24] include coverage for traditional health care services received through an I/T/U. Arizona's approval also included UIOs so long as they are contracted through an IHS or Tribal facility.[25]

Regarding what types of services or practices are eligible for coverage, all four state waiver approval letters from CMS dated October 16, 2024 contain this language, "To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid."[26]

Beyond this provider requirement, CMS provides flexibility for qualifying facilities to determine what services should be covered, stating: "CMS will also permit IHS, Tribal, and urban Indian organization facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations."[27] The letters also note that clinical services eligible for reimbursement do *not* need to meet the definition of "clinical services" under other Medicaid regulations, and that "there is no requirement under this demonstration approval that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility."[28]

Again, this development represents important progress; of course, the effectiveness of these waivers will depend greatly on their implementation. But research conducted by the Public Health Law Center laid out several other challenges. First, an 1115 application can only be submitted by a SMA which undermines Tribal Sovereignty and self-determination. As 1115s require monitoring and evaluation they also inherently demand Tribal Nations apply a Western lens of "evidence-based medicine" to their sacred Traditional Healing practices. This is problematic in several ways. The existing 1115 methodology risks ignoring the well-established, proven effectiveness of many traditional medicines and practices. Tribal communities are the primary authorities for determining what should qualify as a widely accepted healing best practice, and some have done so. For example, the Indian Health Service (IHS) lists several culturally relevant best practices used by many Tribal communities to address substance use disorder and prevent suicides.[29] Further, the IHS and professional medical associations, such as the American Medical Association also already recognize the need for Traditional Healing practices.[30] These traditional practices that have been used for hundreds, if not thousands, of years should be deemed to meet Medicaid's standard for being evidence based and should qualify for coverage. **Although the recent approvals of Section 1115 waivers to cover Traditional Healing in 4 states is a good step, it falls short of guaranteeing comprehensive and consistent coverage for Traditional Healing practices for all Tribes.** Failure to provide comprehensive and consistent coverage creates a process that is inherently invasive and may not protect sacred and sometimes private Tribal practices or ceremonies. Protecting Tribal sovereignty over sensitive cultural data and other Tribal data is a pressing concern and Traditional Healing practices may not lend themselves to processes designed to track patient use or outcomes.

"Real traditional Indian healing should not even be talked about too publicly, it is too sacred for that." – expressed by a young Native woman to the Task Force on Health of the American Indian Policy Review Commission in 1976.

There are examples of how SMAs can better demonstrate respect for Tribal sovereignty. Oregon's waiver renewal request requires medical assistance programs to consider "Tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaskan Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those Tribal-based practices."[31] The Oregon Health Authority (OHA) and the Tribes situated in Oregon have implemented a process by which Tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal representatives.[32] The list of approved Tribal based practices, such as sweat lodges, talking circles, and horse programs among others, and additional information about each, is publicly available.[33]

States should work with I/T/U facilities to explore all possible tools under current law to facilitate greater Tribal self-determination of acceptable healing practices based on their own cultural and religious traditions. The recent waiver approvals show promising development. They expressly acknowledge that "[t]raditional health care practices vary widely by Tribe, facility, and geographic area."[34] They also recognize the need for and importance of providing flexibility for Tribes and Tribal-serving entities to define who qualifies to provide traditional health care practices, and what types of services or practices are eligible for coverage.

Regarding who qualifies to provide traditional health care practices, all four state waiver approval letters from CMS dated October 16, 2024 state that qualifying entities (IHS, Tribal facilities or urban Indian organizations) "are responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices …; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid … for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request." [35]

Regarding what Traditional Healing practices can qualify for coverage, the waiver approvals require that to be eligible for reimbursement, Traditional Healing practices must be provided by *employees* or *contracted providers*: "To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid."[36] (The waivers for California and Oregon also apply to those enrolled in CHIP.)[37]

Beyond this provider requirement, CMS again provides flexibility for qualifying facilities to determine what services should be covered, stating: "CMS will also permit IHS, Tribal, and urban Indian organization facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations."[38] The letters also note that clinical services eligible for reimbursement do *not* need to meet the definition of "clinical services" under other Medicaid regulations, and that "there is no requirement under this demonstration approval

that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility."[39]

All four states waiver approval letters also require states to attest that they are providing "adequate access to secular alternatives" because some of the Traditional Healing practices may be considered religious or spiritual, or have religious components, to comply with federal law and maintain federal funding. [40] States also must attest that they have taken steps to ensure that "beneficiaries have a genuine, independent choice to use other Medicaid covered services" for conditions that are also being treated through Traditional Healing practices.[41] Additionally, states must attest that "traditional health care practices" are not "used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered" and avoid denying "access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. [42]

At this early stage, it is unclear whether these attestations and/or documentation requirements might have unintended consequences, and if so, to what extent (if any). For example, it is unclear whether these requirements could require some kind of state intrusion into or scrutiny of private, sacred Indigenous healing practices, or into relationships between beneficiaries and Traditional Healing practitioners. Presumably, the states will work collaboratively with IHS, Tribal facilities, and urban Indian organizations to implement these requirements in a way that is as respectful and feasible for all, but this is an area where future monitoring will be important.

Apart from an 1115 Demonstration waiver there are other considerations DHS will need to navigate as we seek a path to investing in Traditional Healing services. Many traditional healers are not licensed or certified. To ensure respect for Tribal sovereignty, DHS should develop a process similar to Oregon's Tribal-Based Review Panel to decide what is required to become a traditional healer in Minnesota's respective communities without requiring a formalized licensure or certification process. Even then, traditional healers may or may not be willing to participate in the Medicaid claims process. In the 2023 National Council of Urban Indian Health (NCUIH) report it was noted that among the Urban Indian Organizations (UIOs) interviewed several, "voiced concerns about the administrative burden associated with Medicaid billing,"[43] with one Great Lakes UIO particularly concerned about having to incorporate diagnosis codes. This also raises the issue that participating in this process would require a traditional healer to assign or negotiate a monetary value for their healing services, which may contradict cultural values or other traditional ways. Additionally, given historical persecution of traditional healers, and/or the culturally sensitivity of some practices, some traditional healers may not feel comfortable self-identifying themselves or all of their practices to the government. For UIOs, another challenge identified by the NCUIH report was being able to provide tailored TH when serving a multitribal population. While a state may seek guidance from the Tribal Nations within their borders, the American Indian communities in urban settings hail from a larger pool of Tribes, each with their own approaches to TH that may be similar or different.

Noting all of this, the desire, need and evidence for expanding American Indian community members access to Traditional Healing services is apparent. DHS can take several concrete steps towards this Call to Action by:

- Continuing to engage Tribal Nations, Urban American Indian clinics and organizations, and CMS in finding paths to cover Traditional Healing through Medicaid funding. As noted above, that can involve conversations about and ultimately applying for an 1115 waiver, continuing to pilot coverage through ILOS agreements with MCOs and/or incorporating TH services into efforts to address Social Drivers of Health (SDoH) and primary care innovation.
- Seek American Indian community guidance on establishing a Tribal-Based Practice Review Panel. The goal would be to co-create community standards and consensus around Traditional Healing practices as well as identify initial steps to addressing questions around implementation like:
    - Are Tribal traditional healers in the community willing to assign or negotiate a monetary value for their healing services? If not, what are other appropriate, acceptable options?
    - Would traditional healers be willing to participate in the claim process?
    - How does an individual become a traditional healer and what, if anything, is the licensing or certification process for Traditional Healing practitioners? Is a licensing or certification process appropriate in the determined context?
    - How will Tribal data sovereignty be upheld?
- Implement lessons learned from the Behavioral Health Administration's Mental Health Tribal Healing grant program and consider a statewide grant program for integrated Tribal Healing services.

We need to be offering traditional healing services in all or our facilities. That needs to be the norm. And it's not. That's what healed me, not medicine. DHS needs to look at our Tribes and the government-to-government relations and let Tribes take the reins. The most success I've seen is when our own people are serving our people. – Bois Forte Tribal health staff

What will accountability to American Indian Minnesotans look like for Medicaid in Investing in Tribal Healing services?

- Continuing to engage Tribal Nations, Urban American Indian clinics, and CMS in finding paths to cover Traditional Healing through Medicaid funding
- Seek American Indian community guidance on establishing a Tribal-Based Practice Review Panel
- Implement lessons learned from the Mental Health Tribal Healing grant program

Outcome: Within 2 years of this report's publication DHS will have sought American Indian community guidance on establishing a Tribal-Based Practice Review Panel and have decided on next steps and what resources would be needed to support them.

Call to Action: Reframing What Defines Health and Wellbeing and the Evidence Used to Make Decisions

What is the problem?

"The problem is that Western models are focused on treating illness instead of seeing health as wholeness." Virtual Community Conversation Participant

The growing recognition of health disparities between American Indian/Alaskan Native (AI/AN) populations and other U.S. groups necessitate an urgent shift to center Indigenous perspectives and wisdom in how our health care systems define health, wellbeing, and the evidence generated by health care research to make decisions about how we pay for health care services. As noted in Figure 1, depicting a model of the Anishinaabe Worldview, health is derived just as much, if not more, from behaviors, beliefs, values, and connectedness than access to a Western medical provider. Loss of connection, to traditions, cultural practices, land, nature, and each other, has long been recognized by Indigenous knowledge as one of the main drivers to poor health and well-being.[44,45] Another way of framing it is that an individual's, community's, and society's health is not defined simply by absence of disease, but by the presence of healthy, functional relationship.[46]

Through a Western biomedical model, the outlook for the health of American Indians is bleak. The individual-focused and disease-specific valuation of health, when paired with a colonial and capitalist-based system of health care, narrows both the options, and imagination, for what is possible. While American Indian and Tribal activism helped shift federal policy towards self-determination in the 1970s for programs like IHS through the Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act (IHCIA), how courts have interpreted the federal government's obligation to provide health care for Native Americans has remained through a Western biomedical lens. Research conducted by the Public Health Law Center noted that, in the 2021 case of *Rosebud Sioux Tribe v. United States*,[47] the Eighth Circuit Court of Appeals (which includes Minnesota) affirmed that the federal government has a trust obligation to provide, "*competent physician-led healthcare,*" to the Rosebud Sioux Tribe arising from the 1868 Treaty of Fort Laramie.[48]

In the health care system which Medicaid operates, payment for most health care delivered must be dictated by physicians. The setting of that care must be delivered predominately in hospitals and clinics where almost all physicians practice. Payment for services must follow rules not only developed by physicians but maintained by one their largest organizations, the American Medical Association, with a documented history of racist practices.[49,50] These rules, the Resource-Based Relative Value Scale (RBRVS), largely determine the amount that is paid for a service by the resources a physician requires to provide it, using calculations developed by a culturally homogenous group of physicians decades ago that prioritize procedures and specialty care over primary care, and acute care and new technology over preventative care and traditional knowledge.[51,52] This method of determining payment is inherently flawed when applied to Traditional Healing services and other practices deriving from Indigenous Knowledge. There also exists a gap in knowledge between policymakers and Tribal healers about the cost of traditional medicines and treatments, how they are harvested and obtained, and the challenges of transportation across the varied geographies that American Indian communities live.

Medicaid regulations require that any activities designed to improve the quality of health care services meet certain criteria, including being "grounded in evidence-based medicine" or "widely accepted best clinical practice."[53] These criteria are also rooted in a constrained view of what constitutes acceptable, credible evidence. In medical treatment, there is a "hierarchy of evidence" that focuses on Western scientific studies of various kinds.[54] This hierarchy has been criticized for giving too much weight to some types of academic knowledge while devaluing evidence based on people's actual lived experiences.[55] Related to this critique, there is acknowledgement that conventional Western, "widely-accepted," health care practices are not adequate to meet all the health care needs for American Indian and Alaska Native peoples, assuming such services are even sufficiently available (which they frequently are not).[56] Additionally, Western health care and medical research practices have often caused terrible harms to American Indians.[57]

There have been encouraging signs of a willingness to re-examine what is deemed credible evidence at the federal level. In 2022 the White House Council on Environmental Quality (CEQ) and the White House Office of Science and Technology Policy (OSTP) jointly released government-wide guidance for federal agencies that, "recognizes the valuable contributions of the Indigenous Knowledge that Tribal Nations and Indigenous Peoples have gained and passed down from generation to generation and the critical importance of ensuring that Federal departments and agencies' consideration and inclusion of Indigenous Knowledge is guided by respect for the sovereignty and self-determination of Tribal Nations."[58] In it is also noted that, "Federal decisionmakers have also excluded Indigenous Knowledge from research and policy decisions. This marginalization has resulted from a lack of awareness, unfamiliarity, and methodological dogma, and, too often, racism and imperialism." Several examples from public health and climate health were cited in the guidance. However, while the Centers for Disease Control and Prevention, National Institutes of Health and Indian Health Service were among the agencies contributing to the Interagency Working Group on Indigenous Knowledge, the Centers for Medicare and Medicaid Services (CMS) were not. Given that in the U.S., 43% of American Indian/Alaskan Natives under the age of 65 receive their health insurance from Medicaid[59], and 95% of Elders 65+ are connected to health insurance through Medicare[60], this reveals a critical gap in which parts of our health care system are leading the necessary reexamination of what defines health and how we allocate resources to achieve it.

Opportunities and strengths identified by community

> *"When we are talking about [the] wellness of Native folks, we are talking about all aspects: physical, spiritual, mental, emotional" – Dr. Prairie Chicken, Minneapolis Indian Health Board*

Community conversation participants, Co-creators, Tribal staff, and Urban Indian organization leaders all shared some version of valuing holistic perspectives on health, wellness, and care for "the whole person" – including cultural, spiritual, and mental health, ceremonial resources and social connections, land and water, traditional foods and medicines, knowledge of their uses, and access to nature and green spaces. There was also a consistent priority placed on supporting members' social drivers of health like housing and transportation, education, healthy and culturally relevant foods, but also highly valuing basic needs like rest. Participants too noted the significance of Indigenous epistemologies, not

always aligning with Western cultural systems and assumptions. One example was numerous reflections about the centrality of land, water, non-human nature, and sovereignty to Indigenous medicine and healing practices. Examples that stemmed from this included a desire to have Medicaid support community-based Indigenous agricultural programs, Indigenous suppliers and providers of traditional foods, herbs and other resources used for medicines (like cedar, sage, tobacco, sweetgrass, etc.) and finding ways to promote self-determination and community-based sourcing (ex. when gathering plants and foods for traditional medicines).

> *"[There is a] need for community support and traditional medicines – support to get to ceremonies and traditional plants. Access to sage, berries, and other traditional plants [has to come] from a community-cared-for source (not dependent on capitalism to access our own medicines). Working with programs and communities that care/teach medicines [is helpful]." – Minneapolis Community Conversation participant*

Tribal staff noted that although the White House guidance directed federal agencies to incorporate Indigenous Knowledge into policy decisions, CMS' final rule related to the Medicaid clinic services benefit four walls requirement (see "Medicaid Lever: Access" for background on this policy) for IHS and Tribal clinics has been a point of frustration. Tribal Nations in Minnesota have been active advocates that CMS reconsider its interpretation of federal laws and regulations in applying the four walls policy to federally recognized Tribes as well as calling on Congress to deliver clear action by providing statutory language that IHS and federally recognized Tribes not be required to provide defined clinic services within the four walls of a qualified facility.[61]

What is MN Medicaid doing to address this?

In addition to the work around creating a Traditional Healing benefit noted earlier, DHS has pursued a couple different models that are helping reframe definitions of health, the evidence used to allocate resources, and how DHS pays for services delivered to American Indian members.

Integrated Care for High-Risk Pregnancies (ICHRP) grant program

DHS' Integrated Care for High-Risk Pregnancies is a grant-supported program administered by DHS in full partnership with American Indian communities and Tribal Nations (ICHRP also includes a parallel initiative in partnership with African American community leaders and clinicians in the Twin Cities). Important features of ICHRP include:

- Leadership by a community-based advisory council and fiscal support for community infrastructure. Appropriations within the state's base budget currently fund ICHRP.
- Cultural integration of a perinatal collaborative care model specific to American Indian communities. ICHRP models center on community-based, culturally specific paraprofessionals who reach out to potential clients, identify psychosocial needs, and navigate to appropriate services.

From 2015 to 2019, DHS awarded grant funds as a part of the pilot program to five Tribal Nations focused on improving outcomes of infants exposed to maternal opiate use. With federal funding for communities impacted by the opioid crisis expanding, ICHRP funding for American Indian communities shifted and in 2022 funding was awarded to an organization in Bemidji, Mewinzha Ondaadiziike Wiigaming (often referred to as Mewinzha or MOW) and one in Minneapolis, Minnesota Indian Women's Resource Center (often referred to as MIWRC). Another round of funding was awarded in 2024 to the Ain Dah Yung Center in collaboration with the American Indian Family Center in St. Paul. MOW shared during a site visit that participation in ICHRP, "was one of the catalysts that helped us think about and plan for more integrated care." In addition to providing initial screens for social risks and needs, they have been able to hold quarterly community meetings where they offer plant medicine, review practices such as Yoga and are integrating traditional Indigenous practices. They also hold sessions with Elders and younger families to facilitate intergenerational connection and sharing of wisdom.

Money Follows the Person-Tribal Initiative (MFP-TI)

DHS has historically contracted with Tribes to administer different aspects of home- and community-based serves (HCBS). Building upon this, Minnesota was selected as one of the states to participate in the CMS Money Follows the Person Rebalancing Demonstration Grant as noted in the section, "Medicaid Levers: Access." This program seeks to assist Tribes in providing Medicaid-funded home and community-based services to their members and reduce the use of institution-based services. Among the MFP-TI Principles is honoring cultural identity through program design and enhancing understanding of Tribal Sovereignty in the government-to-government relationship. Four Tribal Nations are participating in this initiative with DHS: Bois Forte Band, Mille Lacs Band, Red Lake Nation, and White Earth Nation.

Call to Action: Reframing What Defines Health and Wellbeing and the Evidence Used to Make Decisions

This report seeks to lift up the pressing need to recognize the importance of not only supporting Indigenous self-determination through words but also finding concrete ways to ensure Medicaid and our health care system broadly appreciates the value of, and pays for, Indigenous-centered, holistic health practices. The existence of bias towards American Indian communities, the documented negative impacts of a colonialist history within Western approaches to research, data, payment, and practice, all contribute to the enduring health disparities documented throughout this and other reports. There is a benefit to us all in understanding and embracing Indigenous and Traditional Knowledge and utilizing more holistic definitions of health. Notably, the U.S. Surgeon General issued an Advisory on the Healing Effects of Social Connection and Community in 2023.[62] Regrettably, there is no reference to the significant amount of work that has been done detailing Indigenous models of health and well-being that extend back generations and have social connection among their core tenets.[63,] The report does briefly call for the incentivizing of, "assessment and integration of social connection into health care delivery….including through public insurance coverage," however does not tackle how such assessments can be tailored to cultural or community contexts, or how payment should be structured. This highlights

the work government agencies need to undertake to authentically engage with communities who hold Traditional Knowledge, and the value to us all in reframing our definitions of health.

To reframe what defines health and wellbeing and the evidence used to make policy and resource decisions, DHS should:

- Work with Tribal Nations and Urban American Indian communities to develop a shared definition of health and wellbeing for American Indian community members.
    - Creating a shared definition can be a guiding force and touchstone when misunderstanding and conflict inevitably arise. This process could entail improving DHS' approach to data sovereignty (see Medicaid Levers: Quality) to ensure not just the definition but the data used to evaluate performance relative to that definition is aligned.
    - This definition can then be applied to DHS policies like community-guided processes for the agency's application for federal grants, state administered grant writing, Request for Proposal (RFP) scoring, contracting, legislative proposals, technical assistance and mandated reporting to the Minnesota legislature.
- Continue to work with federal partners to support interpretations of Medicaid rules and regulations that are aligned with the 2022 White House CEQ-OSTP guidance around Indigenous Knowledge through available levers like State Plan Amendment, Waiver and Demonstration applications.
    - Research conducted by the Public Health Law Center noted that Medicaid regulations require approaches to improve health care quality, "be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations." This offers the opportunity for DHS, CMS, and other state Medicaid agencies to support connections between Tribes, American Indian communities, and national clinician and public health bodies that inform current clinical standards of care to facilitate the reframing of health, and the evidence used to determine clinical standards.
- Continue to co -create, -propose, -implement, and -evaluate state-funded models of care and payment that center an American Indian community-defined approach to health and well-being.
    - The ICHRP model can be explored for other areas of health and well-being identified in ongoing conversation with Tribal Nations, Urban American Indian organizations, and community members.

DHS could be a leader among State Medicaid Agencies and government institutions in helping our health care system honor the values and strengths of American Indian communities. What is needed can be summed up by the authors of the 2022 article, Reclaiming Indigenous Health in the US: Moving beyond the Social Determinants of Health, "This support calls for reframing and allowing for differences in how health is conceptualized in policies, reports, requests for proposals, funding, research, programs, partnerships, and relationships with Indigenous Nations and peoples. In addition, a shift from funding primary health services and interventions to more flexible financial support for planning and systems improvements requires infrastructure investments." [64]

What will accountability to American Indian Minnesotans look like for Medicaid in reframing what defines health & wellbeing and the evidence used to make decisions?

- Working with community co-creators towards greater Tribal and Urban American Indian data sovereignty, redefining health through an Indigenous Determinants of Health framework.
- Explore ways to apply Medicaid rules and regulations that are aligned with the 2022 White House CEQ-OSTP guidance around Indigenous Knowledge.
- Continue to co-create, propose, implement, and evaluate state-funded models of care that center an American Indian community-defined approach to health and well-being.

Outcome: Within 2 years of this report's publication DHS will have a shared, co-created definition of Tribal and Urban American Indian Health & Wellbeing that is used across DHS policies and procedures.

Outcome: With community guidance, DHS will put forth an innovative State Plan Amendment, Waiver or Demonstration application that helps advance how Medicaid pays for health and wellbeing informed by Indigenous Knowledge.

Call to Action: Create a Pathways to an American Indian and Tribal Health Integration team at DHS

What is the problem?

> *"DHS should know that there is still a lot of mistrust in DHS – especially in American Indian communities. For hundreds of years that information has been used against us. So, if you are having a hard time getting the info you want from AI communities that's why. Repairing that trust is a MUCH larger project than these small reports like this. Sharing is difficult for us for that reason. If you are hearing silence when you want data that's why." Virtual Community Conversation participant*

To deliver sustainable change in systems that have for generations upheld and perpetuated inequity requires sustainable investments and realignment of priorities. However, often the resources for such work and the positions within an organization's hierarchy that are tasked with significant transformation are insufficient. This leads to a lack of cohesion and ability to make lasting changes. Efforts are often focused too narrowly on one aspect (ex. medical diagnosis like SUD or social condition like homelessness) and thereby fail to address the overall problem, which is structural racism and inequity. This leads to fragmentation of what resources are made available, duplication of efforts, asks of community members to advise on change, and a subsequent lack of desired impact. Given that Medicaid is a significant source of health care for American Indian communities in Minnesota, Co-creators highlighted both the lack of integration, and tolerance for dysfunction, in how DHS administers various

services as an example of structural racism. They noted that Tribal nations and Urban American Indian clinics often provide the services and supports to help members meet their physical, spiritual, mental and emotional health goals but often they are not billable. When they are, they often are structured in a way that doesn't appreciate their integrated focus, as one member reflected, "there are so many limitations across all of the services because people might not have the 'right' certification for the job, even though they help." More specific examples were provided around community members accessing substance use and behavioral health treatment, supporting children with complex needs like Autism and helping Elders access home health care. One Co-creator summed up how this lack of integration across DHS services and the resultant experience of dysfunction was perceived in their community, noting that, "Not addressing this is an act of discrimination."

Opportunities and strengths identified by community

During conversations with Co-creators and in the facilitated Community Conversations, a number of reflections lifted up the need for a core team that is sufficiently positioned and resourced to continue building off of this report and the efforts undertaken before it. Members voiced a desire for ongoing and sustained engagement with policy and decision-makers about health equity for American Indian communities.

> *"[There is] a disconnection of conversations at the state level around health/equity: not always having the right people at the table, one-and-done [engagement] doesn't work." Bemidji Community Conversation participant*

This engagement needs to be paired with internal accountability to action and change. Community members identified many opportunities where DHS could continue, or begin, to support such efforts like:

- Designing, streamlining, and regularly updating member-facing systems to be accessible at any educational level.
- Developing more Medicaid navigator/advocate supports (including American Indian navigators, cultural competence training, and elder advocates) and ensure adequate public communications and outreach for existing resources.
- Explore ways to alleviate difficulties meeting basic needs, including transportation/childcare supports for those who must travel to seek healthcare.
- Investing in American Indian-led community education and training programs (ex. financial support for American Indian youths and others interested in pursuing both conventional and traditional (Indigenous) medical careers; funding and support for development, hiring and retention of Native American therapists and behavioral health specialists)

Research conducted by the Public Health Law Center noted the potential opportunity around supporting education and training to meet shared goals: "Providing more education and training in culturally competent care for providers also can help to foster more culturally sensitive care. For example, the Minnesota Department of Health released the Mental Health Cultural Community Continuing Education Grant Program in June 2024 for members of Indigenous communities or other communities of color that

are licensed mental health professionals residing in the state of Minnesota that are working for a community mental health provider.[65] Providing more funding like this can act as a tool towards increasing the number of Indigenous community members and other people of color with specialized training in the medical field, increasing representation."

"To improve health for American Indians in Minnesota, we need simpler processes, more funding for culturally competent care, and better access to traditional healing practices." – Virtual Community Conversation participant

What is MN Medicaid doing to address this?

Cross-sector collaboration between states, Tribal Nations and Urban American Indian organizations is critical to expand access to culturally appropriate care for American Indians. DHS has made some progress in this area as noted earlier in reference to Traditional Healing with the Minnesota American Indian Mental Health Advisory Council and DHS collaborating to incorporate "traditional healing into Minnesota's behavioral health continuum of care and to identify and develop a sustainable funding stream for traditional healing."

Table 4. Minnesota DHS teams centering American Indian communities and Tribal Nations as of November, 2024.

DHS Team (Administration/Division)	Positions
Office of Indian Policy (Central Office)	Director, Policy Specialist, IT Analyst
Business Solutions Office (Central Office)	Community Engagement and Tribal Engagement Specialists
Office of the Inspector General (Central Office)	Tribal Nations Liaison
American Indian Team (Behavioral Health Administration)	Manager, Supervisor, Mental Health and SUD Teams
Tribal Collective and MFP Tribal Initiative Team (Aging and Disability Services Administration)	MFP and Tribal Collective Leads, Tribal Relations Specialists
MN Board of Aging (Aging and Disability Services Administration)	Indian Elders Coordinator
Social Security Advocacy Services (Homelessness, Housing and Support Services Administration)	Tribal and Northern MN Coordinator
Federal Relations (Health Care Administration)	Tribal Relations Liaison

DHS currently has several teams whose work centers on American Indian communities and Tribal Nations. Additionally, there are teams focusing on health disparities that also work directly with American Indian communities and Tribal Nations, like the previously mentioned ICHRP grant team, the central office's Community Relations team and the Office of the Medicaid Medical Director's Culturally and Linguistically Appropriate Services (CLAS) unit and Community Outreach Specialist. It is notable that while several teams have a Tribal focus there are no teams currently specifically focused on Urban American Indian communities. Also notable is that among the current roles centering American Indian health, the majority have a defined scope that limits their ability to approach health and wellbeing

holistically. While those with roles that could allow a broader scope (namely the Office of Indian Policy) are currently under resourced to help DHS' current American Indian-focused teams, and DHS more broadly, achieve a holistic, integrated approach to improving the health of American Indians on Medicaid in Minnesota.

Call to Action – Create, Resource and Position a "PATH-I" team at DHS

To achieve broader integration and assist in reframing health as not isolated to one diagnosis or part of the body, DHS should create, appropriately resource, and position a Pathways to American Indian and Tribal Health Integration (PATH) team. This team would be charged with guiding DHS in centering a whole person and whole community approach to American Indian population health. If well positioned they would be able to foster inclusion of all types of healthcare services, account for the settings where those services occur and leverage the strengths and address the challenges surrounding the conditions that American Indian members live, work, and play in, to achieve enduring change.

Initial tasks for the PATH-I team could include:

- Ongoing Community Engagement to listen.
- Follow up with individuals/leaders from Urban American Indian and Tribal communities where there are disparate outcomes in available data and seek guidance to understand, collect, analyze, and act on data more accurately.
- Ongoing Community Engagement to share knowledge about available Medicaid resources.
    - Work with DHS policy subject matter experts to advise policy development and with DHS community engagement specialists to get the word out about new or underutilized policies through community conversations, participation in community events and content creation for traditional and social media.
- Works across DHS administrations, state and local governments (ex. MN Department of Health, MN Department of Children Youth and Families, county human service agencies), with Tribal Nations, Indian Health Services and Urban American Indian health care systems to improve integration of whole person and cultural approaches to health and share opportunities for Medicaid to lead or participate in systems integration.
    - Analyze existing data and policies through a health equity and Indigenous worldview to identify opportunities to improve. Convene and steward an American Indian Data Sovereignty Guidance Panel.
    - Administer grant funding or help current grant funding meet focused needs identified by health equity data analysis and community guidance.
    - Help state systems move towards greater health integration, meeting community members where they are, decreasing unnecessary barriers, valuing all aspects of health (cultural, physical, spiritual, mental, emotional).

What will accountability to American Indian Minnesotans look like for Medicaid in holistic health integration?

- Improved efforts to align and integrate American Indian and Tribal centered work across DHS.
- Ensuring the needs, strengths and challenges of Urban American Indian communities are addressed alongside sovereign Tribal Nations.
- Investment in ongoing, long-term relationship-building and targeted community engagement to address trust gaps, develop sustainable relationships with American Indian communities in Minnesota, and deepen meaningful connections and facilitate high-quality, ongoing community co-creation.

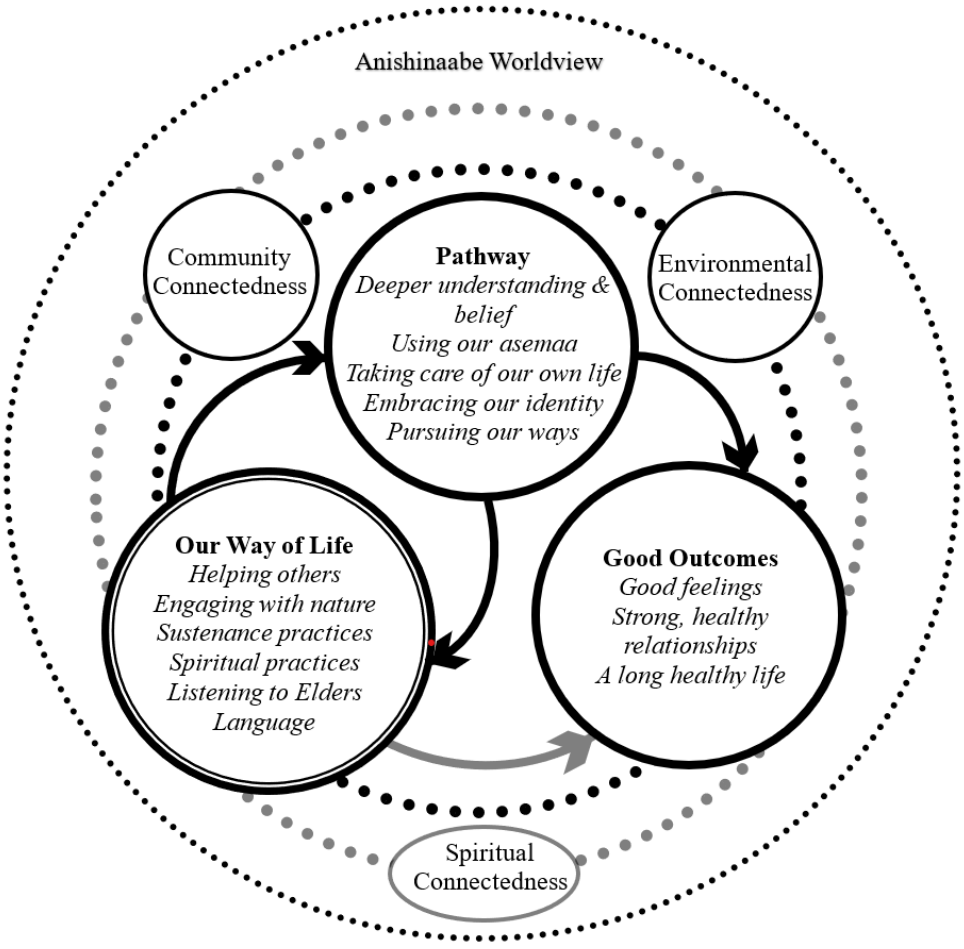
Outcome: Creation of a team within DHS that is appropriately resourced (with positions and grant funding), appropriately positioned, and accountable to advance holistic American Indian community health integration.

Part 2 – A cultural and community-informed definition of health

"If we continue to try and fix things in a colonial context we won't succeed" - Dr. Patrick Rock M.D., CEO, Indian Health Board of Minneapolis, Inc

Health and wellness have long been defined as holistic concepts that encompass more than just the absence of disease, however, the United States' evolution during the Industrial Revolution gave rise to health being defined by one's ability to be economically productive.[66] While many public health organizations and health care systems have put forth holistic definitions of health, the way our health care system pays for health has disproportionately centered the diagnosis and treatment of disease.[67] For American Indian communities and Indigenous cultures, health is tied to much more than disease. A study that sought the wisdom of Elders from Anishinaabe Tribes looked to learn more about the role of language in well-being.[68] Figure 1 from their study illustrates how individual and community values, behaviors and beliefs connect one to wellness.

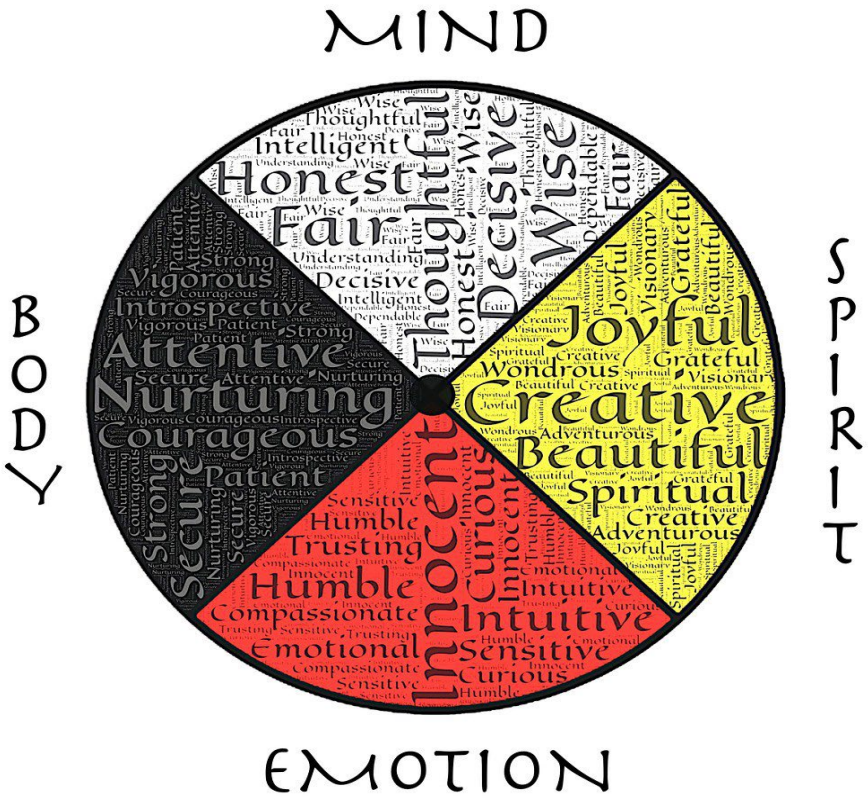
Figure 1. Model of Anishinaabe Worldview (*included with permission*)



Many American Indian communities and Indigenous cultures have used a Sacred Circle or Hoop (also referred to as a Medicine Wheel, a term given by early European settler colonizers to describe the circular structures) to embody health and healing.[69] Figure 2 is an example of the Sacred Circle or Medicine Wheel. The 4 quadrants can symbolize varying aspects of health and life depending on the community and the elder or traditional healer. The 11 federally recognized Tribal Nations in Minnesota

have adopted the Medicine Wheel but it should be noted that not every Tribe uses this framework for health and wellbeing. As noted by Co-creator Dr. Antony Stately, "In urban areas there are over 100 different Tribes represented, and not all use the medicine wheel teachings. The Indigenous way of wellness and well-being is more complex than the Medicine Wheel circle."

Figure 2. Example of a Sacred Circle or Medicine Wheel



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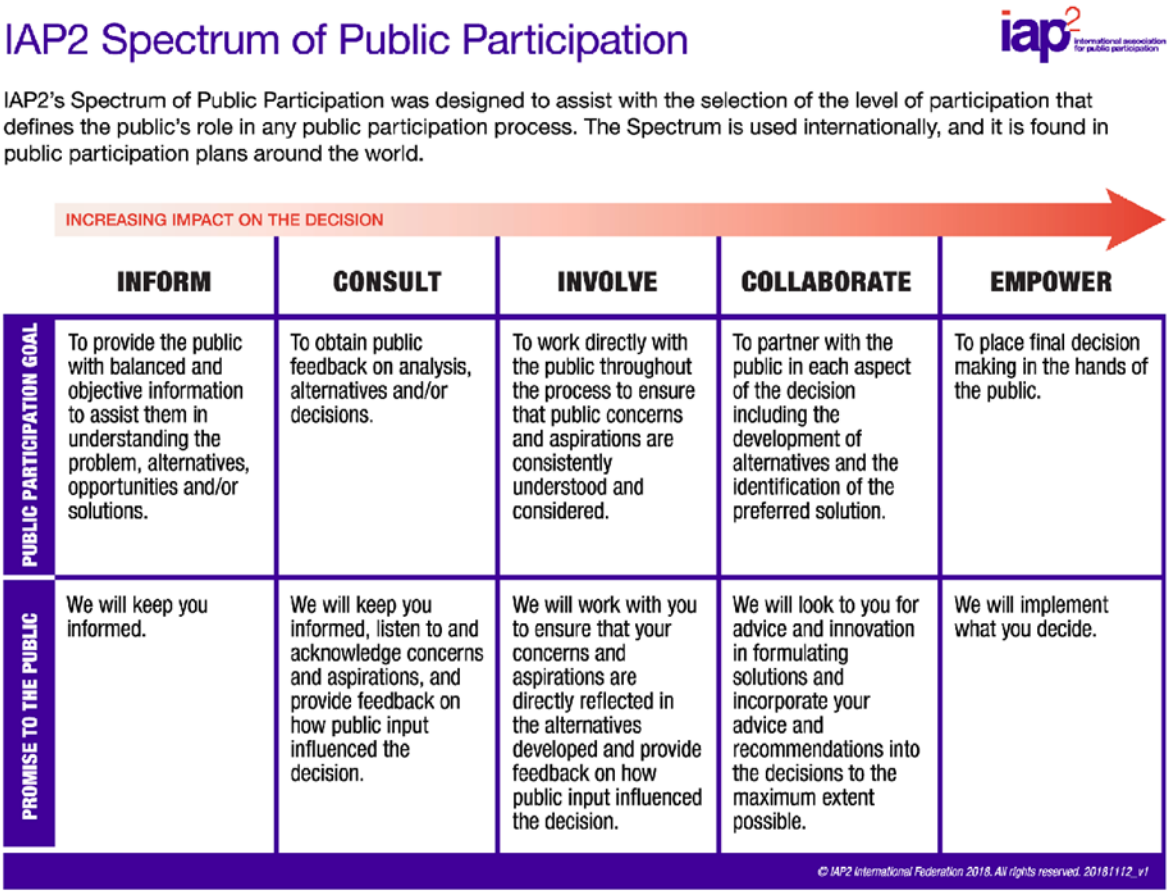
Understanding what defines well-being in any community is crucial to authentic co-creation and partnership towards improving health. In DHS' 2022 Building Racial Equity into the Walls of MN Medicaid report it was acknowledged that, "Communities impacted the most by structural racism and inequity need to be engaged early and provided accountability, as Minnesota strives to dismantle systems of harm and build systems that support the health of all."[1] As part of the iterative process of creating the report and implementing its actions DHS aimed to meet a level of "Involve" in our community co-creation as defined by the International Association for Public Participation's (IAP2) spectrum (Figure 3). In our commitment to push the work of DHS further along the IAP2 spectrum for this report we strived to meet the level of "Collaborate," learning from areas of success and missed opportunity experienced during the 2022 report process.



IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

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Fig 3. Spectrum of Public Participation. (c) International Association for Public Participation www.iap2.org

Process of community-guided report

At the onset of this report a high-level proposal for the intent and process was shared with leadership in DHS' Office of Indian Policy. They provided essential guidance in how to frame our intent and not presume this report and the iterative process around it was desired or a priority of American Indian community members and Tribes. A more detailed description was prepared that discussed our intent, the rationale for this work, a proposed process of engagement and timeline. This was then initially shared at the Tribal and Urban Indian Health Directors' (TUIHD) meeting, held quarterly between Tribal health and human services staff, Urban Indian Organization staff, and staff from DHS and the MN Department of Health (MDH). It was also separately shared with leaders at the Twin Cities Metro Urban Indian Directors group. **The intent shared in these, and subsequent, meetings was to receive guidance on co-creating a report focused on answering 2 primary questions: What policies or structural changes should be prioritized in order to improve the health and opportunity of American Indians on Minnesota Health Care Programs (Medicaid/MA and MinnesotaCare)? And how can MN Medicaid more truly add value and support what Tribal Nations and American Indian communities are already doing to help members realize their full health and potential?** From those initial meetings with

community leaders our team received a consensus of support that this work as proposed would be welcome.

Our proposed process of engagement sought to provide health care and human services staff from every sovereign tribal nation in Minnesota, as well as leaders from Urban American Indian clinics and organizations, the opportunity to participate as much or as little as they had the bandwidth and interest. We proposed multiple levels of commitment initially which included None ("We currently don't have the ability to participate in this process"), Guidance-only (committing to a 90–120-minute meeting to provide initial guidance) and Co-creation (providing initial guidance and then ongoing input and support throughout the report development and distribution process).

Table 5. Initial Pathways report Guidance and Co-Creators

Initial Guidance and Co-creators*	Tribe/Community/Organization Represented
Dr. Antony Stately*	Native American Community Clinic
Dr. Laurelle Myhra*	Red Lake Nation
Dr. Rebecca St. Germaine*	Great Lakes Inter-Tribal Epidemiology Center (GLITEC)
Dr. Kade Lenz*	GLITEC
Karina Forrest Perkins*	Vail Communities
Dr. Charity Reynolds*	Fond du Lac Band of Lake Superior Chippewa
Nate Sandman	Fond du Lac
Chris Davis	Fond du Lac
Pamela Parson	Bois Forte Band of Chippewa
Darin Prescott	Lower Sioux Indian Community
Stacy Hammer	Lower Sioux Indian Community
Dr. Patrick Rock	Minneapolis Indian Health Board
Kate Hemker	Minneapolis Indian Health Board
Louise Matson	Minneapolis Division of Indian Work

Like our 2022 report, after our initial meetings with community leaders and Tribal HHS staff, our report team met with specific DHS divisions involved in the stewardship of policy areas that were consistently prioritized. Those conversations further informed the "Calls to Action" selected for this report and contributed to the background about what Minnesota DHS has, and has not, historically done to advance health and opportunity for American Indian Medicaid members.

From there three new strategies were employed to build upon what DHS learned in the process of the 2022 report and continue moving towards "Collaborate" on the IAP2 Spectrum: working alongside co-creators, convening a data guidance panel and contracting with a facilitator for community conversations.

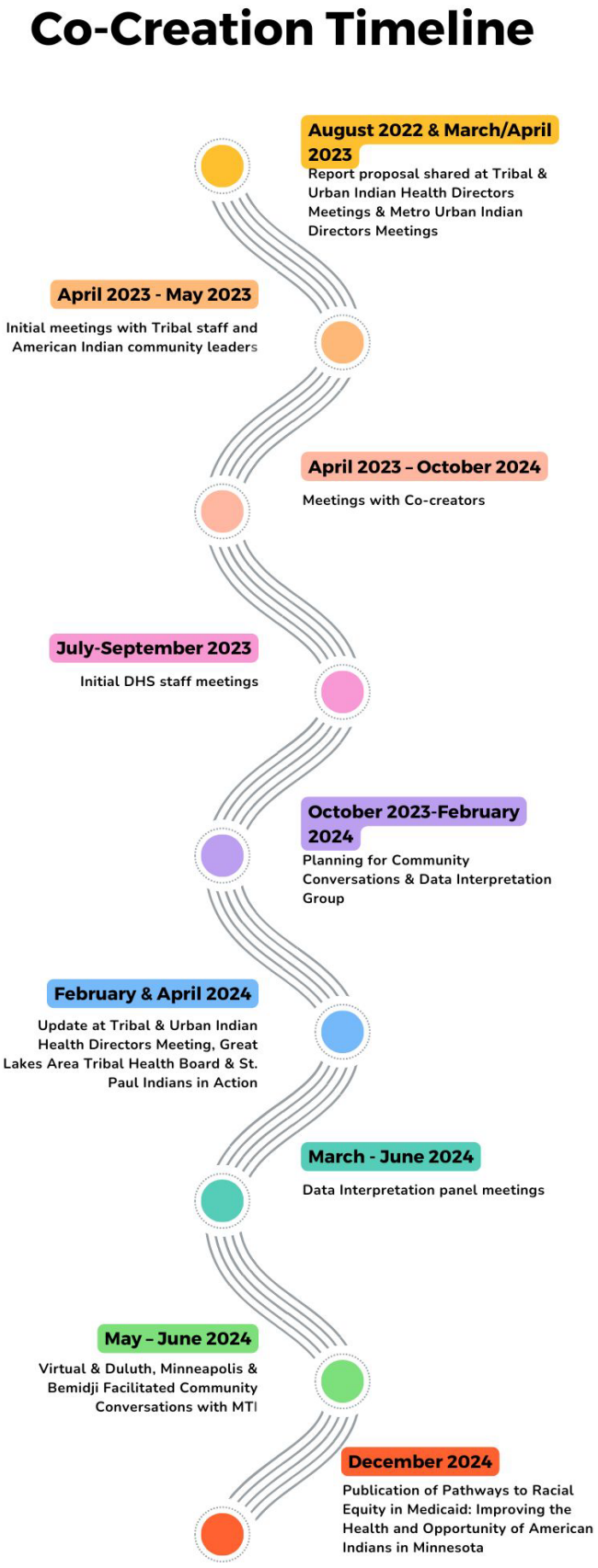


Figure 4. Pathways to Racial Equity Report Timeline

Co-creators

After the initial guidance meeting Co-creators met approximately monthly to hear updates on the report development and provide ongoing direction for our team's efforts as well as critical community connections and recommendations for other community members and organizations we should be engaging with. Over the course of a year this report's Co-creators provided guidance on the data we examined, recommendations for members of the data guidance panel and community conversation facilitators, and reviewed draft versions of the report. Co-creators who also participated as data guidance panel members could apply for a small stipend.

Data Guidance Panel

In early 2024 DHS staff convened, in collaboration with the Great Lakes Inter-Tribal Epidemiology Center and the American Indian Cancer Foundation, MN Medicaid's first American Indian data guidance panel. The intent of this group of American Indian policymakers, tribal leaders, researchers in tribal and urban American Indian organizations and clinical providers, was to review data gathered in response to our initial meetings, suggest additional data that needs to be gathered, and provide guidance and context to data from national and other statewide sources. The work of this panel helped provide the report, and our broader work towards health equity in our Medicaid program, a more authentic narrative around the data presented, as well as informed the Calls to Action in the report.

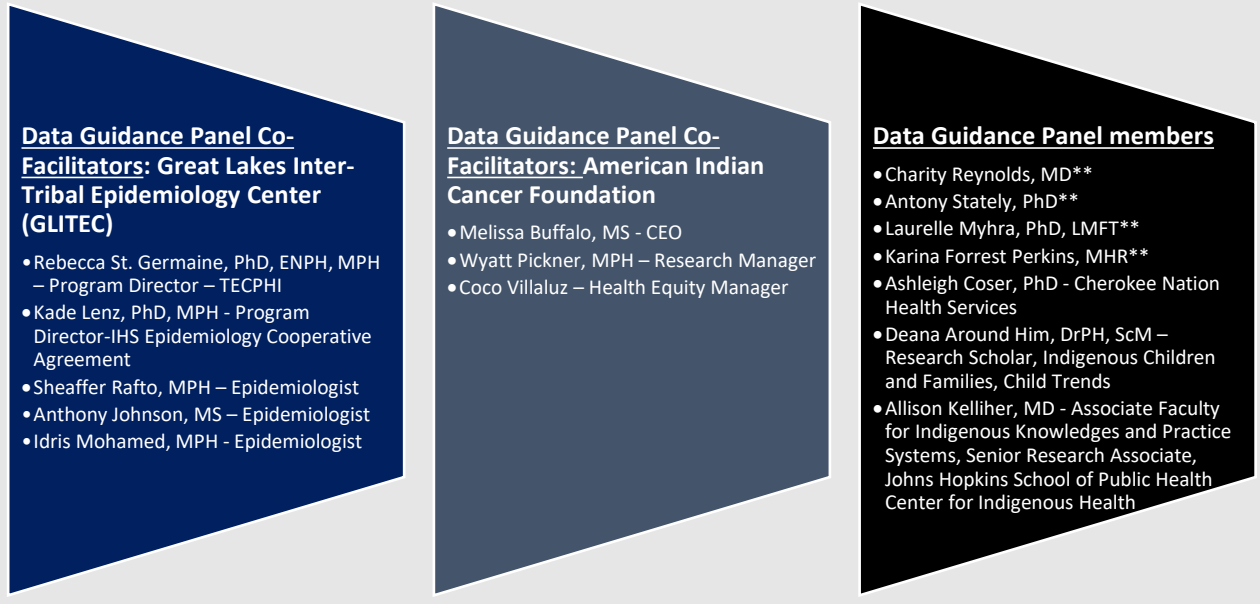


Figure 5. Minnesota DHS 2024 American Indian Data Guidance Panel

Facilitated Community Conversations

Our Community Conversations for our 2022 report occurred amid the emergency response phase of the COVID-19 pandemic. They were therefore limited to virtual events. DHS staff volunteered their time to help coordinate and facilitate the community conversations as well as take notes and analyze themes as there were no formal roles dedicated to this work in 2022. While we were fortunate to have a number of community members with varied lived experiences participate, these limitations did impact our ability to engage with community members and to move towards "Empower" on the IAP2 spectrum.

For this report DHS wanted to hold at least three in-person community conversations in the areas of the state that have the greatest concentration of American Indian community members, the Minneapolis/St. Paul metro, Bemidji, and Duluth. Additionally, since a number of American Indian members live in rural areas, we aimed for two virtual conversations to allow statewide participation. We also early on identified a need to contract with an organization that could be skilled and trusted facilitators of our community conversations. We initially gauged interest from staff at the TUIHD meetings and among our Co-creators to see if Tribes or UIOs had capacity for this work. What we heard from respondents however was a recommendation to work with an organization that had experience working with and living in American Indian communities in Minnesota. This led DHS through a solicitation process and contract with Marnita's Table, Inc (MTI) to conduct a focused series of community conversations. A collaborative undertaking between MTI and DHS, this focused conversation series was designed to extend the relationship building efforts of the department with American Indian communities in the state of Minnesota in order to gather community insights, priorities and guidance on American Indian experiences with healthcare and Medicaid services. The, "Engage! Pathways to Racial Equity," series was successful in bringing together 384 community members across the state of Minnesota during two virtual and three-in person events, hosted in Duluth, Minneapolis, and Bemidji. Designed with the intention of centering American Indian voices, at least 40% of total project

participants – with 76% of those who responded to the ethnicity question on the sign-in sheet - identified as Native, Indigenous or American Indian. 65 percent of participants overall identified as Indigenous, Black, or other people of color, and over a quarter of participants were under the age of 27. The series was co-hosted by DHS staff and leadership who helped welcome community members to in-person and virtual events throughout the five-event series of community conversations, with event design and facilitation provided by the MTI team in the model of Intentional Social Interaction (IZI).

Analysis of the discussion themes shows that conversations largely focused upon:

(1) holistic perspectives on health, wellness and care for "the whole person, including the importance of being able to meet basic needs which for many American Indian participants included access to land, water, cultural practices and history, connection and community support, and matters of sovereignty and self determination;

(2) administrative and systemic barriers to accessing and enjoying the full benefits of Medicaid, including navigation and advocacy, information overload, complexity, and communications issues;

(3) perspectives on the intergenerational and relational nature of healing, wellbeing, medicine, and care; the need for respectful and compassionate communications, anti-racism and cultural competence, alongside the challenges of grappling with historical violence, addressing anxiety, hesitation and stigma;

(4) urban-rural divides and the geographic distribution of resources (and accessibility) in Minnesota, as well as difficulties accessing dental, vision, maternal and perinatal care; and

(5) experiences with telehealth, including strengths, challenges, and opportunities.

Reflections from the discussion themes and quotations from participants are incorporated throughout this report and informed the report's Calls to Action. A full report from MTI is included in the Appendix.

Limitations of our process

While DHS staff was encouraged by the progress we were able to make between our 2022 report process and this report, several limitations were noted. We were able to reimburse our Co-creators for some of their time but not for all of their time and the significant expertise and guidance they provided. We were also eventually successful in working with a contracted organization to facilitate our community conversations but due to internal delays in the contracting process our partners had a significantly truncated period of time in which to organize, conduct, and analyze the community conversations. We lift these challenges up so other teams within DHS and organizations outside DHS that are considering engaging in similar work can learn from our efforts and plan accordingly. Lastly, although we were able to have a much more robust process compared to 2022, **we are still very much aware of the significant heterogeneity within and between American Indian communities**. True engagement won't stop with the publication of this report, and we are committed to finding ways to continue working with our Co-creators, Data Guidance panel and holding more community conversations in an iterative fashion to build upon this work, deepen our relationships, and accomplish our shared goals.

Part 3 - What is the community context that defines and drives health?

"[It's about] traditional and ceremonial wellbeing [too]. Looking at holistic care – mental, physical, spiritual – is just the beginning of the needed framework. Conversations [need to be] had that involve engagement with self and community,"- Minneapolis Community Conversation participant

Strengths: Indigenous Knowledge impacting health and health care services

Indigenous knowledge plays a critical role in shaping the health and well-being of American Indian communities. The principles of holistic wellness, deeply embedded in cultural practices, spiritual beliefs, and the intergenerational transmission of knowledge, serve as a foundation for healing in Indigenous contexts. This approach often contrasts with the Western biomedical model, which focuses predominantly on disease and physical symptoms. Incorporating Indigenous knowledge into healthcare services is essential for addressing the persistent health disparities faced by American Indian communities, as this cultural wisdom reflects a holistic view of health that encompasses the mind, body, spirit, and community.

Historically, Indigenous knowledge has been sidelined in Western medicine, which focuses primarily on treating physical ailments in isolation. However, American Indian communities have long emphasized a more comprehensive approach to health, where well-being is viewed as a balance between the individual, the community, and the natural world. This holistic approach is especially significant when addressing chronic diseases, mental health issues, and substance abuse, which are disproportionately prevalent in American Indian populations due to historical trauma, systemic racism, and inadequate access to culturally competent healthcare.[70,71] The United Nations (UN) Declaration on the Rights of Indigenous Peoples (UNDRIP) further emphasizes the importance of Indigenous peoples' right to maintain and develop their own health systems and practices.[60] According to the UN, Indigenous peoples have the right to their traditional medicines and to maintain their health practices, which includes the use of plants, animals, and minerals for healing, as well as the right to access all social and health services without discrimination.[61] This recognition of the inherent value of Indigenous knowledge in health practices is critical for advancing health equity among Indigenous populations globally and particularly in the United States.

Many Indigenous health and medical innovations have predated and contributed to Western medicine.[72] Numerous medicines that are considered "western" have Indigenous equivalents that were part of traditional practices long before North America was colonized, such as salicin in willow bark which is closely related to aspirin.[73] However, Indigenous healing practices go beyond knowledge of medicinal plants; they also utilize other non-Westernized, non-clinical methods to address health and wellness in a holistic way and to heal cultural trauma. One framework that reflects the strength of

Indigenous knowledge brings to our current health care system is the concept of "Two-Eyed Seeing," developed by Mi'kmaw Elder Albert Marshall.[74] Two-Eyed Seeing emphasizes the importance of blending the strengths of Indigenous knowledge systems with those of Western science, recognizing that both can offer valuable insights into health and well-being. This approach allows for a more comprehensive understanding of health, leveraging the deep cultural knowledge within Indigenous communities while also utilizing evidence-based practices from Western medicine. The beauty of Two-Eyed Seeing is that it does not prioritize one worldview over the other; instead, it fosters collaboration and mutual respect, ultimately creating more holistic healthcare solutions that are culturally relevant and scientifically grounded. Indigenous healing practices, like the use of medicinal plants and spiritual rituals, are not merely alternative treatments—they are expressions of a worldview that sees health as deeply intertwined with community, environment, and spirituality. These practices have been shown to improve mental health outcomes, foster resilience, and strengthen community bonds, all of which are critical to healing. [52]

Moreover, Indigenous knowledge systems offer valuable insights into preventative health. Traditional ecological knowledge, for example, has long guided American Indian communities in managing environmental resources sustainably, which in turn supports access to clean water, healthy food systems, and natural spaces that promote physical and mental well-being. These practices reflect a deep understanding of the environment's role in human health and underscore the importance of maintaining balance with nature.[51,52] The Two-Eyed Seeing approach is a powerful model for this integration, promoting a collaborative, respectful partnership between Indigenous and Western healthcare practices.[55]

As such, American Indian culture and values have been sources of great strength and resilience as these communities have, and continue to, face significant adversity.[75] Many Tribal Nations have been reclaiming and raising up their cultural learnings and practices and actively incorporating them into their wellness and health care services.[76] The Dakota and Anishinaabe (Ojibwe) American Indian communities of Mni Sota Makoce (Minnesota) have contributed to the vibrant health and wellness of the state through supportive community systems and deep respect for non-human relatives, such as the water, land, and animals.[77] The Leech Lake Band of Ojibwe provide culturally focused, community based substance recovery services that incorporate culture through educating participants on the historical trauma and medicinal use of substances, and the history of the Tribe through dance, drum, and traditional teachings, such as the seven sacred teachings (love, courage, respect, honesty, wisdom, humility, and truth).[78] As described by Elders, the Anishinaabe worldview emphasizes the interconnectedness of all life forms, with spiritual connectedness as the guiding force for health.[48] Anishinaabe Elders have described wellness as a lifelong process grounded in the teachings and practices passed down through generations with language, in particular, playing a significant role in conceptualizing health and wellness. Language is seen as a vehicle for transmitting knowledge and cultural values, which are integral to maintaining balance and wellness in life. For many Indigenous communities, revitalizing their language is not only about preserving cultural identity but also about enhancing mental, emotional, and physical well-being. Efforts to support language revitalization, incorporate Traditional Healing practices, and address the structural barriers to healthcare access are essential for improving health outcomes and promoting well-being in American Indian

communities.[48,79]Even through a Western lens of evidence, Traditional Healing has shown benefits in management of diseases like diabetes, substance use disorder, depression, and anxiety.[80,81,82]

At the policy level, federal initiatives have begun to acknowledge the importance of incorporating Indigenous practices into mainstream healthcare systems. The Indian Health Service (IHS), which provides healthcare to American Indian and Alaska Native populations, has made efforts to integrate Traditional Healing practices into their care models. This integration recognizes the value of cultural competence and the need for healthcare services to be respectful of and responsive to the cultural practices of the communities they serve. Despite these efforts, significant barriers remain, including geographical isolation, poverty, and the historical trauma experienced by Indigenous peoples because of colonization.[60, 83]

Incorporating Indigenous knowledge into health care systems provides not only culturally appropriate care but also opportunities for healing at both individual and collective levels. It fosters a sense of empowerment and self-determination, as it honors the rich traditions and wisdom of American Indian communities while addressing health disparities in a way that resonates with their lived experiences.

Strengths: Indigenous Determinants of Health

Indigenous health is conceived as much more interconnected compared to the individualistic Western perspective. An example of the Indigenous approach is that the health of planet earth is equivalent to the health and well-being of Indigenous peoples. Indigeneity can therefore be viewed as an intersectional determinant of health across sectors. It is crucial to acknowledge that Indigenous peoples are not a homogenous group but consist of hundreds of distinct tribal sovereign nations, each with its own unique cultural identity. Unfortunately, this holistic approach to health has been severely impacted by the historical effects of colonialism and efforts by white settlers to disenfranchise and eliminate Indigenous populations through genocide, resettlement, and assimilation. It is important for policymakers to recognize the ongoing and lasting impacts of colonialism including forced removal and relocation from ancestral lands that supported health and well-being for Indigenous peoples for millennia. To counteract the harmful impacts of colonial and paternalistic influences on Western research and data used to drive policymaking decisions, there have been recent attempts to establish and understand Native or Indigenous Determinants of Health.

The World Health Organization's (WHO) definition of SDOH does not fully recognize the profound impact of colonialism on health determinants.[51] However, there is an ongoing global call for action, as evidenced by the 76th World Health Assembly in May 2023, urging health agencies to address Indigenous health comprehensively. This resolution included various key initiatives:

1. Ethical collection of health data for Indigenous Peoples to identify their specific needs and access gaps.
2. Promoting equitable access to culturally and linguistically appropriate health services.
3. Ensuring universal access to reproductive and sexual health care.
4. Increasing inclusivity in policymaking related to Indigenous healthcare, considering barriers such as geographical remoteness, disability, age, language, and access to technology.

5. Safely and ethically implementing research and evidence-based traditional medical services.
6. Boosting recruitment and retention of Indigenous Peoples in healthcare professions.
7. Strengthening healthcare capacity within Tribal territories, while respecting cultural and traditional knowledge and practices.
8. Enhancing mental health and substance use care, as well as nutrition.
9. Promoting greater access to intercultural information and health promotion while respecting Indigenous sovereignty.

There are 37 total recommended indigenous determinants of health when combined with the World Health Organization's 13 identified aspects. Determinants can be grouped in four categories: health sector, food systems, economic systems, and racism.

Health sector determinants include traditional medicine, healing, and spirituality. Among food systems determinants are traditional foods and access to plants vs. processed food. Planned invisibility and intentional, forced displacement are representative of economic determinants impacting Indigenous health. Finally, racism can be seen through the practices of institutionalization and pathologizing of Indigenous people as well as assimilation and indoctrination.

As described earlier, the medicine wheel offers an example of how Indigenous wellbeing can be viewed as interconnected. The four quadrants in the wheel connect the four sacred directions, seasons, and aspects of well-being. Another Indigenous concept, Etuaptmumk (gift of multiple perspectives), equates Indigenous approaches to health to Western ideas and emphasizes the importance of community driven models of healthcare.

Through understanding the strengths inherent in Indigenous Knowledge and the Indigenous Determinants of Health, policymakers can better appreciate the value in improving ongoing, Indigenous-led efforts as well as identify areas where Indigenous Knowledge and addressing the Indigenous Determinants of Health can improve the health of everyone in their communities.

Challenges: The current and historical impact of structural racism on American Indian health

The things that the U.S./State government has done should not be talked about in past tense, they are still happening, and the effects are still largely rooted in our communities. – Dr. Patrick Rock M.D., CEO, Indian Health Board of Minneapolis, Inc

Centuries of colonial oppression, forced displacement, structural and institutional racism, and abusive medical systems have led to widespread trauma, limited economic opportunity, inaccessibility of healthy culturally relevant foods, and diminished access to healthcare for Native Americans.[84] Federal policies, such as the Indian Removal Act of 1830[85] and the General Allotment Act of 1887 [86] promoted colonialism through forced removal of Native people and land theft, thereby disrupting Indigenous food systems and ways of life that were health sustaining, and replacing them with systems that were inadequate and

in many cases, actively harmful.[87] The Indian Appropriations Act of 1851 established small, isolated tracts of land as reservations with the intention of preserving the best lands for European settlers. The Dawes Act of 1887 pushed American Indians to adopt agrarian lifestyles, which ran counter to traditional hunter-gatherer lifestyles practiced for millennia by many Tribes and has had health and social consequences to this day. Many Tribal reservation lands are more susceptible to the impacts of climate change given their historical disinvestment and exploitation from the US government. All told, Tribes have collectively lost 99% of ancestral lands because of colonial policies.[88]

As one study summarizes it, these and other federal policies "have undermined tribal sovereignty, disrupted growing and harvesting practices, altered the diets of Indigenous peoples, and contributed to widespread food insecurity at rates 3–4 times those of non-Indigenous peoples….The removal of Indigenous peoples to reservations and urban areas and the introduction of European foods and rations disconnected Indigenous peoples from their land, foods, cultural knowledge, and concomitant health."[89]

These policies also actively and intentionally disrupted American Indian Traditional Healing practices and medicines, replacing them with Western health care and medical research practices that have often caused terrible harms to American Indians.[90] For example, in the 1950s the U.S. Air Force intentionally administered radionuclides to Alaska Natives without informed consent, proper follow-up monitoring, or prospect of medical benefit, in an event known as the "Alaskan Idiodine-131 Experiment."[91] As recently as 30 years ago, members of the Standing Rock and Pine Ridge Indian Reservations sued the government over experimental hepatitis A vaccine testing carried out on Indigenous children brought to Sioux San Hospital for medical services, alleging that the government obtained parents' consent using misleading, incomplete, and inaccurate information.[92]

These laws were all passed and consistently enforced to the detriment of American Indians while treaty rights were frequently violated or incompletely upheld. Research conducted by the Public Health Law Center noted that, "The federal Indian trust responsibility is a legally enforceable fiduciary obligation under which the legally enforceable fiduciary obligation on the part of the United States to protect Tribal treaty rights, lands, assets, and resources, which includes upholding the treaty responsibilities to provide health care to Native Americans.[93] Beginning in the early 1800s, as a precursor to the Indian Health Service (IHS), treaties between Tribes and the United States provided for medical supplies and physicians' services as partial consideration for Tribal land cessions to the U.S. Many treaties included express and specific commitments to provide health, education, and social welfare supports. For example:

- Treaty with the Makah Tribe, 1855[94]
    - '[E]mploy a physician to reside at the said central agency, or at such other school should one be established, who shall furnish medicine and advice to the sick, and shall vaccinate them . . .'
- Treaty with the Kiowa and Comanche, 1867[95]
    - 'a residence for the physician, to cost not more than three thousand dollars'

- 'The United States hereby agrees to furnish annually to the Indians the physician . . . as herein contemplated, and that such appropriations shall be made from time to time, on the estimates of the Secretary of the Interior, as will be sufficient to employ such persons.'

- Treaty with the Klamath and Modoc Tribes and Yahooskin Band of Snake Indians, 1864[96]
    - 'The United States further engage to furnish and pay for the services and subsistence . . . for the term of twenty years of one physician. . .[.]'

- Treaty with the Ottawa and Chippewa Nations, 1836[97]
    - 'Three hundred dollars per annum for vaccine matter, medicines, and the services of physicians, to be continued while the Indians remain on their reservations.'

Treaties with Tribes co-located in Minnesota have similarly required the federal government to provide support for medical care. For example, through the Treaty with the Chippewa of the Mississippi, 1867,[98] the federal government promised: 'Twelve hundred dollars each year for ten years for the support of a physician, and three hundred each year for ten years for necessary medicines.' The Treaty with the Chippewa, Mississippi, Pillager and Lake Winnibigoshish Bands, 1864[99] and the Treaty with the Chippewa – Red Lake and Pembina Bands, 1864[100] also include provisions for a physician among other commitments in exchange for tracts of land. When adjusted for inflation and to reflect modern monetary values, these amounts would of course be significantly higher. These practices and systems have culminated in disparately negative health outcomes for Indigenous communities, which continue to the present day despite the United States government trust responsibility to provide health care to Tribal citizens."

The intentional destruction of families and communities through genocide or other means, outlawing religious and spiritual practices, cultural appropriation, exploitation of cultural and natural sites sacred to American Indian communities as well as intentional use of the penal system have all worked to suppress Indigenous autonomy, freedom, and health. The compounding social and biological impact was detailed in DHS' 2020 report on the effects of Deep Poverty and Fig 6 from that report illustrates it further.

One example of this is the forced placement of children in residential boarding schools. "Kill the Indian save the man" was a colloquial phrase common during the boarding school period used to justify this widespread, state-sanctioned abuse. Forced labor, illness, indoctrination, and rampant physical and sexual abuse resulted in high rates of suicide, death, and disease as well as loss of hope and disconnection from cultural and community supports. In partial response to the conditions the forced residential boarding school policies created, the Indian Child Welfare Act (ICWA) was enacted in 1978. ICWA aimed to safeguard the best interests of American Indian/Alaskan Native (AI/AN) children and foster the stability of Tribes and families. [101] However, despite significant strides, AI/AN children face numerous challenges to this day, including higher rates of out-of-home placement compared to their White counterparts. In 2021, AI/AN children accounted for 2% of those in foster care, double their share of the general child population.[102]

Figure 6. Structural racism's impact on American Indian communities.

Relatedly, substance use disorders are often linked to historical trauma and inadequate mental health services, intensifying the challenges for AI/AN youth in foster care.[103] Additionally, AI/AN children frequently experience placement disruptions and caseworker turnover, leading to the loss of crucial medical information and continuity of care. This lack of consistent healthcare further jeopardizes their well-being, making it essential to address these systemic issues.[104]

Lack of consistency can be found throughout the United States history in regard to its promises and obligations to Tribal Nations, their citizens and their health. The federal trust responsibility should be unwavering and not subject to the political whims of changes in Congress, judiciary bodies or executive administrations, but this is often not the case. For example, in 2018, the federal Health and Human Services agency denied Tribes' requests to be exempt from state Medicaid work requirements, arguing that an exception for Tribes would represent an illegal race-based preference.[105] Relatedly, some states are challenging a Medicare regulation aimed at promoting health equity and addressing racism in the health care field because the regulation incentivizes providers to create and implement an anti-racism plan.[106] As noted earlier, Tribes are governmental and political entities, not racial groups.[107] Policymakers must be aware of this history and its impact on the current health care system to be effective stewards.

Overview of direct health care policy and practice

The Indian Health Service (IHS) is the principal federal agency charged with fulfilling the U.S. government's responsibility to provide health care services to American Indians and Alaska Natives.[108] The IHS uses a three-tier system, referred to as I/T/U (Indian Health Service, Tribally operated facilities/programs, and Urban Indian health clinics) and provides health care services free of charge to

the Members of 567 federally recognized American Indian and Alaska Native Tribes and their descendants who are eligible for services through a network of facilities and programs. Facilities are managed directly by IHS, by Tribes and tribal organizations who contract with IHS, and by Urban Indian health programs. IHS and Tribes operate over 600 hospitals, clinics and other facilities which are generally located on or near reservations.[109] Figure 7 illustrates where IHS facilities operate in the United States and, notably, a significant majority are west of the Mississippi river. Services provided vary by IHS facility, but typically focus on primary and emergency care services.[109] When patients need services not provided through IHS, they may be referred to receive services through the Purchased/Referred Care (PRC) Program. Funding for PRC is limited and often only available to high-priority emergency cases.[109]

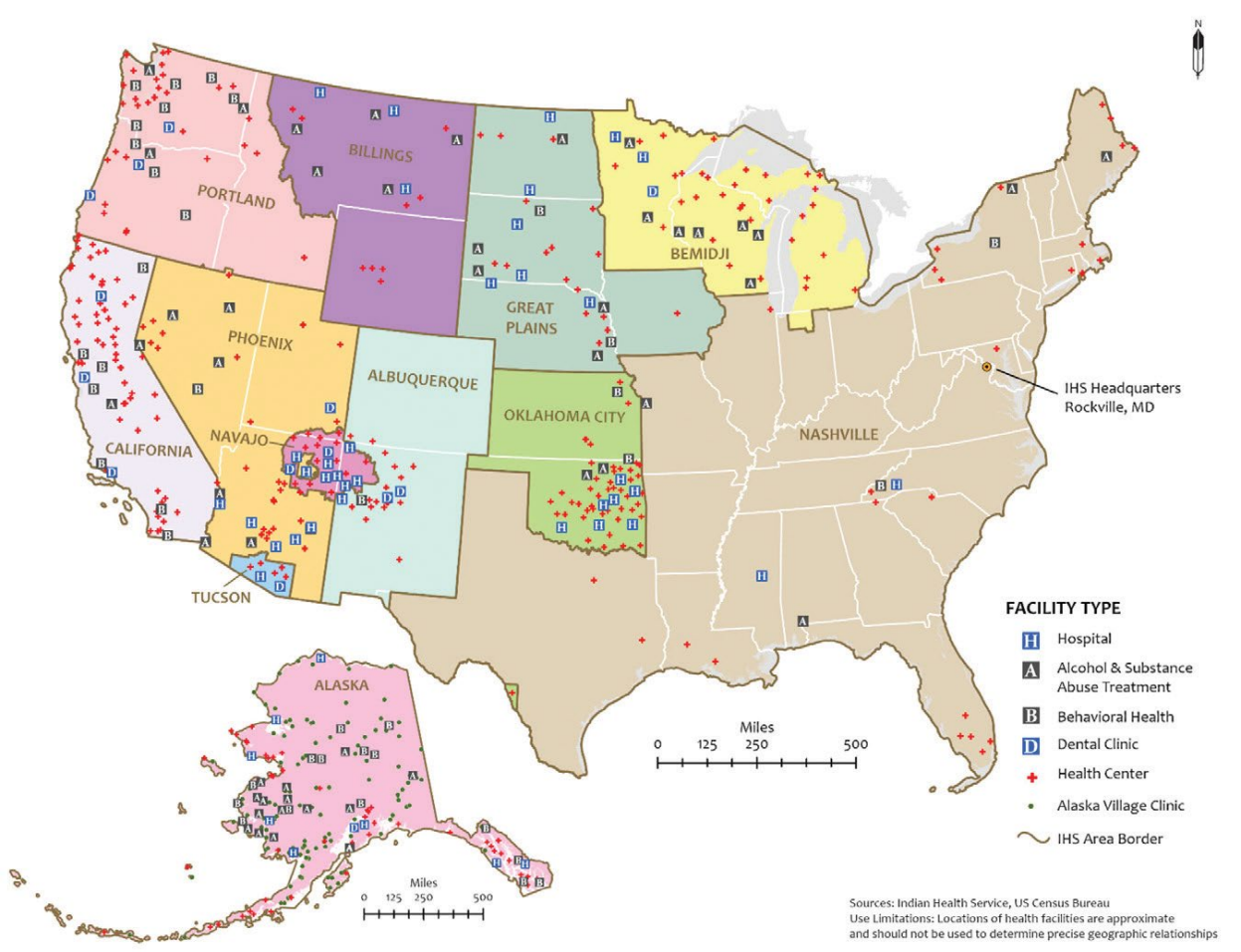
Chronic Underfunding of IHS

According to research conducted by the Public Health Law Center, "One key reason why Native Americans experience disproportionately higher rates of preventable and treatable chronic Illnesses such as heart disease, cancer, diabetes, stroke, and kidney disease is the longstanding Congressional pattern of inequitable funding for IHS. The Government Accountability Office has reported that other government funded health care systems, such as Medicaid, Medicare, federal prisons, and the Veterans Health Administration, receive double and even triple the amount of federal funding per patient compared to IHS.[110] Funding for IHS is also discretionary, which means Congress can deprioritize allocating the funds needed to ensure full health care coverage for all eligible Native Americans. This discretion is a major reason for the chronic underfunding that persists, leaving many Native Americans without the medical care that they were promised and that they deserve."

In 2004 the United States Commission on Civil Rights published, *Broken Promises: Evaluating the Native American Health Care System.* In it they found that, "Annual per capita health expenditures for Native Americans are only 60 percent of the amount spent on other Americans under mainstream health plans" and that, "The Commission finds that IHS funding levels are inadequate by every applicable standard of measurement and in every area of health service delivery within IHS."[111] A 2020 Congressional Research Service report continued to find that IHS' funding structure was inadequate.[112] One cited example is that, "IHS often runs out of funding for specialty services that are contracted out within its fiscal year, leaving many patients to pay fully out of pocket, use health insurance, or go without care."[113]

There is an unfortunately well-known saying in Indian Country that reflects this policy decision and reality, "better get sick by June," reflecting the relationship between access to care and the federal fiscal year, since once IHS money runs out only, "life or limb," will be authorized for direct care.[114]

Figure 7. Map of IHS facilities and regions



NOTE: Colors represent the 12 Indian Health Service Areas (regions): Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. Source: How increased funding can advance the mission of the Indian Health Service to improve health outcomes for American Indians and Alaska natives. (2022, July 22). ASPE.

IHS is a payor of last resort (42 C.F.R. § 136.61.), meaning if an American Indian also has third-party coverage, such as Medicaid or private insurance, those resources must be used first. This preserves some of IHS's limited funding for patients who have no alternative health care coverage and would otherwise have little to no access to health services. However, given the current and historical structural inequities that have led to higher rates of poverty and uninsurance or coverage through Medicaid/CHIP with its relatively low reimbursement rates, this creates an additional disparity in how health care for American Indian communities is financed. In 2022, American Indian/Alaskan Native people aged 0-64 in the U.S. had the highest uninsured rate (19.1%) and the highest rate of coverage through Medicaid/CHIP (43%).[115] When paired with data from the 2020 U.S. Census that found that 89.8% of AI/AN people were aged 64 and under (compared to 83.2% for the U.S. overall)[116] and that per capita spending in the U.S. for IHS was nearly 3 times lower than Medicare in 2021,[113] one can see that the systematic denial of resources not only unfairly disadvantages AI/AN communities, it unfairly advantages other communities who live longer.

Health care bias

The impact of racism and bias on the health care experiences and outcomes of American Indians is both significant and deeply entrenched in historical and systemic inequities. The intersection of racism and bias in healthcare manifests in various ways, from overt discrimination to more insidious, unconscious biases that healthcare providers may carry. Research has shown that American Indians are less likely to receive adequate pain management compared to White patients with similar conditions.[117] A study looking at the influence of race, language and insurance status in a Minnesota pediatric emergency department found that children identified as American Indian and on Medicaid were the only group more likely to leave the emergency department without complete evaluation and treatment.[118] Notably, wait time to see a clinician did not alone correlate with racial disparities in who left without complete evaluation and treatment. Additional scholarship has noted that beyond individual biases, healthcare systems are not designed to account for the cultural and historical context of American Indian health.[119] This systemic shortcoming results in poor communication,[120] lower rates of follow-up care,[121] and inadequate prevention strategies tailored to American Indian populations.[122,]

The impact of this knowledge gap and the experience of implicit and explicit bias is becoming clearer. A 2023 Kaiser Family Foundation Survey on Racism, Discrimination and Health found that 12% of American Indian/Alaska Native adults say they have been treated unfairly or with disrespect by a health care provider in the past three years because of their race or ethnic background compared with 3% of White adults. Almost three in ten (29%) AI/AN adults said they were treated unfairly or with disrespect by a health care provider in the past three years for any reason compared with 14% of White adults. Over half (52%) prepare for possible insults from providers or staff and/or feel they must be very careful about their appearance to be treated fairly during health care visits at least some of the time compared with one in three (33%) White adults. While one in five (19%) reported that their race or ethnicity was a reason why a provider assumed something about them without asking, suggested they were personally to blame for a health problem, ignored a direct request or question, or refused to prescribe pain medication they thought they needed.[123]

These experiences contribute to widespread distrust of healthcare institutions, making addressing the structural and systemic racism within healthcare essential. Only 0.4% of practicing physicians in the U.S. identify as American Indian or Alaska Native, contributing to a lack of culturally informed care. A 2023 study found that, without systemic changes, achieving equitable representation of AI/AN physicians in the workforce would take over 100 years and that even doubling the current rate would take 51 years.[124]

The effect of centuries of colonialism, genocide, and structural racism with a health care system embedded with bias and discrimination is daunting. The disproportionately high prevalence of chronic diseases experienced by American Indians, such as diabetes, heart disease, stroke, kidney disease and hypertension, has led to shorter lifespans compared to other populations.[125] American Indians also experience much higher rates of lung, liver, stomach, kidney, and colorectal cancer compared to White people in the United States because of how institutional racism and inadequate healthcare access result in fewer opportunities for early screening.[126] Approximately 2.5 times more American Indians report experiencing serious psychological distress compared to the general population and in 2020, the suicide

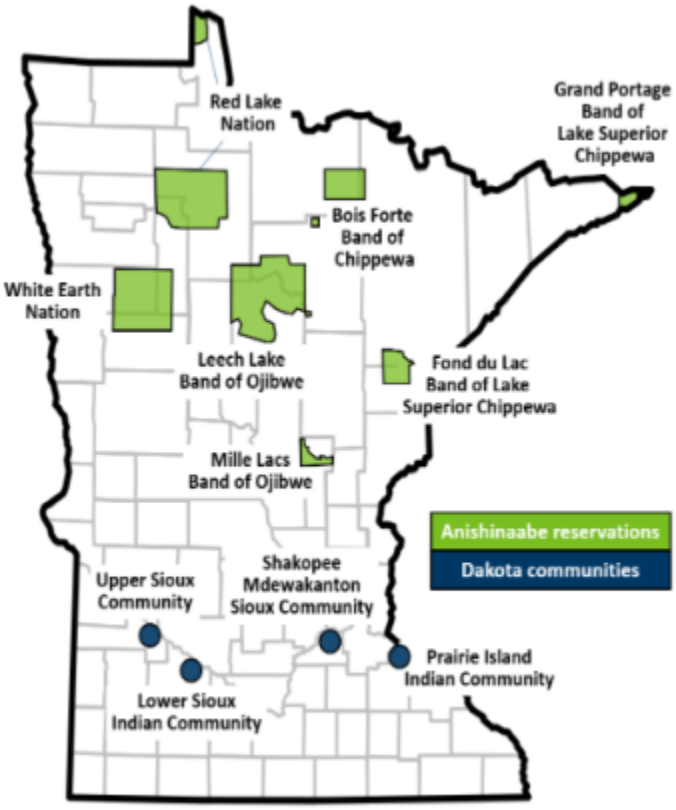
rate among American Indian and Alaska Native adults was about 40% higher than that of non-Hispanic white adults and AI/AN adults had the highest rates of substance use disorder and experienced the highest drug overdose death rates.[127] This is being felt more and more earlier with the suicide rate for AI/AN youth aged 15–24 four to five times higher than for non-Hispanic white females in the same age group.[128]

The physical, spiritual, mental, emotional, and economic toll these compounding insults have on AI/AN communities was exemplified by the COVID-19 pandemic. Table 6 illustrates some of the impact documented thus far of the COVID-19 pandemic on AI/AN communities.

Table 6. COVID-19's impact on American Indians

Impact	Outcome
Life expectancy	• AI/AN life expectancy declined greater than any other racial or ethnic group dropping on average 4.5 years in 2020 to 6.4 years in 2021[129] • AI/AN life expectancy in 2019 was 71.8 and dropped to 65.2 in 2021[130]
Economic	• Challenges with participation in remote work[131] • Significant revenue losses due to less tourism and recreation, casino closures - Exacerbating high poverty and unemployment rates[132]
Health disparities	• Higher rates of infection and deaths from COVID-19[133] • 3.2 times higher age-adjusted rate of hospitalization[133] • Nearly double the deaths compared to non-Hispanic Whites[130] • More likely to be uninsured and limited resources in Tribal health systems[134]
Cultural/ Historical	• Lack of support/ investment in Traditional Healing worsens health outcomes[134] • Historical trauma cumulative effect creates epigenetic changes that can predispose for worse outcomes associated with disease[130]

Overview of Tribal Nations whose lands are found within Minnesota



In present day Minnesota, there are 11 federally recognized Indian Tribal Governments, seven Anishinaabe (Ojibwe) Tribes and four Dakota (Sioux) Tribes along with two urban communities in Duluth and the Twin Cities Metro Area.

The original Dakota Community was established by treaty in 1851. The treaty set aside a 10-mile-wide strip of land on both sides of the Minnesota River as the permanent home of the Dakota. However, in the aftermath of the U.S.-Dakota Conflict of 1862, Congress abrogated all treaties made with them and the Dakota

Figure 8. Map of Tribal Nations whose lands are found within Minnesota

were forced from their homes in the state. The four communities were reestablished in their current localities by acts of Congress in 1886. The four Dakota Communities today - Shakopee Mdewakanton, Prairie Island, Lower Sioux, Upper Sioux - represent small segments of the original reservation that were restored to the Dakota by Acts of Congress or Proclamations of the Secretary of Interior.[135]

All seven Anishinaabe reservations in Minnesota were originally established by treaty and are considered separate and distinct Nations by the United States government. The seven Anishinaabe reservations include Grand Portage, Bois Forte, Red Lake, White Earth, Leech Lake, Fond du Lac, and Mille Lacs. In some cases, the Tribe retained additional lands through an Executive Order of the President. Six of the seven reservations were allotted at the time of the passage of the General Allotment Act. The Red Lake Reservation is the only closed reservation in Minnesota, which means that the reservation was never allotted, and the land continues to be held in common by all tribal members. Each Indian Tribe began its relationship with the U.S. government as a sovereign power recognized as such in treaty and legislation. The Treaty of 1863 officially recognized Red Lake as separate and distinct with the signing of the Old Crossing Treaty of 1863.[135]

The relationship between the state of Minnesota and Tribal Nations is deeply rooted in both conflict and collaboration, shaped by centuries of policy decisions, treaties, and evolving governance structures. The state's interaction with Tribal Nations has historically been marked by efforts to assimilate and control Indigenous populations through treaties and policies that often stripped Tribes of their land, resources, and sovereignty.[136] Today, Minnesota's relationship with Tribal Nations is defined by a government-to-government framework, with regular consultations on policies affecting American Indian communities. In 2019, Minnesota Governor Tim Walz issued Executive Order 19-24, which reaffirmed the state's commitment to meaningful consultation and partnership with Tribal Nations. The executive order aimed to improve communication and ensure that state policies do not infringe upon Tribal sovereignty. In 2021 the Minnesota Legislature passed a law that codified in Minnesota Statutes (2021, section 10.65) the directives under EO 19-24. The Minnesota Legislature created a Tribal-State Relations training program to educate state employees and lawmakers on the history, culture, and governance of Tribal Nations, further strengthening the relationship. The collaboration extends to areas such as health care, education, natural resources, and economic development, where the state, local and Tribal governments work together to address shared challenges and opportunities.

American Indian communities in Northwest Minnesota contribute significantly to the strength of their surrounding regions through health care spending. As detailed in a report conducted by the University of Minnesota in partnership with the Northwest Indian Community Development Center (NWICDC), American Indian-related health care spending generated over $261.5 million in economic activity in 2017 alone, with $180.2 million directly related to spending from Medicare, Medicaid, and the Indian Health Service. This spending supported 2,450 jobs across a range of industries, including professional services, trade, and health care.

The ripple effects of health care expenditures bolster local economies. By generating demand for services such as home health care, substance abuse treatment, and mental health counseling, rural communities foster job creation and income growth, not just in health care, but also in secondary industries like business services and supply chain operations. This spending stimulates broader economic vitality, helping to maintain and grow the workforce in rural regions. The report highlighted how American Indian health care spending serves as a crucial pillar of regional economic strength, offering pathways not only for improving health outcomes but also for supporting sustainable community development across Northwest Minnesota. It also calls for expansion of Native-owned health services and deeper investment in supporting American Indians entering health-related occupations so they can continue to not only contribute to, but benefit from, the prosperity of the entire region.

Tuck, B., & Bhattacharyya, R. (2020). Economic contribution of American Indian health care spending in Northwest Minnesota. Retrieved from the University Digital Conservancy, https://hdl.handle.net/11299/213950.

Urban American Indian communities

As of 2021, approximately 134,138 people in Minnesota identified as American Indian and/or Alaska Native (either alone or in combination with one or more other races) representing 2.4% of the state's population. About 40,333 (30%) American Indians lived on a reservation/community according to 2017-2021 Census estimates, while approximately 50,870 (37.9%) American Indians/Alaskan Natives live in the Twin Cities metropolitan area. The additional 32.1% of American Indians live in greater Minnesota.[137]As noted earlier, if the micropolitan areas of Bemidji and Duluth are included with the Twin Cities metropolitan area, 48% of Minnesotans on Medicaid who identify as Native American live in

an urban setting. This presents unique strengths and challenges both historically and currently. This dynamic that finds American Indians split between urban and (largely rural) reservation settings was set in motion by policy. The “termination” policy of 1953 aimed to end federal supervision of American Indian Tribes, pushing for their full integration as U.S. citizens, despite their citizenship status since 1924. This policy revoked federal recognition, aid, and protections, transferring jurisdiction to states and ultimately resulted in the relinquishment of over three million acres of tribal land.[138] The main strategy behind this shift was Relocation through the Bureau of Indian Affairs. The goal was to assimilate American Indians into urban society by encouraging or coercing them to leave their reservations for major cities. The desired outcome was that Tribal land would then be forfeit, become taxable and available for purchase and development leaving no more reservations, no more Tribal governments, no more obligation for federal assistance and, implicitly and explicitly, no more American Indians.[139] Cities like Chicago, Los Angeles, Denver, San Francisco and Minneapolis, became relocation hubs. American Indians were promised housing, vocational training, and job placement, but many experienced harsh realities instead. While some found employment, most faced low-paying jobs, racial discrimination, and isolation from their cultural communities.[140] The policy had profound social and cultural consequences. American Indians who relocated often struggled to adjust to city life, losing access to traditional supports and facing economic hardships. Some returned to their reservations, feeling disconnected from both urban and reservation life.[141]

However, a new "urban Indian" identity began to emerge, leading to the creation of Native cultural communities in cities. This played a crucial role in the Pan-Indian movement of the 1960s and 1970s and the Twin Cities urban American Indian community had a significant role through the American Indian Movement (AIM). Founded in Minneapolis in 1968 by activists like George Mitchell, Dennis Banks, and Clyde Bellecourt, AIM emerged in response to the discrimination and economic hardships facing urban American Indians. AIM leaders spoke out against high unemployment, poor housing, and racist treatment, fought for treaty rights, and sought to reclaim tribal lands. AIM notably played a role during the 1973 Wounded Knee occupation, where they confronted the U.S. government to highlight the ongoing struggles of American Indian communities.[142] This community-led pushback against federal termination and assimilation policies culminated in the eventual reversal of these policies in the 1970s.

Despite its failure, for many individuals, the Termination policy and Relocation Program had a lasting impact, contributing to the significant increase of American Indians living in urban areas—a shift that continues to influence American Indian life and identity today.

Medicaid’s significance in health care coverage for American Indians in MN

Many federal programs and laws define access for American Indians uniquely, primarily requiring members to be from one of the 574 federally recognized Tribes. Medicaid coverage for American Indian/Alaskan Native populations increased following the ACA Medicaid Expansion.[109] In 2022, roughly 30% (508,383) of all American Indian/Alaska Native were Medicaid/CHIP recipients in the United States.

Medicaid and MinnesotaCare serve as the largest providers of health care access and resources in Minnesota. Medicaid is the state and federal program (Medical Assistance, or MA, in Minnesota) that provides health insurance that covers services for eligible individuals. Minnesota is one of three states

offering a Basic Health Program, named MinnesotaCare in the state to provide low-cost health insurance to people who have higher incomes levels above Medicaid and who do not have access to affordable, employee-sponsored health insurance. Combined, MA and MinnesotaCare are the main Minnesota Health Care Programs (MHCP).

According to a 2024 State Health Access Data Assistance Center (SHADAC) analysis of the 2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, 41.5% of Minnesotans who identify as American Indian/Alaska Native under the age of 65 received health care coverage through Medicaid/MinnesotaCare. That number is even higher for children in MN who identify as AI/AN as 64.5% receive health care through Medicaid/CHIP, the highest percent of any group of children in MN when you look based on race/ethnicity. The number of mothers/birthing persons who identify as AI/AN and are covered by Medicaid/CHIP was even higher at 70.7% based on data from the National Center for Health Statistics.[143] These numbers illustrate how investments in, and cuts made to, MHCPs can significantly impact the access to health and health care for our AI/AN communities.

Table 7. Number and Percent of Minnesotans who receive health care coverage through Medicaid/CHIP, by Race/Ethnicity,2022

Race/Ethnicity	Age 0 to 18		Under Age 65	
	%	Number	%	Number
Hispanic/Latino	40.8%	48,802	27.3%	78,378
White	16.5%	144,007	9.4%	407,179
African-American/Black	64.3%	76,059	42.8%	157,789
Asian	32.7%	25,451	19.8%	58,344
Native Hawaiian and Other Pacific Islander	N/A	N/A	N/A	N/A
Other/Multiple Races	31.6%	46,625	22.2%	69,378
American Indian/Alaskan Native	64.5%	7,912	41.5%	16,107

Source: SHADAC analysis of the American Community Survey (ACS). State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org.

Part 4 - What Levers does Minnesota Medicaid have to Address Racial Equity with American Indian Communities?

When looking at how Minnesota Medicaid can address racial equity with American Indian communities through its policies, the report team decided to approach the work by considering how Minnesota Medicaid policy differs for Tribal members as well as five key "levers" of Medicaid policy development and administration impacting American Indian communities: eligibility/enrollment, access, quality, early opportunities, and the intersection with the Indian Health Service.

How does Minnesota Medicaid policy differ for American Indians?

Like anyone else, American Indians are eligible for Medicaid coverage if their income is below the qualifying maximum amount. There are several Medicaid policies that have evolved that are unique to American Indian communities, however.

Through the Social Security Act, Congress authorized CMS to reimburse IHS for health care services provided to Medicaid-enrolled American Indian/Alaskan Natives (AI/AN) at IHS facilities.[144] For Medicaid services provided through an IHS facility, the Indian Health Care Improvement Act of 1976 (IHCIA) provides IHS with a 100% Federal Medicaid Assistance Percentage (FMAP) reimbursement.[145] This means that all medical services that Medicaid offers, and which are provided at an IHS facility, should be fully reimbursed by the federal government.

In addition to the 100% FMAP, Medicaid has other specific rules that apply to AI/AN enrollees such as:

- excluding certain types of Indian trust income and property in how modified adjusted gross income (MAGI) is calculated for Native Americans, which is important because MAGI determines eligibility for Medicaid;[146]
- prohibiting states from imposing cost sharing for AI/AN enrollees — which means that states cannot require AI/AN patients to pay copayments, deductibles, coinsurance or similar charges for standard covered services;[147]
- allowing AI/AN patients to enroll or modify their enrollment in standard health plans once a month if they choose.[148]

In accordance and in addition to the above, within Minnesota there are currently several specialized regulations for American Indians enrolled in Medical Assistance and MinnesotaCare which include:

Medical Assistance[149]

- Adult American Indians and their adult household members up to 133% federal poverty guidelines (FPG) are eligible. Their children are eligible up to 283% FPG.
- American Indians who qualify and live on a reservation are excluded from mandatory enrollment in managed care and will be covered on a fee-for-service basis.

- American Indians, whether living on a reservation or not, have direct access to Indian Health Service, tribally operated facility/program, and Urban Indian Health Programs (I/T/U facilities), even if the provider is not in network.
- American Indian and Alaska Native MA enrollees do not have MA cost sharing if they currently or have ever received care from an I/T/U provider or a referral from an I/T/U provider to a non-American Indian provider.

Minnesota Care[149]

- Adult American Indian, Alaska Native, and adult household members up to 200% FPG are eligible.
- American Indian, Alaska Native, and household members are not required to pay MinnesotaCare premiums.
- American Indians, regardless of if the person is a member of a federally recognized Tribe, do not have MinnesotaCare cost sharing if they receive care at I/T/U facilities or referral from I/T/U facilities when they receive covered services from other health care providers.
- Non-American Indian of American Indian households are not required to pay MinnesotaCare premiums but are responsible for cost sharing.

To qualify for these types of Medicaid provisions, a person must meet the definition of an "Indian," which is defined as a person who 1) is a member of a federally-recognized Indian Tribe; 2) resides in an urban center and meets at least one of four demographic criteria; 3) is considered to be an Indian for any purpose by the Secretary of the Interior; or 4) is considered to be an Indian for purposes of eligibility for Indian health care services by the U.S. Department of Health and Human Services.

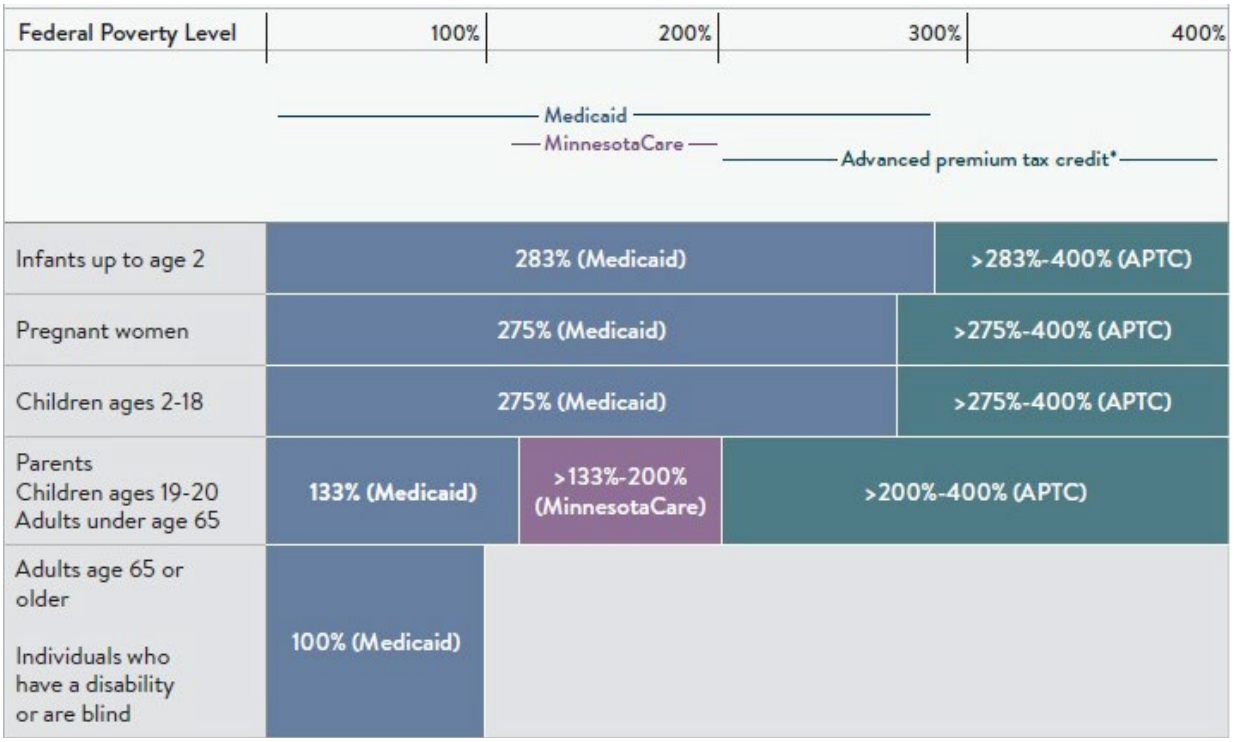
In addition to individual-level policy differences for Minnesotans who identify as and meet criteria for American Indian, Minnesota state statute directs all state agencies to engage in a process of Tribal Consultation, directing state agencies to, "recognize the unique legal relationship between the state of Minnesota and the Minnesota Tribal governments, respect the fundamental principles that establish and maintain this relationship, and accord Tribal governments the same respect accorded to other governments."[150] DHS currently also has three American Indian advisory councils that advise it on policies and procedures in specific areas of focus, the American Indian Advisory Council (on Chemical Dependency), the American Indian Child Welfare Advisory Council and the American Indian Mental Health Advisory Council.

Medicaid Lever: Eligibility and enrollment

Minnesota's Medicaid program, MA, is administered by county and Tribal agencies, under the supervision of DHS. Minnesota also has a Basic Health Program under the Affordable Care Act (ACA) called MinnesotaCare (MNCare) which provides subsidized health care coverage to low-income individuals who aren't eligible for MA. County human services agencies, and Tribal governments choosing to participate, share the responsibility for determining if applicants meet state and federal eligibility standards for MA. MNCare is administered by DHS under federal guidance and DHS, in cooperation with MNsure, the state's health insurance exchange, is responsible for processing

applications and determining eligibility. [151] An individual's eligibility is based on factors such as household income and assets, family size, age, disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by eligibility category. In Minnesota, income eligibility ranges from 100% to 283% of the federal poverty level (FPL) depending on other factors (Fig 9). Depending on their basis of eligibility, individuals apply for MA or MNCare by either submitting an application online through the MNsure website or filing a paper application at a county or Tribal human services agency.

Figure 9. Minnesota's income eligibility for Medicaid, MinnesotaCare, federal tax credits



*Advanced premium tax credits reduce the cost of premiums for coverage purchased through MNSure and were made available under the Affordable Care Act.

Eligibility and enrollment policies, workforce and IT systems for the state's public health insurance programs, together referred to as Minnesota Health Care Programs (MHCPs), therefore have variation that impact communities differently. Most MHCP members must renew and prove their eligibility at least once a year. Failure to complete this process will result in the individual being disenrolled and losing their coverage. Studies show that unstable Medicaid coverage increased emergency department use, office visits, and hospitalizations between 10% and 36% and decreased use of prescription medications by 19%, compared to individuals with consistent Medicaid coverage.[152] It also disrupts efforts to provide ongoing preventive care and care management for those with chronic conditions.[153] Disenrollment may occur because an individual no longer meets eligibility requirements, such as having household income that exceeds program income limits. However, studies[154] and federal agency briefs[155] consistently demonstrated that many people on Medicaid experience procedural disenrollment, including a recent study looking at Minnesota Medicaid enrollees[156]. Procedural disenrollments refer to

cases where individuals are disenrolled because they did not complete the renewal process. More often than not, individuals experiencing procedural disenrollment are still eligible but faced administrative barriers in completing the paperwork or states did not have accurate contact information to notify them of the need to complete the renewal process. Additionally, there have been documented racial disparities in who experiences procedural disenrollment.[157] Eligibility and enrollment is therefore a key lever in forging a path towards greater racial equity.

National opportunities/examples from other states

Medicaid Unwinding impacts on American Indians

Shortly after the federally declared COVID-19 Public Health Emergency (PHE) in March 2020 Congress passed the Families First Coronavirus Response Act. This Act temporarily increased the federal government's share of Medicaid provided states agreed to "maintenance of effort" (MOE) policies with notably among them a prohibition of terminating currently enrolled members or making eligibility standards or determination procedures more restrictive until the end of the federal PHE. [158] In December of 2022 Congress passed the Consolidated Appropriations Act which ended the Medicaid continuous coverage MOE policies and provided a transition period for states to resume pre-pandemic eligibility and enrollment determinations and procedures, effective March 31, 2023. This transition period has been described as the Medicaid "unwind" given it required state Medicaid agencies and the federal government to unwind many aspects of eligibility and enrollment that had been modified during the COVID-19 PHE.

To date, more than 20 million people have been removed from Medicaid because of unwinding.[159] As previously noted, American Indians are overrepresented on Medicaid and therefore more likely to have been impacted by unwinding.[160] Data looking at how different Medicaid members and communities have been impacted nationally by the unwind by race/ethnicity are not yet broadly available. A recent Kaiser Family Foundation (KFF) analysis from nine states that have data available by race for Medicaid unwinding found some variability in disenrollment rates by race.[160] States such as Alaska and Montana had more than 9,500 and 13,000 tribal members disenrolled respectively.[159] However, due to the limited data available from most states at this point it is difficult to surmise the overall impact and any overarching disparities created by unwinding.

States have taken steps to promote sustainable enrollment for American Indian and other marginalized groups, for instance implementing continuous enrollment practices to extend periods between redeterminations that can lead to unintended coverage losses.[161] Continued expansion of income eligibility and outreach, education, and ongoing assistance to navigate reenrollment are other strategies states have engaged to prevent enrollees from lapsing in coverage.[161] Within Indian country, tailoring approaches that the target audience is more likely to respond such as utilizing local radio and newspapers, attendance at Tribal events and culturally-appropriate social or physical media have proven to be promising as well at increasing awareness of reenrollment.[161] CMS and tribal healthcare agencies have also worked to establish and promote the importance of navigators to assist in overcoming barriers to reenrollment. American Indians may face additional challenges such as lack of a physical mailing address, inadequate internet access and administrative challenges with documentation.[161] The National

Indian Health Board has published an extensive manual for Medicaid healthcare navigators on outreach and promotion strategies to engage American Indian enrollees.

Previous and Current MN Medicaid efforts

As noted in DHS' 2022 *Building Racial Equity into the Walls of Minnesota Medicaid: a focus on US-born Black Minnesotans* (BREW) report, issues with navigating MN Medicaid eligibility and enrollment have been known for some time.[1] That report lifted up several Calls to Action regarding simplifying and supporting enrollment and renewal. Among them were to advance continuous eligibility policies that, like the MOE policies in effect during the federal COVID-19 PHE, would extend the periods of time that members were required to go through an eligibility redetermination process. Specifically, the report called on DHS to, "explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 and establish 24-month continuous eligibility for all enrollees age 6 and older."[1]

During the 2023 Minnesota legislative session Governor Tim Walz included a proposal to seek an 1115 waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 that was passed by the Minnesota House and Senate and signed into law. DHS has gone through the process to submit this update to an existing 1115 waiver and received CMS approval in November 2024. Encouragingly, since the 2022 BREW report, 3 states have received CMS approval for extension of multi-year continuous eligibility for children and, in addition to Minnesota, 8 other states are pursuing some form of multi-year continuous eligibility for children.[162] Minnesota Medicaid members have consistently voiced frustration with the complexity and difficulty of the enrollment process and have also highlighted the value of having enrollment navigators available to assist them and family members through the process. DHS' 2022 BREW report called for ongoing support for navigators and funding provided by the Minnesota legislature in 2023 to help Minnesotans retain coverage during the unwind included navigators.

DHS also partnered with navigators through community equity forums and in an ongoing monthly equity partnership space where DHS worked with their contracted managed care organizations, navigators, federally qualified health centers and other community-based organizations to highlight areas of priority during Minnesota's unwind effort. This led to notable changes like:

- Members being able to upload annual renewal documents online
- Information on renewal forms that outline how navigators can help and how to reach them
- Streamlining of questions on the renewal forms and updated training for state/county eligibility workers
- Significantly improved ex-parte or "auto-renewal" rates
- Focused community engagement and the development of a Community Engagement Resource Hub — an online platform for CBOs to find renewal resources and request DHS assistance with community engagements and events

In addition to these broader equity-focused efforts, funding during FY24 was directed by DHS' Health Care Administration to assist Minnesotans in retaining coverage during the unwind and included support for the 11 Tribal Nations of Minnesota to conduct outreach and engagement around the unwind. Outreach activities included social media and radio campaigns, clinic outreach, engagement at Tribal Council meetings, elder gatherings, Pow Wows, health fairs, and the use of printed materials, mass mailings and direct call campaigns. Eight of the Tribal Nations opted to collaborate in a Joint Powers Agreement that provided data on individuals self-identifying as American Indian on their state MHCP eligibility application. Through these agreements, DHS was able to provide information for individuals living within a Tribal Nation's borders and adjoining zip codes. This information was used to cross reference patients at Tribal clinics for direct outreach. Similarly, DHS contracted with IHS to provide data to the 3 IHS clinics located within Minnesota through a Business Associates Agreement.

What does Data tell us about the experience of Medicaid enrollment/renewal of American Indians on Medicaid in MN?

To get a more proximate idea of how American Indian Medicaid members experience DHS' current eligibility and enrollment policies and procedures we looked at data from DHS' recent MA enrollee survey, sought guidance during our initial community member

Incarceration has a profound impact on health, and its intersection with Medicaid eligibility and enrollment policy provides a critical opportunity to address racial health inequities. Rates of American Indian imprisonment in Minnesota were 19 times higher than White Minnesotan imprisonment in 2021.[i] This despite research showing that racial disparities in the Minnesota criminal justice system cannot be attributed to crime commission rates alone. The over-incarceration of American Indians further fragments their access to care and contributes to higher rates of chronic diseases, substance use disorders, and mental health issues. The downstream health impact is stark with research finding that incarcerated American Indian/Alaskan Natives have an increased risk of all-cause mortality.[ii] The Medicaid Inmate Exclusion Policy, which restricts federal Medicaid funding for incarcerated individuals except for inpatient hospital stays, exacerbates these challenges, contributing to fragmented care and worsened health outcomes.[iii] In Minnesota, MA enrollees remain eligible if they are or become incarcerated however coverage is suspended, with benefits limited to inpatient hospital services during incarceration. When an enrollee is released, their coverage is restored. In April 2023, CMS announced a new section 1115 Demonstration that will allow states to partially waive the inmate exclusion and provide Medicaid coverage for select services in a period of time shortly before reentry into the community. CMS requires states to provide a minimum benefit package of three covered services under the Demonstration:

- Case management/care coordination;
- Medication Assisted Treatment (MAT), which must include medication in combination with counseling/behavioral therapies, as appropriate and individually determined; and
- 30-day supply of all prescription medications provided to the beneficiary immediately upon release from the correctional facility.

In addition, states have flexibility to cover additional services physical and behavioral health services that support reentry. **With strong advocacy from Minnesota's Tribal nations and Urban American Indian organizations**, the MN Legislature directed DHS to apply to CMS for an 1115 reentry waiver. DHS is in the process of submitting an application to join the 11 approved and 13 pending (as of 8/19/24) state Section 1115 reentry waiver requests.

i. 2024 Minnesota profile. Prison Policy Initiative. https://www.prisonpolicy.org/profiles/MN.html

ii. Khatri, U., Hakes, J., Buckler, D., Zebrowski, A., & Winkelman, T. (2024, June 30). Association between Incarceration and Mortality in the United States. AcademyHealth - 2024 Annual Research Meeting. https://academyhealth.confex.com/academyhealth/2024arm/meetingapp.cgi/Paper/65875

iii. Albertson, E. M., Scannell, C., Ashtari, N., & Barnert, E. (2020). Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration. American journal of public health, 110(3), 317–321. https://doi.org/10.2105/AJPH.2019.305400

meetings, from our co-creators, and during our Community Conversations, and reflected on data from Minnesota DHS' recent Renewal Equity report that analyzed renewal rates during the 2023-2024 Medicaid unwind period.[166]

MA Enrollee Survey: Enrollment, Renewal and Assistance in the Process

In the survey of MA enrollees, we asked the following question about community organizations:

> Some people have a community organization they trust to help them get services. This is often an organization that serves a particular cultural community or people in a local area. When you would like help finding a health care provider or figuring out which services are covered by MA, would you like to get help from a community organization?
>
> ☐ Yes, which organizations would like to receive help from?
> (Please specify one organization: _____)
>
> ☐ No

One in six MA members said that they would like help from a community organization. The members who were most likely to say yes to this were recent immigrants. 31% wanted to work with a community organization. The group with the second highest preference for working with a community organization was American Indians. One in four (24%) said they want to get help from a community organization. In addition to sharing a cultural worldview, a community organization can also provide for needs not usually provided by a county or state agency. Wanting to work with a community organization was much more common for American Indians in Greater Minnesota (29%) than for members in the metro (19%).

Table 8. Preference for getting help from a community organization

When you would like help finding a health care provider or figuring out which services are covered by MA, would you like to get help from a community organization?	American Indian members			Non-American Indian members
	Statewide	Metro	Greater	Statewide
Yes	24%	19%	29%	16%**

** $p < 0.05$

In a separate question, we asked how MA enrollees would like to get help with a question on the MA application or renewal form. One of the options was to get help from their county or Tribe. Similarly to the above question, American Indians in Greater Minnesota were much more interested in talking to someone at their county or Tribe (21%) compared with only 8% of those in the metro.

Once enrolled in MA or MNCare, the majority of members have an option to select a Managed Care Organization (MCO) that is contracted with DHS. The MA Enrollee Survey found that the most important thing to members when choosing a MCO was that they could see their doctor or another health care provider they had seen before. A large majority of members (83%) checked this box. This was important to people in all demographic groups though it was most important for American Indian/Alaska Native

members (89%).[163] Respondents also highlighted the importance of being able to find what they needed on an MCO's website and helpline hours that meets their needs.

These observations were echoed in DHS' Renewal Equity report with community-based organizations who partnered with DHS noting that technology access is an ongoing need, community members prefer one-on-one renewal assistance with a navigator or assister that shares their language and cultural context, phone support during evening and weekend hours is needed, that the renewal process can be especially complex and confusing for Elders and that sustainable funding for focused outreach and application assistance is needed.[166]

> *"Navigating Medicaid for Elders is a whole different world. We need more education and support in this area." - Community Renewal Outreach Partner*

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

Churn rates among American Indian communities

During DHS' initial guidance meeting with multiple tribal staff and urban Indian organization leaders, as well as in follow-up meetings with our report Co-Creators, we discussed what data could help inform their work and this report's Calls to Action. This was structured by each "Medicaid lever." For eligibility and enrollment, the most common guidance was regarding our enrollment "churn" rates before and during the COVID-19 PHE and resultant MOE policy changes. "Churn" refers to Medicaid members who lose coverage and then later reenroll. Higher rates of churn can be a marker and symptom of a high rate of procedural disenrollment. More simply put, higher churn rates can be a proxy for people who are otherwise eligible for Medicaid coverage losing coverage due to administrative policies and procedures. As noted earlier these preventable gaps in coverage can have direct impacts on health and contribute to racial health disparities. DHS also cited in the 2022 Building Racial Equity into the Walls report how churn is more likely to impact minoritized communities, however available evidence at the time did not look at its impact on American Indian communities specifically.[1]

In response to guidance from our report Co-creators, Tribal staff and community leaders we looked between the years of 2018-2022 at Medicaid and MNCare (MHCP) churn rates for members who identify as Native American compared to all members (Figure C1). Per their guidance this was also further stratified by age (Figure C2), member Zip Code Social Vulnerability Index (SVI) quartile (Figure C3) and payment system (Figures C4 and C5). As county human service agencies and one Tribal government (White Earth) are the processing institutions for Medicaid applications and renewals we were also asked to look at churn rates by county/Tribe (Tables C1 & C2). Technical aspects of this data can be found in the Appendix.

> *"When Covid hit, me and my daughter who was just born was on Medicaid for the entire time. I have experience. I also have experience with MN Care with all three of my babies. The state supported me through all three pregnancies. I'm not eligible anymore, it's very funky, my son is private insurance, my daughter qualifies. My niece is on Itasca care. I'm uninsured, which is a surprise to me, so I'm hoping to get on to a*

program. When the public emergency stopped, I was thrown off, and now I'm trying to figure out what comes next." Virtual Community Conversation participant

In examining overall churn Figure 10 illustrates both the higher rate of churn among MHCP members who identify as Native American compared to all MHCP members and the significant decrease in churn starting in 2020 with the implementation of the COVID-19 PHE MOE policy changes. Pre-pandemic churn rates were higher for Native American MHCP members at all month intervals (3, 6, 9 and 12 months) examined with the 12-month churn rate for Native American MHCP members being 28% higher than all MHCP members in 2018. Encouragingly and expectedly, churn decreased dramatically during 2020-2022. However, there were still disparities noted in the degree of reduction between Native American MHCP members and all MHCP members. When comparing 12-month churn rates between the two groups and the years 2018 and 2022 we noted that Native American MHCP members saw churn decrease 87% compared to 91% for all MHCP members.

Figure 10. MHCP Churn rates for Native American members vs all members, 2018-2022

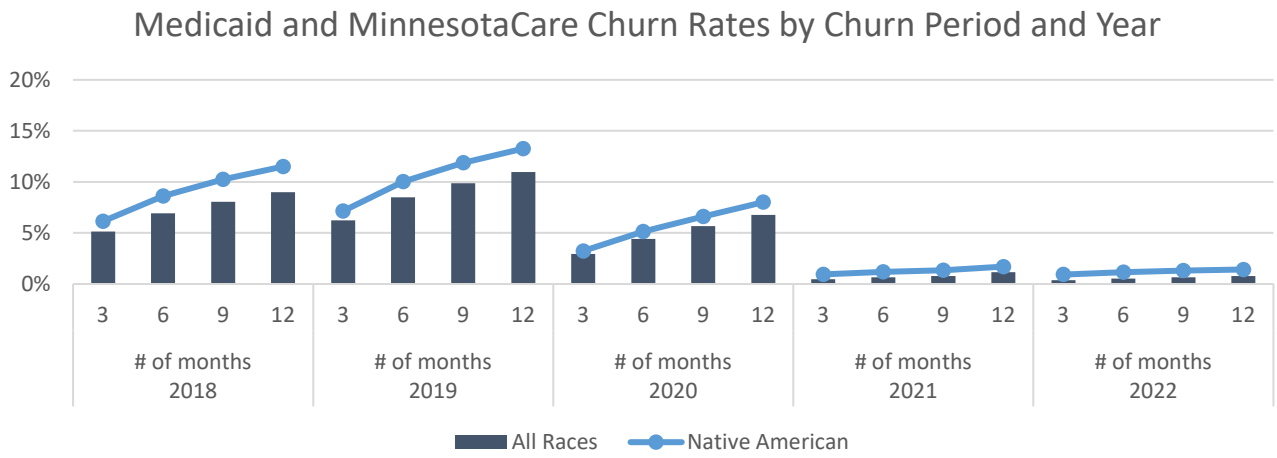


Figure 11 examined 12-month churn rates between Native American MHCP members and all MHCP members by age groups: Early Childhood (Birth to 6 years, 0 days), Childhood (6 years, 1 day to 21 years, 0 days), Adults (21 years, 1 day to 65 years, 0 days) and Elders (65 years, 1 day and older). In all age groups, pre-pandemic churn rates were higher for Native American MHCP members. When comparing 12-month churn rates between the years 2018 and 2022, and by age groups, we did see some differences in impact. Native American MHCP members in the Early Childhood and Elder age groups saw churn decrease more between 2018 and 2022 when compared all MHCP members (92% vs 90% and 89% vs 87%, respectively).

Figure 12 looks at 12-month churn rates between Native American MHCP members and all MHCP members by member Zip Code SVI quartile. The Social Vulnerability Index (SVI) is a Centers for Disease Control and Prevention (CDC) geographic indices of disadvantage that ranks areas on 16 social factors (unemployment, disability, access to transportation, poverty, race/ethnicity, homelessness, etc.). DHS utilizes a Minnesota-specific SVI score developed by the Minnesota Department of Health (MDH) with quartile 1 (Q1) being areas of highest disadvantage to quartile 4 (Q4) having the lowest disadvantage

based on their SVI score. Overall, when comparing Native American MHCP members and all MHCP members, the pattern seen in Figure 12 was similar to the pattern seen in Figure 10. When looking at any differences between SVI Zip Code quartiles, members from Q1 experienced higher churn rates in both groups (peaking at 13.1% and 11.6 % for Native American and all members, respectively, in Q1 Zip Codes in 2019) while pre-pandemic the greatest gaps in churn rates between groups based on SVI Zip Code quartile was seen in Q4 (peaking at a 3.4% higher churn rate for Native American MHCP members in Q4 SVI Zip Codes compared to all members in Q4 Zip Codes in 2019).

Figure 11. MHCP Churn rates for Native American members vs all members, by age, 2018-2022

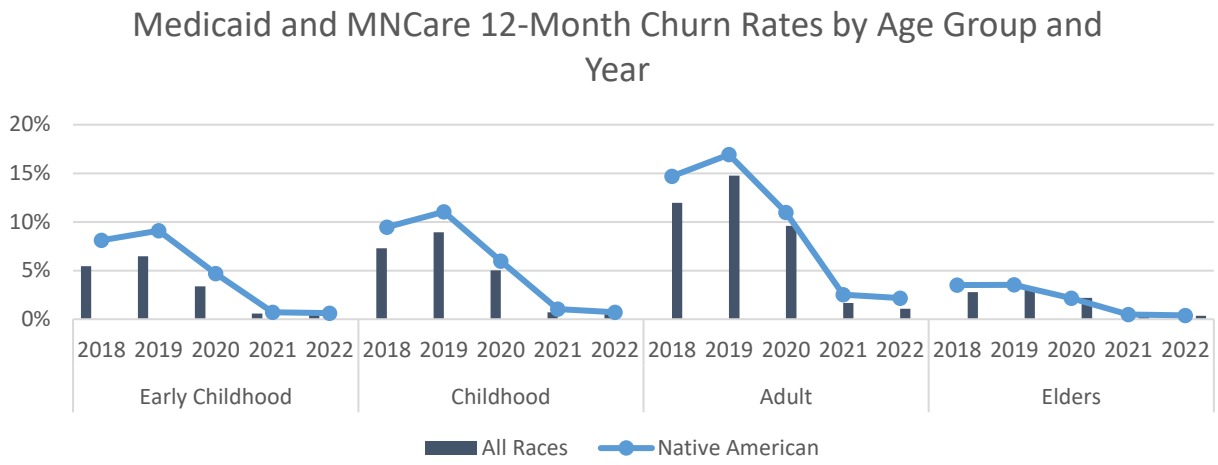


Figure 12. MHCP Churn rates for Native American members vs all members, by SVI Zip code quartile, 2018-2022

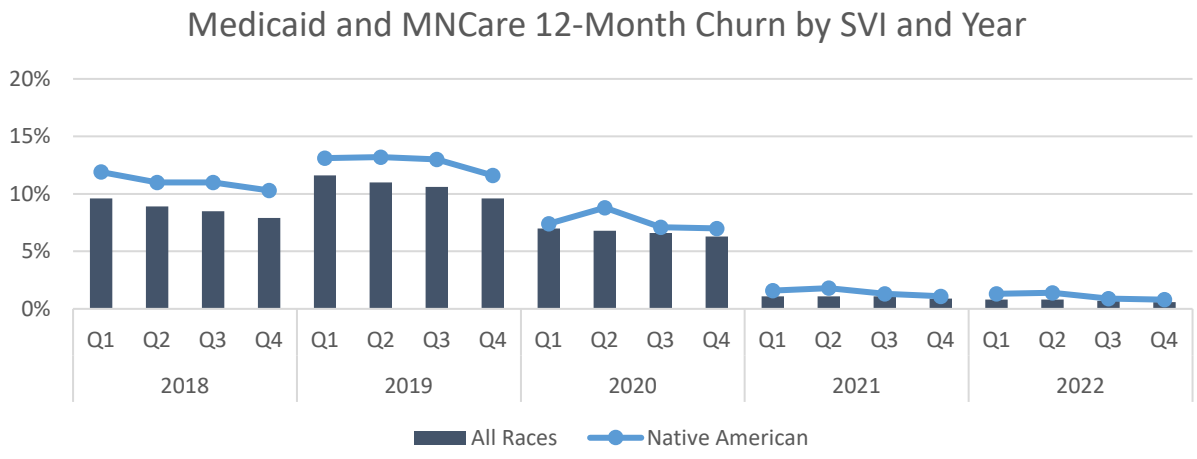
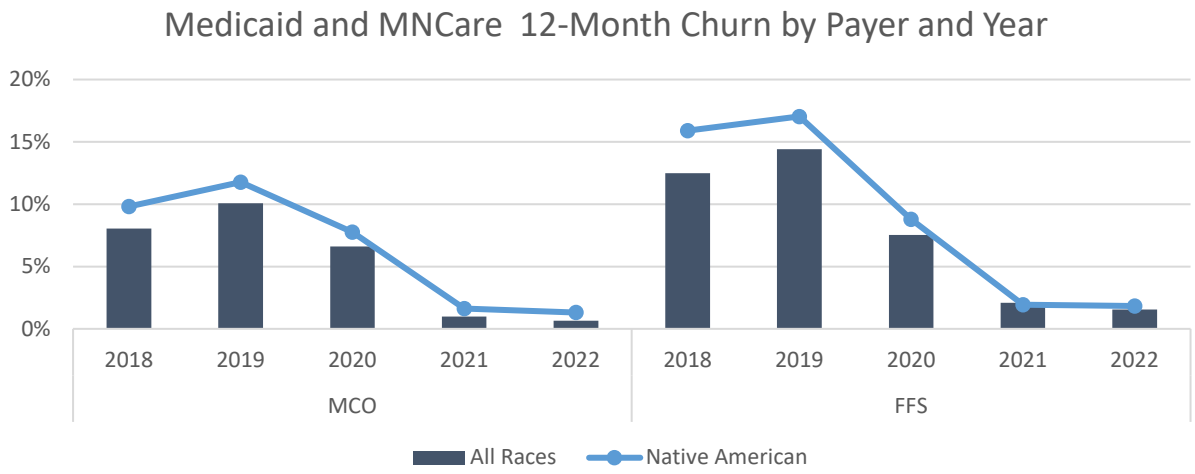
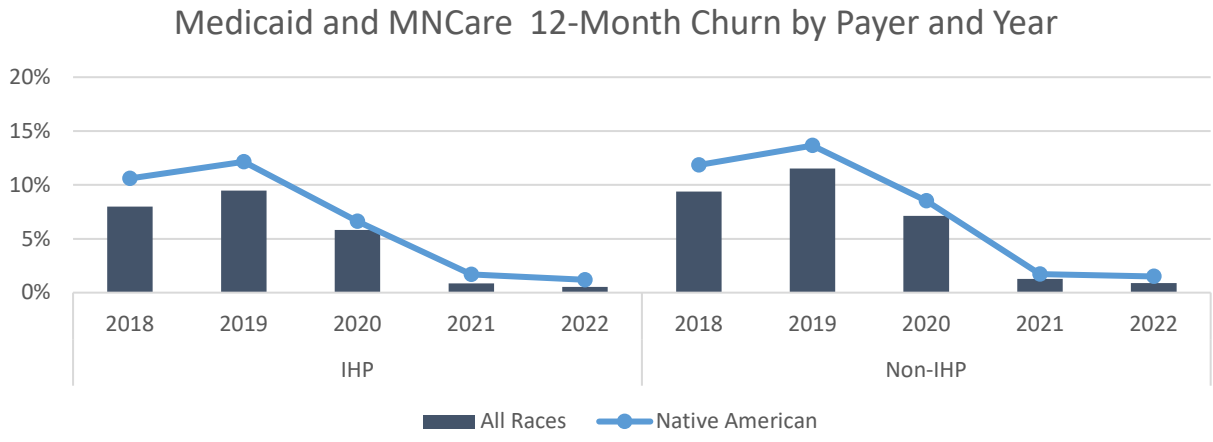


Figure 13. MHCP Churn rates for Native American members vs all members, by MCO and FFS enrollment status, 2018-2022



There was considerable interest in whether there was any difference in churn for members who were enrolled in a Managed Care Organization (MCO) or directly with DHS and their care was paid via Fee-For-Service (FFS) arrangements between providers and DHS. Figure 13 looks at 12-month churn rates between Native American MHCP members and all MHCP members based on MCO vs FFS enrollment. Native American MHCP members covered by MCOs had lower churn rates pre-pandemic. The COVID-19 PHE MOE policies appeared to erase that difference with MCO enrolled members seeing churn rates that were 6.1% and 5.3% lower than those on FFS in 2018 and 2019, respectively, compared to 0.3% and 0.5 % lower in 2021 and 2022, respectively. Relatedly, Native Americans on FFS saw a slightly higher reduction in churn between 2018 and 2022 when compared to all MHCP enrollees (88.5% vs 87.6%).

Figure 14. MHCP Churn rates for Native American members vs all members, by IHP and Non-IHP enrollment status, 2018-2022



Similar to interest in difference among members enrolled in MCOs, there was interest in any notable difference experienced by members based on attribution to Minnesota Medicaid's Accountable Care Organization (ACO) model called Integrated Health Partnerships (IHP). The IHP program incorporates a value-based payment model that takes into account the cost and quality of the health care services provided. MHCP members served under both FFS and MCO are attributed to the IHP from which they receive the most services. Since MHCP members are attributed to IHPs there is the possibility of IHPs who care for populations with higher churn having a harder time reaching quality and cost goals. There is some evidence looking at population turnover among commercial ACOs that points to churn limiting their cost-saving potential and potentially setting up perverse unintended consequences.[164,165] Figure 14 examines 12-month churn rates between Native American MHCP members and all MHCP members based on IHP vs Non-IHP attribution. Overall, IHP attributed members saw generally lower churn than non-IHP members pre-pandemic. The overall pattern between Native American MHCP members and all MHCP members was otherwise the same with Native American MHCP members attributed to IHPs experiencing higher churn rates than seen by all MHCP members attributed to IHPs. This raises some concerns about higher rates of churn within an ACO population and the ACO model's ability to achieve racial and health equity goals while also containing costs and generating savings. **Given the reduction in churn seen with the continuous eligibility policies in place during the PHE the pairing of such policies with ACO models appears to have the potential to help make value-based purchasing models more likely to reach health equity goals.**

"It can be so complicated, and it takes so much time, the amount of time you spend on the phone… the decision I made ultimately was just based on wanting it to end and be over. I did get good care eventually through SSI, but it needs to be more focused." Virtual Community Conversation participant

One of the most frequent reflections shared during initial guidance meetings, sessions with the report Co-creators, and community conversations conducted by MTI, was the variable and often challenging experiences of completing a MHCP application and/or renewal. There were common themes about a lack of clarity, where to go to get needed information, how to navigate system inefficiencies, and delays and frank frustration with the treatment received by American Indian community members when seeking assistance applying or renewing at county human service agencies. One participant shared that it was well known in her community that you wouldn't be treated well at the nearest county office, so some people had started driving another county over if they needed help. Others felt the lack of dignity wasn't worth getting enrolled as they could just go to their Tribal clinic and get seen anyways. This was reflected during a 2024 DHS Medicaid Equity Forum, by a member working at a navigator organization:

"We struggle with the "argument" from our Native American population that they don't need MNsure - they can access health care at Indian Health Services and it doesn't require the paperwork and reporting that MNsure does. It isn't until there is a medical emergency that can't be addressed at IHS that we are asked to help. Are their resources and/or ideas for addressing that? Honestly, I don't blame anyone for opting out of this system...for all kinds of reasons...but if there are resources or efforts to address this issue....we would appreciate them." MN DHS 2024 Medicaid Equity Forum participant

Tables 9 and 10 look at churn rates for counties known to have higher proportions of American Indian/Native American representation. The White Earth Nation also administers MA and is also reported. All other counties are grouped together in a separate category labeled "All Other." Looking across these counties and the White Earth Nation an average 12-month churn rate was calculated, and then individual counties and the White Earth Nation's 12-month churn rate was compared to the average. Jurisdictions that had a churn rate 1 standard deviation (SD) lower were highlighted green and those with a churn rate one standard deviation higher were highlighted yellow while those with a churn rate 2 SDs higher than the average were highlighted red. Table 9 finds that 4 counties and the White Earth Nation all had 12-month churn rates in 2018 that were at least 1 SD lower than average for Native American MHCP members. It also saw 3 counties that had churn rates 1 SD higher and 1 county that had churn rates 2 SD higher. This is particularly notable when you look at Table 10 which looks at 12-month churn rates by Jurisdiction for all MHCP members. Among the counties that had churn rates 1 or 2 SD higher for Native American MHCP members, only one had churn rates 1 SD higher when looking at all MHCP members.

Table 9. MHCP churn among Native American enrollees by select county/Tribe, 2018

Year	County	3 months	6 months	9 months	12 months
2018	Aitkin	2.7%	4.3%	5.4%	6.2%
2018	Anoka	5.5%	7.4%	9.0%	10.1%
2018	Becker	4.7%	6.7%	8.0%	9.0%
2018	Beltrami	4.1%	6.7%	8.6%	9.7%
2018	Benton	4.4%	7.4%	9.4%	11.2%
2018	Carlton	2.5%	4.7%	5.6%	6.5%
2018	Cass	3.0%	5.4%	7.5%	8.7%
2018	Clearwater	6.4%	9.5%	11.4%	12.9%
2018	Cook	5.0%	8.8%	10.5%	11.1%
2018	Crow Wing	4.8%	7.3%	9.2%	10.4%
2018	Dakota	4.3%	6.5%	7.5%	8.2%
2018	Goodhue	6.4%	7.9%	9.4%	11.8%
2018	Hennepin	5.5%	8.1%	10.0%	11.2%
2018	Hubbard	3.1%	4.4%	5.4%	6.2%
2018	Itasca	6.6%	8.0%	8.9%	9.3%
2018	Koochiching	3.3%	4.9%	5.3%	5.7%
2018	Mahnomen	6.0%	9.0%	11.4%	12.1%
2018	Mille Lacs	4.4%	7.9%	9.9%	11.5%
2018	Morrison	5.4%	7.7%	8.5%	8.5%
2018	Pine	3.3%	5.8%	7.0%	8.1%
2018	Ramsey	4.8%	6.8%	8.4%	9.5%
2018	Redwood	6.3%	10.4%	14.0%	15.1%
2018	Scott	2.7%	5.2%	7.7%	8.2%
2018	St. Louis	5.5%	7.7%	9.9%	11.2%
2018	White Earth	1.2%	3.7%	4.8%	5.8%
2018	Yellow Medicine	4.2%	10.9%	12.6%	12.6%
2018	All Other	3.9%	6.2%	7.9%	8.7%

*Green cells are 1 STD better
*Yellow cells are 1 STD worse
*Red cells are 2 STD worse

Mean	9.61%
Standard Deviation (STD)	2.39%

As noted by a Data Guidance group member, "*Data for Natives vs all other races indicate opportunities for clarifying Medicaid eligibility and options for maintaining enrollment for Native Americans. There appear to be some counties where churn (for timepoints shown) are on par for Natives vs others, so supports needed may vary by location. Displaying info on maps overlaying % Native by county may help further define place-based supports needed."* The Data Guidance panel also felt this data speaks to the lived experiences shared by American Indian/Native American members. It provides DHS and our community partners with ways to identify what is working well with partners like White Earth Nation

and the counties that have notably lower churn rates and then proactively engage and support those where there is a notable increase in churn.

Table 10. MHCP churn among all enrollees by select county/Tribe, 2018

Year	County	3 months	6 months	9 months	12 months
2018	Aitkin	4.1%	5.2%	6.3%	7.2%
2018	Anoka	5.5%	7.3%	8.5%	9.3%
2018	Becker	4.0%	5.9%	6.7%	7.4%
2018	Beltrami	4.2%	5.6%	6.6%	7.5%
2018	Benton	3.9%	5.3%	6.2%	6.9%
2018	Carlton	3.6%	5.1%	6.2%	7.1%
2018	Cass	3.7%	5.2%	6.3%	7.1%
2018	Clearwater	4.1%	5.6%	6.7%	7.8%
2018	Cook	5.3%	6.0%	7.2%	8.5%
2018	Crow Wing	4.5%	6.2%	7.1%	7.9%
2018	Dakota	4.3%	5.8%	6.7%	7.5%
2018	Goodhue	4.1%	5.5%	6.6%	7.4%
2018	Hennepin	5.9%	7.9%	9.1%	10.0%
2018	Hubbard	2.9%	4.2%	5.1%	5.9%
2018	Itasca	5.0%	6.7%	7.8%	8.6%
2018	Koochiching	4.1%	5.6%	6.3%	6.7%
2018	Mahnomen	6.0%	8.7%	9.9%	11.0%
2018	Mille Lacs	3.9%	5.2%	6.2%	7.2%
2018	Morrison	3.0%	4.3%	5.0%	5.6%
2018	Pine	3.9%	5.4%	6.5%	7.3%
2018	Ramsey	4.6%	6.3%	7.3%	8.1%
2018	Redwood	4.4%	6.2%	7.6%	8.5%
2018	Scott	4.4%	6.0%	6.9%	7.7%
2018	St. Louis	4.2%	5.8%	6.9%	7.6%
2018	White Earth	2.7%	4.3%	5.5%	5.9%
2018	Yellow Medicine	3.6%	4.9%	6.6%	7.3%
2018	All Other	5.4%	7.2%	8.4%	9.4%

*Green cells are 1 STD better

*Yellow cells are 1 STD worse

*Red cells are 2 STD worse

Mean	7.72%
Standard Deviation (STD)	2.39%

Co-creators and Data Guidance Panel members shared direction for next steps DHS should take to refine data we look at, report and incorporate into decision making as well as being responsive to the data gathered for this report. They recommended data on churn be further refined to look at population health indicators like specific health diagnoses (ex. Substance Use Disorder, Depression, Serious Persistent Mental Illness) or social conditions (ex. Homelessness). Since MA and MNCare applications

and renewals are administered differently, there was a recommendation to look at MNCare specifically as well as refine the overall data to look at what the average length of gap was and if that could be attributed to other demographic or health factors.

Impact of DHS' unwind campaign on American Indian Medicaid renewal rates

At the beginning of DHS' unwind campaign, American Indian (along with Black, Pacific Islander, Hispanic/Latine and Multiracial) Medicaid enrollees lost coverage at renewal time at rates higher than the total population. However, due to the above noted collective and multifactorial efforts between DHS and its community partners, overall disenrollment rates decreased with **disparities in disenrollment for Black and most American Indian enrollees disappearing completely by March 2024** and disparities for Hispanic/Latine enrollees narrowed.

Full details about these efforts and their impact were shared in DHS' recent Minnesota Health Care Programs Renewal Equity Report which examined renewal rates from the July 2023 cohort through the March 2024 cohort. Rates were analyzed by race/ethnicity, age, and SVI Zip Code quartile. Among all groups American Indian enrollees saw higher disenrollment rates and initial disparities progress to lower disenrollment rates and no disparities by the end of the periods examined. The exception being American Indians aged 65 or older who saw disenrollment rates increase, and disparities persist. Tables 11 and 12 and Figures 15, 16 and 17 illustrate these trends. For further descriptive analysis please review the Minnesota Health Care Programs Renewal Equity Report.[166]

Table 11: Average Percent of Total Enrollees Due to Renew Disenrolled by Race and Ethnicity

Race/Ethnicity	July 2023-September 2023	October 2023-December 2023	January 2024-March 2024
Total Population	**28%**	**32%**	**25%**
Hispanic/Latine	38%	37%	27%
Asian	24%	29%	21%
Black	26%	32%	23%
American Indian	32%	34%	20%
Pacific Islander	36%	38%	21%
White	28%	33%	27%
Multiracial	30%	34%	24%
Unknown	26%	30%	23%

Note: All bolded, darker gray areas report higher disenrollment rates than the total population, meaning that the race/ethnic group is overrepresented.

Figure 15: Percent of American Indian Enrollees Aged 0-17 Due for Renewal and Disenrolled

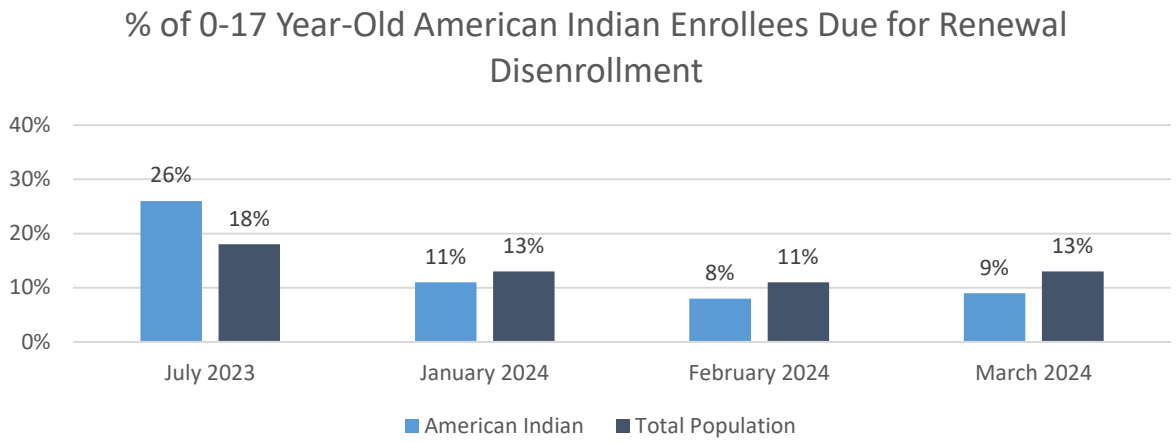


Figure 16: Figure 10: Percent of American Indian Enrollees Aged 0-17 Due for Renewal and Disenrolled

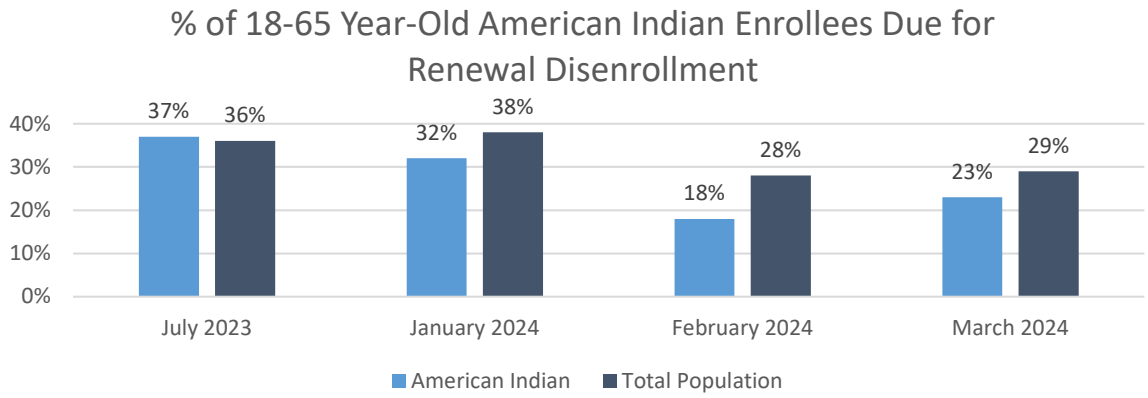
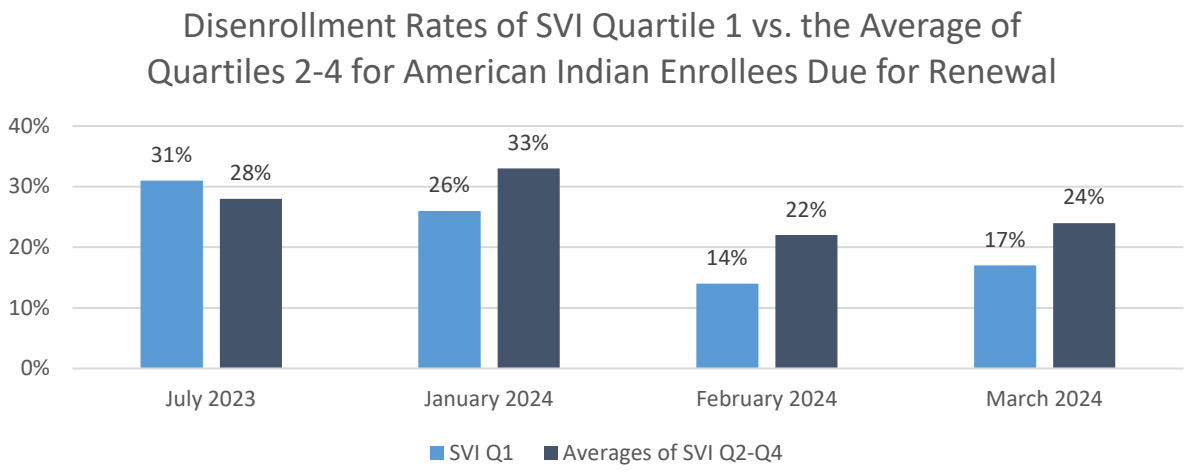


Table 12: Average Percent of Enrollees Aged 65+ Due for Renewal Disenrolled

Race/Ethnicity	July 2023-September 2023	October 2023-December 2023	January 2024-March 2024
Total Population	**12%**	**16%**	**22%**
Hispanic/Latine	20%	23%	27%
Asian	7%	9%	11%
Black	10%	14%	18%
American Indian	13%	21%	25%
Pacific Islander	5%	7%	14%
White	12%	17%	25%
Multiracial	27%	28%	33%
Unknown	26%	29%	33%

Table 12 Note: All bolded, darker gray areas report higher disenrollment rates than the total population, meaning that the race/ethnic group is overrepresented.

Figure 17 - Percent of American Indian Enrollees Due for Renewal and Disenrolled by SVI ZIP Code Quartile



Impact of the Tribal General Welfare Exclusion Act

In addition to examining churn data some tribal staff and report Co-creators shared concerns about the potential impact of community members not realizing certain Tribal benefits should not be counted against them in assessment of their eligibility for state and federal entitlements like Medicaid. The Public Health Law Center's second legal memorandum provides valuable background and details on the intersection of the welfare exclusion doctrine, Tribal government sovereignty, and Medicaid.

The general welfare exclusion doctrine is founded on the idea that government benefits to people who are very low-income should not count as taxable income because that could jeopardize their ability to receive those benefits. The doctrine works to exclude governmental programs benefits, like Social Security, from the recipient's taxable income. Since a person's eligibility for Medicaid and many other public benefits depends on their level of taxable income, this ensures that people with few resources do not lose eligibility for assistance programs by having other assistance programs inflate their income calculation. This doctrine was first codified into law in the 1930s through the Social Security Act of 1935,[167] and it was later expanded to also exclude unemployment benefits, replacement housing payments, disaster relief, and other governmental assistance programs.[168]

The Tribal General Welfare Exclusion Act of 2014[169] applies the welfare exclusion doctrine specifically to Tribal assistance programs, which are tailored for the unique circumstances of Tribal Nations and their citizens. It is a federal law that affects the federal income tax liability for many Tribal citizens. It provides that payments received by Tribal citizens from benefit programs provided by a Tribal government for the general welfare of its citizens should not count as part of the Tribal member's gross income for tax purposes, so long as the benefits provided meet certain guidelines.[170] This provides two important protections: it protects these Tribally-provided payments, programs, or services from being subject to

federal income tax;[171] and it can protect Tribal members with low-income from being disqualified from receiving crucial federal services or benefits — such as Medicaid – that are income-based.

A person's eligibility for many federal programs is based on their "modified adjusted gross income," or MAGI.[172] If their MAGI goes over a certain amount, they will be cut off from income-based benefits and services. The Indian Welfare Exclusion Act of 2014 prevents some Tribal benefits from being added back into the MAGI, which helps maintain the income-based eligibility of some Native Americans for federal programs such as Medicaid.

For a Tribal benefit to qualify for the general welfare exclusion, the benefit must meet all of the following criteria:

- The program must be administered pursuant to guidelines specifying how people qualify for the benefit and be made to any Tribal member who meets the guidelines;
- Be for the promotion of general welfare (meaning based on need);
- Not be "lavish or extravagant" under the facts and circumstances; and
- Not be compensation for services.[173]

The Act also explains that "any items of cultural significance, reimbursement of costs, or cash honoraria for participation in cultural or ceremonial activities for the transmission of [T]ribal culture are not treated as compensation for services."

As a general rule, per capita distributions are distinct from general welfare payments and do count towards taxable income. Some Tribes who operate gaming facilities distribute some of their gaming revenues to members through a per capita system. These per capita payments are subject to the Indian Gaming Regulatory Act which requires them to count towards taxable income.[174]

There also are exceptions to the broad rule that per capita payments do not qualify for exclusion. For example, payments that Tribal members receive through funds held in trust by the Secretary of the Interior and certain settlement agreements between Tribal Nations and the federal government are not taxable income.[175] Many Tribes have entered into settlement agreements, including the Bois Forte Band of Chippewa and Leech Lake Band of Ojibwe.[176] Thus, per capita payments that Tribal members receive resulting from these settlement agreements would not be counted as taxable income for purposes of determining eligibility for governmental services.

Some Tribal Nations co-located in Minnesota have enacted laws and policies relating to general welfare assistance, reiterating that these Tribal benefits should be excluded from an eligible Tribal citizen's gross income when calculating their qualification for state and/or federal assistance.

- For example, Mille Lacs Band of Ojibwe has an Eligible Band Member General Welfare Assistance Program[177] designed to "provide general welfare assistance to Eligible Band Members for services, activities, and needs, including medical expenses such as in-home services, delivered meals, and health and wellness activity expenses; emergency assistance;

dependent care assistance; housing, repair, rehabilitation and utility expenses; energy assistance; health and wellness activity expenses; social services expenses; cultural, spiritual and education services; and other related expenses . . ."

- Tribal Nations have adopted resolutions establishing Tribal COVID-19 relief programs, which were designated to be exempt from taxation. [178]

- Relatedly, Lower Sioux Indian Community put out a notice in 2020 saying that the Community "operates its General Welfare Program and Tribal Elders Benefit Program in accordance with the [Tribal General Welfare Exclusion Act of 2014] and has provided its Qualified Members" funding, such as COVID-19 relief assistance, Tribal Elder Benefit Program, and General Assistance Program/Tribal Benefits Program, must be "excluded from a Qualified Member's gross income in calculating his/her qualification for state and federal assistance."[179]

The impact of the Internal Revenue Service's (IRS) policies and practices on Tribal Nations and their members must also be considered. To prove that a payment qualifies for exclusion under the law, Tribal Nation payors and payment recipients "must maintain accurate books or records" which must be available for inspection by authorized IRS agents.[180] In 2019, ProPublica investigative journalists reported on a study looking at the rates of IRS audits for people based on the county where they live. The study found that the counties with the highest rates of IRS audits were in the Deep South and have predominantly African American and rural populations. Similarly, the study found counties with Native American reservations also experienced disproportionately high audit rates, with the lowest rates being found in counties where the population is predominantly middle income and largely white people.[181]

Engaging the Medicaid Eligibility and Enrollment Lever

Medicaid eligibility and enrollment policies and procedures remain a key lever in forging a path towards greater racial and health equity. Prior to the pandemic there were known racial disparities in who experienced procedural disenrollment. The COVID-19 Public Health Emergency (PHE) provided Medicaid enrollees with continuous eligibility for 3 years. Nationally the "unwind" of these PHE policies has led to millions of people losing health care coverage. In Minnesota, DHS has been working on improving racial equity in eligibility and enrollment policies through community-centered collaborations and community-guided systems changes. This has contributed to most disparities in disenrollment for American Indian enrollees during DHS' unwind campaign being eliminated. Analysis of churn data done in collaboration with Co-creators and our Data Guidance panel illustrates the impact of multi-year continuous enrollment policies as a way to address racial equity in how DHS administers Medicaid. Further evaluation and refinement of policies that impact eligibility, like the Tribal General Welfare Exclusion Act, were also identified as opportunities to advance equity. However, to fully eliminate disparities in churn, and the resultant health disparities due to gaps in coverage, will require further refinement of data, support and accountability for administering partners and continued investment in enrollment navigators and community-led outreach and supports. The Call to Action to create a Pathways to American Indian and Tribal Health Integration team would provide DHS with the infrastructure to ensure MN Medicaid is able to apply the eligibility and enrollment lever toward racial and health equity.

Medicaid Lever: Access

Access refers to enrollees' ability to access care: Is there a primary care provider within a reasonable distance from home? Do they have access to culturally relevant care that is delivered with humility? Do they have reasonable access to specialists, behavioral health care or dentistry? As DHS noted in the 2022 BREW report there is ample evidence that access is a significant barrier for Medicaid enrollees. A 2024 issue brief by the Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy examined recent trends and key challenges in access to care among American Indians and Alaska Natives (AI/AN).[182] They found that more than 80% of people who identify as AI/AN live outside tribal areas and that despite increases in health coverage rates among AI/ANs, there are persistent disparities in health outcomes. Notably, AI/AN Medicaid enrollees, compared to non-Latino White Medicaid enrollees, are much less likely to report they have easy access obtaining needed medical care, tests, treatments, or behavioral health services; and they are more likely to report never being able to see a specialist as soon as needed. ASPE's analysis of several measures of access and affordability in NHIS data did show encouraging trends in AI/AN individuals reporting a usual source of care and in accessing prescriptions, however worry about medical bills remained high (Table 13).

Table 13: Access to Care Trends for American Indian/Alaska Native Population (Ages 0-64), Select Years

	2010	2015	2020	2022
No Usual Source of Care	10.4%	13.6%	10.1%	5.1%
Delayed Care Due to Cost	10.5%	9.2%	5.6%	4.2%
Worried About Medical Bills (18-64)*	55.0%	48.0%	45.0%	48.5%
Delayed Filling Prescriptions (18-64)*	9.3%	6.3%	9.3%	4.5%

Source: ASPE Analysis of MHIS Microdata[iv]

Many American Indians also live in rural areas which also tend to be underserved with health care services.[183] A shortage of medical personnel within rural areas and at IHS facilities creates another barrier to accessing health care services.[184] This additional barrier contributes to longer wait times and many Native American patients being forced to travel significant distances to reach medical facilities or necessary specialists.[185] This inadequate access to comprehensive health care services creates further health inequities and contributes to negative health outcomes for American Indians.

[iv] Notes: 1) Respondents are classified as worried about paying medical bills if they reported being very worried or somewhat worried about paying medical bills. 2) Respondents were asked about delaying refilling prescription medications only if they reported using prescriptions in the past 12 months.

*Data on worrying about medical bills or delayed prescriptions are available from 2011 (the earliest year available), consistently asked only among respondents aged 18-64.

National opportunities/examples from other states

The Centers for Medicare and Medicaid Services (CMS) has focused on overcoming barriers to care for American Indian and Alaska Native (AI/AN) populations, who face unique challenges such as remoteness and cultural barriers. To address these, CMS has developed multiple strategies including protections under Medicaid and CHIP, ensuring AI/ANs can access Indian Health Care Providers (IHCPs), a CMS Tribal Protections in Medicaid and CHIP Managed Care Oversight Toolkit for states, and improving their government-to-government process with sovereign Tribal Nations. Tribal Consultation and the CMS Tribal Technical Advisory Group (TTAG) have been utilized to inform CMS decisions. This section will examine in more detail several other policies and levers CMS is exploring to improve access to care for AI/AN communities: the Four Walls requirement for Medicaid clinic services, the Money Follows the Person Tribal Initiative and Telehealth. We will also briefly cover examples from several other State Medicaid Agencies (AZ, MT, NM, SD).

Four Walls

The Four Walls Requirement under 42 C.F.R. § 440.90 has been an area of focus for Indian Health Service and Tribal Facilities for some time. CMS's current interpretation of the clinic benefit regulations provided in 42 C.F.R. § 440.90 prohibits Medicaid reimbursement for "clinic services" provided outside of the four walls of a facility. The Center for Medicaid and CHIP Services (CMCS) initially issued a State Health Official letter regarding this interpretation in 2016. Subsequent CMS Frequently Asked Questions (FAQ) communications reaffirmed that IHS and Tribal facilities enrolled in Medicaid as clinic service providers are not permitted to claim Medicaid reimbursement under 42 C.F.R. § 440.90, including reimbursement at the IHS All-Inclusive Rate (AIR), for services provided outside the four walls of the clinic facility with an exception for services to people who are experiencing homelessness.[186] Of note, the definition of clinic services at 42 C.F.R. § 440.90 does not apply to Medicaid Federally qualified health center (FQHC) services provided by FQHCs, and therefore FQHCs can claim Medicaid reimbursement for FQHC services provided outside of the four walls of the FQHC. In the 2017 FAQ, CMS provided a timeline by which they would begin reviewing claims by Tribal providers of clinic services under 42 C.F.R. § 440.90 for services furnished outside of the "four walls," intending to start no sooner than January 30, 2021. Due to the COVID-19 Public Health Emergency (PHE), the grace period has been extended several times and is currently extended to February 11, 2025.[187]

Tribal Nations have shared that the "four walls" interpretation would prevent access to community-centered care, limit their ability to meet the unique needs of their members and, "places unnecessary requirements and restrictions on the provision of healthcare in Indian Country that unduly interferes with the CMCS's trust responsibility to federally-recognized Indian Tribes."[188] CMCS has contemplated a path to address these concerns through having interested Tribally-operated facilities transition to a Tribal Federally Qualified Health Center which could allow them to then retain the IHS AIR for services provided outside the "four walls" if the State Medicaid Agency (SMA) submits a State Plan Amendment to establish the IHS AIR as an Alternative Payment Methodology (APM). Concerns have persisted about broader impacts of this policy and recommended shift as well as the timeframe in which to establish it. In response to iterative conversations with Tribal Nations and SMAs, in July of 2024 CMS issued a proposed rule that included creating an exception to the four walls requirement for IHS and Tribally

operated clinics as well, as a SMA option, exclusions for behavioral health clinics, and clinics located in rural areas.[189]

Money Follows the Person Tribal Initiative

The CMS Money Follows the Person - Tribal Initiative (MFP-TI) Rebalancing Demonstration Grant seeks to assist Tribes in providing Medicaid-funded home and community-based services (HCBS) to their members and reduce the use of institution-based services. It lists as its goals to

- Increase the use of HCBS and reduce the use of institution-based services providing Long-term Services and Supports (LTSS)
- Eliminate barriers in state law, state Medicaid plans, and state budgets which previously made it difficult to use Medicaid funds to offer patients long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Provide quality assurance and improvement of HCBS

The MFP-TI offers five state grantees (MN, OK, ND, WA, WI) and their identified Tribal partners the resources to build sustainable HCBS specifically for Indian Country.

- Under the MFP-TI, tribal members with functional limitations or cognitive impairments who live in an institutional setting for over 90 days in a row can get assistance with daily living tasks such as bathing, dressing, or eating. These services are intended to help these individuals move back into the community.
- The MFP-TI may also be used to develop HCBS infrastructure for AI/ANs using applicable Medicaid authorities. Funding is intended to support the planning and development of:
    - An in-state HCBS Medicaid program tailored to AI/ANs presently in an institution
    - A service delivery structure with administration delegated by the state Medicaid agency so Tribes or Tribal organizations can:
        - design an effective program or package of Medicaid community-based LTSS
        - operate day-to-day functions pertaining to LTSS program(s)

Telehealth

American Indian communities faced great disparities prior to the COVID-19 and even more so while experiencing the pandemic. IHS took action to expand telehealth services to prevent, detect, treat, and recover from COVID-19.[190] A reported 80% of telehealth services through IHS are audio only due to connectivity and affordability. This leaves an opportunity to recognize that access to quality internet services is needed to improve overall health and health equity. Travel costs are a problem for American

Indians as well, especially those seeking to receive specialty care which is often underfunded in Indian Health Services facilities.[191] In addition to travel, time is another consideration as patients must spend time away from work and often seek child-care. It has been reported that for every dollar spent in telehealth, $11.50 was saved in travel and child-care related expenses without any decrease in quality.[191] The Indian Health Care Improvement Act (IHCIA), extended by the Affordable Care Act, expanded Native American access to Medicaid and Medicare. These increases in insured may stimulate the growth of telemedicine in rural reservations as long as reimbursement for telemedicine services increases.[191]

State Medicaid Examples: Arizona

The Arizona Health Care Cost Containment System (AHCCCS) administers Medicaid through a mandatory managed care delivery system. AHCCCS seeks to address AI/AN health care needs through three specific waivers: the American Indian Medical Home Waiver, the Uncompensated Care Payment Reform Waiver and the Traditional Healing Services Waiver.[192] All Medicaid enrollees, except American Indians/Alaska Natives (AI/AN), must join a managed care organization (MCO). AI/AN individuals have the option to enroll in either an MCO or the AHCCCS Fee-For-Service (FFS) American Indian Health Program (AIHP), which provides access to services through Indian Health Service (IHS) facilities, tribally operated 638 health programs, and urban Indian health clinics.[193] AIHP offers a comprehensive array of medically necessary physical and behavioral health services for enrolled members to include prevention, annual wellness checks, dental, vision, pharmacy, and emergency services. Limited services include behavioral health residential, non-emergency or elective surgeries and nursing home placement. As an added benefit to choosing AIHP, members may choose to be a part of an American Indian Medical Home (AIMH). AIMH is designed as an added benefit in addition to AIHP that provides a nurse care manager to help coordinate all health care appointments and supports Primary Care Case Management (PCCM), diabetes education, care coordination, and promotes participation in the state Health Information Exchange (HIE) for American Indian/ Alaska Native members. The AIMH program is a voluntary program. AIHP members who choose to participate may disenroll or change AIMH sites at any time.

The Uncompensated Care Payment Reform Waiver provides payment methodologies for non-covered services delivered by IHS and 638 facilities. While the Traditional Healing Services Waiver facilitates reimbursement for Traditional Healing services provided through IHS, tribally operated, or Urban Indian health programs, ensuring these culturally significant services are accessible to Medicaid-eligible AI/AN members. On October 16, 2024, CMS approved the waiver allowing the state to amend the Arizona Health Care Cost Containment System to “provide expenditure authority for coverage of traditional health care practices.[194] This approval is effective through September 30, 2027.

State Medicaid Examples: Montana

Montana has expanded Medicaid options for Native Americans, including a special enrollment period that allows members of federally recognized Tribes to apply at any time for a zero cost-sharing plan, which eliminates additional out-of-pocket costs.[195,196] However, American Indian descendants who are not federally recognized do not qualify for the same benefits but may receive tax credits and cost-sharing reductions.

Though there isn't a dedicated Native American-focused Managed Care Organization (MCO), Montana Medicaid provides an All-Inclusive Rate (AIR) for outpatient services at tribal federally qualified health centers (FQHCs), reflecting the unique care needs on reservations. The program also reimburses for

services provided by Tribal Community Health Aides, enhancing healthcare access within reservations and reducing the need for travel. This initiative has led to better preventive care and reduced trauma from delayed treatment. Additionally, Montana Medicaid has successfully negotiated tribal rates for nursing facilities, preventing facility closures and providing critical services closer to home. These efforts not only improve healthcare access and outcomes for tribal members but also relieve financial burdens on Tribes and the state.[11] Additionally, the state reimburses services provided by Tribal Community Health Aides, further supporting culturally appropriate care delivery.

State Medicaid Examples: New Mexico

New Mexico is working to incorporate tribal healing services into MCO offerings, making these services available to all members, not just AI/AN. This initiative faces challenges, such as maintaining the authenticity and ritualistic nature of tribal healing practices. The Centennial Care program collaborates closely with Indian Health Service (IHS) and tribal health clinics to provide medical services, allowing AI/AN individuals the flexibility to access care through these facilities or the MCO network.[197]

A significant development is the proposed Navajo Indian Managed Care Entity (IMCE), an initiative spearheaded by the Navajo Nation in partnership with Molina Healthcare. The IMCE aims to provide culturally informed, comprehensive care tailored to the needs of Navajo Medicaid beneficiaries. It emphasizes primary care, chronic disease management, and social determinants of health, integrating Traditional Healing and modern healthcare services. The IMCE also plans to include community reinvestment initiatives, focusing on workforce development and economic growth within the Navajo community. The program is designed to offer enhanced benefits, such as wellness incentives, dental services, and transportation assistance while ensuring access to tribal and non-tribal healthcare providers across New Mexico and neighboring states. The IMCE pilot project represents a significant step towards self-determination in healthcare for the Navajo Nation, promising improved health outcomes and access to culturally competent care.[198] On October 16, 2024, CMS approved New Mexico's 1115(a) waiver amending New Mexico Turquoise Care to "provide expenditure authority for coverage of traditional health care practices."[199] This approval is effective through December 31, 2029.

State Medicaid Examples: South Dakota

Through a 2019 1115 waiver proposal, the South Dakota state Medicaid agency is exploring alternative ways of delivering healthcare services to dual Medicaid/Indian Health Service (IHS) eligible individuals.[200]This initiative leverages existing facilities, such as Federally Qualified Health Centers (FQHCs) and urban Indian health clinics, to improve access to care. FQHCs are reimbursed at a cost-based uniform rate, 100% fee-for-service, to reduce non-emergent emergency room usage and address unmet healthcare needs among American Indian populations. The state is partnering with regional Tribes, tribal organizations, the IHS, the Great Plains Tribal Chairmen's Health Board, and urban Indian health facilities to identify needs and develop sustainable healthcare solutions. This collaboration includes utilizing telemedicine, emergency services, specialty care, and hospitalist services to enhance healthcare access in reservation communities. Additionally, the outreach program through Avera health care system provides educational and training opportunities, further supporting healthcare improvements in these areas.[201]

Alaskan Native Tribal Health Consortium

According to research conducted by the Public Health Law Center, some Tribal Nations have responded to a lack of care by implementing their own health care training programs. One example of this innovative thinking includes Alaska's dental health therapist program.[202] Because of a severe shortage of dentists in Alaskan Tribal communities, the Alaskan Native Tribal Health Consortium developed a two-year training program designed to build a workforce of Native, midlevel oral health care providers who can provide basic oral health services such as preventative care, fillings, and simple extractions.[203] This program has been tremendously successful, and was bolstered by the Swinomish Tribe's decision to create its own dental health therapist licensing law. These Alaska-trained midlevel providers are now being employed by several Tribes in the lower 48 states.[204]

Previous and Current MN Medicaid Efforts

Access remains a challenge for MHCP members broadly. DHS has made several policy changes over the last few years to help with barriers that impact all members, but that data has shown impact American Indian members at higher rates, like cost-sharing, transportation, and dental care.

Cost Sharing

The 2023 Minnesota legislature passed several laws to eliminate or reduce the burden cost-sharing has on MHCP members. Effective January 1, 2024, members in MA had cost-sharing completely eliminated. Those in MNCare saw limits to cost-sharing for prescription drugs and medical supplies to treat chronic diseases (no more than $25 per one-month supply for each drug and $50 per month in total for all related medical supplies with "chronic disease" defined as diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors). Additionally, several other services and treatments must be provided without cost-sharing in MinnesotaCare: (1) additional services or testing required after a mammogram, as determined by a provider; (2) drugs used for tobacco cessation and tobacco cessation services; and (3) PrEP and PEP medications when used for HIV treatment and prevention.

Transportation

The 2021 legislature passed legislation to make it easier for MA enrollees to use their Non-Emergency Medical Transportation (NEMT) benefit to access public transit passes. In 2023 the legislature also established a fuel adjustor for NEMT provider rates to support the availability of NEMT in rural areas in particular.

Dental Care

Dental payment rates have been raised in hopes that it will make it more sustainable for dental providers to serve MHCP enrollees. In 2023 a comprehensive adult dental benefit was also added along with coverage of nonsurgical treatment for periodontal disease.

Broad Efforts to Improve Access

In addition to legislative direction there have been many efforts to improve access to care for MHCP members and several have focused on or centered American Indian communities. In 2018 DHS created a resource guide for Native Americans in Minnesota to help in navigation of what is available for members who are or are not on Medicaid.[205] Below are a few other examples of efforts to increase access to MN Medicaid for American Indian community members specifically (and is not intended to be an exhaustive list or review).

DHS was selected to participate in the National Center on Substance Abuse and Child Welfare's (NCSACW) Substance Exposed Infants In-Depth Technical Assistance (SEI-IDTA) program to improve the safety, health, permanency, and well-being of American Indian infants with prenatal substance use exposure and the recovery of American Indian pregnant and parenting women and their families. There were three overarching goals to this program: Screening and assessment of pregnant women and exposed infants; Joint accountability and shared outcomes; Services for pregnant women, substance-exposed infants, and their families.[206] Participating mothers, infants and families saw improved outcomes, increased family stability throughout the prenatal and postpartum periods and several successful graduates of the program went on to become peery recovery coaches and counselors. Recommendations that came out of this work included:

- Increased grant funding is needed for infrastructure and capital projects in rural Minnesota.
- More culturally based, family-centered treatment facilities are needed for women that allow them to bring children with them.
- More supportive housing options that support recovery are needed in rural Minnesota as well as in the metro area. Housing eligibility policies need to support family reunification and allow for a safe environment for moms to be in recovery and with their children.
- Tribes need to be able to bill Medicaid and third-party payers for cultural interventions.

The Behavioral Health Administration at DHS (which oversees Minnesota's mental health and substance abuse prevention and treatment services that are paid for with state and federal funds) has a dedicated American Indian Team whose goal is to empower and nurture cultural resiliency and equity for healthier American Indians, their families, children, communities and Tribal Nations living in Minnesota. The Team focuses on providing resources and developing policies for American Indian families, children, communities and Tribal Nations within Minnesota through authentic and cultural engagement with American Indian partners including the American Indian Mental Health Advisory Council and the American Indian Advisory Council (Substance Use Disorder). Improved access is achieved primarily through administering grants that support culturally specific direct care and services as well as workforce development like provider training supports.

DHS' Aging and Disability Services Administration has worked with the Minnesota Board on Aging to support the American Indian Elder Desk. The American Indian Elder Desk aims to increase awareness of and improve access to services for Indian Elders in urban Indian communities and on 11 Indian reservations across Minnesota. The Indian Elder Desk specialist helps Indian and non-Indian community agencies develop culturally sensitive programs and services and works directly with Indian Elders

promoting aging services and programs. Wisdom Steps is a culturally based preventive health promotion program developed by and for American Indian Elders, with support from the Indian Elder Desk. Wisdom Steps fosters community and tribal partnerships and coordinates resources to provide increased advocacy and access to services that will improve the health of American Indian elders through health screenings, health education and healthy living activities.

DHS has been engaged in the CMS Four Walls policy deliberations, raising the concerns noted by Tribal Nations with CMS directly. In response to the July 2024 proposed rule DHS worked alongside Tribes to submit a comment in September 2024, co-signed by the leaders of 10 of the Tribes, chiefly noting they are, "principally concerned about the requirement that outpatient care delivered by IHS and Tribally operated health care clinics be under the supervision of a physician. This restriction does not apply to other similar service providers and would reduce access to care for American Indians… limiting IHS and Tribal health care clinics to those services that are under the direction of a physician places those providers in the untenable position of either delaying needed care to involve a physician without any clinical justification, or excluding those services from the full federal funding authorized under the law. The IHS and Tribal clinics would be subject to requirements other participating providers simply do not have to observe for the delivery of many vital health care services including primary and behavioral health care, home health, and even emergency transportation."[207]

DHS has also sought to support Urban Indian Organizations' ability to deliver care where needed by their community members. In 2023, legislation was passed that allowed Federally Qualified Healthcare Centers that are also UIOs to elect from among three reimbursement options, one of which is a rate equivalent to the all-inclusive rate payment established by the Indian Health Service.[208] This legislation also allowed an IHS facility or a Tribal health center operating under a 638 contract or compact to elect to enroll in medical assistance as a Tribal FQHC and then requires DHS to establish an alternative payment method for a facility or center that makes this election that is equivalent to the method and rate for those that do not make such an election.

What does Data tell us about the access to health care of American Indians on Medicaid in MN?

To understand how American Indian Medicaid members access care we looked at data from DHS' recent MA enrollee survey, sought guidance during our initial community member meetings on data to evaluate regarding member access, received direction on that data form our Co-creators and Data Guidance Panel, and engaged directly with members and American Indian community members at our Community Conversations.

MA Enrollee Survey: Navigating Care

The MA Enrollee Survey found that about one third of American Indian MA members said they have difficulty navigating important MA processes such as finding a health care provider, and figuring out which health care services are covered. This is similar to the rates among other MA members. In contrast, transportation to health care appointments was a challenge for many more American Indian members than for other members (24% vs 12%). We also found differences between American Indian

groups. One such difference is between those who live in the seven-county Twin Cities metro area and those who live in other Minnesota counties (referred to as Greater Minnesota). American Indians who live in Greater Minnesota tended to report less difficulty navigating MA benefits than did those in the metro area, though the differences were not always statistically significant.

Table 14 illustrates that finding a provider was difficult for about one in three MA members overall as well as for those who are American Indian. Figuring out if MA will pay for health care services they need was also difficult for nearly one-third of all MA members as well as for American Indians. Figuring out their copay was a difficult task for 17% of non-American Indian members but only 13% of American Indian members. As noted earlier, as of January 1st MA members no longer have co-pays, though when the survey was conducted in 2022 that wasn't consistently the case. Of note, American Indian MA members were not subject to copays[209] so it is concerning that 13% of AI MA members were still unsure of their co-pay. This is evident of the need for better communication between DHS and its AI members in general and about how the program is uniquely tailored for them.

Table 14. Access to information on benefits and costs

Percentage of MA members who indicated that they have a hard time with each aspect of MA	American Indian members			Non-American Indian members	
	Statewide	Metro	Greater	Statewide	
I had a hard time finding a health care provider who will accept MA.	36%	39%	34%	31%	
I had a hard time figuring out if MA will pay for the health care I need.	29%	29%	30%	31%	
I had a hard time finding a health care provider who schedules appointments when I am available.	18%	24%	13%	17%	
I had a hard time figuring out how much my co-pay will be.	13%	18%	9%	17%	
I had a hard time getting to the doctor's office or clinic because I do not have access to a car or public transportation (e.g., bus, train).	24%	31%	18%	12%	***
I needed a free ride to the doctor's office or clinic, but I did not know how to schedule it.	23%	28%	18%	12%	***

Note: Statistical significance of P ≤ 0.001 is denoted with ***

Transportation in getting to health care appointments is a much bigger barrier for American Indian members than it is for others. 24% had a hard time getting to a provider because they lack a car or public transportation (compared with 12% of non-Native members). 23% needed a free ride to their provider but didn't know how to schedule it (compared with 12% of non-Native members).

Twice as many American Indians in the metro had difficulty with transportation than those in Greater Minnesota. This was notable, given that MA members in the Twin Cities metro should theoretically have less difficulty with transportation given the shorter distances to health care providers and that public

transit is available in many areas. However, this finding is at least in part aligned with findings from a 2021 CMS report to Congress on the Medicaid Non-Emergency Transportation (NEMT) benefit utilization. CMS reported that nationally between 2018-2020, Medicaid members residing in the USDA's Frontier and Remote (FAR) area codes had higher NEMT utilization than the national average and that, utilizing the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics (NCHS) urban-rural classification scheme, those residing in metropolitan statistical areas were less likely to use NEMT than those in micropolitan and non-core areas.[210]

MA Enrollee Survey: Telehealth

Telehealth can be a valuable alternative to in-person care, especially for people who have transportation barriers. As shown in Table 15, American Indians and other MA members had similar levels of interest in using either audio or video telehealth.

Table 15. Interest in using telehealth in the future.

Are you interested in using health are by phone or video in the future? Select the type you would like to use in the future (check one).	American Indian members			Non-American Indian members
	Statewide	Metro	Greater	Statewide
Phone call only	14%	13%	15%	17%
Video call only	7%	4%	9%	10%
Either video or phone	49%	46%	52%	46%
Neither video nor phone	30%	37%	25%	28%

Note: Differences between groups were not statistically significant.

A big difference in this chart is that while 37% of American Indians in the metro area said that they don't want to use either type of telehealth, only 25% of those in Greater Minnesota said this.

A further analysis of the relationship between transportation and telehealth found that these resources don't seem to be substitutes, but instead seem to go together. Seventy percent of those in the metro area without transportation difficulties said they're interested in using telehealth. In contrast, only 47% of those *with* transportation difficulties were interested in using video or phone telehealth. We found the same relationship in Greater Minnesota (57% of those with transportation barriers and 73% without transportation barriers are interested in using telehealth).

We find a different dynamic among American Indians who had at least one telehealth visit in the past 12 months. This group had a more positive perception of telehealth than members of other racial/ethnic groups on many telehealth topics, as reported by Wilder Research[211]. For example, when asked if they would have felt more comfortable sharing their thoughts and feelings via *telehealth*,

- 22% of all American Indians reported this was true (compared to only 10% of all MA enrollees)

- 27% of all American Indians who received behavioral health services said this was true (compared with 11-20% of each other racial/ethnic group).

In addition, American Indian members were more likely to say that whether health care is in person or via telehealth won't impact how much say they have in decisions that affect their health care, or how confident they feel that they can manage their health and treatment.

One of the major benefits that telehealth is touted for, is that it allows people to get care they wouldn't otherwise have been able to get. Almost all American Indians (90%) who had experienced behavioral health care via telehealth said that telehealth has allowed them to get care they wouldn't otherwise have received. For American Indians using telehealth, they seem to value this form of care and feel that it has allowed them to get care when they would have otherwise gone without. However, many other American Indians are not interested in telehealth, including those who have transportation barriers.

Almost all American Indians (90%) who had experienced behavioral health care via telehealth said that telehealth has allowed them to get care they wouldn't otherwise have received.

MA Enrollee Survey: Digital Access

Searching for information on the internet is an important resource today, though not everyone has access to it. As seen in Table 16, seventy percent of American Indian members said they have internet access at home. About half (54%) had a desktop or laptop computer, a significantly lower rate than for non-American Indians (65%). This is important because using a smartphone can make it more difficult to read materials online, especially if our websites are designed for full-size computer screens.

Given that most American Indian members have home internet access, it is probably not surprising that when we asked how they want to search for information on their MA benefits on their own, most (62%) said they want to search via a website. This was true of MA members in general too. Using an app was also of interest to over half (55%) of American Indian members. Using a paper booklet to find information was of interest to American Indian members more than to non-American Indian (35% vs. 29%), but it was especially of interest to American Indian members in the metro area (39%).

Sometimes members can't find the information they're looking for on their own. We therefore asked them how they want to get help with finding information. Like most MA members (78%), a large majority of American Indian members (72%) said they want to talk with someone over the phone to get help. This was quite a bit higher for American Indians in the metro area (80%) than Greater Minnesota (65%). Similarly, but not statistically significant, American Indians in the metro had a higher rate of wanting to use a video call like Zoom (25%) than those in Greater Minnesota. In contrast, though again not statistically significant, more members in Greater Minnesota (29%) wanted to talk with someone in-person in their office than did those in the metro (18%).

Again, seventy percent of American Indian MA members have access to the internet, and 85% have access to at least one device that could be used to access the internet. Most want to use the internet when they're looking for information on their own. However, we need to remember the members who

don't have access to the internet and to these devices, and make sure they have access to the information they need.

Table 16. Preferences for communicating and accessing help

	American Indian members			Non-American Indian members	
Which of these do you currently have at home? (CHECK ALL THAT APPLY)	**Statewide**	**Metro**	**Greater MN**	**Statewide**	
Has internet access at home	70%	71%	69%	76%	
A desktop or laptop computer	54%	50%	58%	65%	*
A smartphone or tablet	77%	74%	79%	81%	
Any of these: desktop or laptop computer, smartphone or tablet	85%	86%	85%	90%	
If you need to search for this kind of information on your own, how would you like to find it? (CHECK ALL THAT APPLY)					
Use a website	62%	64%	60%	73%	*
Use an app on your phone or tablet	55%	58%	51%	47%	
Use a paper booklet that lists services and providers covered in your area	35%	39%	32%	29%	
If you can't find the information on your own and you need help, how would you like to receive help? (CHECK ALL THAT APPLY)					
Use an online chat box	41%	42%	40%	43%	
Write an email	29%	31%	27%	34%	
Talk with someone over the phone	72%	80%	65%	78%	*
Talk with someone through a video call like Zoom	21%	25%	18%	16%	
Talk with someone in-person at their office	24%	18%	29%	24%	

*p<0.05

This is a difficult challenge for DHS. It requires ensuring an adequate network of providers. MHCP networks often lack specialty providers such as dental and mental health. It also requires that DHS make sure members know which providers they can go to. This requires that DHS makes this information readily available to members. Currently, DHS and MCOs do this thru their websites as well as by calling their respective member helpdesks.

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

Guidance from our report Co-creators and initial meetings with Tribal staff and community leaders as well as our Community Conversations drew reflections on DHS' Restricted Recipient program, access to culturally specific care and geographic access to care.

Restricted Recipient Program

Several participants shared concerns about Medicaid Restricted Recipient programs and the potential for disproportionate impacts on American Indian members. The Patient Review and Restriction programs (PRRs), also known as 'Lock-in' programs, enable state Medicaid programs to control a Medicaid enrollee's overuse, and possible abuse, of physician services and prescription drugs without having to terminate Medicaid benefits by allowing states to restrict enrollees suspected of over-utilization to a single designated provider, pharmacy, or both.[212] At least 46 states and Medicaid agencies operate a PRR program.[213] Federal regulations[214] and CMS[215] have encouraged states to implement the PRR program to address fraud and waste prevention efforts and the opioid epidemic.

There is strong evidence that PRR programs reduce costs for Medicaid programs throughout the United States.[98] Other benefits have included a decrease in the use of narcotic medications, multiple pharmacies and physicians, and emergency department visits,[216] without an impact on access to maintenance medication for chronic diseases among restricted patients or mortality rates.[217]

However, other research has also found unintended consequences as a result of the PRR programs including a significant increase in out-of-pocket refills and enrollees dropping out of Medicaid.[218] Per state statute,[219] Minnesota DHS has implemented a Restricted Recipient Program (MRRP)[220] however DHS has not examined its impact on members to determine if there is a disparate impact related to a member's identified race or any other demographic factor. Nationally, PPR outcomes associated with race and ethnicity have not been clearly examined in the literature reviewed and would benefit from further analysis.

Access to Culturally specific Care

> *"What comes to mind is accessibility of cultural health and wellbeing services, going into a clinic where people look like you, because you know that the experience is going to be different. I know that when I go into a clinic and I have a [white] provider who doesn't reflect my culture, my body goes into like a trauma response. I am in the Twin Cities though, and I feel like we have access to some of those resources." – Virtual Community Conversation participant*

Access to holistic care and allowing for the integration of Western and traditional medicines was a common priority. This was viewed in a number of ways from having access to health insurance, quality medical care, and healthcare resources like mental and behavioral healthcare, preventative care, dental, maternal and child healthcare support (including doulas, midwives and home birth or water birth) to what could be more broadly defined as drivers of health – community safety, spiritual and holistic practices. Barriers were commonly noted to include a lack of Indigenous healthcare professionals and providers along with the necessary support for training, hiring and retention.

Geographic Access to Care

> *"Transportation is a challenge when seeking healthcare. Access to affordable transportation services or telehealth options would help overcome this obstacle. I*

haven't used audio-only telehealth services, but I see its potential for remote areas. Prioritizing telehealth accessibility and culturally competent care through Medicaid would greatly benefit our community." Virtual Community Conversation participant

The geographies which Tribal Nations and American Indian communities are spread across was frequently raised as a contributing barrier to community members having consistent access to care. Guidance from initial meetings with Tribal staff, our report Co-creators, and community leaders led us to look at what were the top 10 clinics and hospitals in the years 2019 and 2022 for the following broad categories of service claims for MHCP members who identify as Native American: Primary Care, Inpatient and Outpatient Behavioral and Mental Health, Dental Care, Emergency Care, General Inpatient Care and Inpatient Maternal Care (birthing hospitals). Data Guidance Group members identified Primary Care, Dental Care and Outpatient Behavioral and Mental Health settings as areas of initial priority to examine. This data is shared below in the following tables and examines providers based on number of unique enrollees and unique claims. From it we can see some patterns emerge. Among the top 10 providers of Dental Care to American Indian MHCP members in 2019 only two (the 9th and 10th) were outside of the 7-county Twin Cities Metro. This was the same in 2022. A recent DHS examination of Urbanicity among American Indians on MA found that in 2024, 52% of American Indian MA enrollees lived outside an Urban Area and 48% lived in an Urban area (defined as living in either the 7-county Twin Cities Metro, Duluth, Bemidji or Brainerd). When that is taken into consideration, out of the top 10 providers of Dental Care to AI MHCP members, 9 were located in Urban Areas, highlighting a significant gap in Dental Access for Non-Urban AI MHCP members.

Table 17. Top 10 clinics used by MHCP enrollees who identify as Native American/American Indian: Dental care

2019		2022	
COMMUNITY DENTAL CARE-MAPLEWOOD	Maplewood	COMMUNITY DENTAL CARE-MAPLEWOOD	Maplewood
DENTAL DELIVERY SYSTEMS PA	Savage	CHILDRENS DENTAL SERVICES INC	Minneapolis
CHILDRENS DENTAL SERVICES INC	Minneapolis	DENTAL DELIVERY SYSTEMS PA	Savage
DENTAL ASSOCIATES OF ST PAUL PA	St Paul	DENTAL ASSOCIATES OF ST PAUL PA	St Paul
COMMUNITY DENTAL CARE INC	St Paul	AL-SHIFA DENTISTRY	Maple Grove
UNIV OF MN SCHOOL OF DENTISTRY	Minneapolis	UNIV OF MN SCHOOL OF DENTISTRY	Minneapolis
AL-SHIFA DENTISTRY	Maple Grove	COMMUNITY DENTAL CARE INC	St Paul
APPLE TREE DENTAL	Coon Rapids	SOUTHERN HEIGHTS DENTAL GROUP	Faribault**
NORTHLAND SMILES	Deerwood**	APPLE TREE DENTAL	Mounds View

NORTHERN DENTAL ACCESS CENTER	Bemidji*	NORTHERN DENTAL ACCESS CENTER	Bemidji*

*** = Non-urban, outside of the Twin Cities metro. * = Urban, outside the Twin Cities metro*

Table 18. Top 10 clinics used by MHCP enrollees who identify as Native American/American Indian: Behavioral and Mental Health care

2019		2022	
WHITE EARTH MENTAL HEALTH PROGRAM	White Earth**	NYSTROM & ASSOCIATES LTD	Eden Prairie
SANFORD BEMIDJI MAIN CLINIC	Bemidji*	WHITE EARTH MENTAL HEALTH PROGRAM	White Earth**
FOND DU LAC HUMAN SERVICES DIVISION	Cloquet**	FOND DU LAC HUMAN SERVICES DIVISION	Cloquet**
ESSENTIA HEALTH DULUTH CLINIC	Duluth*	LAKELAND MENTAL HEALTH CENTER	Fergus Falls**
UMMC FAIRVIEW PHYSICIANS	Minneapolis	LINQ CARE INC	Minneapolis
INDIAN HEALTH BOARD OF MINNEAPOLIS	Minneapolis	ASSOCIATED CLINIC OF PSYCHOLOGY	Minneapolis
EMERGENCY PHYSICIANS PA	Bloomington	HUMAN DEVELOPMENT CENTER INC	Duluth*
ASSOCIATED CLINIC OF PSYCHOLOGY	Minneapolis	INDIAN HEALTH BOARD OF MINNEAPOLIS	Minneapolis
SANFORD HEALTH BEHAVIORAL HEALTH	Bemidji*	EMERGENCY PHYSICIANS PA	Bloomington
WHITE EARTH SUBSTANCE ABUSE PROGRAM	Ogema**	WHITE EARTH SUBSTANCE ABUSE PROGRAM	Ogema**

*** = Non-urban, outside of the Twin Cities metro. * = Urban, outside the Twin Cities metro*

The top 10 outpatient Behavioral and Mental Health providers was a little more balanced with 7 of the 10 found in Urban Areas in 2019 and 6 in 2022.

Table 19. Top 10 clinics used by MHCP enrollees who identify as Native American/American Indian: Primary care

2019		2022	
SANFORD BEMIDJI MAIN CLINIC	Bemidji*	SANFORD BEMIDJI 1611 ANNE ST CLINIC	Bemidji*
SANFORD BROADWAY CLINIC	Fargo**	SANFORD BEMIDJI MAIN CLINIC	Bemidji*
SANFORD I-94 CLINIC	Fargo**	SANFORD BEMIDJI MAIN CLINIC	Bemidji*
SANFORD BEMIDJI 1611 ANNE ST CLINIC	Bemidji*	SANFORD I-94 CLINIC	Fargo**
ESSENTIA HEALTH DULUTH CLINIC	Duluth*	SANFORD BROADWAY CLINIC	Fargo**
SANFORD HEALTH MAHNOMEN CLINIC	Mahnomen**	SANFORD HEALTH MAHNOMEN CLINIC	Mahnomen**
HEALTHPARTNERS BLOOMINGTON	Bloomington	ESSENTIA HEALTH FOSSTON CLINIC	Fosston**
ESSENTIA HEALTH FOSSTON CLINIC	Fosston**	SANFORD SOUTH UNIVERSITY	Fargo**
ESSENTIA HEALTH DEER RIVER CLINIC	Deer River**	FAIRVIEW CLINICS-BLOOMINGTON OXBORO	Bloomington
SANFORD SOUTH UNIVERSITY	Fargo**	MANKATO CLINIC LTD	Mankato**

*** = Non-urban, outside of the Twin Cities metro. * = Urban, outside the Twin Cities metro*

The top 10 Primary care providers most accurately reflected the Urbanicity analysis with 4 of the 10 providers found in Urban areas in both 2019 and 2022.

Accessing the Access lever

> *"Access issues appear to vary by Tribal/cultural affiliation, and careful consideration of geography, history, and types of culturally tailored/grounded/informed services by location are needed to unpack what the data really mean and how to design and implement improved strategies going forward" – Data Guidance Panel member*

A policy, benefit or service is only impactful if people can access it. This is amplified even further by policies and benefits aimed at addressing health disparities due to structural inequity and racism. In examining the impact and potential of the access "lever" within Medicaid to address health equity for American Indian communities we note both broad and specific, successes and struggles. Pending federal decisions like the CMS' four walls policy and Medicaid telehealth guidance could either bolster or undermine commitments to health equity for American Indian communities. Other state Medicaid agencies have explored and implemented innovative approaches to workforce development, managed

care and benefit administration to support improved access for their American Indian members. And as American Indian Medicaid members in Minnesota have shared repeatedly, addressing access means improving affordability and availability of both transportation to care, and care that is culturally specific and responsive. Minnesota DHS is utilizing the access lever to improve racial equity both broadly through federal advocacy in partnership with Tribal nations, participation in federal pilot programs like the Money Follows the Person - Tribal Initiative, resourcing teams focused on American Indian member access to perinatal, substance use and mental health care and disability services and implementing policies like eliminating or reducing cost-sharing and bolstering the NEMT benefits. Conversations with Co-creators and Data Guidance Group members about DHS' data on where the most common providers of primary care, mental health and dental care were located in relation to where American Indian MHCP members live identified an ongoing need to support workforce development and retention in rural areas of the state. DHS can also better evaluate the impact on access of policies like the Restricted Recipient Program that may appear neutral as written but given known implicit and explicit biases among health care systems and providers, exacerbate inequities in access to the care American Indian members deserve. The Call to Action to Invest in Traditional Healing would provide DHS a framework to expand access to culturally specific services for American Indian members and continue learning how access more broadly can be improved to address long standing health disparities.

Medicaid Lever: Quality

By enforcing federal regulations and implementing standards, CMS uses a number of methods to require state Medicaid agencies meet or improve the quality of care received by members. Requirements like reporting on a comprehensive quality strategy or explicit standardized measures like those maintained by HEDIS (Healthcare Effectiveness Data and Information Set) or the Core Set of Adult and Child Health Care Quality Measures allow some comparisons across states and communities on the quality of care received by Medicaid members.

Managed Care Organizations (MCOs) can play a significant role in helping state Medicaid agencies improve the quality of healthcare for their members. Ideally, they provide coordinated, integrated care management, work with primary care providers, specialists and other health and social services to prevent gaps in care and improve health outcomes across communities. In 2024, CMS issued two final rules that looked to enhance quality, strengthen transparency and accountability, improve access to care and bolster Medicaid member engagement across MCO and fee-for-service (FFS) systems.[221,222]

Collaboration with Tribal Health Organizations and Indian Health Services (IHS) is vital in delivering culturally appropriate care and improving access to essential services. The CMS Health Equity Index rewards exceptional care delivery to underserved populations, including AI/AN communities, and emphasizes standardized data collection to promote health equity. Additionally, CMS incorporates a Health Equity Index reward to incentivize exceptional care delivery to underserved populations, including AI/AN communities, and emphasizes data collection and standardization to enhance health equity. [223]

Better data collection and research, particularly involving AI/AN populations, can help address the disparities in quality of care through culturally relevant strategies.[224] As sovereign Nations, Tribes should

have control over what data is collected from their people, and who has access to that data.[225] Within that it is also important to note the ethnic, cultural, and linguistic differences between Tribal Nations and that American Indians' access to quality health care often largely depends on where they live.[226] American Indians are often left out of the conversation and undercounted in data due to aggregated data, which can hide inequitable health impacts. [227] It is critical to continue improving the ability of Medicaid systems to disaggregate racial and ethnic data to ensure that American Indian people's experiences are represented so that policies based on more accurate data can be prioritized.[228] This gap in data can lead to underfunding and lack of accountability for equitable coverage. Standardizing the disaggregation of race, ethnicity, Tribal affiliation, and language data can promote equitable driven decision making and increase accountability for equitable health outcomes.

> DHS is in the process of establishing an American Indian Food Sovereignty Funding Program to improve access and equity to food security programs within Tribal and American Indian communities. The program will assist Tribal Nations and American Indian communities in achieving self-determination and improve collaboration and partnership building between American Indian communities and the state.

National opportunities/examples from other states

Medicaid has undertaken several efforts to address health disparities among American Indian and Alaska Native (AI/AN) populations through various quality metrics, reporting mechanisms, and improvement projects. States have employed quality metrics across several domains, including chronic disease management, preventive care, maternal and child health, and behavioral health. Regular reporting on these metrics can be crucial for monitoring and enhancing AI/AN health outcomes.[229]

States implement targeted improvement projects supported by federal and state grants, focusing on chronic diseases, mental health, substance abuse, and maternal and child health. Innovative state programs exemplify strategies to enhance care through innovative payment models and incentivized quality reporting.[230] CMS has also utilized 1115(a) Demonstration waivers to allow states to implement experimental, pilot, or demonstration projects that promote the objectives of Medicaid by offering flexibility to test innovative approaches in care delivery, coverage, or payment models. These waivers have given states the ability to tailor their Medicaid programs to meet specific needs, including those identified by Tribal Nations and American Indian communities.

State Medicaid example: California

California's Medi-Cal program has developed initiatives to improve health outcomes for AI/AN populations through the Quality Improvement Project (QIP), focusing on preventive care, chronic disease management, and patient satisfaction. California Department of Health Care Services (DHCS) collaborates with tribal health organizations to establish culturally appropriate care models and enhance data collection methods.[231] The Medi-Cal Managed Care Quality Improvement Strategy includes

performance metrics specific to AI/AN health, emphasizing community engagement and culturally relevant interventions.[232]

State Medicaid example: Arizona

The Arizona Medicaid agency, through the Arizona Health Care Cost Containment System (AHCCCS), has addressed health disparities among American Indian populations by focusing on chronic disease management, maternal and child health, and behavioral health. Key initiatives have included the American Indian Medical Home (AIMH) program and health information exchange (HIE) incentives, aimed at improving care coordination and health equity.[233] AHCCCS collaborates with tribal consultants and health organizations on projects such as the Tribal Care Coordination Program and maintains transparency through annual reports and health equity dashboards.

1115 Waivers

Recognizing the importance of culturally appropriate, high quality care for American Indian members, four states (Arizona, California, New Mexico, and Oregon) petitioned CMS for flexibility to provide culturally appropriate Traditional Healing services through their Medicaid programs using a process known as a "Section 1115(a) demonstration waiver."[234] These waivers seek permission to expand Medicaid reimbursement to include Traditional Healing services at IHS facilities, Tribal clinics and Urban Indian Organizations (UIOs).[235] After some initial partial approvals and several years of waiting, CMS fully approved the four states' waivers to provide coverage for Traditional Healing services on October 16, 2024.[236] All four waiver approvals allow for coverage of traditional health care practices received by eligible beneficiaries through facilities operated by IHS and Tribes, and three out of the four (CA, NM, and OR) approved coverage for services received through facilities operated by UIOs as well. For Arizona, it appears that UIO services are covered only if the UIO is providing the services through a contract with an IHS or Tribal facility. Below is a high level, preliminary summary of key information about each state's waiver request and approval:

- In 2016, **Arizona** submitted an 1115(a) Medicaid waiver to CMS requesting approval to reimburse Traditional Healing services provided IHS or Tribal facilities.[237] In 2022, CMS approved most of Arizona's waiver request but did not approve the Traditional Healing services portion. CMS noted in a October 14, 2022 letter that it "recognizes the state's goals of addressing disparities in the American Indian and Alaska Native community and will continue to work with the state" on the request for coverage of Traditional Healing services.[238] Arizona's waiver application defined "traditional healing" as a "system of culturally appropriate healing methods developed and practiced by generations of Tribal healers who apply methods for physical, mental and emotional healing. The array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity." [239] Arizona's demonstration waiver also defines 1) covered Traditional Healing services, 2) qualified Traditional Healing providers, and 3) qualifying entities. In October 2024, CMS approved the Traditional Healing services portions of Arizona's waiver, for services received through an IHS or Tribal facility (including services received from urban Indian organizations contracted with an IHS or Tribal facility), effective through September 30, 2027.[240].

- Since 2019, **New Mexico**'s 1115(a) demonstration waiver has provided an annual $2,000 member-managed budget for specialized therapies, including Native American healers, to enrollees who need nursing-facility level of care and who receive home and community-based services (HCBS).[241] Tribal members who need nursing-facility level of care are mandatorily enrolled in a health plan.[242] Tribal members who are ineligible for HCBS and who are enrolled in a health plan may have access to the $2,000 annual sum for Traditional Healing as a "value-added service," subject to the health plan. In 2020, New Mexico submitted a request to renew its 1115(a) waiver that seeks approval for an additional $500 annual self-directed budget for Traditional Healing services for Tribal members enrolled in managed care who do not need nursing-facility level of care.[243] On October 16, 2024, CMS approved New Mexico's 1115(a) waiver amending New Mexico Turquoise Care to allow for coverage of traditional health care practices received through facilities operated by IHS, Tribes, or urban Indian organizations.[244] This approval is effective through December 31, 2029.
    - New Mexico's 2022 expanded proposal includes "prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel . . ."[245]
    - The proposal notes that "[s]ome Tribes, Nations, and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious, historical ties, and privacy."[246] This highlights the importance of protecting Tribal Nations' privacy and sacred practices as sovereign nations.
- In 2021, **California** submitted an 1115(a) waiver to cover substance-use disorder services provided by traditional healers affiliated with Indian Health Care Providers. The coverage would be provided through the state's county-based substance use disorder managed-care delivery system.[247] On October 16, 2024, CMS approved California's 1115(a) demonstration waiver request to amend the California Advancing and Innovating Medi-Cal to cover traditional health care services that are received through IHS, a Tribal facility, or an urban Indian organization facility.[248] This approval is effective through December 31, 2026.
- In 2022, **Oregon** submitted an 1115(a) waiver renewal requesting reimbursement for "Tribal-based practices[.]"[249] It also requested the ability to cover health-related social need services for Tribal members who are not enrolled in a coordinated care organization.[250] On September 28, 2022, CMS approved other requests but did not approve the reimbursement for Tribal-based practices (among other things).[251] On October 16, 2024, CMS approved Oregon's waiver, allowing the state to amend the Oregon Health Plan and provide coverage for traditional health care practices delivered by or through facilities operated by IHS, Tribes, and urban Indian organizations.[252] This approval is effective through September 30th, 2027.
    - The waiver renewal request includes this language: "A medical assistance program shall consider Tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaskan

Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those Tribal-based practices."[253]

- The Oregon Health Authority includes several examples of Tribal-based practices, including sweat lodges, talking circles, and horse programs.[254]

In addition to the above waiver requests, Tribal health centers in **Utah** have suggested that Utah should take a similar approach and seek an 1115(a) waiver to allow Traditional Healing services to be billed under the state's Medicaid program.[255]

The recent waiver approvals show promising development. They expressly acknowledge that "[t]raditional health care practices vary widely by Tribe, facility, and geographic area."[256] They also recognize the need for and importance of providing flexibility for Tribes and Tribal-serving entities to define who qualifies to provide traditional health care practices, and what types of services or practices are eligible for coverage.

Previous and Current MN Medicaid efforts

MN DHS has explored various approaches to addressing health care quality in general[257] and for American Indian MHCP members. As noted earlier, several administrations in MN DHS have dedicated staff and funding to work on better integration of Medicaid resources with other state and federal resources in the areas of behavioral health, substance use disorder, housing, and elder and disability services. Within administration of health care services, several examples of focusing on improving quality care for American Indians can be found in DHS contracts with MCOs and through the Integrated Health Partnerships.

Managed Care contracting

MN DHS has utilized its MCO contracting process to prioritize improvements in the care received by American Indian communities since its 2022 MCO procurement cycle. In the request for proposal DHS asked applicants to, "*Describe how your organization solicits and/or receives enrollee feedback regarding enrollee satisfaction, communications, service delivery, provider networks, and health plan operations… Describe efforts to use this feedback to assess how structural racism impacts enrollees' experiences and to improve health outcomes for the MHCP population."* More specifically, applicants were asked to, "*Describe steps your organization has taken and/or will commit to taking to reduce implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care. How are these actions monitored? How will these actions be sustained and/or adjusted in the future? How will these actions improve health outcomes and address disparities in health outcomes for Black and Indigenous people during and after pregnancy?*" This expectation that MCO partners engage in addressing explicit racial health disparities in care has been followed by implementation of financial withholds tied to decreasing racial disparities and support for use of In-Lieu of Services (ILOS).

MN DHS' intent in utilizing financial withholds in MCP contracts is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of

essential health care services. The measures are tied to decreasing racial disparities and DHS can withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets based on improvement over previous annual performance rates. For contract year 2023 DHS assessed each measure's overall rate for 2023 against the MCO's baseline rate from Contract Year 2021 and calculated the MCO's overall rate and healthcare disparity gaps for each measure for both achievement and improvement (MCOs can receive partial points for partial improvement). A disparity gap was defined as a lower rate for communities of color (i.e., non-Hispanic White rate is larger than rates for other race populations). It was measured as a performance rate difference between the reference population (non-Hispanic White) and each of the following race and ethnicity groups: non-Hispanic White and Black/African American, non-Hispanic White and Native American/Alaskan Native, non-Hispanic White and Asian/Pacific Islander, non-Hispanic White and Hispanic. For a given measure, if there is a race/ethnicity disparity gap for any of the subgroups in the Reporting Period, then the MCO was eligible to earn Improvement Points if it achieved improvement in the healthcare disparity to reduce the gap between the reference population (e.g., non-Hispanic White) and the population of color (without affecting the drop in the rate for the White population, compared to the baseline rate). A list of measures subject to this quality withhold can be found in Table 20 below. Full details about the technical aspects of the MCO quality withhold can be found online.[258] MN DHS is working with MCO partners on how best to share the results of the disparity gap contract withhold efforts thus far.

Table 20. List of Withhold Measures (Performance and Compliance) and related details

Measure	Age Group	Points Allocated	Type of MCO Contract
***Childhood Immunization Status (CIS) – (i) Combo 10**	2 years	16	Family & Children (F&C)
***Well Child Visits in First 30 Months of Life (W30) – (i) W15; (ii) W30**		16 (8+8)	F&C
***Child & Adolescent Well-Visits (WCV)**	All (3 to 21 years)	16	F&C
Prenatal and Postpartum Care (PPC) – (i) Postpartum Care; (ii) Timeliness of care	All Child-bearing age	16 (8+8)	F&C
***Initiation & Engagement of Alcohol, Opioids, & Other Drug Dependence Treatment (IET) – (i) Total Engagement; (ii) Total Initiation**	All (13-65+)	16 (8+8)	F&C
***Follow-up After Hospitalization for Mental Illness (FUH) – (i) 7 day; (ii) 30 day**	All (6-65+)	16 (8+8)	F&C
***Emergency Department Utilization Rate (EDV)**	All (0-64)	1	F&C
***Hospital Admission Rate (ADM)**	All (1-64)	1	F&C
***30 Day Readmission Percentage (RDM)**	All (1-64)	1	F&C
***Annual Dental Visit (ADV)**	18 to 64; 65+ years	15	Special Needs Basic Care (SNBC) & Seniors
***Initial Senior Health Risk Screening or Assessment (SHRA) – [DHS Developed]**	64+ years	30	Seniors
Service Accessibility / Care Plan Audit	Not applicable	15	SNBC & Seniors
Stakeholders Group Reporting	Not applicable	15	SNBC & Seniors
No Repeat Deficiencies on the MDH QA/TCA Examination	Not applicable	1 point for F&C; 15 points for SNBC & Seniors	All 3 contracts

In lieu of services or settings (ILOS) authority allows state Medicaid agencies, through their MCO contracts, to pay for alternative services without the need for waiver approval when it is medically appropriate and cost-effective. The ILOS policy was established with the revision of the CMS Managed

Care Regulations on April 25, 2016. This provided a path forward for innovative financing for services intended to improve the quality of care in a more member-specific way including addressing identified barriers and opportunities related to social drivers of health (SDOH). Generally, ILOS can only be covered if: (1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service; (2) Members are not required to use the in lieu of services, and (3) the in lieu of services are authorized and identified in the managed care plan contracts. As noted earlier, in 2024 MN DHS approved an ILOS for members in Indigenous communities served by Blue Plus to access culturally and linguistically competent health care services through a $500/member/year benefit for members who pursue tribal, indigenous healing services for holistic and culturally appropriate care received at an in-network provider contracted for those services. All contracted MCOs did elect to pursue an ILOS in 2024 and while no others explicitly focused on American Indian communities, most did focus on health conditions that disproportionately impact American Indian members like diabetes, nutrition insecurity and access to perinatal services.

Beginning in 2013, MN DHS developed Integrated Health Partnerships (IHP), Minnesota Medicaid's version of an Accountable Care Organization.[259] Our current Integrated Health Partnership model allows DHS to contract with innovative health care delivery systems with the goal of providing high-quality, efficient care. Integrated Health Partnership participants receive a population-based payment for care coordination and are required to design a specific intervention that addresses health care disparities in their population. This equity intervention is an opportunity for IHPs to innovate and advance efforts such as community partnerships, screening, referral, care coordination for social needs, and other strategies to meet their target population needs. IHPs focus on different social risk factors and use a variety of methods. Similar to the ILOS selected by MCOS, in 2023 there were not any equity interventions that IHPs explicitly focused on American Indian members however most did select conditions that disproportionately impact American Indian members like housing insecurity, transportation barriers, involvement in carceral settings, substance use disorder, food insecurity and addressing other social drivers of health.[260]

The Federally Qualified Health Center Urban Health Network (FUHN) is a 501(c)3 nonprofit of 11 federally qualified health clinics (FQHC), predominantly based in the Twin Cities and Mankato metro areas. In 2012, 10 founding clinics, including the Indian Health Board of Minneapolis (IHB, a UIO) and the Native American Community Clinic (NACC), formed an Integrated Health Partnership (IHP). IHPs are Minnesota Medicaid's Accountable Care Organization (ACO) model where DHS contracts with provider organizations (IHPs) to provide primary care and other covered services to MHCP members. The IHP program incorporates a value-based payment model that takes into account the cost and quality of the health care services provided. Through the initial IHP cycle, the participating FUHN clinics achieved more than $26 million in savings for the state. These clinics continue to enhance health care quality outcomes, and in 2024 IHB and NACC received the following Health Resources & Services Administration (HRSA) awards Community Health Quality Recognition (CHQR) badges:
Access Enhancer (NACC), Health Disparities Reducer (NACC), Addressing Social Risk Factors to Health (IHB) and Advancing Health Information Technology (IHB).

Source: https://www.fuhn.org/

What does Data tell us about the quality of health care and patient experience of American Indians on Medicaid in MN?

To understand more about the quality of health care received by American Indian Medicaid members in MN DHS looked at data from Minnesota Community Measurement reporting, sought guidance during our initial community member meetings, received direction on from our Co-creators and Data Guidance Panel and engaged directly with members and AI community members at our Community Conversations.

Minnesota Community Measurement Health Care Disparities By Insurance Type reporting

Obtaining healthcare coverage provides opportunities to assess quality of care and access to resources. DHS contracts with Minnesota Community Measurement (MNCM) to measure health care quality by type of health insurance, examining rates for members enrolled in Managed Care Organizations (MCO), and uses this to inform the agency's health care purchasing strategies. As DHS noted in the 2022 BREW report, "it has been noted for more than a decade that enrollees in Medicaid managed care have significantly lower rates in common health care quality measures across the board compared to other payers."[1] The most recent report looked at results for service provided in 2022. Notably, when compared to commercial and other purchasers across years 2018-2022, gaps widened for all 3

Table 21. Summary of Minnesota Health Care Disparities by Insurance Type, 2022

QUALITY MEASURE	2022 MHCP MCO Statewide Rate	2022 Other Purchasers Statewide Rate	2022 Rate Difference (MHCP – Other Purchasers)	Rate Difference Over Time^ (MHCP – Other Purchasers
PREVENTATIVE HEALTH MEASURES				
Breast Cancer Screening	57.4% (N=59,404)	78.4% (N=286,078)	-21.0%*	Gap widened* (2018-2022)
Childhood Immunization Status (Combo 10)	34.9% (N=3,634)	61.7% (N=2,887)	-26.7%*	Gap widened* (2018-2022)
Colorectal Cancer Screening **	52.7% (N=143,247)	70.0% (N=1,250,516)	-17.3%*	Gap widened* (2018-2022)
CHRONIC CONDITIONS MEASURES				
Controlling High Blood Pressure	66.1% (N=11,514)	70.5% (N=8,258)	-4.4%*	Gap widened* (2020-2022)+
Optimal Diabetes Care	34.9% (N=46,869)	46.9% (N=241,729)	-12.0%*	Gap stable (2018-2022)
Optimal Vascular Care	43.3% (N=17,642)	57.6% (N=142,830)	-14.3%*	Gap stable (2018-2022)
Optimal Asthma Control – Adults	42.8% (N=33,974)	54.0% (N=94,177)	-11.2%*	Gap narrowed* (2018-2022)
Optimal Asthma Control - Children	48.9% (N=17,968)	56.6% (N=34,711)	-7.7%*	Gap narrowed* (2018-2022)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	91.3% (N=37,830)	93.1% (N=104,822)	-1.8%*	Gap narrowed* (2018-2022)
Adolescent Depression: Remission at Six Months	5.8% (N=4,503)	7.4% (N=10,255)	-1.5%*	Gap stable (2019-2022)^^
Adult Depression: Remission at Six Months	7.5% (N=24,685)	10.8% (N=75,340)	-3.4%*	Gap stable (2019-2022)^^

*Statistically significant difference (p<0.05) ^Based on last five years (2018-2022)
^^First year of current measure specifications available
**The eligible age range for the Colorectal Cancer Screening measures was expanded from 50-75 to 45-75 in 2022 to reflect updated USPSTF recommendations and to align with NCQA measure.

Table 22. Summary of Minnesota Health Care Program MCO statewide rates by race/ethnicity, 2022

MEASURE	2022 MHCP MCO Statewide Average	Asian	Black	Indigenous/ Native	Multi-Race	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
PREVENTIVE HEALTH MEASURES									
Breast Cancer Screening	57.4%	●	▼	▼	●	●	▲	▲	●
Childhood Immunization Status (Combo 10)	34.9%	NR	▼	●	●	NR	●	▲	●
Colorectal Cancer Screening	52.7%	▲	▼	▼	▼	▼	▲	▼	●
CHRONIC CONDITIONS MEASURES									
Controlling High Blood Pressure	66.1%	▼	▼	●	●	NR	▲	●	●
Optimal Diabetes Care	34.9%	▲	▼	▼	▼	●	●	●	●
Optimal Vascular Care	43.3%	▲	▼	●	●	●	●	▲	●
Optimal Asthma Control - Adults	42.8%	▲	▼	▼	●	●	▲	●	●
Optimal Asthma Control - Children	48.9%	▲	●	▼	●	●	●	●	●
MENTAL HEALTH MEASURES									
Adolescent Mental Health and/or Depression Screening	91.3%	▲	▼	●	●	●	▲	●	●
Adolescent Depression: Remission at Six Months	5.8%	●	●	●	●	NR	●	●	●
Adult Depression: Remission at Six Months	7.5%	●	●	●	●	●	●	●	●

▲ Significant above statewide MHCP MCO statewide average
● Average
▼ Significantly below statewide MHCP MCO statewide average
NR = Not reportable; did not meet the minimum number of patients needed for statistically reliable results

preventative health measures available for comparison while having a mix of widening, narrowing or staying stable for the 5 chronic condition and 3 mental health measures (Table 22). Since 2018, MNCM has also reported quality measures for MHCP members enrolled in MCOs by Race/Ethnicity. Since that time it has been noted that among Medicaid enrollees, Indigenous/Native members consistently experience even lower rates on a majority of measures than all other groups of enrollees except those that identify as Black (Table Q2). In 2022 rates for enrollees identified as Indigenous/Native were below the MHCP statewide averages on six out of the 21 measures examined - Breast and Colorectal Cancer Screening, Optimal Diabetes Care, Optimal Asthma Control among adults and children and Follow-up for Depression at 6 months in Adolescents (although, notably, Depression Remission at 6 months was not below statewide average). There were no measures where Indigenous/Native members experienced significantly higher rates. Recent iterations of the report have provided

some additional granularity, for instance looking at the subcomponents of Optimal Diabetes and Vascular Care. For Indigenous/Native members it is notable that among the subcomponents for both they had lower rates of being Tobacco free, for example. As noted earlier, tobacco use can be interpreted and reportedly differently based on cultural contexts so that data will need further refinement in future years.

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

> *"Metrics typically used by Medicaid to determine quality are important to assess for Native Americans in MN for population comparisons, though additional considerations for Native Americans may be needed as coordination/alignment with cultural preferences, other providers (e.g., traditional, IHS) may be a factor in defining quality for Native individuals" – Data Guidance Panel member*

The intersection of cultural practices and having resources to access care in the first place were among the most common reflections shared when asked about "quality care." Quality was often referred to when discussing barriers to health and wellness like transportation challenges for those who must travel to obtain needed care, childcare and the need to take time off work in order to seek care, the importance of accessible "emergency response care" and experiences of fractured care and treatment systems requiring "stronger health advocates" and ways around "having to visit and travel to multiple places of care." When reflecting on what quality of care means to them, participants of the in-person Community Conversations shared the following, emphasizing the need for culturally appropriate, comprehensive care and meaningful choices:

- Health insurance coverage that doesn't lapse.
- Whole person care.
- Good doctors, clinics, hospitals.
- Being able to go to preferred providers.
- Doctors who don't discriminate [against] you.
- Indigenous advocates and navigators in hospitals, department of corrections. Native relatives in these roles.
- Advocacy around medical terminology and interacting with medical providers.
- Understanding all options including traditional medicines; holistic treatment practices.
- Human Services: Give admin. time for traditional practices.

Similarly, participants pointed to the effects of generational and historic trauma, emphasizing the need to move past stigma in pursuit of quality care and the impact trusted providers have on one's experience of care. A lack of trusted providers was frequently referenced as a barrier to accessing and experiencing quality care.

These reflections intersect with other key themes and the levers which Medicaid has to address health and racial equity such as the structural and administrative complexities of navigating Medicaid and the medical system, the desire for more and better trained patient care advocates and cultural care

advisors, challenges arising from disparities in the geographic distribution of healthcare resources (related to the urban-rural divide), and the centrality of mental, emotional, and spiritual health to wellbeing as a whole.

"Quality" data as it currently exists therefore is not well suited to capture what participants, Co-creators, Tribal staff and Data Guidance Panel members consistently lifted up as indicators of a health care provider or system's quality. From a lens of the quality of data we currently have available and utilize to identify strengths, gaps and opportunities along race and geography, our Data Guidance Panel provided DHS staff guidance on several considerations and opportunities to pursue and pitfalls to avoid (Table 23)

Table 23. Data Guidance Panel Health Equity Data Considerations

Health Equity Data Consideration	Opportunity/Pitfall
Disaggregation by Tribal Affiliation	Opportunity: Facilitate member connection to Tribal supports. Identify programs that are working on a population level. Can give or supplement insights when surveys have low response. Allocate resources equitably (ex. Tribal Nation compared to County). Pitfall: How identified (self-identified vs. Tribal identified) can be difficult to determine. Impact reliability of data. Issues of Tribal Sovereignty.
Claims Data: Evaluate data on claims made vs. paid	Opportunity: Where is care being delivered but not paid? What are the disparities in this? How does that contribute to access and quality metrics?
Mapping data	Opportunity: Look at relationship to Tribal geography, where American Indians live, and where they receive Medicaid services. Look at rates of currently measured services by county, compare rates for AI members and non-AI members in counties. Share with counties and providers to prioritize resources. Consider paying providers more/differently in areas that face greater gaps for American Indians.

Activating the Quality lever

In DHS' journey of centering communities who experience health disparities due to historical and current structural racism, one consistent reflection has been that quality of care and culture are bound in ways our current system is not equipped to measure. This is a significant hurdle all health care systems face in aiming to eliminate health disparities and move beyond the "Triple Aim" of improving population health, enhancing the care experience, and reducing costs; to the "Quintuple Aim" that has added addressing the wellbeing of the workforce and advancing health equity.[261]

To fully activate the "Quality lever" in Medicaid and advance racial health equity will require bolstering our current system and redefining "quality" moving forward. Improving the data Medicaid collects on

race/ethnicity and geography through disaggregation and partnership with Tribal Nations and American Indian communities while respecting Tribal Data Sovereignty is vital. MN DHS' conversations with Co-creators and community members around quality health care led to this report's **Call to Action: Reframe What Defines Health and Wellbeing and the Evidence Used to Make Decisions**, where we note creating a definition of health, wellbeing, and quality, that more fully captures what American Indian communities value, and using that to determine what their owed portion of health care funding pays for, is essential. Once this is accomplished, other tools like Managed Care Contracting and In-Lieu of Services, 1115 Demonstration waivers, Quality measurement and reporting can better align to elevate the priorities of Tribes and American Indian communities, pay providers and health systems who provide high quality care appropriately and foster a trust not yet experienced between our health care system, Sovereign Tribal Nations and Urban American Indian communities.

Medicaid Lever: Early opportunities

As noted in MN DHS' 2022 report on Building Racial Equity into the Walls of MN Medicaid, "*The environment and level of support children are raised in during their first five years is critical to reaching their full potential. Early experiences shape brain development in a way that impacts not only education and school readiness, but lifelong health."*[1] Medicaid plays a crucial role in the health coverage of low-income pregnant individuals and young children in the U.S., covering approximately 45% of all births and providing essential services, particularly for women of color, including AI/AN populations.[262] The U.S. maternal health crisis disproportionately impacts Black, Hispanic, and AI/AN women, with these groups experiencing higher rates of maternal mortality and morbidity.[263] American Indian and Alaska Native (AI/AN) children also face significant health disparities, including higher rates of developmental challenges due to prenatal alcohol and substance exposure. These challenges are exacerbated by systemic issues such as high poverty rates, limited access to healthcare, and underfunded services resulting in AI/AN populations experiencing elevated rates of infant mortality, Sudden Infant Death Syndrome (SIDS), Neonatal Abstinence Syndrome (NAS), and higher prevalence of mental illness and substance use disorders.[264] Medicaid is also crucial in addressing the healthcare needs of American Indian and Alaska Native (AI/AN) children and families within the child welfare system. Medicaid coverage of family and youth peer support in 33 states bridges trust, cultural, and language gaps, enhancing engagement and providing cost-effective mental health support.[265] These programs diversify the behavioral health workforce, increasing accessibility for disadvantaged communities. Moreover, effective collaboration between healthcare providers and child welfare services is essential for addressing challenges that disproportionately affect children's well-being. Biased clinical evaluations often harm racial and ethnic minority families, affecting reporting and response outcomes.[266]

In response to these challenges, states have increasingly leveraged Medicaid policies and programs to improve health outcomes for AI/AN communities from prenatal stages through early childhood by focusing on expanding insurance coverage, enhancing prenatal care, and providing culturally responsive services. Strategies to mitigate perinatal racial health disparities have included expanding access to doula services, increasing midwifery care, and adopting group prenatal care models. These approaches have been shown to improve maternal health outcomes, enhance patient education, and provide peer support, demonstrating the potential of Medicaid to foster more equitable health outcomes.[144]

National opportunities/examples from other states

There has been increased attention and action to what state Medicaid agencies are doing to address maternal health and how CMS can support them.[267] Efforts to extend Medicaid postpartum coverage to 12 months have rapidly expanded since a provision in the American Rescue Plan Act of 2021 gave states a new option to extend this to members via a state plan amendment. As of August 2024, forty-six states and the District of Columbia have implemented such coverage.[268] Increasing coverage for mothers and birthing persons, both perinatally through postpartum extensions as well as increasing coverage of persons of child-bearing age preconception through expansion of Medicaid through the Affordable Care Act, provides an opportunity to address racial health disparities from the start.[269] Ensuring access through Medicaid to services like group prenatal care, doula care, birth center and midwifery care, substance use disorder treatment and addressing mental health and the social drivers of health during pregnancy have all been put forth as important elements to addressing the maternal health crisis. The CMS Innovation Center announced the Transforming Maternal Health (TMaH) model in December of 2023 and will announce the state Medicaid agencies selected for participation in January 2025.[270] The model aims to support innovative approaches to improving maternal health care services for pregnant and postpartum mothers and their newborns, reduce disparities in access and treatment and reduce overall program expenditures, by supporting a multimodal approach that incorporates many of the noted policies and clinical care approaches into a value-based purchasing arrangement.

A recent National Academies report, Launching Lifelong Health by Improving Health Care for Children, Youth, and Families, noted several policies that should be pursued to take advantage of Medicaid's early opportunity, namely universal, automatic enrollment for newborns in Medicaid or CHIP unless otherwise covered; ensuring continuous eligibility for uninsured children up to age 26; requiring multiyear continuous eligibility for children form 0-6 years old; and modernizing and strengthening the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.[271]

Maryland's Healthy Babies initiative seeks to broaden Medicaid benefits to include comprehensive pregnancy and postpartum coverage irrespective of U.S. citizenship status.[272] Relatedly, Medicaid-funded Comprehensive Screening and Connection Programs have been used to assess social determinants of health impacting long-term child and family well-being. These programs have shown potential to in reducing some racial disparities in maternal and child health outcomes. A randomized control trial (RCT) of Family Connects, a nurse home visiting program tailored to a family's specific needs and level of risk that is active in 16 states, found reductions in maternal anxiety and depression as well as emergency room care for children between Black and White families[273] and a previous RCT demonstrated decreased emergency care for infants with Medicaid coverage.[274] HealthySteps is another program that integrates a child developmental specialist into pediatric primary care and provides different tiers of support to families based on needs identified during comprehensive screenings. It is active in 23 states and has shown evidence of improved well-child visit rates, early screening and referral rates, timely vaccination and maternal mental health screening and referral.[275,276,277] Emerging evidence points to families on Medicaid and those from Black and Hispanic communities seeing fewer disparities in receipt of screenings and intervention.[278] However there remains a paucity of data on these models as they apply specifically to AI/AN communities, regardless of health insurance status.

Tribal Nations and American Indian communities have worked to tailor Medicaid policies to improve health outcomes for AI/AN children, particularly from prenatal to age three. The Parent-Child Assistance Program (PCAP), a case management-based home visiting model from the University of Washington, has been adapted by the Lake Country Tribal Health Consortium (LCTHC) in Northern California to addresses

substance use and maternal depression through enhanced health insurance coverage, well-child visits, and safety planning, leading to improved health outcomes and family support.[279] California's American Indian Maternal Support Services (AIMSS) program offers perinatal case management and home visitation services for AI/AN families.[280] The state's approach also includes extensive reforms under CalAIM, focusing on children's mental health and integrating these services into Medicaid.[281] The Family Spirit Program is an evidence-based home visiting model that was designed, implemented and has been evaluated by the Johns Hopkins Center for American Indian Health in partnership with Navajo, White Mountain Apache and San Carlos Apache tribal communities since 1995. Over 100 Tribal communities and 26 states have adopted this model which has demonstrated evidence of the effectiveness of paraprofessionals as home visitors to impact behavioral and mental health disparities in American Indian communities. [282]

Previous and Current MN Medicaid efforts

Minnesota has long been a leader in health care system transformation, and MN DHS' priorities for maternal health policy have consistently focused on reducing health and racial disparities. Minnesota was the second state to offer a doula benefit through Medicaid program, starting in 2014. In 2023 legislation, notably brought forth by a community collective of Black and Indigenous birth workers, was passed and signed into law that made it easier for doulas to enroll in MHCPs and provided significant increases in payment rates to Doulas to help improve access to doulas for Minnesotans on MHCPs.

In 2015, Minnesota passed legislation to improve birth outcomes for high-risk pregnant people on MHCPs by addressing two of the largest risks to healthy births – opioid use and low birthweight. The Integrated Care for High-Risk Pregnancies (ICHRP) legislation contains specific recommendations about identifying priority populations in geographic areas where adverse birth outcomes are highest. The driving force behind ICHRP has been a goal to fund community-led initiatives to disrupt patterns of care that are believed to contribute to Minnesota's disproportionately high rates of maternal and infant mortality and other adverse health outcomes for Minnesota Medicaid-eligible African Americans and American Indians. Through engagement with African American and American Indian community members and providers serving these communities, three central themes have emerged: (1) African American and American Indian communities desired perinatal and postpartum care that reflected their culture and their community's specific strengths and needs; (2) African American and American Indian communities wanted access to perinatal and postpartum care in alternative settings such as free-standing birth centers, and they wanted support from doulas and/or community health workers reflective of their communities and familiar with their lived experience; and (3) African American and American Indian community members desire integrated care that includes help identifying gaps in care, areas of risk or need, and assistance in applying for and engaging in available care or community supports. Out of these learnings, Minnesota DHS worked with community members and the MN legislature to pass additional ICHRP statutes and secure state grant dollars to pursue these goals. To date, Minnesota DHS has contracted with mixed success with several different "qualified integrated

perinatal care collaboratives" in the Twin Cities metro area, rural areas in the northern part of the state and Tribal reservation lands.

The Tribal Integrated Care for High Risk Pregnancies (ICHRP) program, a collaboration between DHS and five Tribal Nations - Fond du Lac Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Mille Lacs Band of Ojibwe, White Earth Band of Chippewa, and Red Lake Band of Chippewa Indians - offered valuable lessons that can inform future initiatives aimed at improving maternal health in American Indian communities. The community-led, culturally grounded care models helped to reduce stigma and increase engagement among pregnant women navigating a substance use disorder (SUD). Tribes demonstrated the value of incorporating peers with lived experience, such as recovery coaches, into care teams to build trust, encourage treatment participation, and provide support throughout pregnancy and recovery. Critical to success was the need for improved collaboration between Tribal programs and county child protective services (CPS). While some counties were perceived as supportive, others presented barriers to collaboration, highlighting the need for system-level engagement and policies that foster trust and cooperation. Additionally, the fear of child removal due to substance use was a significant barrier that prevented many pregnant women from seeking care early in their pregnancies. Tribes addressed this by ensuring non-judgmental, culturally sensitive services that focus on family preservation and reducing harm. Tribal communities also found success in embedding cultural elements into daily interactions and recovery activities, which helped women reconnect with their traditions and provided a sense of belonging and support. This culturally responsive approach, combined with the support of peer coaches and strong partnerships within and outside of tribal agencies, helped reduce stigma and encouraged women to engage in long-term recovery and parenting. Finally, workforce challenges—such as hiring and retaining paraprofessionals like community health workers and peer recovery coaches—emphasized the need for sustainable funding and training support to maintain these essential services.

In 2021 the Dignity in Pregnancy and Childbirth Act was passed and signed into law to address inequities in maternal health care. This legislation includes a requirement for all hospitals with obstetric care and/or hospitals with birth centers to develop or access a continuing education curriculum and must make available a continuing education course on anti-racism training and implicit bias. Also in 2021, the Minnesota Legislature created new releasing authority for the Department of Corrections related to pregnant and recently post-partum individuals called the Healthy Start Act. The Commissioner of Corrections now has the authority to conditionally release an incarcerated person from prison to the community, to engage in work, vocational training, substance abuse or mental health treatment, education, or parenting education, while completing their sentence, if they are either Pregnant or within eight months post-delivery. This Healthy Start conditional release ("Healthy Start release") may last the duration of the pregnancy and up to one year of the newborn child's life. Notably, between 2013 and 2020, 34% of pregnant women sentenced to serve time in Minnesota prisons identified as Native American.[283]

A 2018 MN DHS report examined some of the intersections between early childhood systems, American Indian communities, and Medicaid in Minnesota, finding challenges in accessing Medicaid services, particularly in rural communities, due to limited provider networks and complexities of navigating the system. It also noted the importance of Medicaid funding in supporting partnerships between Tribes, counties and community partners in

enhancing care that meets the needs of American Indian communities.[284] The Minnesota Department of Health's (MDH) 2022 Family Home Visiting Report[285] highlighted the Family Spirit Community of Practice, established in 2020, which utilized the Family Spirit model to adapt a traditional Continuous Quality Improvement process with elements from a Community of Practice approach that acknowledged and elevated the importance of traditional practices, shared learning, and peer connections. Seventeen agencies (Tribal Nations, nonprofit organizations, and community health agencies) participated in in the CoP with model expertise and training provided by the Johns Hopkins Center for American Indian Health. As the MDH report noted, in Minnesota local home visiting programs, employee public health nurses can seek third party reimbursement for eligible home visiting services using Medical Assistance for participants enrolled in Medicaid.

MN DHS also applied for the CMS Transforming Maternal Health (TMaH) model in September 2024, proposing to implement TMaH through a regional approach that included the cities of Saint Paul, Minneapolis, Duluth, and Bemidji (where the majority of American Indian births covered by Medicaid occur in Minnesota). MN DHS' model proposes to transform maternal health care through (1) Improving access to community-centered, culturally responsive care through midwifery, doula and community health worker services; (2) Incentivizing the growth of culturally aligned midwifery-led services in the model test areas; (3) Expanding partnerships and equitable impact through collaboration between federally qualified health centers, free standing birth centers, clinics, independent providers, Tribes, hospitals and health systems in the model test areas; (4) Supporting data-informed, patient experience-guided care; (5) Creating sustainability through a value-based payment model where outcomes, metrics and "value" will be grounded in equity and patient experience.

What does Data tell us about the health and experience of birthing American Indians and young children on Medicaid in MN?

Approaches to ensuring racial and health equity must begin with an analysis of the current realities of American Indian families and communities. MHCPs serve 40% of all birthing persons in Minnesota and 9 out of 10 American Indian birthing persons. According to the most recent Minnesota Department of Health (MDH) Maternal Mortality Report, from 2017-2019 American Indians represented 1.7% of the total births in the state and 12% of pregnancy associated deaths. The majority of these deaths were noted to be preventable.

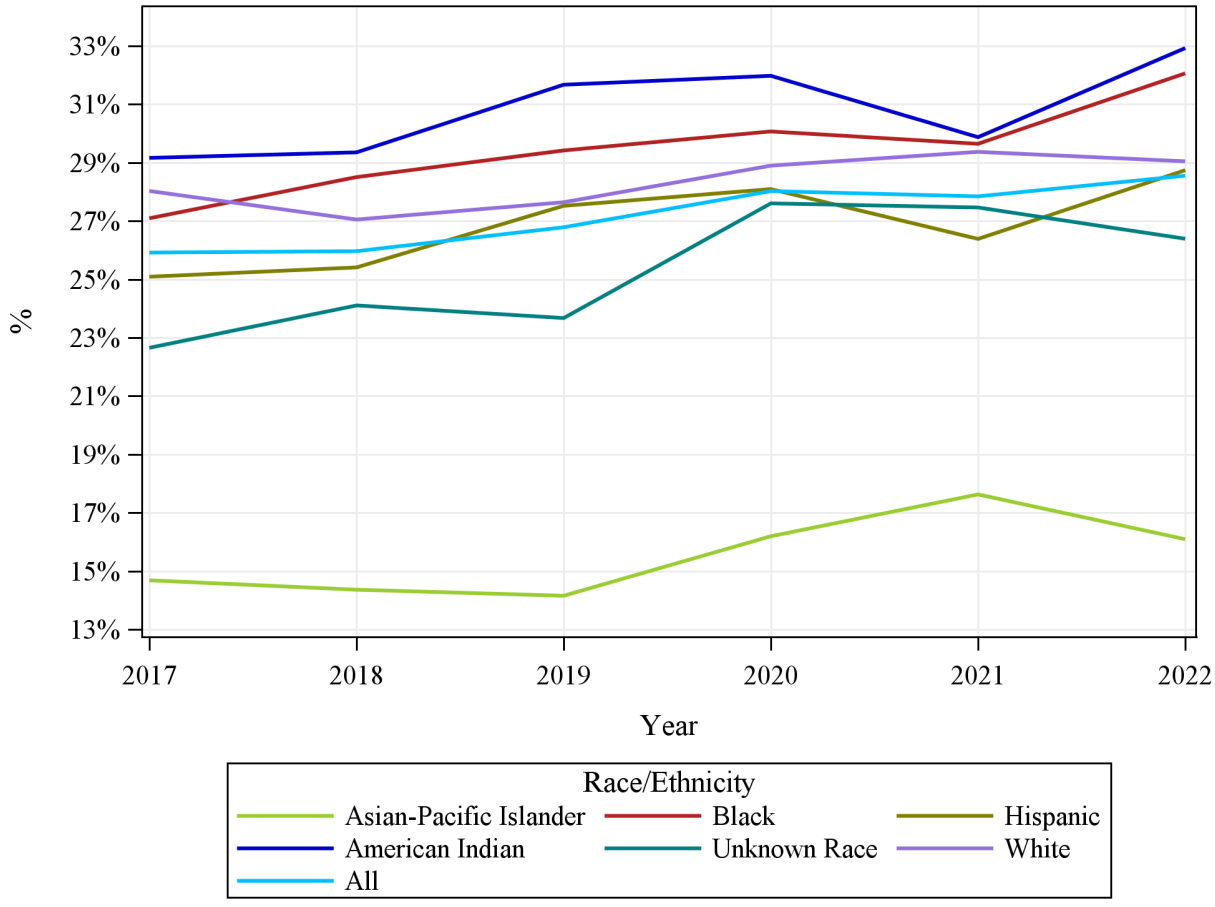
Data from 2019 indicates of all children living in poverty (11.2%), American Indian child poverty rate is much greater at 37.1%.[286] American Indian children are 18.5 times more likely to be placed in out of home care.[286] As noted earlier according to a 2024 SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, in Minnesota 64.5% of American Indian/Alaskan Native children are covered by Medicaid.

To understand more about the experience of American Indian MHCP members who are or have been pregnant and/or caregivers of young children MN DHS looked at data from the legislatively mandated 2024 DHS Maternal and Infant Health Report, sought guidance during our initial Tribal staff and Urban Community leader meetings, received direction on from our Co-creators and Data Guidance Panel and engaged directly with members and AI community members at our Community Conversations.

Maternal and Infant Health Report

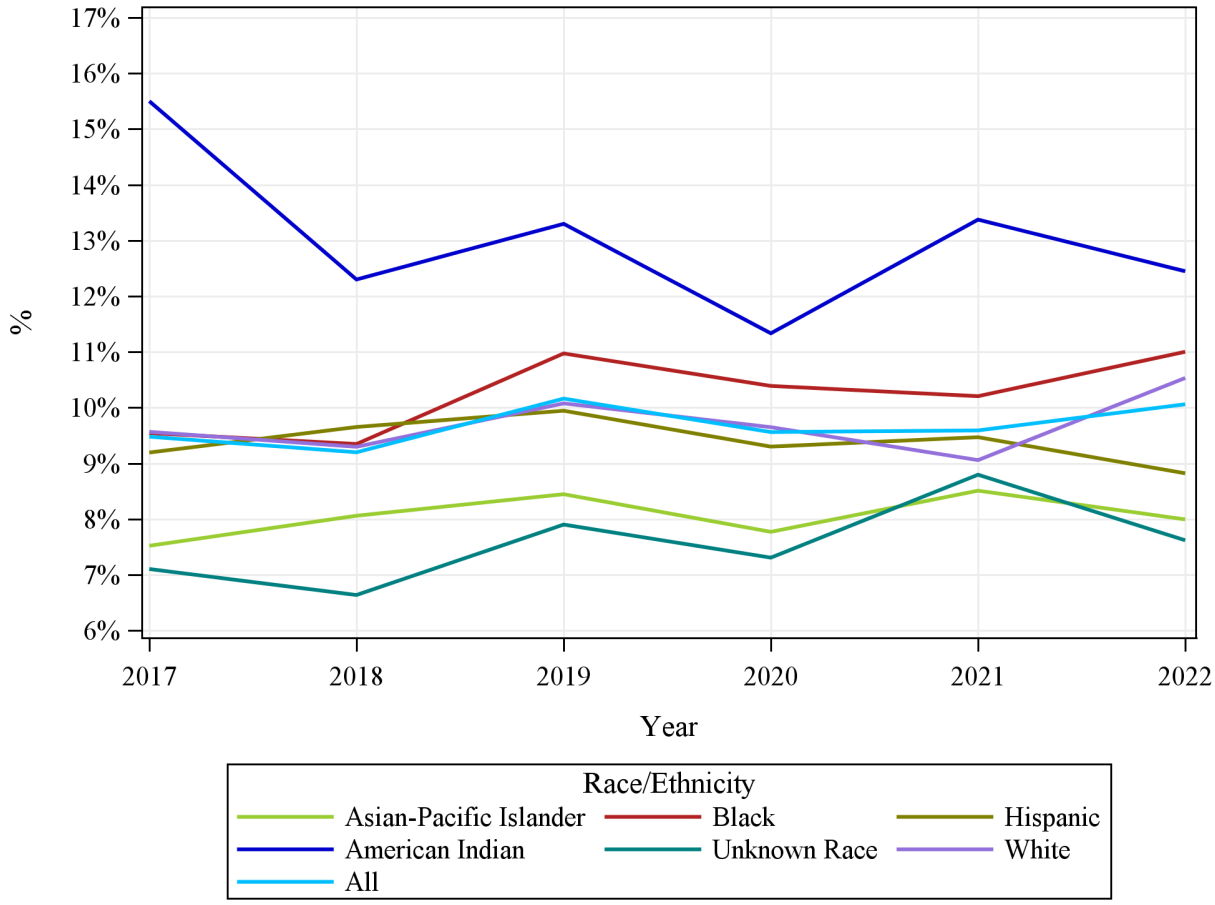
This report was created to provide information to the legislature on the receipt of services and health outcomes for pregnant and post-partum women enrolled in the Medical Assistance program. Reporting is aggregated by race-ethnicity. The first Maternal and Infant Health Report was released in 2022, and DHS has been directed to provide biennial updates in subsequent years. In the 2024 report American Indian women had the highest rate of cesarean sections (average rate of 31% between 2017 and 2022), infants born prematurely or with a low birth weight (average rate of 16% between 2017 and 2022), and infants who spent time in the NICU (average rate of 34% between 2017 and 2022), across all years and race and ethnicity groups.

Figure 18. Percent of women who delivered a live newborn via cesarean section by race and ethnicity



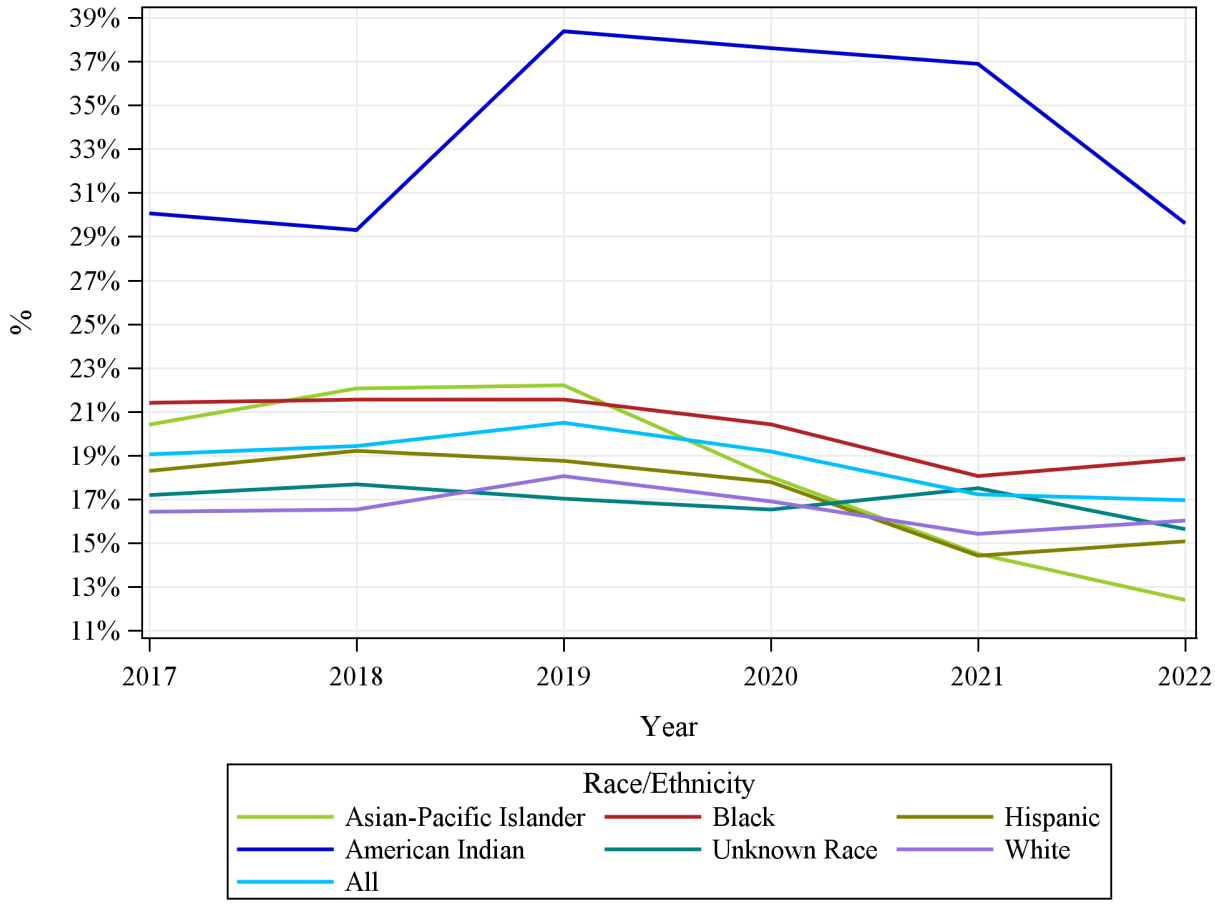
On average, the rate of newborns delivered via cesarean section has slowly increased from 26% in 2017 to 29% in 2022. Across all years, American Indians had the highest rate of cesarean sections, peaking in 2022 at 33%.

Figure 19. Percent of newborns born prematurely by race and ethnicity



Overall, across all years, about 10% of newborns were born prematurely. American Indian women consistently have the highest rate of newborns born prematurely; with a rate of over 15% in 2017. In 2018, this rate decreased substantially to 12% but that rate remained greater than the average rate for all women (10%) and increased to 13% in 2019 and 2021. In 2022, the rate of newborns born prematurely to American Indians is 12%, which is 20% smaller than the rate reported for year 2017.

Figure 20. Newborns cared for in the Neonatal Intensive Care Unit (NICU) by race/ethnicity



Overall, regardless of race/ethnicity, the percent of women who gave birth to a child who spent time in the NICU remained relatively constant at about 19% in 2017 and 2018. In 2019, the rate increased to 20%. After 2019, the overall rate of newborns who spent time in the NICU began to drop with a rate of 19% in 2020 and 17% in 2022. American Indians had rates that were between 58% (2017) -114% (2021) higher than the overall average rate across all years.

As the report noted, "*There is no one single race or ethnic group that fairs worse or better on all items. Differences in disparity exist across each of the reported metrics but one cannot always say which group always fairs best or worst. However, in general terms, the American Indian population seems to regularly appear towards the lowest range of the performance spectrum on most indicators… Factors such as environmental toxins, stable housing, food insecurity, comorbid medical conditions, disease severity, geographic variance in access to health care, provider enrollment rules, and socio-economic differences in the population of public health programs beneficiaries can be difficult, if not impossible to discern in these data alone.*"

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

"I had to apply when I was pregnant. It was hard to navigate and explain." – Bemidji Community Conversation participant

The relational context in the perinatal period of life, and the intergenerational nature of health and healing, captures the essence of many of the reflections shared with DHS in conversations with Co-creators and community members. Family and community connections as a form of health praxis were evident throughout experiences shared about supporting pregnant people, children and Elders as care givers and holders of knowledge.

While there were largely positive views of perinatal coverage among those with Medicaid experience that participated in this process, there was also a notable gap in understanding of what options were available, notably doula and midwifery care. This was reflected in one Data Guidance member noting that DHS could, "Effectively communicate eligibility for pregnant persons in high Native population counties as well as opportunities for sustained coverage in first years of child's life." There was also an expressed desire for more expanded options through Medicaid like in-home delivery support and support for Indigenous birthing practices and settings. One Co-creator noted the partnership that has been formed by the Native American Community Clinic (NACC) and the Twin Cities Birth Justice Collective, a group of Black and Indigenous birth workers who have collectively advocated for policy changes and investments that support culturally-specific and appropriate care including increasing doula rates and exploring the establishment of an Indigenous Birth Center in the Twin Cities.

Participants in initial conversations with Tribal staff and Urban American Indian community leaders repeatedly brought forth examples of the challenges faced by families navigating supports and services for young children with complex care needs. One example provided noted difficulty in getting proper and timely reimbursement for children diagnosed with depression NOS (not otherwise specified) who have experienced trauma but aren't at the level that meets Post Traumatic Stress Disorder (PTSD) diagnostic criteria, contributing to a delay in services. Another noted that the system of early childhood services and early intervention remains fragmented even for members who have received the necessary evaluations and documentation. This leaves the question of how members who have less resources and capacity to navigate the system ever get care? Particularly for families seeking out a diagnosis and assistance for a child with Autism Spectrum Disorder (ASD) or other developmental diagnoses like Fetal Alcohol Spectrum Disorder (FASD). One Urban Indian Organization has tried to make direct connections to behavioral health home service providers in their area in order to get children seen sooner for evaluations and avoid delays in diagnosis and receipt of services. Similarly, other leaders reflected on the need for clinicians to receive more training to provide early childhood mental health services and adult mental health services in a co-located model as often times the parent/caregiver doesn't have the capacity to get care for themselves even if identified.

Lastly, concerns about supports for mothers and birthing persons navigating substance use disorder and the intersection with the child welfare system were regularly brought forth by participants in initial conversations. A common scenario was shared over multiple conversations of the health care system not felt to be safe for Tribal and American Indian community members leading to less care being

provided for families. As one participant noted, “Then they don’t seek care until there’s an emergency, then the blame gets put on the parents/families and ICWA [sic – Indian Child Welfare Act] gets involved when really it was the system of care that started the cycle.” Another noted, “A lot of racism in the systems. They are acting like they are ‘saving’ our children, but no, we can do that. We can protect and save our children.” In addition to engaging in broader education and awareness about these concerns with providers, participants recommended DHS examine the number of referrals by clinical site (hospital or clinic) of American Indian children on MHCPs to Minnesota’s Child Protection Services agency and then analyze the health outcomes of American Indian children at sites with disproportionately high referral rates to determine if there is a correlation and share this data with community members to co-create possible solutions.

> *Then they don’t seek care until there’s an emergency, then the blame gets put on the parents/families and ICWA [sic – Indian Child Welfare Act] gets involved when really it was the system of care that started the cycle.”*

Seizing the Early Opportunity Lever

There is a significant body of literature that has detailed the positive impacts Medicaid coverage of children and pregnant persons has on long term health, educational and economic outcomes.[287] The Congressional Budget Office (CBO) released a working paper in 2023 where they analyzed the impact of one additional year of Medicaid coverage in childhood. They found that children who gain a year of Medicaid coverage earn an estimated 0.5 percent more annually as adults and that earnings would be largest among the youngest children and those with the lowest incomes.[288] While this analysis did not include a breakdown of impact by race or ethnicity it is notable that, in Minnesota, American Indian community members experience one of the highest uninsured rates and have among the highest rates of reported forgone care.[289] This points to a significant need to continue investing in policies that keep eligible American Indian members connected to Medicaid and address the palpably eroded trust between American Indian community members and our human service and health care systems.

To seize the “Early Opportunity” lever MN DHS must continue to participate in and lead recent national efforts to expand postpartum coverage, extend multiyear continuous eligibility during early childhood, offer culturally specific services during the perinatal period, and continue testing innovative ways to pay for better and more equitable outcomes in pregnancy and early childhood. Despite Minnesota’s leadership and innovation in developing maternal health benefits for Medicaid members it continues to see disparities in outcomes for American Indian mothers and birthing persons, most notably among cesarean section rates and infants born prematurely or with a low birth weight or admitted to the Neonatal Intensive Care Unit. MN DHS’ conversations with Co-creators and community members around early opportunities highlighted that American Indian community members experience with not just the physical health care system, but the mental/behavioral health and child protection systems impact their trust in systems overall and ultimately their ability to get the support needed. The iterative community conversations and examination of published literature make clear that American Indian members deserve better awareness of what benefits are available, say in which perinatal and early childhood efforts should be prioritized, and consistent engagement to rebuild trust so every child in Minnesota has what they need to thrive and reach their full potential. The Call to Action to create a Pathways to

American Indian and Tribal Health Integration team would be a step towards that vision for a more equitable start for our youngest community members.

Medicaid Lever: Intersection with Indian Health Service

Historically arranged and managed as a federal system, Indian Health Services (IHS), the federal health care provider, and health advocate for American Indians, is now primarily managed by Tribal Governments. This health care delivery system is now commonly described as the "I/T/U" system (IHS, Tribal 638 programs, Urban Indian Organizations/UIOs). This has allowed for greater involvement to reduce disparities and increase health outcomes through expansive cultural considerations among American Indians across the country and more so in American Indian communities within states such as Minnesota. Medicaid plays an important role in funding health services for American Indian and Alaska Native people through providing health insurance coverage to American Indian and Alaska Native people and serving as an important source of revenue for the I/T/U facilities and programs.[290]

While many American Indians are eligible to receive services free of charge through IHS, as noted earlier, services are limited to those who are members or descendants of federally recognized Tribes.

Like anyone else, American Indians are also eligible for Medicaid coverage if their income is below the qualifying maximum amount. Access to Medicaid allows for increased access to providers outside of the IHS system, which is needed due to the chronic underfunding of IHS.[291] Nationally, 30% of nonelderly American Indian/Alaska Native people are enrolled in Medicaid and 44% of AI/AN children are enrolled in Medicaid or CHIP.[292]

Through the Social Security Act, Congress authorized CMS to reimburse IHS for health care services provided to Medicaid-enrolled Native Americans at IHS facilities.[293] For Medicaid services provided through an IHS or Tribal 638 facility, the Indian Health Care Improvement Act of 1976 (IHCIA) provides IHS with a 100% Federal Medicaid Assistance Percentage (FMAP, the federal government's share of Medicaid-funded services) reimbursement.[294] This means that all medical services that Medicaid offers, and which are provided at an IHS or Tribal 638 facility should be fully reimbursed by the federal government.

In addition to the 100% FMAP, Medicaid has other specific rules that apply to AI/AN enrollees such as:

- excluding certain types of Indian trust income and property in how modified adjusted gross income (MAGI) is calculated for Native Americans, which is important because MAGI determines eligibility for Medicaid;[295]
- prohibiting states from imposing cost sharing for AI/AN enrollees — which means that states cannot require AI/AN patients to pay copayments, deductibles, coinsurance or similar charges for standard covered services;[296]
- allowing AI/AN patients to enroll or modify their enrollment in standard health plans once a month if they choose.[297]

To qualify for these types of Medicaid provisions, a person must meet the definition of an "Indian," which is defined as a person who 1) is a member of a federally-recognized Indian [T]ribe; 2) resides in an urban center and meets at least one of four demographic criteria; 3) is considered to be an Indian for any purpose by the Secretary of the Interior; or 4) is considered to be an Indian for purposes of eligibility for Indian health care services by the U.S. Department of Health and Human Services.[298]

The IHS and Tribes can bill for services provided to patients enrolled in Medicaid and other types of health insurance. Third-party reimbursement including Medicaid reimbursement is an important source of revenue for IHS and is especially important for Tribal health programs which can rely on third-party reimbursement for 50-60% of total funding.[299] Since Medicaid funds are not subject to congressional appropriation limits and Medicaid claims are processed throughout the year, facilities receive Medicaid funding on an ongoing basis throughout the year for covered services.[300]

The Fond du Lac Band of Lake Superior Chippewa (FDL) have utilized the 638 program to improve the services and access their members have to achieve their health. "When we were able to capture and bill CMS reimbursement, FDL was one of the first Tribes to try and Fond du Lac began to put more investment into human services for the community. Significant growth in staffing and services over the last 20 years (approximately 100 staff to over 400 staffed positions). CMS provides a good reimbursement stream that allows Fond du Lac to invest back into the community services. American Indians living in their area of coverage have seen increased access to services and higher quality because of this expansion over the last 20 years. The ability to provide consistent health access to services, it has opened up opportunities to expand access to SUD and Behavioral Health services. Fond du Lac has been seen as a leader on how to collect for reimbursement and has led other Tribes to seek guidance from FDL to collect reimbursements, expand services, and create new opportunities." – Nathan Sandman, Associate Director of Human Services at Fond du Lac Band of Lake Superior Chippewa

The Indian Self-Determination and Education Assistance Act (ISDEAA) authorized Tribes to assume the management of IHS programs under what is termed a "638 contract." This works like a block grant with a total budget amount, providing Tribes with more flexibility in determining how resources are used to meet community members' needs. Funding is also unique in it can carry over from one fiscal year to the next without additional justification and Tribal 638 programs are eligible for many other federal grants (ex. Health Resources and Services Administration grants under Section 330 of the Public Health Service Act) that IHS programs are not. Revenue collected by 638 programs from commercial or public insurance is also treated as supplemental and does not impact the amount considered in funding agreements.[301]

National opportunities/examples from other states

Medicaid FMAP for UIO services

As noted above, the Indian Healthcare Improvement Act (IHCIA) both added services provided to American Indian and Alaskan Native Medicaid members in IHS and Tribal health care facilities to be covered by Medicaid and set the FMAP at 100% for, "services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian Tribe or tribal organization."[302] This only applies to AI/AN Medicaid beneficiaries however, non-AI/AN beneficiaries who receive services at IHS and Tribal 638 facilities are not eligible for 100% FMAP. The IHCIA also directed the Secretary of Health and Human Services to enter into contracts with Urban Indian Organizations (UIOs) however they were not included in the amendments to the Social Security Act and therefore not eligible for 100% FMAP. This has resulted in some UIOs being excluded from state Medicaid provider networks.[303] The American Rescue Plan Act of 2021 (ARPA) aimed to address the ongoing impact of the COVID-19 pandemic on multiple sectors and with that intent temporarily extended the 100% FMAP to services provided to Medicaid beneficiaries by UIOs and Native Hawaiian Health Care organizations.[304] Notably, there was no distinction made about the Tribal or AI/AN status of the beneficiary, so all Medicaid-covered services delivered to enrolled members at UIOs were eligible for 100% FMAP. A National Council of Urban Indian Health report estimated that, "If all twenty-two states in which UIOs are located participate in 100% FMAP, NCUIH projects that $70,407,559 of UIO Medicaid costs will shift from State governments to the Federal government during the two-year period of the temporary 100% FMAP provision." [305] However, the legislation did not mandate state Medicaid agencies to adjust payment rates to ensure this federal investment made it to UIOs. In their report NCUIH noted that, as of August 2022, none of the six UIOs interviewed had seen a financial benefit from the passage of ARPA and that, "NCUIH estimates that if all twenty-two states in which UIOs are located received 100% FMAP as authorized, the states will have saved $38,912,984 without any financial benefit to UIOs as of August 2022." They also noted that two states, Minnesota and Colorado, elected to directly share financial savings from ARPA's 100% FMAP provision with UIOs. MN also passed legislation in 2023 that authorized grants to the lone UIO in MN, the Indian Health Board of Minneapolis, of $3.750 million in fiscal years 2024 and 2025, to share in the ARPA FMAP savings.[306] Similarly, in CMS' recent approval of Tribal Healing services as part of the 1115 Demonstrations for Arizona, California, New Mexico and Oregon, services received from urban Indian organizations continue to be disadvantaged because they are not eligible for the 100% FMAP, but are only eligible for the state service match rate.

Nuka System of Care

The National Academies 2024 report Launching Lifelong Health highlighted one community-centered approach to a system previously governed by IHS in Alaska, the Southcentral Foundations (SCF) Nuka System of Care. Based in Anchorage, Alaska, the Nuka model evolved from the community's desire for better control over their healthcare, emphasizing physical, emotional, mental, and spiritual wellbeing, consistent with the Indigenous worldview of health as a holistic, interconnected state. As noted by Dr. Doug Eby, this philosophy that health care must be co-created and co-produced by the people it serves, who are referred to as "customer-owners," underscores the idea that community members are not passive recipients of care, but active participants with ownership over their health journey. SCF has

prioritized building long-term, trust-based relationships, which in turn foster better health outcomes. The transformation of behavioral health services has been particularly notable. By integrating behavioral health into primary care, offering group sessions, and providing same-day appointments with specialists, SCF has significantly reduced rates of substance abuse, depression, and trauma symptoms among customer-owners. There have also been dramatic improvements in health outcomes and experiences with SCF reporting from 2000 to 2017, "a 26%, 47%, and 59% drop in deaths due to cancer, heart disease, and cerebrovascular disease, respectively; a 58% drop in infant mortality; a 40% drop in emergency room visits; a 36% drop in hospital admissions; 97% customer-owner satisfaction; and 95% employee satisfaction."[149] SCF has accomplished this by threading together multiple sources of funding. According to SCF's funding white paper, "Just over one third (37%) of SCF's money comes through the IHS. This is possible because of treaty agreements acknowledging that the United States will pay for tribal health care, and because U.S. law allows for tribal organizations to have autonomy and the opportunity to take responsibility for their own programs and services, instead of having them administered by the federal government…Most of the rest of SCF's funding is fee-for-service. Approximately 7-10% of SCF's funding is other money, including SCF's Health Resources and Services Administration (HRSA) grant."[307] Notably, SCF is also a Federally Qualified Health Center (FQHC) and does not collect co-pays or deductibles or members who are Alaskan Native and American Indian ("customer-owners") but does collect them for non-customer-owners. Medicaid is the largest secondary payor for SCF and, because it is a tribal organization, it has a negotiated all-inclusive daily rate payment. Although SCF doesn't participate in formal value-based or alternative payment models their report notes that their fixed amount of funding from IHS functions similarly to at-risk contracting as it is able to keep any savings generated but suffers a loss if it runs over cost. This has generally aligned with their approach which, "focuses on reducing costs by working with customer-owners to improve their overall wellness. SCF's financial approach shows that by pursuing multiple revenue sources and working to reduce costs, health care organizations can achieve financial stability even in challenging times."[178] Other healthcare systems across the country (ex. U.S. Department of Veterans Affairs, Cherokee Indian Hospital Authority) and even internationally (ex. First Nations Health Authority in Canada, National Healthcare Group in Singapore) have learned from and/or adopted elements of the Nuka approach as a blueprint for promoting health equity and improving outcomes on a broader scale.

What does Data tell us about the health and experience of American Indians on Medicaid in MN as it intersects with IHS?

MN DHS and its report Co-creators could not find substantial research on the health outcomes and experiences of American Indians on Medicaid in Minnesota concerning their interactions with Indian Health Service (IHS). This lack of information on how the intersection of the state Medicaid agency and IHS contributes to health outcomes for American Indians in Minnesota was also reflected in how community members had little understanding about the connection. As one Community conversation participant noted,

> *"The process was always very complicated (with Medicaid and [MinnesotaCare]). I used to work for DHS and what I heard from American Indian clients was that they didn't understand how [Medicaid] interacted with Indian Health Services. People*

were confused about where they could use [Medicaid] and didn't understand they had access to insurance even though they were enrolled."

Reflections and Guidance from Co-creators, Data Guidance Panel and Community Conversations

Participants in initial conversations with Tribal staff and Urban American Indian community leaders noted that, although nationally more than 70% of American Indian and Alaska Native community members live in urban or suburban areas, historically only 1% (of the already chronically underfunded) IHS budget is spent on urban Indian health care.[308] One concrete example shared was how this hampers UIOs ability to pay clinicians and staff equitably, leading to reported high rates of turnover and lack of consistent services to patients. Another was an inability to obtain federal funding for infrastructure like buildings and facilities. The financial impact on Tribal clinics and UIOs alike when their Medicaid-eligible patients were not enrolled in MHCPs was also a frequently shared stress. This was driven by Tribal and UIO facilities approach to care for the person in front of them with a Fond du Lac Tribal health staff member noting, "*What's unique about Tribes is that if they can provide a service that's not reimbursable, they still provide it and fund ways to pay for it, and other non-tribal facilities don't do that. They just don't offer the service. It would be nice to be able to get reimbursed for those services*." Participants noted the increased value of having enrollment navigators on-site for this reason.

Participants in the Community Conversations highlighted similar challenges they have faced in the enrollment and renewal process and how that was tied to not understanding the connection between Medicaid and IHS. One participant reflected, "*What if we had someone to help us with the processes. Especially our Elders, they didn't have the internet and forms are confusing*." To improve the enrollment and renewal process for American Indian community members, Community Conversation participants highlighted the need for more timely communication, reduced wait times for assistance and support, a more streamlined renewal process, clarity about how Medicaid and Indian Health Services work together for those with coverage from both sources, and, in general, an updated and user-friendly application and enrollment system.

Community Conversation participants and co-creators similarly described the importance of navigators in supporting people through the application and enrollment process with one co-creator declaring, "*Navigators are critical!*" Community Conversation participants highlighted the need for navigators who are American Indian and/or who have received training on cultural competency and eligibility and enrollment rules specific to American Indians. One Community Conversation participant emphasized the need for culturally appropriate services and the desire to see, "*Indigenous advocates and navigators in hospitals, department of corrections. Native relatives in these roles*."

"…one of the most meaningful experiences that I have with Medicaid, and even the IHS health system, is that with my first pregnancy, I was deemed a high risk, and my child was diagnosed with a birth defect that required a higher level of care than some place like CAS like I guess…could provide to me or my child, and through the IHS contract program as well as Medicaid, I received a referral, to the U of M in the cities, for all of my maternal fetal care as well as the month long NICU stay that my son had when he was delivered. And if not for Medicaid, and the referral system that was in place, his care would have ultimately ended up costing me close to a half a million dollars. Luckily, he's gonna be turning 9 next month and he is, perfectly healthy and

I'm just incredibly grateful for, the support and the systems that were in place when I needed that higher level of care and the people who were involved in facilitating that process." Virtual Community Conversation participant

Several groups in the Minneapolis Community Conversation described existing community resources they value and would like to see supported. Among these were recommendations to "*support MNsure navigator at [Minneapolis American Indian Center or Native American Community Clinic] and other tribal and urban clinics (it's helpful)*," and comments about the value of the Native American Community Clinic (NACC) and the Indian Health Board of Minneapolis (IHB), which one participant suggested help "*breakdown a lot of red tape, [if you're] not getting help – [they can] help [with] insurance, co-pay (no money), [if you] don't get [your] meds*."

Implementing the Intersection with IHS lever

Structural racism's compounding impact in our health care system is made evident by the intersection of Medicaid and IHS. IHS is supposed to serve as the health care safety net for American Indian and Alaskan Native community members as well as part of the treaty obligations owed to sovereign Tribal Nations from the federal government. However, IHS' chronic underfunding is further exacerbated by the significant number of community members who are either uninsured or get health care coverage through Medicaid and Medicaid's relatively low provider rates.[309] Despite these structural inequities, I/T/U facilities and programs are not only finding ways to meet their community's health needs but leading in innovative approaches to care delivery and financing that are inspiring more equitable outcomes around the country and world. More Medicaid-specific data on the experience of members within the I/T/U system will be helpful to identify areas of strength and opportunities for increased support and collaboration. MN DHS' conversations with Co-creators and community members about the intersections between IHS and Medicaid highlighted the impact of inequitable funding streams, particularly on the greater restrictions UIOs must meet their community members' needs. All participants noted the financial and member experience benefit in having on-site enrollment navigators. Therefore, finding ways to extend periods of eligibility for Medicaid members, and improve the enrollment supports at I/T/U organizations and other organizations (ex. FQHCs) serving a high proportion of AI/AN Medicaid enrollees will be important steps to supporting the intersection of IHS and Medicaid. The Call to Action to Reframe What Defines Health and Wellbeing and the Evidence Used to Make Decision will support openness to the needed innovation in payment and service delivery I/T/U facilities have long delivered and the Call to Create a Pathways to an American Indian and Tribal Health Integration team at DHS can provide the internal infrastructure to propose, implement, evaluate and scale community co-created solutions in partnership with I/T/U organizations.

Conclusion - How MN Medicaid can learn from and lead with American Indian communities

"The role of racism in health disparities is often overlooked by medical facilities and providers, yet it is a reality well understood by the patients who navigate these systems. The medical community must address and confront racism and stigma directly, acknowledging these issues as collective challenges rather than approaching them from a position of assumed expertise." - Dr. Charity Reynolds, Fond du Lac Band of Lake Superior Chippewa

This report reflects numerous reflections from community members and leaders about what is working well and what isn't when it comes to Minnesota Medicaid supporting the health and wellbeing of American Indians, and the priorities of Tribal Nation staff and Urban American Indian organization leaders. It links DHS' data with outcomes of interest provided by the report's Co-creators as well as innovations from other state Medicaid agencies and best practices seen in the literature. As DHS strives to be an organization that not only administers publicly funded health insurance, but helps support the conditions where Minnesotans thrive in community and live their healthiest and fullest lives, it needs to lay out a vision and approach to addressing population health. Population health approaches center that the health of communities isn't based solely on an individual's health behaviors or engagement with the health care system, but that health stems from the intersection of social, economic, natural, and built physical environments, access to basic resources, and connection to community. These concepts mirror models of Indigenous Determinants of Health and ways of being that have existed for generations. Therefore, as DHS seeks to develop, implement, and iteratively evaluate an integrated population health strategy to eliminate health disparities and meet our commitments to health and racial equity, there remains much it can learn from, and create together with, American Indian communities and Tribal Nations.

The process to, and result of, "Pathways to Racial Equity" revealed several similarities to our previous work. Community members were both interested in contributing and wary of DHS and our ability to follow through on our commitments. Guidance from community conversations notably centered on the experience of folks enrolling in Medicaid and seeking culturally specific care. There were distinct differences too. The added degree of complexity in navigating Indian Health Service, Tribal clinics and Medicaid was a challenge. The holistic approach to health that included connections to people and place was an undervalued strength. The political status of American Indians in the U.S. and the existing treaty rights' connection to health care were also often unrecognized.

Co-creators too reflected on the impact of this experience with one noting that, "*Through this experience, I have learned to translate the daily challenges my patients face into advocacy at the policy level, to help focus on their holistic health rather than individual issues*," and another that, "*There is a "false narrative" out there that all native people get "free healthcare" and that access to Medicaid and*

state sponsored health coverage is ongoing and never-ending, and easy to get. But the data belies this narrative." Co-creators highlighted the importance of Medicaid decision-making processes including representation from communities impacted whenever possible, and expressed how critical it was that the principle of Tribal nation data sovereignty was recognized. The degree and impact of Medicaid churn on community members was also lifted up with one Co-creator noting, "*I think one of the things that I learned through this process, was the importance of the work we need to do around reducing the churn in Medicaid enrollment… just a few weeks or a month of being without health coverage can be so deleterious to one's health outcomes*."

> "Oftentimes, as Native community members and scholars, we must start engagements with partners by reminding them that being American Indian or Alaska Native is a political identity in addition to a racial/ethnic identity and that Tribal Nations have an important government-to-government relationship with the United States federal government. Understanding these characteristics of our people and communities is foundational for strengthening systems to support our health and well-being. It was refreshing to work with a state-level team who not only entered conversations… with this knowledge but also embraced a willingness to learn what they can do to better meet the needs of Native people living in Minnesota…meetings included opportunities to build relationships, learn about available data, and provide constructive feedback... I appreciate that the Minnesota Medicaid team is ready and willing to learn how they can do things differently and take an active role in systems change to promote improved health for Native people in the state." – Deana Around Him, Cherokee Nation citizen, Research Scholar, Child Trends

Leading Together

This report and process continues to build a case for community co-created and co-led approaches to population health. DHS staff and Co-creators alike found the collaborative approach both deeply rewarding and impactful. As one Co-creator noted, "*I appreciated the collective work we did together as community partners and leaders on this report. It was helpful for me to hear the perspectives of others, and learn their experiences of frustration and success in serving our community, and to witness the power of putting our minds together to imagine creative solutions for improving the health and wellbeing of our relatives,*" with another reflecting, "*by doing so, we can foster a more equitable healthcare environment.*"

Therein lies the opportunity to learn and lead, together. To do so requires us all to be aware of our health care systems as designed, the history behind them, and their modern-day impact on our communities. When it comes to finding a path towards racial equity, we must be aware that, while systems of oppression have been leveraged similarly across racially marginalized communities to devastating effect, as noted earlier, Tribes are governmental and political entities, not racial groups. It is therefore incumbent upon policymakers to be aware of the history, Tribes' sovereign status, and the levers that can and should be utilized to achieve health through reconciliation, repair and ultimately, justice. As a Guidance Panel member noted, "*The adverse health outcomes present in Native*

communities today are the result of decades of systemic inequity that will require intentional time and effort to undo. No single player in the health system can be responsible for or expected to fix things; however, leveraging the power of community voices and collaboration can uncover solutions and foster the collective will to steer things in a better direction."

Many paths lay before us to realize health and opportunity for all. We must walk hand in hand with our communities if we are to find the best ones.

Acronyms, Terms and Definitions

Indian Health Service (IHS), Tribal 638 programs, Urban Indian Organizations/UIOs ("I/T/U" system): The IHS uses a three-tier system, referred to as I/T/U - Indian Health Service, Tribally operated facilities/programs, and Urban Indian health clinics - and provides health care services free of charge to the Members of 567 federally recognized American Indian and Alaska Native Tribes and their descendants who are eligible for services through a network of facilities and programs. Facilities are managed directly by IHS, by Tribes and Tribal organizations who contract with IHS, and by Urban Indian health programs.

Western Biomedical Model: Western biomedical models are approaches to healthcare that focus on diagnosing and treating physical and biological aspects of illness, largely based on scientific and evidence-based practices. Rooted in Western medical traditions, these models emphasize pathology, disease processes, and the use of medical interventions, such as medications, surgeries, and other technological treatments, to manage symptoms and restore health. This model often operates within a framework that views the body as separate from the mind and environment, focusing predominantly on physical health rather than holistic or cultural aspects of well-being.

Centers for Medicare and Medicaid Services (CMS): Federal agency that administers the nation's major health care programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Basic Health Program (BHP), and the state and federal health insurance marketplaces.

Medicaid: In Minnesota, Medicaid is called **Medical Assistance (MA).** MA is Minnesota's largest health care program, serving children and families, pregnant people, adults without children, seniors, and people who are blind or have a disability. In addition to "straightforward" MA, there are several MA-affiliated programs, including the Minnesota Family Planning Program and Medicare Savings Program.

MinnesotaCare (MNCare): MinnesotaCare is a Basic Health Program for low-income Minnesotans. Enrollees get health care services through a health plan they choose that serves MinnesotaCare enrollees in their counties.

Minnesota Health Care Programs (MHCPs): Includes all of Minnesota's public health care programs: Medical Assistance and affiliated programs, MinnesotaCare, Minnesota Family Planning Program, and Medicare Savings Program).

MNsure: Minnesota's state-based insurance marketplace for individuals and families who are not eligible for public programs and need alternate health care coverage.

Section 1115 Waivers: Medicaid Section 1115 waivers are mechanisms that allow states to test new approaches in Medicaid that differ from federal program rules. Authorized under Section 1115 of the Social Security Act, these waivers enable states to implement experimental, pilot, or demonstration projects that further the objectives of the Medicaid program. Section 1115 waivers are often used to promote flexibility in Medicaid programs, allowing states to expand eligibility, improve benefits, or test innovative payment and delivery models, such as managed care. Waivers must be budget-neutral to the federal government, meaning the costs of the demonstration cannot exceed what the federal

government would have spent without it. Approval is granted by CMS and is typically time-limited, requiring periodic renewal and evaluation.

Medicaid Managed Care Organizations (MCOs): health plans that contract with State Medicaid Agencies to deliver healthcare services to beneficiaries. MCOs operate under a managed care model, receiving a fixed monthly payment (capitation) per enrollee to cover a specified set of services, including preventive care, primary care, specialty care, and sometimes additional benefits like behavioral health or dental services. The goal of MCOs is to improve care coordination, enhance health outcomes, and control costs by promoting efficiency and accountability in service delivery. States oversee MCO performance through contractual agreements and monitoring to ensure compliance with Medicaid requirements.

Fee-For-Service (FFS): a payment model in health care where providers are reimbursed for each individual service or procedure they deliver. Under this model in Medicaid, providers bill the State Medicaid Agency directly for specific services rendered to patients, such as office visits, diagnostic tests, or medical treatments, with payment based on established rates for each service. In Medicaid, FFS can be used for beneficiaries who are not enrolled in managed care plans or for services excluded from managed care coverage.

Medicaid In Lieu of Services (ILOS): refers to non-traditional services provided by Medicaid managed care organizations (MCOs) as substitutes for covered services that are typically more costly or medically restrictive. These services, offered "in lieu of" standard Medicaid benefits, are intended to meet beneficiaries' needs in more flexible or holistic ways. ILOS may include supports like housing assistance, nutrition services, or non-emergency transportation—services that address social determinants of health and help prevent the need for more intensive medical care. While optional, ILOS must be cost-effective, medically appropriate, and designed to improve health outcomes.

Medicaid Non-Emergency Medical Transportation (NEMT): a benefit that provides transportation assistance to Medicaid beneficiaries who lack access to reliable transportation for medical appointments and services. NEMT covers rides to and from healthcare providers, pharmacies, hospitals, and other medical facilities for routine, non-emergency care, helping to ensure beneficiaries can access preventive and necessary medical services. Services can include various modes of transportation, such as public transit, vans, taxis, and mileage reimbursement, depending on the individual’s medical needs and availability of transport options. NEMT is mandated under federal Medicaid regulations but may vary by state in terms of administration and eligibility.

Accountable Care Organizations (ACOs): groups of healthcare providers, such as doctors, hospitals, and other healthcare professionals, who voluntarily come together to coordinate care and improve health outcomes for a specific patient population. ACOs aim to provide high-quality care while reducing unnecessary spending by emphasizing prevention, care coordination, and avoiding duplicative or avoidable services. Providers in an ACO share responsibility for the cost and quality of care and may share in savings if they meet specified performance and cost-efficiency benchmarks. ACOs are used in various healthcare programs, including Medicaid, Medicare, and commercial insurance, as part of value-based care initiatives.

Integrated Health Partnerships (IHP): Minnesota Medicaid's Accountable Care Organization (ACO) model. DHS contracts with provider organizations called integrated health partnerships to provide primary care and other covered services to Medical Assistance (MA) and MinnesotaCare enrollees. The IHP program incorporates a value-based payment model that takes into account the cost and quality of the health care services provided. Some IHPs share savings and/or losses under a risk/gain payment arrangement, based upon how their spending for a defined set of services for enrollees attributed to them compares to spending for this set of services for a prior period. A portion of shared savings is contingent on an IHP's scores on various quality measures. Enrollees served under both fee-for-service and managed care are attributed to the IHP from which they receive the most services. IHPs continue to be reimbursed as health care providers under the MA and MinnesotaCare programs, receiving payments from DHS for services provided to MA fee-for service enrollees, and payments from managed care organizations for services provided to MA and MinnesotaCare managed care enrollees. The population-based payments replace certain care coordination payments that the health care provider may have previously received.

DHS Data Specifications

Race and Ethnicity Data Quality

Enrollee applications to Minnesota Health Care Programs do not mandate reporting race and ethnicity since, per federal guidelines, that information is not used for determination of eligibility and therefore cannot be mandatory. However, reliable and dependable race and ethnicity data is needed to inform disparities in access, utilization, and enrollment. DHS' Health Care Research and Quality team has developed a methodology to help reduce the amount of missing race and ethnicity data using imputed data from several sources: the Medicaid Management and Information System (MMIS), Minnesota Eligibility Technology System (METS) and MAXIS – Minnesota's computer system to determine eligibility for public assistance programs (nutritional supports, cash assistance, housing, etc.) and some health care programs. This has resulted in the amount of missing race data among MHCP enrollees to be limited to ~9% and the amount of missing ethnicity data to be ~5%.

Applicants to Minnesota Health Care Programs may choose as many races as apply to them. Asian-Pacific Islander, American Indian/Alaskan Native, Black/African American and White race groups are exclusively composed of individuals who are of non-Hispanic ethnicity. For those who identify as American Indian or Native American there is an option to choose one tribal affiliation among Minnesota's 11 federally recognized Tribes, an "other" category or a free text option. For those who select multiple races, if they identify as American Indian as one of them then they are classified as American Indian in data pulls (even if they identify with multiple races).

Social Vulnerability Index Data

The Social Vulnerability Index (SVI) is a Centers for Disease Control and Prevention (CDC) geographic indices of disadvantage that ranks areas on 16 social factors (unemployment, disability, access to transportation, poverty, race/ethnicity, homelessness, etc.). DHS data in this report that references SVI utilizes a Minnesota-specific SVI score developed by the Minnesota Department of Health (MDH) to focus efforts throughout Minnesota's COVID-19 pandemic emergency response. MDH cross-walked the

census-track level data into Minnesota's ZIP codes and then ranked the ZIP code areas of the state and divided them into quartiles (with quartile 1 (Q1) being areas of highest disadvantage to quartile 4 (Q4) having the lowest disadvantage) based on their SVI score.

Churn Data

Churn was defined as a member having a gap in enrollment for the specified time – ex. "12 month churn" was determined by a member being disenrolled and then successfully re-enrolling within 12 months.

Age was defined as such, calculated as of January 1st on the year of interest.

Early Childhood	Birth to 6 years, 0 days
Childhood	6 years, 1 day to 21 years, 0 days
Adults	21 years, 1 day to 65 years, 0 days
Elders	65 years, 1 day and older

Attribution to county vs Tribe was by county of financial interest for White Earth and by county of residence for counties.

Zip codes were based on zip code provided at application or renewal. Zip codes that are associated with post office boxes are excluded from the report.

For payment systems priority was set as: IHP attribute --> MCO --> FFS

Due to the COVID-19 public health emergency and the continuance of enrollment in MHCP programs, churn for 2020-2023 is not representative of 'usual' churn.

The 360|Report

Minnesota Department of Human Services –
Engage! Pathways to Racial Equity in Medicaid
May-June 2024

Facilitated by MTI

Event Dates: 14 May, 28 May, 5 June, 11 June, 13 June 2024

Report Publication Date: Friday, 31 July 2024
Lead Evaluator: Elexis Trinity, Director of Research & Projects

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The 360 Report | Executive Summary & Overview

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversations
May-June 2024

The 360 | Executive Summary, Event Overview & Demographics

A collaborative undertaking between Marnita's Table and the Minnesota Department of Human Services (DHS), this focused conversation series was designed to extend the relationship building efforts of the department with American Indian communities in the state of Minnesota in order to gather community insights, priorities and guidance on American Indian experiences with healthcare and Medicaid for the purpose of incorporation into the forthcoming Pathways to Racial Equity report, its call-to-action, and ongoing efforts toward racial equity in Medicaid services. Hosted by Marnita's Table and the Department of Human Services in May and June of 2024, the Engage! Pathways to Racial Equity series brought together 382 community members across the state of Minnesota during two virtual and three-in person events, hosted in Duluth, Minneapolis, and Bemidji.

Table 1: Demographics[1]

	Total Participants	Respondents, Response Rate (Ethnic ID)[2]	IBPOC[3]	Am. Indian.[4]	Under 24/27
Virtual Events	271	157 (58%)	152 (sign-ins)	110 (sign-ins)	

[1] For a more detailed breakdown of the conversation demographics for each event and the project overall, see the addendum "A Note on Project Demographics" at the end of this executive report.
[2] Indicates the number of respondents/response rate for the ethnicity ID question from the sign-in sheets used for the virtual and in-person events. All 271 participants of the virtual events completed sign-in sheets online (overall survey response rate: 100%), while 51 of 111 participants of the in-person events completed hand-written sign-in sheets (overall survey response rate: 46%). Together, between virtual and in-person events, we received a total of 322 paper and online surveys from a pool of 382 total participants, for an overall survey response rate of 84%.
[3] Not all of these participants responded to the sign-in sheet ethnicity ID question, thus both the sign-in sheet responses and the in-room counts are included in this column. Data sources for the above numbers are noted in the accompanying parentheticals accordingly.
[4] Includes variations listing specifical tribal affiliations, variants of "Native," "American Indian," or "Indigenous," and biracial or multiracial American Indian identities.

			230 (in-room counts)		99 (sign-ins)[5] *(aged 4-27)*
Duluth	35	9 (26%)	8 (sign-ins) 30 (in-room counts)	8 (sign-ins)	13 (in-room counts, under 24)
Minneapolis	50	23 (46%)	23 (sign-ins) 45 (in-room counts)	22 (sign-ins)	10 (in-room counts, under 24)
Bemidji	26	13 (50%)	13 (sign-ins) 24 (in-room counts)	13 (sign-ins)	11 (in-room counts, under 24)
Total	382	202 (53%)	196 (sign-ins) 329 (in-room)	153 (sign-ins)	133 (*aged 4-27*)

Designed with the intention of centering American Indian voices, 329 participants (86%) were Indigenous, Black or other people of color according to in-room counts, the majority of whom identified as Indigenous, Native American or American Indian. Of the total 382 participants, 202 submitted a post-event sign-in sheet response including their ethnic ID (response rate for this question: 53%). Of the 202 respondents to this survey question, 196 self-identified as a person of color, with 153 of those participants identifying as American Indian (often including specific tribal affiliations). Based on the survey responses, 97 percent of respondents who included their ethnic ID were people of color, while 76 percent of respondents specifically self-identified as American Indian. Over a third of participants (35%) were under the age of 27, based upon in-room and survey data. This event was hosted in English.

Event participants had the opportunity to engage with information about Medicaid in Minnesota, how to learn more about renewal processes, and the Department of Human Services' racial equity in Medicaid work to-date during the community conversation, which featured in-depth small group engagement during the Mindstorm guided discussion sessions. Participants of these discussion groups described their experiences with Medicaid (and telehealth options), shared cultural, spiritual and ceremonial health practices they value, identified key priorities for policy development and support, and enumerated challenges they face when seeking healthcare, with many electing to share personal stories and first-hand perspectives on the topic. Analysis of the discussion themes shows that conversations largely focused upon (1) holistic perspectives on health, wellness and care for "the whole person, including the importance of being able to meet basic needs which for many American Indian

[5] Although we asked the "Under 24" question in-person (and thus, in-person numbers are based on in-room counts from a demographics activity facilitated during the event), virtual participants were not asked this variation of the question. Instead, they indicated their named generation on the sign-in sheet following the event. Based on this information, it is possible to note that 99 of 271 virtual event participants identified themselves with the generation born between 1997 and 2020, a loose proxy for the youth measure (in this case, participants aged 4-27).

participants included access to land, water, cultural practices and history, connection and community support, and matters of sovereignty and self-determination; (2) administrative and systemic barriers to accessing and enjoying the full benefits of Medicaid, including navigation and advocacy, information overload, complexity, and communications issues; (3) perspectives on the intergenerational and relational nature of healing, wellbeing, medicine, and care; the need for respectful and compassionate communications, anti-racism and cultural competence, alongside the challenges of grappling with historical violence, addressing anxiety, hesitation and stigma; (4) urban-rural divides and the geographic distribution of resources (and accessibility) in Minnesota, as well as difficulties accessing dental, vision, maternal and perinatal care; and (5) experiences with telehealth, including strengths, challenges, and opportunities.

The series was co-hosted by staff and leadership of the Department of Health and Human Services who helped welcome community members to in-person and virtual events throughout the five-event series of community conversations, with event design and facilitation provided by the Marnita's Table team in the model of Intentional Social Interaction (ISI). Project coordination, logistics and outreach were led by senior project director Sammie Ardito Rivera and training director Lauren Toussaint. Materials design, research, project evaluation and analysis were conducted under the supervision of research director Elexis Trinity with support from operations and evaluation manager Lars Goldstein, editorial assistant Johanna Keller Flores, and other members of the MTI team.

The following report consists of qualitative discussion data collected from the above activities and the thematic analysis of their results conducted by the Marnita's Table research team.

Addendum: A Note on Demographics

Given the emphasis of this project on engaging American Indians in Minnesota in conversations about pathways toward equity in Medicaid, the following note details the overall conversation demographics and the breakdowns of each event, both virtual and in-person, with an emphasis on disaggregating Native, Indigenous, and American Indian participants' self-reported ethnicity data from the broader Indigenous, Black and Other People of Color (IBPOC) measures reported in the above executive summary.

Virtual Events:

Among the 271 total participants of the **two virtual events** hosted on Zoom on May 14 and June 13, 2024, 230 were Indigenous, Black or other people of color according to in-room counts. Additionally, of the 271 virtual participants, 157 submitted a post-event sign-in sheet survey including a response to the ethnic ID question (response rate this question: 58%). In the sign-in sheet survey (which is an open-ended free-response style question, rather than a series of pre-determined check boxes), 108 participants self-identified as Native or American Indian, 2 participants identified as biracial (Black and American Indian, Norwegian and Native, respectively), 4 identified as Asian or Asian American (including one who self-identified as

"Hindu"), 37 identified as Black, African or African-American, 1 (one) identified as Mexican, and 5 identified as White, while 116 participants declined to answer the question. Thus, **across both virtual events, approximately 70% of sign-in sheet respondents who included their ethnic ID**, or 110 of 157 respondents to this question, **self-identified as Indigenous** (including the two biracial participants), based on a 58% response rate for this question. In total, 152 of 157 responses to the ethnicity question self-identified participants from Indigenous, Black or other communities of color, representing 97% of respondents and 56% of participants. All participants of the virtual events are required to complete the sign-in sheet survey (100% response rate), though they are not required to answer every question. Since the survey asked participants to indicate their generation rather than their exact age, we are able to report **that 99 of 271 respondents indicated that they belong to the youngest generation** (born between 1997 and 2020), but not the number of participants under the age of 24.

In-person Events:

Out of 111 participants of the three in-person events hosted in Duluth (May 28th), Minneapolis (June 5th), and Bemidji (June 11th), our in-room research team recorded 99 participants of color including Indigenous, Black and other people of color. Additionally, 34 of 111 participants were under the age of 24.

In **Duluth**, 10 of 26 total participants completed sign-in sheets (survey response rate: 38%), of whom 8 self-reported Indigenous identity (including Fond du Lac, Anishinaabe, Haudenosaunee, Ojibwe, and White Earth), 1 (one) identified as White, and 1 (one) declined to answer (90% response rate for this question). Thus, for **Duluth, 80% of survey respondents (8 of 10) self-identified as Indigenous.**

In **Minneapolis**, 26 of 50 total participants completed sign-in sheets (survey response rate: 52%), of whom 22 self-reported Indigenous identity (including Anishinaabe Turtle Mountain Ojibwe, Mandan Hidatsa and Arikara Nation, Chippewa – Cree Tribe of Rocky Bay Montana, Leech Lake, Oneida and Ojibwe, Lakota River Sioux Tribe Cheyenne, Saginaw Ojibwe, Kiowa, Cheyenne River, Chippewa, Mi'kmaq and Passamaquoddy, Dakota, Spirit Lake, Red Lake, White Earth, St. Croix Ojibwe, Flandreau Santee, and biracial or mixed race Indigenous identities), while 1 (one) self-identified as Black, and 2 declined to answer (88% response rate this question). Thus, for **Minneapolis, 85% of survey respondents (22 of 26) self-identified as Indigenous.**

In **Bemidji,** 15 of 35 total participants completed sign-in sheets (survey response rate: 43%), of whom 13 self-reported Indigenous identity (including Leech Lake, Red Lake Band of Chippewa/Ojibwe and White Earth), and 2 declined to answer (response rate for this question: 87%). Thus, **for Bemidji, 87% of survey respondents (13 of 15) self-identified as Indigenous.**

Project Demographic Summary

Across all five events, we welcomed a total of 382 guests to the Table, with 322 participants completing sign-in sheet surveys (online or in person) after one of the events and 202 submitting responses to the ethnicity question. Of these 202

respondents to the ethnicity question, 153 participants self-identified as American Indian (including those of biracial or mixed Indigenous identity). Altogether, **76% of those who responded to the ethnicity question on the sign-in sheet self-identified as Native, Indigenous or American Indian** (sometimes including specific tribal affiliations). Actual percentages of American Indian participation may have been higher than that reflected in the sign-in sheet data depending upon the composition of non-responding participants.

Of the 322 survey respondents (and 382 total participants), **133 participants (or 41% of respondents and 35% of total participants)** indicated that they **belong to one of the youngest generations** (born between 1997 and 2020).

Since the known percentage of American Indian respondents is higher among those who attended in-person events, the thematic analysis section of this report distinguishes between in-person event feedback and that resulting from the virtual events. In the raw aggregated notes section upon which the analysis is based, whether an event was virtual or in-person, when and where the event was hosted is noted above the feedback submitted from each small group discussion by the scribe/notetaker for each conversation.

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversations
Mindstorm

Questions for Discussion:
Choose the topic or topics your group finds most important to discuss.

1. **What does health and wellbeing mean to you?** What does it look like to really thrive? Do you feel that you have the things you need to be healthy and well? If so, what are those things? If not, what would help you to thrive and feel well?

2. **Do you have family or cultural traditions and routines related to health that are important to you?** If so, what are they? Are there ways your culture supports or encourages good health? Please share! Do you work with any traditional healers? If not, would you like to? What kinds of traditional healers or healing resources would you like to be able to access? Are there any ceremonies, practices, or resources that you use and value for your health and the wellbeing of your family? Are there any that you don't have access to, but would like to be able to access?

3. **Do you have any experiences with Medicaid / MN Care?** If so, what have those experiences been like? Are there ways that Medicaid / MN Care plays a role in helping or hindering the health and opportunities available to you and your community to thrive? What policies or structural changes should be prioritized to improve the health and opportunity of American Indians in Minnesota healthcare programs (Medicaid/MA and MinnesotaCare)? If you or someone you love needed to enroll in Medicaid / MN Care, would you know what steps to take?

4. **Are there any obstacles you face when seeking healthcare?** If so, are there specific resources or forms of support that would help you to overcome those obstacles? Have you or a family member used audio-only (telephone only) telehealth services to access care? If so, what was your experience? What would you like to see Medicaid / MN care prioritize? Are there any supportive resources you wish more people knew about and were able to access? How can MN Medicaid add value to and support what Tribal nations and

American Indian communities are already doing to help members realize their full health and potential?

5. **Do you have any questions for DHS?** Is there anything you'd like to know more about? Anything DHS should know?

6. **Is there anything that we didn't ask that we should have?** What isn't here that you would like to see? Are there any questions you have? Please share your question(s), and any answers that your group discusses.

The 360 Report | Mindstorm Themes & Analysis

DHS Engage! Pathways to Racial Equity
Community Conversations
May-June 2024

Overview & Methodology:

The following is a summary and analysis of the discussion notes submitted by small-group conversation facilitators during the Mindstorm sessions hosted virtually (statewide) and in-person in Duluth, Minneapolis, and Bemidji between May and June of 2024. A collaborative venture between Marnita's Table and the Minnesota Department of Human Services (DHS), this focused conversation series was coordinated to extend the relationship building efforts of the department with American Indian communities in the state of Minnesota in order to inform community members of their options and opportunities to renew healthcare coverage and, most centrally, collect community insights, guidance and wisdom on American Indian experiences with healthcare and Minnesota Medicaid for the purpose of incorporation into the forthcoming Pathways to Racial Equity report, its call-to-action, and ongoing efforts toward racial equity in Medicaid services. This discussion was undertaken by a total of 382 participants in individual small group discussions with dedicated scribes (notetakers) assigned to each group.[6] All events across this series were open to the public and welcomed participants from all over the state of Minnesota.

[6] All participants received the same instructions and discussion questions and were guided to focus on the themes and topics they considered most important to discuss. Transcriptions of the orally reported highlights and key observations from these discussions as summarized by participants during the event can be found on page 36 of this report.

Participating small groups submitted an aggregate total of 33 pages of notes and transcriptions from their conversations. In keeping with project demographics and priorities, participation was facilitated in English during all events, virtual and in-person. Handwritten discussion notes from the in-person events were transcribed by members of the Marnita's Table research team before analysis. The responses and discussion themes emerging from individual small-group sessions have subsequently been aggregated and deidentified where necessary for the purposes of this analysis. The full text of the submitted notes is available on page 48 of this report, while a facsimile of the Mindstorm packet distributed during these conversations, including instructions and questions, has also been included *(see: page 6 for more details)*.

Because of the free-flowing nature of the hour-long small group discussions which were guided in an intentionally non-rigid manner in order to allow for flexibility, participant choice, and community-based responsiveness in accordance with the model of Intentional Social Interaction, many of the themes emerging during these conversations occur across individual discussion questions and overlap with topics raised by participants. Accordingly, the thematic content of this Mindstorm has been analyzed holistically with care and attention to both the substance and the context of participant discussions, and every attempt made to render topical linkages apparent and to highlight the many instances where themes overlap and participant stories and comments reference previous discussion themes or insights. Methodologically, techniques of both content and textual analysis were applied to these ends. The key themes emerging across both events have been summarized and outlined below in Table 2.

Table 2. Overview of Key Themes, Community Perspectives & Priorities from DHS Engage! Pathways

"Like water through a canyon, as long as it takes, we need to make changes."
– discussion participant, Duluth

Key Theme: Holistic perspectives on health, wellness, and care for "the whole person – *including cultural, spiritual, and mental health, ceremonial resources and social connections, land and water, traditional foods and medicines, knowledge of their uses, and access to nature, green spaces.*

"The problem is that Western models are focused on treating illness instead of seeing health as wholeness."

Health and wellbeing look like:

- **Whole-person concept of health and wellbeing**, **spiritual, mental and physical balance**; freedom from disease and freedom of choice; **intergenerational connections, supportive relationships, companionship and community**.
- **Ability to meet basic needs** – especially rest, healthy and culturally relevant foods, and access to nature/green spaces, housing and transportation, education and knowledge about one's cultural practices.
- **Holistic, allowing for the integration of Western and traditional medicines, including access to health insurance, quality medical care, and healthcare resources broadly defined –** community safety, spiritual and holistic practices, mental and behavioral healthcare, preventative care, dental, maternal and child healthcare support (including doulas, midwives and home birth or water birth support).

- **Ability to practice one's cultural ceremonies and traditional practices**, ceremonial and social support in times of need, **storytelling and historical memory.**

Key Theme: Urban-rural divides and the **geographic distribution of resources (and accessibility)** in Minnesota; **challenges accessing dental, vision, maternal and perinatal care.**

"[We] need greater access to sweats, ceremonies and traditional healers in urban areas (without having to go back to the reservations)."

Highlights:

- **Uneven distribution of resources among urban and rural areas** (with cultural or traditional healers like medicine men especially more likely to be located in rural areas requiring reliable transportation and free time to access).
- **Challenges accessing or obtaining coverage for dental, vision, emergency services and in-home maternal or perinatal care; care experience more fractured in rural areas,** dental providers reluctant to accept Medicaid, preferring private insurance.
- **Transportation, time off work, childcare major barriers** for those who have to travel to seek the care they need (especially in search of specialists or cultural care), even when transportation support exists, coordinating and accessing this support can be difficult.

Key Theme: The user experience: navigation, communications and administrative barriers to accessing and enjoying the full benefits of Medicaid.

"To improve health for American Indians in Minnesota, we need simpler processes, more funding for culturally competent care, and better access to traditional healing practices."

Highlights:

- **Information overload,** not always clear **where to go to get needed information, application process can be intimidating; greater clarity** about enrollment, care options, plan differences, and decision-making processes needed.
- Challenges navigating **long delays, system inefficiencies, overly complex administrative processes, and unclear or delayed communications;** desire for greater access to **Medicaid navigators/advocates who are themselves American Indian and/or who have been provided with adequate cultural competency training**.
- More clarity, support and protections against **gaps/lapses in care, smoother and more transparent renewal process** ("Renewal process causes gaps that could/should be avoided").
- **Systems** should be regularly **updated, streamlined**, and designed to be **accessible at any educational level.**
- **Coordinated care appreciated, but "complex" or overly narrow eligibility requirements a barrier.**
- **Mixed perceptions of Medicaid** ("Positive in terms of coverage, but difficult due to bureaucracy"), **largely positive views of perinatal coverage and coverage for children** among those with Medicaid experience (though many expressed interest in expanded options for pregnant people, including traditional doula and midwifery care, in-home delivery support, "Indigenous birthing" and water birth options, etc.).
- **Desire for ongoing and sustained engagement with policy and decision-makers** about health equity for American Indian communities, ("[There is] a disconnection of conversations at the state level around health/equity: not always having the right people at the table, one-and-done [engagement] doesn't work.").

Key Theme: Ceremonies, routines and cultural practices; centrality of sovereignty, access to traditional knowledge, land and food culture for American Indian health and wellbeing.

"Cultural practices are preventative care practices!"

Highlights:

- **Centrality of land, water, non-human nature, sovereignty to Indigenous medicine** and healing practices, physical, cultural and spiritual wellness; **significance of Indigenous epistemologies, not always aligned with Western cultural systems and assumptions** ("Support reclaiming Native traditional ways of viewing the world, not the capitalistic Western world views"); **self-determination and community-based sourcing important**, including when gathering plants and foods for traditional medicines ("not dependent on capitalism to access our own medicines").

- **A range of significant ceremonies and medicines incorporated into participant health praxis**, including sweat lodges, smudging, powwows, music and the arts, visits with traditional healers and medicine men, beading classes, tent ceremonies, naming ceremonies, funerary practices, morning offerings, prayers, use of traditional foods and herbs (cedar, sage, tobacco, sweetgrass, broths and soups, etc.), traditional seasonal activities with family and community.
- **Accessibility of traditional medicines, ceremonies and other health practices includes** not only the right and ability to practice, but also dedicated spaces and sufficient resources, the **elimination of pressure to justify or explain the significance of their use by Western medical providers or social workers.**
- **Not enough traditional healers available,** transportation support for those who must travel to visit a traditional healer and adequate compensation for healers needed; **desire for "community education" and youth training programs** for those interested in learning traditional healing practices, **alongside concerns about licensing/certifications/"vetting" as a barrier** to accessing such healers.

Key Theme: Respectful and compassionate care and communication, anti-racism and cultural competence; grappling with historical violence; addressing anxiety, hesitation and stigma.

"Experience with Medicaid is [a] cultural competencies issue."

Highlights:

- Concerns about **primary and historic trauma, resilience, grief management, "coping mechanisms" and self-care or self-medication, healing or addressing despair,** what it takes to get out of "survival mode" and truly thrive.
- **Effects of colonialism and ongoing histories of colonial violence** upon American Indian health and wellbeing, contemporary contexts of healing, seeking care, navigating Medicaid and the American medical system.
- **Addressing hesitation, anxiety, "shyness" and frustration –** identified as barriers to seeking care, persisting through challenges navigating Medicaid, seeking or receiving care (trust and a sense of safety critical for overcoming hesitancy).
- **Need for more American Indian providers (including therapists and counselors), liaisons, advocates and navigators; funding and support for Native youth interested in medical careers;** as well as cultural competency training for medical professionals and Medicaid support roles.
- **More resources, safe therapeutic spaces and support for those suffering from substance use disorders or seeking mental health support; respect, compassion, human-centered, and stigma-free treatment.**

Key Theme: Relational context and intergenerational nature of health and healing – *support for elders, pregnant people, children and families.*

"Patients want to be healthy [and] well within [the] larger social context."

Highlights:

- **Emphasis on family health and social-relational practices, community events and connection** ("walks as a family, smudging together," "seasonal traditional family activities"), parenting as a form of health praxis ("cedar ceremonies, baby wearing and bonding"), honoring and accessing the knowledge of elders and passing on traditional knowledge and historical memory to the young ("Role of grandparents, spiritual leaders," and "Teaching our young people about our culture, how to do smudging, etc. [is an important part of health and wellbeing]").
- **Concerns about intergenerational trauma and socioeconomic struggles** ("[I have] known families who haven't had resources for generations – dealt with addiction for generations. People in that situation can't pull themselves up from their bootstraps.").
- Need for **more elder advocates,** special consideration for **different communication needs of elders**
- **Importance of knowledge transmission across generations for sustaining Indigenous medicines and ceremonial practices.**

Key Theme: Experiences with telehealth: strengths, priorities and challenges.

Highlights:

- **Telehealth (including audio-only or captioned services) useful for routine appointments, but in-person visits largely preferred** for comprehensive care and/or the sense of personal connection with a compassionate provider**.**
- **Interest in broadening telehealth options** for those living in remote areas without accessible care options or otherwise struggling with accessibility and transportation challenges.

- **Barriers and challenges:** lack of necessary technology/devices or ability to navigate such devices, inadequate internet service/limited internet service providers, lack of phone device or service, long waitlists for telehealth care ("need a 24/7 phone call for service").
- **Concerns about telehealth experience:** lack of emotional connection, concerns about ability to diagnose conditions virtually, elder-specific concerns about navigating technology and dealing with impairments of hearing or sight during telehealth visits, encounters with telehealth providers unable to access patient charts/records when receiving care.

Themes & Analysis: Summary

Question Set 1: The Meaning of Health & Wellbeing

We asked: *What does **health and wellbeing mean** to you? What does it look like to really thrive? Do you feel that you have the things you need to be healthy and well? If so, what are those things? If not, **what would help you to thrive and feel well?***

Across both the May and June virtual and in-person events, a total of twenty-six (26) discrete discussion groups (15 virtual and 11 in-person) submitted notes from their conversations in response to this question. Across both populations of participants, health and wellbeing was widely framed in holistic terms inclusive of care and wellbeing for "the whole person." Collectively, such whole-person perspectives on health and wellbeing included concepts like the ability to meet one's basic needs (for self and family), access to health insurance and affordable/accessible conventional medical care, balanced physical, spiritual and mental health, a sense of joy and personal fulfillment, freedom from anxieties and disease, cultural or traditional care and ceremonial resources for wellbeing, meaningful social relationships and intimate connections, as well as access to traditional foods and medicines, knowledge of their uses, access to nature, green spaces, and opportunities for physical activity, often undertaken with children and other family members. "[There is a] need to consider the whole person," argued one participant in Duluth, "Healthcare likes to break things apart (heart health vs. mental health, etc.), [but] Native people understand health applies to the whole person – [it's] all connected." Participants of the virtual events echoed these themes, sharing the following comments in a similar vein:

> [Health and wellbeing is] the overall quality of life and it means physical health, mental wellbeing, and spiritual health; it's not just health – it's all wellbeing, and encompasses a lot of things – and emotional intelligence.
>
> [The] problem is that Western models are focused on treating illness, instead of seeing health as wholeness.
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> To me, health and wellbeing signify a comprehensive state where physical vitality, mental clarity, and emotional resilience intersect, supporting thriving by embracing regular physical exercise for strength and flexibility, adopting a balanced diet that nourishes my body, prioritizing adequate sleep for optimal cognitive function, and fostering meaningful relationships that offer support and positivity."

Importantly, this focus on holistic health was frequently linked to community relations, social contexts and obligations. Shared one group in Minneapolis, "Optimal wellbeing [is

about] where you put your energy, care of body *is* care of spirit – holistic care that leads to sustained healing, justice and care. [It's about] community and resources, wellbeing leading to happiness and life without worrying about survival." Said another participant of this Minneapolis discussion group in response, "[It's about] traditional and ceremonial wellbeing [too]. Looking at holistic care – mental, physical, spiritual – is just the beginning of the needed framework. Conversations [need to be] had that involve engagement with self and community," highlighting the interpersonal, social, and community contexts of such a view of holistic health and wellbeing. Health and wellbeing in this perspective is not only of and for the whole person, but equally in service to the whole family and the whole community, interconnected, relational, and intergenerational in nature (for example, in Duluth, some characterized their ideal of health as "children's health and wellbeing," while in Bemidji, another pointed to the significance of having "a community, those there to take care of your…elderly"). Eleven of fifteen small groups of virtual participants also highlighted the importance of supportive relationships, companionship, and mutual care for health and wellbeing. For many, the ability to support one's family and community were central motivating factors in sustaining their own health, with ceremonial and cultural practices fundamental to these efforts. Virtual participants shared the following stories to illustrate these connections:

> I work at the Indian Health Clinic which is a medical clinic, and we've been around now for over 50 years. I've worked there for 20. In the years it's been in existence, we've evolved tremendously to make patient services more accessible. One of the duties that I have is that I function as an Indigenous spiritual helper. What does that mean? We have patients being seen in one of the many exam rooms, and if there is a need for mental or spiritual health, in addition to the usual greetings, I go in and we talk about what it is that they need, whether it's information or other resources. Sometimes there are elderly people who are nearing the end of life, and one of the ceremonies that mean a lot to them is that I bring them a pair of moccasins, they want to know that they are prepared to go. And that they have what they need to face that.
>
> In our family, we are connected to the American Indian community through ancestral ties, honoring and preserving our heritage through stories, traditions, and mutual respect for Native American cultures. My grandfather was a member of Cherokee Nation.
>
> I am a member of Red Lake, so traditional ceremonies and medicines are important to me. Morning and bedtime smudges and prayer [are a big part of this].

To this comment, a member of the same group replied:

> I am from Red Lake Nation too. Wellness means ALL of me – physical, mental, everything I need to be in my community. Very holistic. I'm actually on my way to a ceremony right now.

Among participants of the in-person events, comments concentrated largely on the foundational significance of the ability to meet basic needs for promoting a sense of health and wellbeing, with several groups pointing to the importance of social service infrastructures, even as some of the complexities of these infrastructures and services are exposed in the personal stories participants shared. Said one participant, "[It's] all interconnected and [I'm finding] – I raised kids on assistance and been on section 8. Without the program I wouldn't have had that kid." Another shared that critical "resources [of which they made use] included food stamps, housing support – [I] was creative to make food last," they said. "Wasn't always healthy, but it made meals.

Making decisions also meant letting bills go and being in survival mode." In fact, the idea that health and wellness is a state beyond survival, characterized by some as "thriving" and by others as freedom from worry or anxiety, or the ability to "do the things you need to do," "being whole [and] satisfied with what you have," was also a strong and consistent thread across not only this section of the Mindstorm, but throughout the small-group conversations during both the in-person and virtual events.

Participants of the two virtual events underscored the role financial stability plays in their wellbeing, sharing that:

> [There is] not enough income to sustain wellbeing [in my life].
>
> Money is an important factor to have good health.
>
> [We are] barely living paycheck to paycheck, but not doing anything in our lives that are fulfilling. – There's so much need, and no one wants to fill the gap.
>
> Health and wellbeing are everything to me. I think the only thing bringing me down is inadequate money. – Having money is good health to me.

Some participants of the in-person events also noted the kinds of gaps and lapses that exist in social service infrastructures meant to provide support for basic needs, with one noting that "There's no in between…on welfare. [It takes] two months to kick in and [actually] get support, [and then it's] not enough to pay rent." When considering the kinds of resources that fall under basic needs, in-person commenters included reliable transportation (frequently identified as a barrier to seeking and accessing care), exercise infrastructure ("[We] need a gym in Duluth [for us] similar to the Hinkley gym for Native [American community members]" one participant opined, whilst another in Bemidji asserted that "24/7 access to a gym to help [work around] our schedules [would make a big difference]"). Other comments pointed to the importance of different kinds of community spaces and events for gathering around healthy activities such as walking, bike-riding, gardening and cultivating nutritious, traditional foods. For one group in Minneapolis, this meant "access to spaces to be healthy, physical – nature," getting "back to land, traditional food, medicine, [and] having knowledge of [its] uses," and a wealth of plant foods like spinach, fruits and carrots, and sufficient rest.

Employment and educational opportunities also appeared frequently in participant descriptions of basic needs, as did the ability to access necessary medications (such as insulin and Narcan), access to high quality food, stable affordable housing, mental and behavioral healthcare, access to traditional midwives and doulas for culturally appropriate perinatal care, and knowledge about one's own health status and available resources ("Knowing what to access in your community [matters]," contributed one participant). One group emphasized the need to take "an Indigenous perspective on [the] social determinants of health," linking the discussion about basic needs with the broader context of whole-person health and strong interest in integrated and holistic perspectives on health and wellness.

Comments in this section also prefigured themes explored in greater detail elsewhere in this Mindstorm, such as concerns about primary and historic trauma (including colonization), resilience, “coping mechanisms,” challenges around self-care or self-medication, and healing from or addressing despair. Some of the ways participants raised these issues is reflected in the following contributions from the discussion notes of the in-person events:

> Mental health is a part of wellness.
>
> [You] need coping mechanisms to take care of yourself…At one point, pre-colonization, we had all that, and lost a lot of ways to cope [as a result of colonial violence].
>
> People need skills to get out of despair.
>
> [What I need to be healthy and well is] online counseling and therapy (instead of jumping [through] hoops), [and access to a] culturally Native therapist.

Additional supporting themes which are surfaced in this section and highlighted elsewhere include discussions about what quality care looks like and barriers to health and wellness like “resource disparities,” transportation challenges for those who must travel to obtain needed care, childcare and the need to take time off work in order to seek care, “narrow eligibility criteria [for Medicaid] limiting those needing access to care,” the importance of accessible “emergency response care” and experiences of fractured care and treatment systems requiring “stronger health advocates” and ways around “having to visit and travel to multiple places of care.” In addition to underscoring the significance of social determinants of health and the ability of patients to meet basic needs, these points intersect with other key themes emerging across the Mindstorm discussions for the series as a whole, such as the structural and administrative complexities of navigating Medicaid and the medical system, the desire for more and better trained advocates, challenges arising from disparities in the geographic distribution of healthcare resources (related to the urban-rural divide), and the centrality of mental health to wellbeing as a whole. When reflecting on what quality of care means to them, participants of the in-person events shared the following, emphasizing the need for culturally appropriate, comprehensive care and meaningful choices:

> Health insurance coverage that doesn’t lapse.
>
> Whole person care.
>
> Good doctors, clinics, hospitals.
>
> Being able to go to preferred providers.
>
> Doctors who don’t discriminate [against] you.
>
> Indigenous advocates and navigators in hospitals, department of corrections. Native relatives in these roles.
>
> Advocacy around medical terminology and interacting with medical providers.
>
> Understanding all options including traditional medicines; holistic treatment practices.

Human Services: Give admin. time for traditional practices.

Question Set 2: Family & Cultural Traditions

We asked: *Do you have **family or cultural traditions and routines related to health** that are important to you? If so, what are they? Are there ways your culture supports or encourages good health? Please share! Do you work with **any traditional healers**? If not, would you like to? What kinds of traditional healers or healing resources would you like to be able to access? **Are there any ceremonies, practices, or resources that you use and value** for your health and the wellbeing of your family? Are there any that you don't have access to, but would like to be able to access?*

In this section, twenty-eight (28) discussion groups (17 virtual and 11 in-person) submitted notes describing family and cultural routines and practices important for their health, as well as any perspectives or experiences they may have with traditional healers. Taken together, notes from the discussions across both formats encompass a range of practices and priorities valued by participants. Ceremonies, routines and other practices highlighted here included sweat lodges and traditional medicines like cedar, tobacco, sweetgrass and sage (two of the most prominent responses across groups), as well as "different ceremonies to maintain health and balance [such as] round dance ceremonies, boxing," prayers and morning offerings, "access to powwows where you move your body," tent ceremonies, funerary ceremonial practices "of burying loved ones" including "stress reduction, grief management," naming ceremonies, gardening, and "traditional practices [like] carrying clean water, picking berries, planting/harvesting crops." Several commenters also mentioned the value of participating in traditional arts like "music, drums, singers," beading classes, "ribbon skirts and crafting [because it] brings joy." In the words of one Minneapolis participant, "Art is healing too. When my daughter sees American Indian art, that's healing too. Art gives a sense of identity, pride [in seeing] images of my people."

Several groups took the time to add notes about the kinds of barriers they face in pursuing these practices, such as the need to invest in and support traditional seasonal activities, financial barriers, and the "urban versus rural [divide], bridging the gap" in available resources. Such observations appeared in conversation notes from both the in-person and virtual events, with participants of the latter describing the differences between resources available (and accessibility of those resources) in the cities and Greater Minnesota in the following ways:

> [I] cannot access medicine men in the cities.

> What comes to mind is accessibility of cultural health and wellbeing services, going into a clinic where people look like you, because you know that the experience is going to be different. I know that when I go into a clinic and I have a [white] provider who doesn't reflect my culture, my body goes into like a trauma response. I am in the Twin Cities though, and I feel like we have access to some of those resources.

> [We] Need greater access to sweats, ceremonies and traditional healers in urban areas (without having to go back to the reservations).

In fact, many comments about barriers faced by those seeking to practice traditional medicine or incorporate other forms of ceremonial, cultural and traditional healing focus on the high demand for traditional healers and limited numbers of such practitioners – "[We get ten] or more requests per week at Essentia for traditional healers," reported one participant in Duluth. Traditional healers were widely valued by participants, though many throughout the Mindstorm noted the need for more healers and availability among existing healers, expanded opportunities to access knowledge about traditional medicines, difficulties accessing often-rurally located healers from the Twin Cities and other urban areas, the importance of knowledge transmission across generations and geographic locations, and the need to ensure that such healers are able to be adequately compensated. Thus, it is unsurprising that training, knowledge transmission and community investment in developing new generations of traditional healers (and other American Indian medical professionals) emerged as a key supporting theme in this section, expressed in a range of comments such as those below, drawn from across the in-person events:

> Being able to travel to places where people have knowledge or bringing knowledge to [the] city [is critical]!

> Elders and traditional healers, different therapies, licensed Native healers [are important to me].

> [It's hard because there is a] waitlist, not enough traditional healers.

> Teaching our young people about our culture, how to do smudging, etc.

> Access to knowledge around traditional medicines and how to use them [really matters].

> [When it comes to] traditional healers [we] need to know who they are and how to access them (two participants [of our small discussion group in Bemidji] use traditional healers).

> [We] need community teaching/education around traditional healers.

> Provide funding to train young people to come into medical practices.

> [We are] wanting community education programs around traditional services.

> Fund young people to go to camps to learn traditional healing practices.

At the same time, a number of participants of the in-person events emphasized that processes of credentialing and licensing traditional healers can themselves be a profound barrier, or even cause of harm, to American Indian communities, a position exemplified by comments like the following:

> Vetting of the people providing the services should not be causing harm to our community.

> Eliminating the requirement of credentials/licensing for traditional healers [would help].

Underpinning the discussions among participants about cherished traditional practices and barriers to pursuing such practices is another key theme from across this Mindstorm which was highlighted here: the extent to which land and cultural sovereignty are central to American Indian health and wellbeing. While different groups and commenters approached the topic in different ways, commenters regularly connected access to land, self-determination, and Indigenous epistemological roots with their practices of ceremonial, cultural and spiritual medicine. In several cases, participants of the in-person events explicitly linked these issues to the challenges of grappling with colonialism, capitalism, and Western epistemological hegemony, arguing, for example, as one Minneapolis discussion participant did, that

> [There is a] need for community support and traditional medicines – support to get to ceremonies and traditional plants. Access to sage, berries, and other traditional plants [has to come] from a community-cared-for source (not dependent on capitalism to access our own medicines). Working with programs and communities that care/teach medicines [is helpful].

Relatedly, it was not uncommon to encounter in the discussion notes admonitions from participants about the need to work toward "curbing reliance on practices outside of culture." Some of the ways different discussion groups from the in-person events articulated these issues are highlighted in the quoted material below from the notes of their conversations:

> Traditional teaching [requires] access to the land.
>
> We don't have the land to do it. Access [to] natural resources [is essential].
>
> We need spaces to reconnect with our culture.
>
> How do we get quiet spaces in nature to practice?
>
> Reclamation leading into the teaching and healing practices [is part of the process].
>
> [I feel that we have] been brainwashed to be fearful of our own medicines.
>
> Support reclaiming Native traditional ways of viewing the world (not the capitalistic Western world views).
>
> Our traditional world views were taken away from us, we now have to re-learn these views and practices which takes community, time, resources.

Comments among participants of the virtual events expanded the conversation on this theme to consider what it looks like to bring together Western medicine and traditional American Indian medicines, weighing the challenges created by pressure to justify the use of traditional practices or experiencing of "discounting" Indigenous healing in conventional Western medical settings. A few of the ways participants approached these discussions are highlighted in the quoted material below:

> At the Indian Healthcare Clinic where I work, we have access to medicines. And why do we use those? It's because we want to purify ourselves before we appear with a Western medical provider. It's asemaa and I know another word for that is tobacco, but it's not tobacco. There's also willow bark and sage, if someone has medical issues where they can't use smoke, we have

> sage oil and other things we can use. We also use sweetgrass – and why is that important? It's because we do want to go in there in a good way. It's also a cultural ethical consideration because it is necessary for our healing, we're a very spiritual people and we look to those medicines to prepare for our healing. I do work with traditional healers. I was at a DHS conversation not too long ago where we were working on getting more access to those medicines. We talked about what issues are important to our communities, and a lot of what we talked about is the opioid epidemic, but we also looked at what kind of traditional healers can perform what I call maintenance. We focus on our spirituality that way. We want to be able to say that we are good spirits when we leave the clinic. We have a quarterly healing ceremony which because of the amount of people who have been attending we have to hold them in the park.
>
> [One participant] recalls a 'discounting' of cultural traditions by the allopathic medical center during Lieutenant [Governor Peggy] Flanagan's childbirth experience. Patients want to be healthy/well within [the] larger social context. It's our problem as a health system to create the integrated experience that patients desire. Not react negatively to patients who want to bring in other practices."
>
> Some traditions held alongside medical practices, as a spiritual/therapeutic element. Community support is an important aspect of healing.
>
> I've been taking traditional tinctures. I also have high blood pressure medication. I've been using natural remedies to try and help the Western medicine.

As elsewhere in this Mindstorm, participant comments also evinced a commitment to the intergenerational nature of health and wellbeing and the importance of children and elders in considerations of traditional and ceremonial healing. Some emphasized the need for "access to [healers for] pregnancy/Indigenous birthing" with one Bemidji participant sharing that "for myself, home birth midwives are not covered, but in the future, I hope they'd be," and described important practices like "seasonal traditional family activities," or "walks as a family, smudging together," "cedar ceremonies, baby wearing and bonding," making sure that one's "kids know how to pray" and learn grass dances and other ceremonial traditions. Others pointed to the "role of grandparents, spiritual leaders [for] mental health," and suggested that "group engagement is needed." One Bemidji participant wanted to "revitalize family circles that come together to practice traditions/traditional ways of song and dance," while another offered that their community recognized the "need [for] traditional life teachings for each stage of life – [and] funding to support this," going on to share that it is a "challenge missing traditional life teachings at earlier stages of life and having to catch up." This intergenerational social context for healing and wellbeing was also apparent among the notes submitted by participants of the virtual conversations, in which the family was an important locus for the practice of cultural traditions and routines, and elder care continued to be an important concern in small group conversations. One virtual participant shared the following story as they advocated for the importance of elder advocates:

> I listen to a lot of elderly people who access healthcare at the medical clinic, and they talk about diabetes, and they talk about living independently. Getting care in their homes helps them to manage their diabetes independently. Often times when they leave the home there can be challenges for how they manage their blood sugar while they travel to the clinic. I always wish we had an elder advocate in our clinic who can sit with them and ask if there's anything they need, what is their blood sugar like, do they need anything to drink, do they need water. We are still

> working on that, and we don't have it yet, but I'd love to have someone who could help with that, reassure them that they will have a good experience there and have their needs met.

A few groups also used this section to share additional modes of care or resources they hoped to see made available to their communities, as in the case of the Bemidji participants who said, "I wish our reservation could open its own treatment center to help people dealing with substance use disorder," and asserted a need for "Better program[s] for young people in treatment. [Should be run by] people who get along with kids, someone who will listen."

Question Set 3: Experiences with Medicaid/MN Care, Policy Priorities

We asked: *Do you have any **experiences with Medicaid / MN Care?** If so, what have those experiences been like? Are there ways that Medicaid / MN Care plays a role in helping or hindering the health and opportunities available to you and your community to thrive? **What policies or structural changes should be prioritized to improve the health and opportunity of American Indians in Minnesota** healthcare programs (Medicaid/MA and MinnesotaCare)? If you or someone you love needed to enroll in Medicaid / MN Care, would you know what steps to take?*

A total of twenty-six (26) small groups (16 virtual and 10 in-person) submitted notes in response to this question, highlighting challenges they have faced when attempting to navigate Medicaid and the medical system, including structural, administrative, and communication barriers, material constraints, trust barriers, issues related to gaps or lapses in coverage and unexpected changes in high-cost prescriptions. A few groups also raised concerns about the difficulty of accessing dental care specifically. Among virtual participants, institutional challenges with navigating Medicaid and managing medical and insurance communications were also a prominent topic of discussion, though participants additionally offered general perceptions of Medicaid, telehealth barriers and challenges, and costs of care more broadly.

Participants regularly described encountering difficulties navigating Medicaid and fielding communications about insurance and healthcare issues, with particular concern about the challenges facing American Indian elders attempting to obtain coverage and care, a theme illustrated in comments like those below from the notes of the in-person events:

> [I found Medicaid to be] difficult, intimidating. All the application hoops. If you don't know, learning about navigation [is really important].
>
> Gathering the information needed to respond to online application questions [was difficult].
>
> [Although the coverage is] good for kids, can be especially challenging for elders to navigate.
>
> I had to apply when I was pregnant. It was hard to navigate and explain.
>
> There were so many benefits, but it was hard to navigate.

[I'd like to see] better communication in what it takes to get service.

What if we had someone to help us with the processes. Especially our elders, they didn't have the internet and forms are confusing.

You sit on the phone on hold for too long.

Notably, many participants emphasized that Medicaid coverage was valuable and especially good for essential services, pregnant people and those with children, though navigation and communication challenges sometimes made it difficult to know how to get enrolled, what services would be covered and how to get access to needed care. Among virtual participants, similar experiences were highlighted, with comments suggesting that the user experience could be improved by more timely communication, reduced wait times for assistance and support (as well as for care generally), a more streamlined renewal process, clarity about how Medicaid and Indian Health Services work together for those with coverage from both sources, and, in general, an updated, comprehensive and user-friendly system. As elsewhere in this Mindstorm, some participants suggested a need for competent and culturally relevant navigators, and "culturally sensitive care." Some had experience using a navigation support service but shared that available navigation support systems also came with a long wait time for those in need of assistance. Below, a few of the ways virtual participants described these issues are highlighted in quotations from the discussion notes:

The process was always very complicated (with Medicaid and MCRE). I used to work for DHS and what I heard from AI clients was that they didn't understand how [Medicaid] interacted with Indian Health Services. People were confused about where they could use [Medicaid] and didn't understand they had access to insurance even though they were enrolled.

I have used Medicaid and found it helpful for covering essential health services. However, the application process can be confusing and slow. Simplifying enrollment and increasing awareness would improve access and opportunities for American Indians. If needed, I would know the steps to enroll but support would be beneficial.

I have a person who helps me with my Medicare. Her name is N—— and she lives in South Carolina but is able to help me here. But there's kind of a wait time that can be hard, and you have to deal with the wait if you want the service.

I have had mixed experience with [Medicaid]. [I] benefit from coverage but struggle with administrative delays. Needs more efficient process and better communication. Prioritizing easier access and culturally sensitive care would improve outcomes for American Indians. More straightforward instructions (to enroll) are needed.

(In response to the above comment, another participant shared): I agree with what she said– benefits are good but delays and confusion are a problem. Another person [in our group] also agreed.

Delayed responses and lack of communication/updates [are an issue].

[Medicaid] needs a more comprehensive and updated system that is "more user-friendly.

Want more ways to know how to go about enrollment.

> [My experience with medicaid was] positive in terms of coverage, but difficult due to bureaucracy.
>
> Streamline [the] process and enhance cultural competency.
>
> [I have experienced] administrative issues, sometimes I don't get attended to in time, just sitting down there and not getting anything for a long time because of administrative issues.
>
> The[y] dislike the annual renewal [process] and filling out the application. And it's such a struggle to get all of our patients to get them, get them done and get it up to date.
>
> Yeah, I've had experiences with Medicaid, sometimes it wasn't so good especially when it came to verifying my insurance.
>
> Medicaid is a favorable insurance for families with average income and their reluctance to be of help sometimes is concerning.
>
> My experience with Medicaid is kinda conflicting to me. I'm a huge fan of the benefits but some of the processes and criteria involved causes a lotta unnecessary delay sometimes.
>
> The paperwork, the endless paperwork [is overwhelming].
>
> I remember feeling overwhelmed, when I was going through the process, and I was told I had a 30-day deadline to enroll in my employer's health coverage or else.

A related issue surfaced in the in-person events involved gaps or lapses in coverage related to the renewal process. One Minneapolis commenter argued that the "renewal process causes gaps that could/should be avoided," going on to say that "navigation was *a lot.* [There were] problems with understanding coverage, dental especially…[There is a] need to acknowledge it as a support system that is not available to all. [It seems like there is an] incentive to not be able to grow because you risk losing your insurance. [There are] holes that need to be covered." In Bemidji, another commenter said: "At Red Lake they get put on Prime West, but living on reservation they don't need that, there's an exemption so they can be straight [Medicaid]. Lapse[s] in coverage can be challenging." Other commenters echoed similar concerns about the complexities of understanding coverage, and in Bemidji, questions about the implications of different forms of insurance coverage for obtaining dental care were of particular salience, with commenters sharing the following insights:

> If a service like 'dentures' is not available on the reservation, we have to pay for it.
>
> Dentistry is very difficult. They would rather pull your tooth than work on it.
>
> Dental is really hard to access. They would rather take private insurance.

A number of groups discussed a small set of miscellaneous barriers and challenges they have faced during the conversation about their experiences with Medicaid, and though some appear more generally directed toward the broader experience of seeking healthcare, they will be discussed here in the context in which the comments originated. Among virtual participants, cost was a factor several participants foregrounded in their discussions of Medicaid experience and barriers they have faced when seeking healthcare. In Bemidji, one group discussed transportation barriers (a recurrent theme

throughout the Mindstorm), suggesting that "Some of the elders in our community do not have access to rides. It is very complicated to set up rides. [There are] lots of stipulations to getting a ride." In Minneapolis, another group discussed challenges facing those dependent on regular medications, with one participant noting that "diabetic supplies and insulin change constantly," and another confessing, "I didn't like that they kept changing their high-cost drugs that I needed monthly." A few groups raised a set of issues related to trust and a sense of safety when seeking healthcare, as in the case of one Duluth commenter who echoed discussions about hesitancy to seek care which appear elsewhere in this Mindstorm, opining that "If you don't feel safe where you go to have your healthcare, you won't go to have your healthcare." In Minneapolis, during their small group's discussion of challenges with the renewal process, one commenter emphasized the importance of compassionate customer care, suggesting that support professionals should focus on "giving confidence to seek help, care, [demonstrating] compassion in the process. Provider knowledge [is] expanding. What does it look like to grow and be willing to learn and be people centered?"

Several sections of this Mindstorm ask, in different ways, about participant priorities, and what DHS might do to support what American Indian communities and people are already doing to promote and maintain health and wellbeing. In this section, several groups of Minneapolis participants described existing community resources they value and would like to see supported, recommended to one another community resources for Medicaid support, or suggested resources which do not currently exist that they would like to see available in their communities. Among these were recommendations to "support MNSure navigator at [MAIC or NACC][7] and other tribal and urban clinics (it's helpful)," and comments about the value of the Native American Community Clinic (NACC) and the Indian Health Board of Minneapolis (IHB), which one participant suggested help "breakdown a lot of red tape, [if you're] not getting help – [they can] help [with] insurance, co-pay (no money), [if you] don't get [your] meds." Other comments suggested that there is a need for "more funding support for community-based navigation support programs, as well as gyms, wellness spaces, other kinds of preventative health resources," or proposed interest in "set[ting] up private places for detox with areas to use drugs away from students, kids, families (safe center to use drugs)" in the interest of compassionate care for those managing substance use disorders.

Among virtual participants, the limitations of telehealth care options also emerged as a supporting theme here, with participants noting "dead spots" and underdeveloped "wifi/broadband" networks in rural areas that make connecting to telehealth appointments difficult, challenges navigating unfamiliar technologies, and gaps in cellular service affecting the ability of potential patients to access even audio-only telehealth services. Even so, at least one commenter in this section (and others elsewhere in this Mindstorm) expressed interest in seeing telehealth options for care expanded. Some of the ways participants described these obstacles and issues are highlighted below:

[7] Transcription "NACE" unclear in the notes, might be a reference to the Minneapolis American Indian Center or, perhaps more likely, the Native American Community Clinic, also in Minneapolis.

> Central Minnesota, Hinckley, Onamia, McGregor – in Hinckley, we have dead spots for telecommunications, so we have real problems with telehealth appointments. I'm sure there are places that have dead spots, but it really makes it harder.
>
> Medicaid should open more priorities to telehealth.
>
> In the northern areas, the wifi/broadband is not well developed, you have people living on farmsteads for generations [who] don't have the access or familiarity to the technology.
>
> Cell phones are super popular on the reservation Mille Lacs, but it doesn't do any good if you can't connect to cell service.

Virtual participants also shared several personal stories illustrating their perception of Medicaid in ways that resonated with comments made by participants of in-person events characterizing their perceptions of Medicaid as positive in terms of coverage and benefits (especially for essential medical services, pregnant people and children), but challenging with respect to administrative issues like navigation, paperwork, enrollment and renewal processes, and delayed communications, among others. The complexities of eligibility and challenges of adjusting to post-Covid policy changes also surfaces in these discussions. A few such comments and stories are highlighted below:

> When Covid hit, me and my daughter who was just born was on Medicaid for the entire time. I have experience. I also have experience with MN Care with all three of my babies. The state supported me through all three pregnancies. I'm not eligible anymore, it's very funky, my son is private insurance, my daughter qualifies. My niece is on Itasca care. I'm uninsured, which is a surprise to me, so I'm hoping to get on ta program. When the public emergency stopped, I was thrown off, and now I'm trying to figure out what comes next.
>
> I do work for the medical clinic, and we have patient navigators. Patient navigators will often help patients to apply for Minnesota Care. I wish that could be extended to help with Medicaid enrollment. That's kind of an experience. It's a wish of mine, but who knows where that's gonna go in the future. We see a lot of advertisements on TV that changes are coming and do you want to apply for Plan C or D and here's a number to call. But I think it needs to be a lot more focused than that, where you can have a navigator to go over the different Minnesota care plans and then go over the cost of care and help you eventually make a decision. It can be so complicated, and it takes so much time, the amount of time you spend on the phone… the decision I made ultimately was just based on wanting it to end and be over. I did get good care eventually through SSI, but it needs to be more focused.
>
> So, maybe I'll share my personal experience with, Minnesota Medicaid. I'm just to kind of, get the ball rolling. So, for the first 21-22 years of my life, my primary source of health care was the IHS [Indian Health Service] health system…as well as Minnesota medical assistance. It was not until I had delivered my first child that I had ever subscribed to my own health plan or not been the dependent of somebody on Medicaid. So that was kind of a rude awakening for me and my paycheck, I remember. But one of the most meaningful experiences that I have with Medicaid, and even the IHS health system, is that with my first pregnancy, I was deemed a high risk, and my child was diagnosed with a birth defect that required a higher level of care than some place like CAS like I guess…could provide to me or my child, and through the IHS contract program as well as Medicaid, I received a referral, to the U of M in the cities, for all of my maternal fetal care as well as the month long NICU stay that my son had when he was delivered. And if not for Medicaid, and the referral system that was in place, his care would have ultimately ended up costing me close to a half a million dollars. Luckily, he's gonna be turning 9 next month and he is, perfectly healthy and I'm just incredibly grateful for, the support and the systems that were in

> place when I needed that higher level of care and the people who were involved in facilitating that process.
>
> Yeah. Medicaid has been absolutely, invaluable to my life and the quality of life that my children have had as well.
>
> My family is considered lower middle class. Both my husband and I work full time as parents and even though I am not – no longer – eligible for Medicaid based on my income as an adult, I am still particularly grateful for the coverage that I still receive for my children. I love that Medicaid has expanded benefits for my children. I love that Medicaid has expanded benefits for children under the age of 18. And that even for some of these families who are a bit higher income than others in the community that we're still receiving that help and that cost-effective reimbursement. That's an extra $300 back in my pocket every month that I otherwise would not have because I'm still within that. The income guideline for my dependents, so for larger families especially, if you have that primary insurance it takes a little bit of the brunt away from the impact that paying for that health insurance, especially in some of our markets, can otherwise have.

Notably, similar comments appear elsewhere in the Mindstorm, as in the case of a virtual participant who shared in the notes for Section 4 of the discussion guide, “I felt very taken care of as a pregnant woman, keeping my baby on it. I wasn’t in a very solid financial position, in a state of transition, and I just give thanks for being on it as a pregnant person, because I walked out of the hospital without a huge bill, which is a big deal in the U.S. You can document that in the notes, I’m grateful for that.”

Question Set 4: Obstacles (Seeking Healthcare), Resources for Support

We asked: (a) *Are there any* ***obstacles you face when seeking healthcare?*** *If so, are there specific* ***resources or forms of support that would help*** *you to overcome those obstacles?* ***(b) Have you or a family member used audio-only (telephone only) telehealth services*** *to access care? If so, what was your experience?* ***(c) What would you like to see Medicaid / MN care prioritize?*** *Are there any* ***supportive resources*** *you wish more people knew about and were able to access?* ***How can MN Medicaid add value to and support what Tribal nations and American Indian communities are already doing*** *to help members realize their full health and potential?*

Twenty-nine (29) small groups (18 virtual and 11 in-person) chose to address this set of questions focused on obstacles participants face when seeking care, audio-only telehealth experiences, and community priorities for Medicaid. In this section, many participants of the in-person events chose to revisit and expand upon issues raised in other sections of the Mindstorm small group discussions. Participant comments suggested that basic needs have “a domino effect” on health and wellbeing, accessibility of care and resources, emphasizing that costs of care are not only financial and material, but also emotional, psychological, and physical, directly impacting their health and wellbeing. Discussion groups revisited challenges accessing dental, vision, and perinatal care, often linking them to the geographic distribution of resources and urban-rural divides. They described challenges around anxiety, hesitation and stigma when seeking care, describing the difficulties of dealing with trauma and mental health concerns, and reiterated the importance of clear, consistent and respectful

communications (and care), presented in a manner suitable for patients from a range of educational backgrounds. Importantly, comments also returned to the idea that land, water, food and questions of sovereignty or self-determination are central to American Indian health and wellbeing, and advocated for broader, long-term sustained community dialogue and community-informed decision-making. Desire for better advocacy, support and protections for elders (and those providing eldercare), youth and those suffering from substance use disorders again appears in this section, as did discussion of the strengths and challenges of telehealth options.

On the question of basic needs, transportation issues were particularly highlighted, though housing, food, and financial vulnerability in general also feature among the cited challenges participants of the in-person events faced. Some emphasized that choices about care are especially limited for the financially vulnerable or pointed to difficulties faced by unenrolled American Indians, while others linked such challenges to hesitancy seeking care or noted the obstacles facing those who cannot qualify for Medicaid, but also cannot afford care. Among virtual participants, the cost of care more generally – including both money and time – was most highlighted. Below are some of the comments participants of the in-person and virtual events submitted on this theme:

In-person, selected comments:

> Transportation is a big problem.
>
> Transport[ation is a major struggle] – physically, emotionally ([it's draining to experience the] tensions and emotions that are caused by trying to use your healthcare).
>
> [I have struggled with] financial barriers, transportation, limit[ed] hours.
>
> Rural transportation; access to transportation [is tricky].
>
> [It's hard] having to drive 70 miles to deliver your baby.
>
> Housing → [and other basic needs] all [have] a domino effect [on health].
>
> Social security and resource access [is hard for me] – and collections took taxes which was going to be used for a vehicle [to resolve transportation barriers to receiving care].
>
> [Participant] wants to go where he wants to go [for care] and [is] worried about the bill and no insurance. Son is already on bills. People cannot afford to twice and has no food.
>
> Restrictions [are a barrier], and [I] make too much to qualify for MNSure.
>
> Fon Du Lac only helps with enrolled members, blood quantum rule.
>
> Many people will neglect their health because of the barriers that prevent them [from being able to access care].

Virtual, selected comments:

> [The] primary obstacle is finances.
>
> Expensive for healthcare, no subsidy available.

[The] cost of healthcare alone is a lot, and I don't have a car, so [there is also the cost of my] time and cost of transportation [to consider].

Cost of healthcare is relatively high – reduction in the cost of healthcare would go a long way.

[I have had] issues with accessing medication, the medication wasn't covered, and they had to pay out of pocket. Was helped to find a way to reduce cost, but it was not convenient or useful.

To some extent, finances are an obstacle.

Time is a challenge–busy schedules.

Availability of resources and finance to get the resources.

Related to transportation challenges and the urban-rural divide, many participants of both the virtual and in-person events described difficulties they have faced accessing dental, vision, and desired perinatal care (especially midwifery services) and emergency or preventative care resources, citing the constraints produced by the uneven geographic distribution of resources. Some of the ways participants discussed these issues are raised below:

I haven't gotten [referral] letters, not one for dental.

[*Facilitator asks:*] How do you feel your healthcare is here? [*Participant responds:*] It's okay. Fon du Lac can't help here. No one takes [Medicaid] here [in Duluth]. [My] daughter needs dental surgery, needs braces and it needs monitoring.

In order to get healthcare, I need to go to the cities.

Dental provider also told me that I need to go to the cities.

No one accepts [Medicaid] here [in Duluth].

My son needs glasses, but medical insurance is a problem.

I live in Grand Portage [which is] very rural. [It] feels like [there are] not high-caliber health care providers. [Currently, a] family friend needs help, but [there is] no hospice in [the] entire county. [I] wonder what will happen when [*my*] husband is dying?

Dental [care] is a concern. People will drive to another town to see a dentist.

[We need] communities that are walkable [in Minneapolis] – close to the area, rural areas (accessibility).

[It's hard to get] midwife coverage.

I just feel like when you go to IHS to get help, they are not giving us quality care.

Limited access to appropriate healthcare facilities especially in remote areas, don't provide appropriate care. [*Virtual participant.*]

Availability of resources would go a long way. [*Virtual participant.*]

Physical distance from healthcare; commuting to doctor, transportation [are all significant barriers]. [*Virtual participant*.]
Dental care: [there is] no way to find any appointments in the Twin Cities to get dental care. [*Virtual participant.]*

Working at a free clinic in the Phillips Neighborhood, [I have found it] difficult to find places to refer

patients to who are seeking dental care. [*Virtual participant*.]

Lot of people like UCare because you get a free gym membership; if more MCOs had health care benefits like free gym memberships, that would help a lot of families get exercise and access health care.

With respect to anxiety, hesitation to seek care, and concerns about trauma, mental health and stigma, participants pointed to the effects of generational and historic trauma, emphasizing the need to move past stigma in pursuit of quality mental health care (and coverage for such care), as well as trusted providers. A selection of comments on this theme are highlighted below:

Knowing you are worth having health insurance [is a challenge].

[It's] intimidating. I deserve good health. [But not feeling that way is a] common thing that [the] younger generation has internalized.

Becoming more aware of the generational trauma, what families have been through [is absolutely essential].

[There needs to be a real] acknowledgment of the obstacles [we face], history.

Mental health – understanding mental health [matters].

Access to therapy, past the stigma [would help].

Finding quality mental health care [is difficult].

Mental health coverage/access for invisible diagnosis [is an obstacle for me]. Having a local mental health provider that I could see that takes my insurance because I have to do all telehealth for mental health appointments.

There is a distrust with women. Looking for female practitioners.

Among virtual participants, hesitation issues were more frequently linked to "shyness" or anxieties about potential outcomes (sometimes informed by historical health inequities for American Indian patients) when approaching healthcare professionals, and the psychological difficulties of self-advocacy for such patients. A selection of comments illustrating such perspectives is reproduced below:

Shyness in approaching healthcare personnel [is an obstacle].

[One] obstacle I face is shyness to approach the health care personnel.

> Fear of the unknown and not wanting to find out you have a health problem; lot of Native American families have historical health disparities in the family history (i.e. high blood pressure, diabetes) [which can contribute to these anxieties].
>
> Shyness is an obstacle. Not everyone has the courage to advocate for themselves…There needs to be more awareness programs, more flyers, more information."
>
> Fear and anxiety about diagnosis [has been an obstacle for me].

In their discussions about the kinds of communication processes that work best, in-person participants urged that medical communication needs to be "respectful" to qualify as "care," with some recommending "constant reminders for things you need to follow up," and others sharing that they "prefer reminders from [their] healthcare provider, and maybe not [their] insurance provider," suggesting perhaps that more relationally-based communications are more effective and welcome. Others described the utility of "infographics," arguing that "MNSure and Medicaid could do better here," or, returning to issues around the renewal process, shared that, for them, "[The] renewal process is a huge obstacle. Language and conversations that are not explained/reasonable [are frequent barriers]. Engagement that provokes arguments based in frustration [often results]." Virtual participants also discussed outreach and communications, considering how flyers, social media, and outreach processes might be made more widely available and accessible. Some of the ways participants of the virtual events described these issues is highlighted below, in the notes from one group's discussion on this theme:

> One of the obstacles I encountered you couldn't get equitable access to services. I feel there's a way to be introduced or enlightened on what resources where we need to search. The healthcare as a whole should be upgraded to in terms of availability. Outreach is so important.
>
> [*Facilitator asks*:] What is the best way for you to be reached?
>
> [*Participant responds*:] Flyers should consist of the best resources. Where you can access resources where you can find the best hospitals, you know. That goes a long way.
>
> [*Facilitator asks:*] What about social media?
>
> [*Participant responds:*] I've always thought it was frustrating that when you go on social media, if you want to know something about like health like for example, I wanted to fill out a survey for my area school district. The school district wanted us to participate in the survey and I'm like where is this survey I can't find it anywhere, but you know if I logged on to my Facebook page and wanted to know gossip or like some dramatic thing that's happening, I would know it in 2 seconds. So, I've always found that frustrating that if data really is super available and you can really make a presence with things on social media but it seems like people are so much more interested in in sharing drama and negative things than they are about sharing things that are beneficial to our health. So, I always found that frustrating.

As in the in-person events, however, virtual event participants felt strongly that respectful and compassionate communications were an important element of making Medicaid and healthcare systems better and more accessible, with a number of comments linking such respect and empathy in communications with needed anti-racism efforts and issues of cultural competency. In the words of one virtual participant,

"experience with Medicaid is [a] cultural competencies issue, and there is a limited providers' network." Other participants made these connections in ways illustrated by the following excerpts from the discussion notes:

> [One of the] biggest obstacles I'm faced [with] is discrimination and the way doctors explain or miscommunicate and talk to me as a patient.
>
> Having somebody who is culturally competent or looks like me is rare to find.
>
> They often don't talk about my stress, the things affecting me every day. But my doctors often just tell me I'm fat. I'm a caregiver for my husband, it's hard to find the support.
>
> I'd like to bring up something that relates to this and the question before – the experience of being an adoptee. Forms to this day don't leave a place to indicate that you are adopted and that can be really frustrating. And the blatant racism.
>
> Racial discrimination [is an issue] and [it is related to the experience of] low accessibility [of care].

Some groups were especially pointed in their consideration of the need for ongoing and meaningful community dialogue and engaged decision-making, expressing these interests and concerns in ways illustrated by the following quotations from the notes of the in-person events:

> We need to have these sessions more often.
>
> DHS is perpetuating the disparities we see.
>
> DHS needs to change the policies that are in place.
>
> If we could get our leaders who run the reservation to have an open meeting to discuss these things [that could make a big difference].
>
> If we could have a bigger meeting maybe that might make a difference.
>
> We need transparency to what is happening in Medicaid.

A smaller subset of comments also returned to consider the centrality of land, water, food, sovereignty and self-determination, raising the issue in comments like those below:

> [I need to be able to] access traditional medicines and foods.
>
> Disconnection to food and to people and to health [is a big problem].
>
> How about a program that is including food and healthy food? [There is a saying that the] 'Garden is women's sweat.' Having hands in soils [is medicine].
>
> Land – place and space to grow foods and medicines, foraging [– these are essential to health].
>
> [A barrier I have faced is] water, access to clean water.
>
> Seasonal family traditional activities [are important].

On the need for better advocacy, support and protections for elders, youth, and those suffering from substance use disorders, participants proposed the following ideas in the notes from their in-person and virtual discussions:

> There should be better protection for elder[s]. Sometimes guardians are needed.
>
> We had a mentorship program for our youth [here in Bemidji], but the program ended.
>
> It's hard to find someone to do a Rule 25 [to get help for someone suffering from a substance use disorder]. It takes so long people end up going back out for lack of support.
>
> There is no support entailed to help people get the treatment they need.
>
> There should be a 24-hour treatment center here in Bemidji.
>
> I think for me, I can kind of speak for my dad who is going to be 88 this summer. He's kind of hard hearing and so I'm seeing for the first time the lack of patience people have with explaining what's going on and what he needs to do, and so as his caretaker, I have to really make sure that I understand really well so I can explain it to him later. I saw one provider do something that worked really well, she took the time to ask him after each step what he heard to make sure he really understood, and that was really effective. So, I'd like to see more people do that. *[Virtual participant.]*

Both in-person and virtual participants spent time enumerating the benefits and challenges associated with telehealth and audio-only telehealth appointments, offering a range of perspectives from which emerges a mostly-positive view of telehealth alternatives as one additional option in a wider healthcare landscape which for some needs and circumstances *can* offer a solution to transportation challenges, or a convenient way to meet some basic health needs, though a number of complexities and barriers were also raised by both groups of participants. Several discussion groups submitted notes describing their preference for an emotional connection with healthcare providers and suggesting that such a personal and relational experience is less common or more difficult to achieve in telehealth models. Others focused on challenges related to long waitlists for telehealth services, the difficulties of navigating potentially unfamiliar technologies, and the gaps and interruptions in internet and cellular phone service which make connecting to such resources difficult, especially for elders and those located in more rural areas (or lacking base technologies like access to a phone or computer).

Below are some of the ways that participants of the in-person events raised these issues:

> [I] have no phone, landline or cell phone, can't have both – lose cell phone then no more phones [so telehealth is inaccessible to me].
>
> [You need] access to internet to get help. [The] waitlist on telehealth [is] too long, setting up appointment[s] is big barrier, need on-call [services and support].
>
> [There is a need for] more internet providers, not just Xfinity only at Red Lake building, need more internet service providers [to make telehealth more accessible].

I've used phone only appointments and it was okay. I used them but didn't have my chart on file, so they didn't know my personal background.

…Having a local mental health provider that I could see that takes my insurance [is a challenge], because [of that] I have to do all telehealth for mental health appointments.

Similarly, virtual participants had much to say on this theme. Some of the ways they approached the topic are highlighted in the quoted material below:

Telehealth is convenient, saves time for routine appointments such as for medication prescriptions.

Using tele-health that was very helpful, [I was] able to attend with other family members.

A major obstacle one person [in our group] shared was that telehealth did not provide an emotional connection and by that, they meant the provider was not able to understand how they felt. This person feels like telehealth could be useful for consultation but not urgent [health concerns]. Telehealth may not be able to validate your feelings, or you may not be able to understand your concerns and it can be difficult to diagnose someone [virtually].

I've used telehealth services before, it's a very good service but I prefer the physical visits. I think it is more effective than the telehealth services. [*In response, another group member replies:*] I agree. I prefer in-person too.

My experience with audio-only telehealth services has been positive for routine check-ins, but I believe in-person visits are essential for more comprehensive care and examinations.

No internet access issues can also be a barrier.

I think this [question about telehealth] is really an important question also. I had mentioned some of those disparities when I spoke the last time, but to have some other kinds of considerations, especially for elders who might say that my eyesight isn't that good, I can't read what's on this form here, or I don't know how to use the technology here, or even the font is hard to read or too small – these can seem like small things, but they are important to elders who can't see very well. There are a lot of people I know who are elders who talk about these issues with technology and not being able to access telehealth for example, for those reasons. Or they might have seen on TV about this phone that reads out whatever the person you are talking to said, I don't know what the service is called but it's supposed to be for people who are hearing impaired or sight-impaired – I wish that they could have access to those resources. It would be great to make these resources available with some training for how to use them. Often, I think there can be some shame about saying that they can't hear you, so they will nod along even though in reality they can't hear, which leads the provider to think that they can hear them. I think there can also be some anger when they feel like they are having issues that aren't being heard or taken seriously. I have a friend who is an attorney and a doctor also – which is a strange mix – but he worked at one of the reservations up there, and he started losing his eyesight, and called me up one day and said what's going on down at the clinic there, they sent me a report on my metabolics and I can't read it, so I said I will go down there and read it to you.

Transportation is a challenge when seeking healthcare. Access to affordable transportation services or telehealth options would help overcome this obstacle. I haven't used audio-only telehealth services, but I see its potential for remote areas. Prioritizing telehealth accessibility and culturally competent care through Medicaid would greatly benefit our community."

Prioritize language accessibility and telehealth options for all.

[When it comes to] language barriers – having an interpreter available [helps].

[Medicaid] should open more options for telehealth.

Participants of the virtual events also used this section of the Mindstorm to expand upon or continue conversations about administrative challenges with Medicaid or healthcare more broadly, pointing to long delays, system inefficiencies, and overly complex administrative processes in particular. Comments in this section also highlighted confusion about where to go for information about enrollment and coverage with some suggesting that existing resources are unclear and others emphasizing experiences of information overload, or general issues around the lack of clarity or confusion they have experienced when seeking information about their options and attempting to make decisions about health insurance and care. Such themes are illustrated in the excerpts below:

On long delays, system inefficiencies, overly complex administrative processes:

[Our group had a] discussion on delayed responses when seeking or reaching out about healthcare. New updated systems and making it user friendly to all education levels [would make a big difference].

Another person [in our group shared] – and other people echoed – that the delayed response in healthcare is a major obstacle. Another person further said that a long waitlist – if it is very difficult to make an appointment with a healthcare provider – a long wait time might inhibit the person from going back to the service they need. The delayed response in healthcare was emphasized by another person [in our group] as well. Somewhat related to this, a person wrote that inefficient workers were another obstacle in accessing health care.

Long wait times, fear and anxiety about diagnosis.

I would say personally I haven't really experienced any, in my case the diagnosis process was amazing. But there's this administrative delay, and not for me but for some of my family members there's [something] controlled by us, which I haven't experienced personally, but I think of the administrative delay.

I have experience with Medicaid/MN Care, which has provided essential healthcare but can be difficult to navigate. These programs help but sometimes delay access to treatment.

My role is in quality and compliance and making sure programs are credentialed. I make sure the programs from the providers are credentialed, one thing that is frustrating, we need to register differently because we're a tribal entity, so we have to reach out and ask questions. The help desk doesn't understand tribal healthcare and don't understand how to help us navigate those forums. It's an opportunity to really improve the folks working the help desk had more understanding on how tribal healthcare works and how the tribes connect with State of Minnesota healthcare system.

On where to go for information about coverage, enrollment; information overload and lack of clarity/confusion about options and decision-making:

[It's been difficult] trying to figure out what is actually covered by insurance and what is not covered by insurance.

> Where to find a doctor to go to, and making a commitment, navigating the h[ealth]c[care] system [– these are things I struggle with].
>
> Choosing a plan was difficult because it was unclear what the differences were, and being assigned one meant the pediatrician their kid went to fell out of network and was turned away. The process for correcting that took too much time, so had to pay out of pocket.
>
> When it comes to the lack of information in the healthcare system it can be confusing and overwhelming.
>
> Understanding who [can] qualify for Medicaid and understanding who are eligible for Medicare [is confusing]. The process can be cumbersome and time consuming to complete the application form when English isn't your first language.

In the words of one participant, linking this issue with other key themes from the overall discussion: "To improve health for American Indians in Minnesota, we need simpler processes, more funding for culturally competent care, and better access to traditional healing practices."

Question Set 5: Participant Questions for DHS

We asked: *Do you have any **questions for DHS?** Is there anything you'd like to know more about? Anything DHS should know?*

In this section, thirteen (13) small groups (7 virtual and 6 in-person) submitted notes outlining two categories of feedback: (1) lingering questions that participants had for the Department of Human Services (DHS) and (2) information that they believe DHS should know. The comments in this section have been organized accordingly and reproduced below for the department's consideration.

From in-person participants:

Questions for DHS:

- "Why are things so expensive? Drugs? Childbirth?"
- "Waterbirths" [Can these be covered and made accessibly available?]
- "Why aren't midwives covered [for] home births specifically?"
- "What should I be doing as a kid?"
- "How do we more easily get health information that is relevant and answerable?"
- [One commenter also wanted to know where the sticky stat data on the numbers of American Indian birthing people on Medicaid came from.]
- "Income changes jeopardize care – how can we curb this? Cushion period?"
- "Can we create a service of coverage that is aimed at relief? Percentage based."

Things DHS should know:

- "Make mental healthcare more accessible."
- "Medicaid should cover fresh fruits and veggies."
- "More transportation coverage."
- "Help to fix cars, replace transmissions."
- "Low interest loans to support needs: fix car, pay rent."
- "There is no access."

From virtual participants:

Questions for DHS:

- **Internal Racial Equity Qs:**
  - "Is employment among Minnesota DHS, Medicaid workers and healthcare providers racially equitable?"
  - "Will a qualified doctor from a minority community receive equal opportunities?"

- **Outreach and communications:**
  - "How do you [inform] people about Medicaid? What strategies do you use to reach out to people?"

- **Policies, Initiatives and Next Steps:**
  - "I'd like to know more about how DHS plans to improve healthcare accessibility for marginalized communities. Are there specific initiatives in place to address cultural competency in care? What steps are being taken to streamline the Medicaid enrollment process?"
  - "[I'd like to] learn more about social determinants of health within Medicaid programs. How is DHS collaborating with community organizations to provide support beyond medical care? How does DHS plan to enhance healthcare access in rural areas, especially for American Indian communities?"

Things DHS should know:

- "I just want to tell DHS to carry out **more awareness** programs and **more studies like this."**
- "DHS should know that there is **still a lot of mistrust** in DHS – especially in American Indian communities. For hundreds of years that information has been used against us. So, if you are having a hard time getting the info you want from AI communities that's why. Repairing that trust is a MUCH larger project than these small reports like this. Sharing is difficult for us for that reason. ***If you are hearing silence when you want data that's why**."*
- "Part of me feels like there if there was a better process for even automatic enrollments or **some sort of streamlined ability to identify people in the community who maybe lack access to healthcare** or, you know, have maybe

reduced access or, you know, the financial eligibility [it would be a huge improvement]. In a lot of different I think other areas of our life you know health care being the one that we really need, there's a simpler application process and there's so many people who go without health care coverage just because navigating the system, advocating for themselves. Those can be real challenges. Whether we have communication, language barriers, you know, our, cultures are not intersecting, I think. Sometimes I feel like maybe if there was more of like that, like door-to-door type knocking type effect, that sometimes we would get more enrollment numbers **because open enrollment I think can be really overwhelming for a lot of people too**."

Question 6: Anything Else?

We asked: *Is there **anything that we didn't ask that we should have?** What isn't here that you would like to see? Are there any questions you have? Please share your question(s), and any answers that your group discusses.*

Fourteen (14) groups (8 virtual and 6 in-person) submitted notes in response to this open-ended section of the Mindstorm. Among participants of the in-person events, the responses in this section can be organized into five thematic subgroups. Four comments represent additional questions participants had for DHS and three recommend things DHS should know, support or fund. Three comments name questions participants wish we had asked in this Mindstorm, highlighting additional areas of participant interest and concern which may be valuable in future engagement efforts. Ten comments suggest a desire for ongoing engagement and relationship building or speak to the kinds of people who should be involved in such efforts, and a desire for transparency and follow-up on this project. Four comments speak to the value of community participation in policy and decision-making, citing to the courage and vulnerability it takes to share one's story and experiences in such a forum. The comments submitted by in-person participants have been organized into these categories accordingly and reproduced below:

Questions for DHS:

- "Why is there not more community involvement?"
- "Why is there not Indigenous people at all levels of DHS and healthcare?"
- "Why do they want to use us in photos but not actually help?"
- "[What are] DHS['s] accountability measures for equity?"

Things DHS should know/support/fund:

- "More scholarships for Native people to become doctors."
- "Finding more stable federal funding to support more community health programs that address social and cultural and economic barriers to healthy eating, exercise."
- "DHS could be more transparent with what they are hoping to do with this information."

Questions we should have asked:

- "More specific questions about mental health. What do you need that will help you? Impacting employment."
- "[Questions about] social security/disability benefits."
- "[Questions about] culturally relevant communication about practitioners, different kinds of therapy."

More of this: desire for ongoing engagement, community-informed policies, and relationship building:

- "Networking and connecting and staying connected.
    - Need more information and discussions.
    - Strengthen our relationship.
    - Where are the decision makers in the space? We need them here.
    - Being shared openly, umbrella.
    - Feedback to community.
    - Come back and [do more] engagement."
- "I feel that DHS should do more to get more public opinions on more subject matters."
- "Transparency is key."
- "Need more awareness."

Value of community participation

- "Reimbursement of community story."
- "Had to put a lot of trust in the Table and vulnerability and may cause body responses."
- "An individual has a lot of courage to share their story."
- "Involvement of community story."

Among virtual participants, submissions in this section of the Mindstorm can be organized under four key headings. Two comments speak to the desire for more opportunities for engagement and dialogue like those offered by this project. Three comments represent general ideas about health and wellbeing or the event materials. Three comments describe community resources or opportunities. And two groups used this space to submit the entirety of their discussion notes in a single section of the Mindstorm, rather than divided by discussion topic or question set. Although the content of these notes has been thematically analyzed and incorporated into the section-by-section discussion by theme, the full text of the notes and transcripts from the discussions can be found on page 48 of this report (entries for this section start on page 79). The remainder of the comments submitted by virtual participants for this section of the Mindstorm have been organized accordingly and reproduced below:

More of this (ongoing engagement):

- "I will advise the organizers that more of this program should be carried out. Like more outreach."

- “Creating more insights and more of this program, it’s really educative [sic].”

General comments on health and wellbeing and/or the event/materials:

- “Wellbeing is very important and not just one thing. It means different things for everyone (it’s not just health, but also other components.”
- “Keep being stronger and getting better.”
- “Some of the sub-questions could have been their own questions, especially the specific ones about community resources and needs.”

Resources/opportunities:

- “Lot of MCOs attend Native American events as vendors, it would be great to see DHS at these events tabling.”
- “Hennepin County has a community-events calendar they can share.”
- “MA-PD program, Native Americans don’t have a premium they need to pay but after the pandemic, a lot of people are getting put on spend-downs. Native American people should not have to pay spend downs.”

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversation Series Kickoff
14 May 2024

Mindstorm: Oral Report Notes

About These Notes

The below notes were taken by members of our research team during the oral report-out from the Mindstorm small-group focused conversations during the Engage! Pathways to Racial Equity in Medicaid Kick-off event hosted virtually on Zoom on May 14, 2024. During this activity, participating discussion groups nominate a representative

from their small group discussion to share with the larger group a few key themes emerging from their conversations. Groups have been numbered according to the order in which they presented.

Group 1: Wellbeing and health: So, in the group we discuss[ed] about wellbeing, and I just found out that people have different meanings. They understand wellbeing in different perspectives and according to the whole, to the group, it just came to a conclusion that wellbeing is different in different persons, different domains. It's in both physical, mental, emotional and social aspects of a person's life, involvement in terms of such as happiness, life, satisfaction, full, and the overall contentment. So, I think, you know, some, so most people just think that well-being is just like and well-being. And I'm not sick. So, that's all. But you have to consider those factors that it is physical. Mental, emotional and the social aspect of your life. Yeah, maybe when we talk about health, we can focus more on the physical. But yeah, so, both held it is the state of a person's body and the sense of to seize or injury. So, when we talk about well-being, people should not just think about health. Cause health it's, well, health is under wellbeing, so you should focus on physical mental, emotional and the social.

Group 2: Thank you so much, we talked about a lot of the questions, I think. Some of the pieces that I'm reminded of are just how important it is to be incorporating awareness of. Diversity equity inclusion work. In all of these areas and also knowing that that always doesn't incorporate proactive anti-racism work, which is different than DEI work. So just making a note of that, the importance of access. To traditional medicines. Listening for perhaps what isn't being said. Especially when folks are feeling vulnerable, it was shared that, you know, sometimes maybe their shame around one's experience or medical story. So, listen for what's actually not being said. I think is important. And then I think lastly, a population that maybe sometimes isn't always heard from is that of those of us who are adoptees. And how do our stories and our histories and lack thereof come into play with, in the systems as well. Thank you for listening.

Group 3: So, one of the conversations that we had in S——'s and my group was that lot of the times it's very challenging to know where to begin finding a medical provider if you don't know or if you don't have insurance. It's just a very challenging step to begin finding your health care provider or knowing who to go to for what.

Group 4: Really the main emerging theme in our group was just kind of the delay in service. It came – it kept coming up repeatedly and in multiple questions. So, I would just say that's kind of the big takeaway in our group.

Group 5: There was one thing that I thought was really powerful and that was the person shared that with more complex medical needs, Medicaid didn't cover some things and so then it just kind of seemed pointless. And that really stuck with me.

Group 6: I know we talked quite a bit about the importance of physical and mental health being. You know being accounted for when we're talking about health and wellbeing. The importance of advocating for yourself. Having, insurance options. And coverage for the service that you need. And then. The other aspect of health and wellbeing is that. You know, ensuring that our body is at its utmost level, so happy, healthy. Being in a calm environment. And then of

course doing the things that maintain health, drinking water, getting exercise and, discussions about also yoga. Around obstacles, I, I think maybe, in addition to what has already been mentioned is. Sort of where there is hesitancy and sharing. What you're experiencing so it was described as being shyness, having shyness that that's an obstacle. And then learning, this process of what it means to advocate for yourself and having that courage, but it's not necessarily something that you are kind of already know how to do, you kind of have to learn some of those skills of, advocating on behalf of yourself and your loved ones. And I think. Awareness again also came up. Creating information that is gonna be accessible but also you know information that you know allows for people to be able to understand the complexity of health and health care.

Group 7: When I showed the question, do you have any questions for, DHS is there anything you'd like to know more about anything they just should know one of the participants said for Medicaid She likes, she likes their coordinated care, but. They have complex eligibility. And me and L——— kind of talked about it if she can speak to it like. I was kind of wondering like what kinds of complex eligibility like. Like what exactly? But you know, we didn't, she didn't get to elaborate a lot, but we just talked about, I thought that was a good point like everything can't go the way it should when it comes to, coordinated care. So, that kind of stuck out for me. I don't know.

Group 8: I know we talked quite a bit about like sort of access to transportation and I don't remember the name of what it's called, but the transportation that you get for your appointments and actually get to the hospital in clinics and that there's been a lot of barriers. And just like lack of accessibility and just lack of like basic patient care and compassion, it seems like, from a lot of. A lot of times experience using those transportation options. And then towards the end of the conversation, we were also just talking about, I was saying, wouldn't it be really nice if there was a way that you, not that you could just avoid any sort of like, racism or any sort of biases. It's not gonna be 100% foolproof, but wouldn't it be really nice if there were a patient directory and you were able to find providers who are going to be trained in and on culturally competent health care and being able to take care of, provide health care for Native folks and then R—— also added on and said yeah, wouldn't it be nice if to be able to accept Medicaid if you had to have completed so many CEs towards culturally competent health care. So that's sort of, that was a big thing. I remember her saying that she wanted to share. Yeah, we were talking about, the struggle with disability benefits and just not having, the right resources to get through the Medicare system without facing some challenges along the way such as having the right providers and having them listen to you when you walk in the room and like fully understanding your story rather than taking you at like face value of like what you're coming in to do. There're some other aspects in people's lives that affect their health and that's something that's not considered when they walk into the medical room. So those were some of the things I noted down. And just more talking about what challenges were faced by marginalized communities and Tyra you also mentioned smudging and bringing that into the rooms and being questioned by providers about smudging and what that is and not really fully being accepted into spaces, and that's something that was seen as valuable. To a lot of people in our discussion group.

Group 9: My group was all introverts. Shout out to K—— for really participating in the chat.

Our group talked about cost and specifically how finances are a huge obstacle to being healthy. And that, yeah, that one piece the most. Health organizations can start is just looking at the cost of access to care.

Group 10: And in my group, our discussion was very short, but we definitely talked about the obstacles that people face when getting a hold of Medicare or even healthcare. We also talked about how we can't get like they can't get ahold of certain medicines because of the kind of Medicare that they have or the health plan that they have. But yeah, that was kind of the gist of what we talked about. So, we didn't get too much, but yes.

Group 11: We had a shy group as well. I talked most of the time. But a lot of my sharing was my personal experience with health. So just having my family members pass away in the past year and a half, all due to health-related illnesses and just how important it is for me to care about health and wellness as the matriarch now of my family. So having like everyone kind of depend on me now, it's really important that I take care of myself. So, I just shared a lot of personal information, but it was it was received well in the chat by a couple of folks which wish was validating so I was really glad to have shared but yeah, we had a shy introverted group and I'm a flaming extrovert, so…

Group 12: I don't think my group has shared. So, K—— and I, group had a wonderful conversation and two themes that came up a couple of times was how, you know, health goes beyond the physical, you know, it's mental, emotional, spiritual and it'd be great if insurance and Medicaid reflected that such as like, you know, providing a free subscription to the Y[MCA], so, people can really practice that. And then additionally, you know, now that the weather is wonderful and, you know, it's nice outside. How great it would be if organizations such as the DHS can go to community events, and you know get people talking about their health and healthcare.

Group 13: So, when it came to the first question, what does health and wellbeing mean to you? We talked about how you know, physical, spiritual and mental health all contribute to the overall health of one's, wellness. And so that was a really fruitful conversation in the chats and we kind of talked about how food and nutrition and rest were all very important. And then for number 4, we had a lot of feedback as well, too, in regards to obstacles that individuals face when, seeking health care. Two of the answers that stick out to me that I remember right now are finances and being shy and I think oftentimes being shy comes from being afraid and things that we don't know about things that we don't know, and the unknown is always something to fear. And so, we did have our scribe who was very helpful and very resourceful. I think your name is L——. I hope I'm not mistaken your name again. But she talked about mentor[ing] and navigators and so That's the way for people to be able to like, access insurance help if that's something that they're looking for. We drop the chat; we dropped the link in the chat as well too and so... Yeah, that's about it. I don't know if I missed anything, but. Yeah.

Group 14: Hi, everyone. So yeah, I saw in our group, we actually spoke about the different obstacles we actually experienced trying to access some health care services. Which some part of it was a long wait list, some people had to go through before they actually, get to meet a particular health practitioner. And we actually spoke about our health. What's to do? The

physical, emotional aspects of being healthy, we also spoke about, we didn't really speak, talk much about. We really emphasized the effect of telehealth. Which sometimes one doesn't have this, you know, human connection with the person you're actually speaking with in the other end. So sometimes it happened that you know you don't get to. The person doesn't get to validate your feelings about what you're feeling and cannot really be of help to you at some point.

Group 15: Yeah, I think one of the main takeaways from our group was, just a caution to not discount – some of the main takeaways from our group was, just a caution to not discount some of the traditions or other things that people want to bring in and all the traditions or other things that I was, just a caution to not discount some of the traditions or other things that people want to bring in and all the onus is really on the health system to create that integrated experience that patients are wanting. We just have to figure out a way to do that. These people want to be healthy and well within a social context, that patients are wanting. We just have to figure out a way to do that. These people want to be healthy and well within a social context.

DHS Engage! Pathways to Racial Equity in Medicaid
Bemidji Community Conversation
28 May 2024

Mindstorm: Oral Report Notes

About These Notes

The below notes were taken by members of our research team during the oral report-out from the Mindstorm small-group focused conversations during the Engage! Pathways to Racial Equity in Medicaid Kick-off event hosted in Duluth (in-person) on

May 28, 2024. During this activity, participating discussion groups nominate a representative from their small group discussion to share with the larger group a few key themes emerging from their conversations. Groups have been numbered according to the order in which they presented.

Group 1: I'm one of the older folks in the room, we had a question about what healthcare or wellbeing was like in the 60s when you grew up. For me, we were on welfare, we were always put into general hospital or group clinic, so you felt you were part of a lower-rung healthcare, you always felt like you were a second-class citizen. When you go there you don't see representation, you don't see your own face there. They don't know who you are. We got to talk about [what it looks like] to have wellbeing in your life, what does that mean to you. I remember learning about my cultural connections to my community to provide leadership: value yourself and your community, catalyzing the community to see ourselves as worthy as anyone else. That whole effort in addition to our traditional teachings builds a foundation to healthcare. If you don't have a good mindset on where you are, where you come from, if you don't have that, a lot of things fall apart. Without the support system, these things can fall apart, that's why we do all the negative things in our lives and without those things we need. To live in a dual society, as American Indians, but in a white society.

Group 2: We talked about affordable housing, currently I'm homeless and I can't afford housing, because I got in a shitty situation. We also talked about access to healthcare and mental healthcare, it's a big problem in our community, when we talk about everyday health, they don't realize. Reliable transportation, not having access to a gym. In Hinckley, there was a native gym. Having culturally inclusive therapists, more access to sweat lodges [is important]. At Essentia, there are 10 or more requests per week for traditional healers.

Group 3: I did enjoy all the conversations, [we] discussed every question. One of the things that stuck with me was basically how access to services has been a big struggle over the years. There have been programs that become available, but they're so hard to apply and get all these grants. The community can't even take it, so they don't have to pay any out because it's so hard to apply for it. Which I know you're working on, which is good to see. We mentioned schools, we should be a leader for data in Native American communities. We're bringing in data, but they're patting themselves on the back, it needs to lead to change. We need to stop patting ourselves on the back, but actually do something about those numbers. I'm hoping to make those changes in the next few years. Like water through a canyon, as long as it takes, we need to make the changes.

Group 4: Access to traditional healers, we don't have a listing of traditional healers we can turn to. I don't know if that's something people want to formulate, in my experience when I sought help, I didn't always know, I kept looking until I found the help I needed.

Group 5: We spoke about the challenges that come with healthcare. It's a house of cards, one thing goes wrong, everything else goes. Everything they've faced, their kids have faced, they've shown nothing but grace, integrity, one of the most impressive mothers I've ever had a pleasure to meet, when you need help with NA there are no services available here, they're only available in the cities. what if you don't have transportation, they can't get services in this town.

We need to look at how to improve the system for the most vulnerable, the most needing people in the community, take a look at fixing at what is already here

DHS Engage! Pathways to Racial Equity in Medicaid
Minneapolis Community Conversation
5 June 2024

Mindstorm: Oral Report Notes

About These Notes

The below notes were taken by members of our research team during the oral report-out from the Mindstorm small-group focused conversations during the Engage! Pathways to Racial Equity in Medicaid Kick-off event hosted in Minneapolis (in-person) on June 5, 2024. During this activity, participating discussion groups nominate a representative from their small group discussion to share with the larger group a few

key themes emerging from their conversations. Groups have been numbered according to the order in which they presented.

Group 1: We said not worrying, being joyful, no anxiety, being able to do what you need to do. Going to ceremony. Being whole, being satisfied with what you have. For [question] number two, we said prayer, being outside, being at ceremonies, eating traditional food, music, drums, stuff that keeps us going. Our biggest obstacles are access to land, water, medicine, growing our own food, using traditional foods and we need land to do that, that's our biggest obstacle to traditional food.

Group 2: We had some good conversations, talking about health and wellbeing and what it means to us. We talked about how interconnectedness and that balance for some of us, connected gardening, which ties into the next questions, about family and cultural traditions and routines. Gardening and being out and getting your hands dirty, the spiritual connectedness is important to us. We come from people and generations that are sustainable, we shared a lot of experiences of state programs with obstacles in care, we talked about different programs and regarding health care and mental health.

Group 3: I dominated the conversation, that's why they made me become the speaker. We talked about what health and wellbeing. My input is that we all have a holistic person in us, emotional, social, intellectual, physical, all those things add up to a role. It holds you strong, when things break down in our community, and it usually does, twine is a lot weaker than a rope, a lot of people find themselves without those things. Maybe they don't exercise, or don't have social connections, or they have mental health issues, so they fall into despair, and many reach for drugs and alcohol to make themselves feel better and they look in the wrong place. If you don't have this rope, it affects the way you cope. With art, it's a healing thought, if people can identify with it, it is healing in of itself. We are all healers in one way or the other. Everywhere we look is our cultural healing and people look for that to gain health and wellbeing. [We also spent time] talking about our experiences with Medicaid, some people say they can't get services for some places, it's hard to find healthcare where they are located that meet the needs.[8]

Group 4: We were sharing about health and well-being. It's about being holistic if we choose, there are different ways of being holistic culturally. This earth and medicine flows from the earth, if the pesticides don't kill a lot of the things. It's in things we are eating, what's not being broken down by our bodies. In terms of families and cultural traditions, who are we relating to when we go to the doctors, because even when talking about high blood pressure, who have they tested, and if you have pain, your blood pressure will be high. Instead of creating these band-aids, how do we get to the root cause and heal from there. What would it be to have an inclusive table with the black African American table, the indigenous community, what kind of transformation can we have with government.

Group 5: I'm a nurse at Abbot, I'm also a chair at a birth equity program that other nurses created to decrease disparities in the communities here. We're on a grant that's ending this fall.

[8] Scribe unable to capture all comments shared by this group (technical difficulties).

I came here tonight to make connections to hear everyone's voice, to see who else is working in equity and healthcare. Who is seeking to promote equity in healthcare. To summarize the first question, the health and wellbeing, when we have access, we need providers that actually take Medicare/Medicaid. That's a huge barrier, there's that mental health ceremony, being able to incorporate our ceremonial practices in the healthcare environment. At the mother-baby center, Abbot has a policy about smudging, but the center didn't know about until we had to come in 9 years later to inform them about this policy. One of the biggest barriers is to have culturally competent care and to incorporate it

Group 6: I like to be kind and eat good things.

Group 7: We talked about co-pays, transportation, communications with phones, cell phones, house phones, Internet as well. Safe spots for people that use, having a building rather than doing it on the street. More benefits, more options for different things for Medicare/Medicaid.

Group 8: We talked about holistic health and wellbeing, acknowledging your emotional, mental and spiritual. When one is deficient, how do you improve that. How can you use this to incorporate with western medicine. We talked about prayer, community support, cultural practices are preventive care practices. Providing more resources around these traditional medicines, having more traditional medications available through healthcare system. We need more compassionate providers, what is it like to grow, to be people centered. One thing we asked: we talked about care for self. Offering more cultural practices for imagining, having conversations in community. It will determine what the next generations need, but also what they could use.

DHS Engage! Pathways to Racial Equity in Medicaid
Bemidji Community Conversation
11 June 2024

Mindstorm: Oral Report Notes

About These Notes

The below notes were taken by members of our research team during the oral report-out from the Mindstorm small-group focused conversations during the Engage! Pathways to Racial Equity in Medicaid Kick-off event hosted in Bemidji (in-person) on June 11, 2024. During this activity, participating discussion groups nominate a

representative from their small group discussion to share with the larger group a few key themes emerging from their conversations. Groups have been numbered according to the order in which they presented.

Group 1: We talked about healthcare access, ceremonies, transportation prepaid health plans.

Group 2: Building a health gym on the rez that we all have access to. Having a pool for the elderly, for people with mobility issues, it's very important that they still have a place where they can exercise. There is only so much that bikes and treadmills can do, and usually for young people, we need more activities and exercises for older groups. Having more activities for people, like bike rides and other things, there is often not enough to do in groups.

Group 3: Our group talked about [question] number two. We talked a lot about traditional medicines, we talked about how we got into these things that disrupted our way of live. From birthing, through teenage years, to adulthood. Some of the things that helped us were no longer available. It's important for us to have these opportunities. Being in Bemidji, seeing some of the disparities, we need to have this ongoing, not just one time. Our community members need this space to build trust and share their stories. Rural health, transportation needs to be billable, we need stronger advocates in hospitals, in department of corrections, medical terminology, understanding options, traditional medicines, holistic healing practices, having admin giving more time for more traditional practices. [We also talked about] being able to provide more funding for traditional healers, need access to sickness healers, mental health, pregnancy aides, we need funding for traditional healers, we need traditional healing practices taught, we need nutritional resources, having seasonal activities in and around Minnesota. Need greater frequency of traditional healers, need more traditional life teachings at earlier stages of life. We could go on and on, our voice hasn't been heard in so long, if we can continue to have these conversations, to advocate for us because we are worth it.

Group 4: I came here [to share that] DHS is part of the system that drives health disparities. We only have two equity policies created in 2008, if you want to change something, you need to change the policies in each of the agencies. Changing the funding criteria, eligibility, but you need to have something that drive those practices. The agency needs to be held accountable for these things; you need to change the policies that govern the decision making behind system.

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversation Series Finale
13 June 2024

Mindstorm: Oral Report Notes

About These Notes

The below notes were taken by members of our research team during the oral report-out from the Mindstorm small-group focused conversations during the Engage! Pathways to Racial Equity in Medicaid Finale event hosted virtually on Zoom on June 13, 2024. During this activity, participating discussion groups nominate a representative

from their small group discussion to share with the larger group a few key themes emerging from their conversations. Groups have been numbered according to the order in which they presented.

Group 1: We all talked about what health means to us, and traditional practitioners. And I think it was mentioned about our obstacles with Medicaid, what are the drawbacks with Medicaid and the benefits and how we think Medicaid could actually improve. T——, can you share that fun fact? I was sharing that Minnesota passed the kids extension care for kids from birth to age 6, which is something that came out of the first report, but that's really been helping people across the state. B——: I think that's really great, worth celebrating that even if your income changes, your child can remain on their care plan.

Group 2: For the question about obstacles to care, affordability was kind of the main thing. There were some questions about whether you could also have private insurance as well as be on Medicaid, and Regina (the scribe in my room) explained to the group that you can. That's nice learning. [On question number] two, I think that was, oh, there's a lot of answers about what health and well-being is to you, focusing on family traditions and the need for sleep.

Group 3: We had a mixed group. Some of the big things our group touched upon: we talked a lot about access to care in rural Minnesota, telemed[icine] – having a good enough internet connection was a big thing that came up. One of the big things that another participant in our group brought up was inequity in healthcare and healthcare access and we had a pretty dynamic conversation about how are we increasing that? How are we, getting more involved? How are we gathering information and I had even brought up and we kind of collaborated on the availability of that information. We also had a really great conversation about getting information out to communities, how that happened. And how much more that gets out into, the communities and it's reaching people that otherwise that information wouldn't, like somebody said that they really enjoyed flyers. We talked a lot about access to care. We also heard from people who talked about needing more specialized help when seeking care.

Group 4: Similar to Elijah, we had a very quiet group, just talked about wellbeing, exercise and physical activity and sports. A lot of it was primarily through chat. I think somebody mentioned diabetes care and programs for that, so I thought that was pretty highlighted in our chat. In our group a lot of people didn't have or hadn't experienced obstacles with Medicaid, but one family shared their experience with care for diabetes on Medicaid.

Group 5: We had kind of a quiet group. When we went through the questions, what I had shared throughout the questions, um, I used to work at the Native American Community Clinic, but I also go to the Indian Health Board for my primary care though, and what I do like seeing at both of those clinics is that you can go there for medical, dental, mental health – I get calls all the time for preventive care reminders, mammograms, they do have a good primary care clinic, but at the same time there are

cultural things that they provide, like the [something] ceremony, beading classes, [something] classes. I did work at NACC, and we would have a list like, [this person] is insured, they get moved into care, but [this person] is not insured, so we could move them through an insurance process. I think those clinics are good at providing care mentally, physically, all around. But I do live in Richfield and there's nothing like that around here, I do go to the cities for care. My kids go to Allina which is nothing like that.

Group 6: Some additional support about Medicaid enrollment, what the process is would be helpful. See the benefits of telehealth, but also realize that sometimes in-person might be better. Also had some questions for DHS about what kinds of programs are in place for cultural competency.

Mindstorm Notes | Raw Aggregate
DHS Engage! Pathways to Racial Equity in Medicaid

Please note: While the small group discussion notes in this document have been organized by discussion question, ordered by date of the events (bolded in the texts) and separated by discussion group (indicated by the dotted lines), not all groups submitted notes in response to every question.

Question 1: What does health and wellbeing mean to you? What does it look like to really thrive? Do you feel that you have the things you need to be healthy and well? If so, what are those things? If not, what would help you to thrive and feel well?

May 14, 2024 – dIZI #1

- Creating good eating habits and diet, attending ceremonies to help solve problems when someone is having a hard time. Not enough income to sustain wellbeing. Having access to healthcare and resources within the community and limiting barriers to access spiritual/holistic practices.

- Being healthy and wellbeing means feeling mentally and physically balanced.
- Taking care of oneself physically and emotionally.
- Having a supportive relationship/system and personal growth in selfcare.
- Taking care of yourself physically, emotionally, and mentally.
- Being free and feeling like you don't have to worry about being safe, treatment for diseases for everyone (FREEDOM)
- Complete awareness of your physical state.

- Rest and good food.

- Health and wellness are very important to me-money is an important factor to have good health
- Money, good health is necessary for me to be healthy, more resources, access to healthcare.
- Tele-health is a good alternative to office visit, I use closed caption
- Healthcare for my child is important, a supportive environment and good healthcare providers

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- Think about holistic health, especially with maternal health. Mindfulness, yoga, spirituality. Related to reduced stress, better outcomes. Drives ability to access care. Must keep this and behavioral health "part and parcel" of everything we do in health care.

- It's a good way of life
- General connection to cultural practices and community and being able to find that through ceremonies or companionship.
- Been hard to rebuild that in the city.
- Barely living paycheck to paycheck but not doing anything in our lives that are fulfilling.
- There is so much need and no one wants to fill the gap.

- For me health is a state of being free of disease. And it doesn't just have to be physical.
- Health encompasses the entirety of the mind; mental, physical, spiritual. Health is a basic necessity of life.
- Access to general health care is a necessity so they can access medications, psychology, mental health
- Health and wellbeing refer to the overall state of a person's physical and mental health. It includes factors like exercise, nutrition, sleep, and emotional well-being. It's all about taking care of oneself.
- Health is top-notch for me, so I need to be sound physically, mentally and emotionally to be really healthy. And by so doing I take my daily routine that includes exercise seriously.

- Health and wellbeing are everything to me I think the only thing bringing me down is inadequate money
- My family is not separate from me - so my family's health also really matters to me. It feels and affects my own health
- Having money is good health to me
- Our cultural ceremonies where we talk and share health issues. And also, yoga classes too.

- Mental health is important, when it is down it can be difficult, it isn't talked about enough. Having a support system and basic needs met makes it easier to manage mental health.
- Access to the resources you need is important, medication supply chain issues, and barriers to access. Transportation to appointments and pharmacies. Big barrier to access, as well as costs.

- The MN care is my mum, she loves to self-medicate. Health and wellbeing to me means complete social and mental wellness.

- I work at the Indian Health Clinic which is a medical clinic, and we've been around now for over 50 years. I've worked there for 20. In the years it's been in existence we've evolved tremendously to make patient services more accessible. One of the duties that I have is that I function as an indigenous spiritual helper. What does that mean? We have patients being seen in one of the many exam rooms, and if there is a need for mental or spiritual health, in addition to the usual greetings, I go in and we talk about what it is that they need, whether it's information or other resources. Sometimes there are elderly people who are nearing the end of life, and one of the ceremonies that mean a lot to them is that I bring them a pair of moccasins, they want to know that they are prepared to go. And that they have what they need to face that.

- Do I have what I need to be healthy and well? Yes, do I get healthcare when I need it – I don't like to, but I do. It also has to do with why Indian men don't seek healthcare. A few years back with Dr. Deanna from [*inaudible*] we did an interview with ten men from Minnesota, and it was a discussion about why Indian men avoid healthcare. It's really something we need to address. I think some of that is PTSD related. But also, if a person lives on the reservation, they're not always able to get to the hospital, the Indian Health Center when they need to because they don't have transportation, or because they don't have what they need to get there. Sometimes they die because they waited too long to get seen. I'm sure in some sense it could be policy related. I know the IHS is establishing medical care clinics in the communities themselves, so things are changing, but I think that they need to change even more so.
- Health and wellbeing mean a lot to me, and I feel like I have the necessary resources, such as the regular checkup.

May 28, 2024 – Duluth, MN

- Children's health and wellbeing
- Child is wonderful and pays attention in school
- Summer programming for kids for Indian Ed Student
- Father not showing up consistent and that brings up child behavioral concerns
- Kids are very resilient, each with their own personality
- 8 children, some days hard, some days are easy
- Very loving and caring with siblings
- Brother passed away, mother is primary support
- Honest with children especially as they were previously in foster care

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- Stable/affordable housing
- Food
- Access to reliable transportation is needed
- Need a gym in Duluth, similar to Hinkley gym for Native
- Mental health is a part of wellness
- Culturally inclusive therapists
- Coverage for ceremonies
- Need to consider the whole person, health care likes to break things apart (heart health vs. mental health, etc.). Native people understand health applies to whole person – all connected.

June 5, 2024 – Minneapolis, MN

- Lot of people struggling with coping skills that can lead to a … [unintelligible].
- Need coping mechanisms to take care of yourself
- People need skills to get out of despair
- Need holistic view of health; social, emotional, spiritual, intellectual
- At one point pre-colonization we had all that & lost a lot of ways to cope
- Need to look upstream – employment, education, etc.

- People reaching for drugs to fill that void

- Access to spaces to be healthy, physical – nature
- Back to land, traditional food, medicine, having knowledge of uses
- Vegetables – carrots, broccoli, spinach, green beans, lettuce, fruits, cartwheels
- Physical health and mental health
- Therapy
- Having health insurance

- Not worrying. No anxiety. Joyful.
- Being able to do the things you need to do.
- Having the ability to pick up and hold my son.
- Being whole. Being satisfied with what you have.

- Health and wellness
- Explained to me, used to lead a wellness program. Dr. L described it as a ball and leaving it out creates bubbles and makes it hard to roll. What was said about survival mode and self-care. You learn through public health work and [the] more [I] learned, [the more it] got me upset. 9/10 women in cheaper route can be unhealthy route. Due to chronic stress. As Native people we have low [life] expectancy rate and once upon a time we were thriving and now we are picking up the pieces.
- 9/10 women/birthing people looking into
- Employed
- On assistance
- Pregnant women employed
- % of working women and work site benefits
- Misinforming data and we need to see the whole instead of the portion. Misrepresenting the people and within our community and the beauty and power of the people.
- Does increase better outcomes
- Being healthy spiritually, mentally, physically
- Tough to keep balance, one foot in one foot out.
- Trying to keep everything together.
- All interconnected and [I'm finding] – I raised kids on assistance and been on section 8. Without the program I wouldn't have had that kid.
- Resources, included food stamps, housing support, was creative to make food last. Wasn't always healthy but it made meals. Making decisions also meant letting bills go and being in survival mode.
- Would implement healthy food and undoing habits and undo outcomes of the body. Being mindful of gut health. Health and well-being understanding – based on growing up.

- Insured, health (good doctors, clinics, hospitals), emergency response care, good

doctors who don't discriminate you.
- Do what you can, nobody tells you what to do.
- Be healthy yourself, for your family, always take medication.
- Need transportation
- Not understand how to navigate system – how do I find it, are we going to get someone to help or care
- It's hard to get started, damned if you do damned if you don't
- There's no in between (daughters, job) on welfare. 2 months to kick in and get support. Not enough to pay rent.
- Have online counseling, therapy (instead of jumping hoops) culturally native therapist
- Go to struggle, not being judged
- Mobile stations to stop at hotspots, all please more accessible

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- Optimal wellbeing – where you put your energy, care of body is care of spirit, holistic care that leads to sustained healing, justice and care. Community and resources. Wellbeing leading to happiness and life without worrying about survival.
- Traditional and ceremonial wellbeing. Looking at holistic care – mental, physical, spiritual – is just the beginning of the needed framework. Conversations had that involves engagement with self and community.
- How does Medicaid help with spiritual wellness? It doesn't, in relation to local practices.

June 11, 2024 – Bemidji, MN

- Health insurance coverage that doesn't lapse, holistic care, being able to go to preferred providers, whole person care.
- Waking up in the morning
- Taking care of immune system, taking care of hygiene on a daily basis.
- Preferred provider to me would be traditional doulas and midwives

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- To be rich, to have a stable paycheck,
- Know if you have a disability
- You need a gym where you can work on staying healthy
- 24/7 access to a gym to help our schedules
- Healthy workplaces, managers need training sometimes there is nitpicking and it affects your mental health
- More community events are needed
- Elders' walk, children's walk, bike riding

- Have a community, having those there to take care of your, taking care of your elderly
- Free of diseases, chronic diseases
- Physical, mental, spiritual health. Physical exercise, diet, sleep, mental health, connecting through your spirituality, knowing what to access in your community.

- Being in balance with mind, body, soul, indigenous perspective on social determinants of health.
- Stemming from social and economic environments and opportunities
- Accessibility, despite having to travel for treatment, access to insulin, employment, housing, Narcan, using community resources
- Social and economic indicators of health, resources are not available, disparities of what is available
- Narrow eligibility criteria limiting those needing access to care
- Housing/housing stability
- Dental care
- When accessing care, having transportation, childcare, taking time off work
- Food, access to healthy food, especially for children
- Rural health transportation system needs to be sustainable beyond just billable services
- Need greater, stronger health advocates. Not having to visit and travel to multiple places of care
- Indigenous advocates and navigators in hospitals, department of corrections. Native relatives in these roles.
- Advocacy around medical terminology and interacting with medical providers
- Understanding all options including traditional medicines; holistic treatment practices
- Availability and accessibility
- Human services, give admin time for traditional practices

June 13, 2024 – dIZI #2

- Health and wellbeing. Preventative care is really important for me (mammogram, dental etc.). I am a member of Red Lake so traditional ceremonies and medicines are important to me. Morning and bedtime smudges and prayer.
- I'm from Red Lake nation too. Wellness means ALL of me. Physical, mental, everything I need to be in my community. Very holistic. I'm actually on my way to a ceremony right now.
- Problem is that western models are focused on treating illness instead of seeing health as wholeness.
- Outsiders want to come in to Tribes and urban areas
- Love participating in sports. Marathons.
- Practicing health habits on a daily basis so that instead of just surviving you are thriving.
- I take my check-ups seriously. Eating healthy and exercising too.
- Go to the gym every day.
- I feel I have what I need. More time for self-care and stress management would help me thrive even more.
- Health and wellbeing mean balance across mental, physical, emotional realms.

- The overall quality of life and it means physical health, mental well-being, and spiritual health, it's not just health and – it's all well-being and encompasses a lot of things – and emotional intelligence.
- Health and well-being mean active and healthy and having insurance.

- I'm from Red Lake Minnesota.
- Health and wellbeing are to be able to do what I love, with sound mind and body
- Health and wellbeing are fundamental to me, involving a holistic balance encompassing physical fitness through regular exercise routines, nutritional wellness with a focus on wholesome foods, mental clarity through adequate rest and emotional strength nurtured by supportive relationships, all contributing to my ability to thrive and enjoy life fully.
- Health and well-being to me means to be in the right state of mind.
- It means me being fit physically and emotionally.
- In our family, we are connected to the American Indian Community through ancestral ties, honoring and preserving our heritage through stories, traditions, and mutual respect for Native American cultures. My grandfather was a member of Cherokee Nation.
- I am related to the American Indian community through my paternal grandfather, who was a member of the Navajo nation, making me affiliated with the Navajo tribe.
- Health and well-being mean a lot to me. Without being in a good health your well-being is complicated.
- I have faced obstacles in healthcare in accessing specialized care due to limited provider availability in my area and encountering language barriers during medical appointments which have sometimes led to misunderstandings about my treatment options.

- Health and wellbeing mean a lot to me. Physical activity goes a long way. Keep mental and physical health stable.
- To me, health and wellbeing signify a comprehensive state where physical vitality, mental clarity, and emotional resilience intersect, supporting thriving by embracing regular physical exercise for strength and flexibility, adopting a balanced diet that nourishes my body, prioritizing adequate sleep for optimal cognitive function, and fostering meaningful relationships that offer support and positivity.
- Health and wellbeing, for me, mean a balanced physical, mental, and emotional state. To thrive, I need to feel energetic, stress-free, and positive. I have what I need, such as supportive relationships, nutritious food, exercise, and sleep. More time for self-care would help me thrive even more.
- My family practices include cooking with fresh ingredients and regular exercise. Our culture promotes health through balanced diets and meditation. I don't currently use traditional healers but am interested in herbal remedies and traditional massage. I value yoga and community health workshops and would like more access to these resources.
- Take care of self and make sure is enjoyment
- Also keeping a good weight

- Balance in body, mind, and emotions
- Deeply connected to culture and community harmony
- Thriving is feeling energetic, stress-free, & positive
- Positive relationships, nutritious food, exercise, and sleep

- More self-care time to enhance wellbeing
- Good state of mind, physical condition, and stable financial status
- Access to services needs to be improved
- Home cooked meals
- Yoga and natural remedies
- Mindfulness and community gatherings
- More access to holistic wellness resources
- Access to herbal medicine and acupuncture
- Exercise and healthy eating
- 20 minutes of morning family exercise
- Access to traditional healer, culturally competent providers, better mental health services, economic opportunities, and to thrive and feel well
- Need better access to services

- For me, health and wellbeing mean having balance in all aspects of my body both mentally and physically. Even spiritually and socially too. Health and wellbeing mean having a balanced life where physical, mental, and emotional needs are met. Thriving looks like having energy, resilience, and a positive outlook. For me, essential elements include regular exercise, nutritious food, supportive relationships, and time for rest and hobbies. If lacking, better stress management and work-life balance would help me thrive and feel well.
- Maintaining a strict diet always works for me and regular exercises
- Health and wellbeing to me is very important

Question 2: Do you have family or cultural traditions and routines related to health that are important to you? If so, what are they? Are there ways your culture supports or encourages good health? Please share! Do you work with any traditional healers? If not, would you like to? What kinds of traditional healers or healing resources would you like to be able to access? Are there any ceremonies, practices, or resources that you use and value for your health and the wellbeing of your family? Are there any that you don't have access to, but would like to be able to access?

May 14, 2024 – dIZI #1

- Attending sweat ceremonies within the community, having respect for elders and utilizing Traditional Medicines related to heal illness during the cold winter months for herbal soups once a month. Gaining trust and connection to community members in the Indigenous Community to access Traditional healing support/healers. Gaining the education and knowledge on handling/usage of Traditional Medicines.

- Cultural routines and beliefs according to your values to know what will and will not work for you.
- Boil water and apply it on your face (if you have skin issues) it would fade within a few days.
- Everyone has cultural beliefs and, in the past, Africans used aloe vera for skin conditions.
- Herbs are traditional elements of health.
- Native/traditional food that's good for you. Food in Walmart isn't organic and leads to short life span.
- Go back to our roots and practice what our ancestors use to do to teach our generations how to live a healthy life.

- I do have cultural traditions and routines, yes, my culture supports good health. I don't really know about traditional healers though.
- Yes, I have a cultural tradition that are very important. And would love to work with a traditional healer if possible.

- Recalls a "discounting" of cultural traditions by the allopathic medical center during Lt. [Governor Peggy] Flanagan's childbirth experience. Patients want to be healthy/well within the larger social context. It's our problem as a health system to create the integrated experience that patients desire. Not react negatively to patients who want to bring in other practices.

- Practice smudging and not be questioned by medical staff and social workers, having to explain what smudge is and explain what traditional medicines are and having to have our medicines is important.
- Gender affirming care.
- If people are going to get paid through Medicaid they should have to go through cultural trainings — they misdiagnose people because of the biases.

- Attending community events in May for American Indian month; opportunities to get connected with resources and information; Powwow for Hope; the event had healthy food available to promote eating healthy
- Spiritually, we have sweats; release negative energy during the sweat; helps with mental and spiritual well-being
- Sun dances in South Dakota; helps find your spirituality.
- Medicine men on reservations; cannot access medicine men in the cities
- Need greater access to sweats, ceremonies and traditional healers in urban areas (without having to go back to the reservations)

- Relatives like to take walks after they eat, and I think that is one way that they promote good health. What are yours?
- No, I don't

- Desire to re-connect with traditions and build routines and traditions with their own family if they can. Desire for the resources and connections to enable that.
- Some traditions held alongside medical practices, as a spiritual/therapeutic element. Community support is an important aspect of healing.

- Generally, health and wellbeing are the overall state of someone's physical and mental health. It is important to be able to advocate for ourselves, have insurance options, and coverage for the services that we need. These are things that happen in our bodies and, when the body is at the utmost level, you are happy, healthy and you have a calm environment in your body and mind. Doing things like drinking enough water, getting exercise, and things like yoga can help.

- There are some traditions for my health. I take water in the morning, and it helps keep me healthy. I take water in every two hours. That's what I'm doing. Many times, I do yoga, that has also been very helpful.
- I love taking my health well-being serious and I do take mental and social health advice from my doctor
- I've been taking traditional tinctures, I also have high blood pressure medication. I've been using natural remedies to try and help the Western medicine.

- What comes to mind is accessibility of cultural health and wellbeing services, going into a clinic where people look like you, because you know that the experience is going to be different. I know that when I go into a clinic and I have a [white] provider who doesn't reflect my culture, my body goes into like a trauma response. I am in the Twin Cities though, and I feel like we have access to some of those resources.
- At the Indian Healthcare Clinic where I work, we have access to medicines. And why do we use those? It's because we want to purify ourselves before we appear with a Western medical provider. It's [word] and I know another word for that is tobacco, but it's not tobacco. There's also willow bark and sage, if someone has medical issues where they can't use smoke, we have sage oil and other things we can use. We also use sweetgrass – and why is that important? It's because we do want to go in there in a good way. It's also a cultural ethical consideration because it is necessary for our healing, we're a very spiritual people and we look to those medicines to prepare for our healing. I do work with traditional healers. I was at a DHS conversation not too long ago where we were working on getting more access to those medicines. We talked about what issues are important to our communities, and a lot of what we talked about is the opioid epidemic, but we also looked at what kind of traditional healers can perform

what I call maintenance. We focus on our spirituality that way. We want to be able to say that we are good spirits when we leave the clinic. We have a quarterly healing ceremony which because of the amount of people who have been attending we have to hold them in the park.

- I listen to a lot of elderly people who access healthcare at the medical clinic, and they talk about diabetes, and they talk about living independently. Getting care in their homes helps them to manage their diabetes independently. Often times when they leave the home there can be challenges for how they manage their blood sugar while they travel to the clinic. I always wish we had an elder advocate in our clinic who can sit with them and ask if there's anything they need, what is their blood sugar like, do they need anything to drink, do they need water. We are still working on that, and we don't have it yet, but I'd love to have someone who could help with that, reassure them that they will have a good experience there and have their needs met.
- My family takes Traditional medicinal herbs cooked as a soup regularly.
- I just wanted to add cedar is another great one that I really love personally.

May 28, 2024 – Duluth, MN

- Birth of daughter
- Shakopee – 6th day in the area and gave birth at 30 weeks
- Native American women came to talk with me about medical things, didn't see child/daughter for 15 minutes
- My son was in Chicago with his dad
- Strength as a present parent
- Respite care not available and wasn't given
- Cultural
- Kids know how to pray; one does grass dances, but other sibling doesn't want to

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- Sweat lodge very important
- Access to powwows where you move your body is needed – transportation
- 10x or more requests per week at Essentia for traditional healers

June 5, 2024 – Minneapolis, MN

- Identity and culture helped me get out of addiction and find ways to cope
- Known families who haven't had resources for generations – dealt with addiction for generations. People in that situation can't pull themselves up from their bootstraps.
- Grandparent
- Traditionally always someone to help with mental health. Spiritual leaders.
- Healing in different ceremonies/powwows
- Everything we do
- Art is healing too. When my daughter sees American Indian art that's healing too. Art gives a sense of identity/pride/images of my people

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- Walks as a family, smudging together
- Mental and spiritual health, quiet time, sweat lodge, time commitment, could be more options
- Being able to travel to places where people have knowledge or bringing knowledge to city
- Urban vs. rural, bridging the gap
- Smudging frequently, cleansing, 4 medicines; cedar, tobacco, sweetgrass, sage.
- Using existing spaces to create opportunity – this center.

- Prayer. Making a morning offering.
- Being at ceremony/pride
- Being outside
- Food – all life events bring comfort and solace
- Music. Drums, singers.

- Gardening as integral and sustainable
- What is our body not breaking down?
- Cultural traditions
- Ribbon skirts and crafting; brings joy.

- Take meds every day – prayers, places for smudging (smudge room), go to sweat lodge (sweating/sauna) helps with blood pressure, ceremony
- Do you use tobacco, why asking tobacco usage, yes, higher premiums
- Funerals, smoke cigarettes, usage of tobacco, party trip, share tent ceremonies, sweat lodges are good
- Elders and traditional healers, different therapies, licensed Native healers
- Waitlist, not enough traditional healers

- Need for community support and traditional medicines – support to get to ceremonies and traditional plants. Access to sage, berries, and other traditional plants from a community cared for source (not dependent on capitalism to access our own medicines). Working with programs and communities that care/teach medicines
- Where are we sending funding?
- Cultural practices are preventative care practices!
- Prayer. Community support. Traditional practices and techniques. Preventative care.
- Engagement with resources/practices only available to paying people! Finding roots and fighting systemic violence through all of the above.
- Curbing reliance on practices outside of culture.

June 11, 2024 – Bemidji, MN

- Ceremonies. Sweat lodge, cleansing, having a spiritual leader in the community you can go to, medicines, naming ceremony.
- Cedar ceremony. Baby wearing and bonding.
- For myself, home birth midwives are not covered but in the future, I hope they'd be. Often medicine man and healers live in the country, so we need transportation to get to them or for them to come to us.

- We only have one place in town that deals with mental health
- Beading classes
- Sweat lodges
- Teaching our young people about our culture, how to do smudging etc.
- Traditional teaching access to the land
- We don't have the land to do it. Access natural resources
- How do we get quiet spaces in nature to practice
- We should remove the cap
- We are figuring out our identity
- Having access to traditional remedies
- We need spaces to reconnect with our culture
- Group engagement is needed
- Vetting of the people providing the services should not be causing harm to our community
- I wish our reservation could open its own treatment center to help people dealing with substance use disorder
- Better program for young people in treatment. People who get along with kids, someone who will listen.

- Using traditional medicines (smoke, give thanks, ask for guidance)
- Access to knowledge around traditional medicines and how to use them
- Different ceremonies to maintain health and balance (round dance, ceremonies, boxing, etc.)
- Seasonal traditional family activities
- Medicines
- Revitalize family circles that come together to practice traditions/traditional ways of song and dance
- Boxing
- Physical activities (walking, biking, swimming) with family
    - Oxytocin releases
    - Do with family
- Traditional healers: need to know who they are and how to access them
- Two participants use traditional healers
- Need access to sickness healers, pregnancy/Indigenous birthing
- Traditional practices; carrying clean water, picking berries, planting/harvesting crops

- Need community teaching/education around traditional healers
- Reclamation leading into the teaching and healing practices
- Been brainwashed to be fearful of our own medicines
- Need to provide adequate funding for traditional healers
- Eliminating the requirement of credentials/licensing for traditional healers
- Wanting community education programs around traditional services
- Provide funding to train young people to come into medical practices
- Fund young people to go to camps to learn traditional healing practices
- Nutritional resources that cover costs of healthy food
- Supporting/investing in seasonal activities
- Need greater frequency and availability of traditional healer visits
- Need traditional life teachings for each stage of life – funding to support this!
- Challenge missing traditional life teachings at earlier stages of life and having to catch up
- Support reclaiming Native traditional ways of viewing the world (not the capitalistic Western world views)
- Our traditional world views were taken away from us, we now have to re-learn these views and practices which takes community, time, resources
- Ceremonial practices of burying loved ones
- Stress reduction; grief management
- Grief management is a barrier leading to mental health
- Disconnection of conversations at the state level around health/equity
    - Not always having the right people at the table
    - One and done doesn't work

June 13, 2024 – dIZI #2

- I'm driving to another state right now for ceremony. Although there are closer places to me. My father made the choice to separate us from his Tribe in order to maintain his sobriety. That separation made it so the ceremonies I have been a part of have been through other nations/communities.
- Transportation is a huge barrier to get to ceremony for many people.
- I personally don't like the idea of DHS paying people for ceremony because it supposed to be a pay-what-you-can thing.
- Incentives or grants to help people get to a healer would be preferred. Removing the barriers instead of the state getting in the middle to pay. Another option would be for DHS to provide funding to get more native people to get mental health practitioner training and other education and training so they can really help their community.
- Family gatherings
- Social connections are important.
- Eating together and using natural ingredients is a priority.
- Our culture encourages health with practices like tai chi and herbal tea. I haven't worked with traditional healers but would like to try acupuncture and herbal treatments. I value meditation and traditional ceremonies for wellbeing, and I wish I had more access to these.

- I never had experience with traditional healers as an adult but I'm open to it because I was introduced as a kid and it's a better purifying process to me and a way to get back and connect with my roots.
- Our family's tradition for wellness is deeply rooted in detoxification. We have teas for every mood and believe everything is connected.
- I was raised in a strict household and raised to be mindful of my health and that stayed with me.

- The diabetes program and that runs in my family. I have a few family members on Medicaid. The majority of the time they get everything they need.
- Culturally, they value health more than anything in the community.

- Grandfather was Cherokee, so is some cultural insight. One shared practice is mutual respect for everyone

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- Regular family diners
- Tarot reading
- Prayer
- Meditating
- Traditional healers
- Preparing medicinal herbs

- For me, I connected in our family tradition as an elder, I can remember when I was a little younger, and there were these traditional healers, I had family members who knew about these treatments and I was quite younger, and I think about how I don't have access to them now. It's part of the culture, and I don't mind connecting with them, but right now I don't really have access to them.
- This is a family thing that is very important to us.
- I think about how my mom always encourages us to try to get everybody to eat vegetables, to get jobs, she tries to encourage us to take our [something] seriously, even if we don't really like wild [sometime]. I'm not really sure about access to a traditional healer. We try to get slimmer, so we don't eat as much as we want to.
- I and my family use to engage in exercise

- Sure, so I'm not Native, so I work for the Mille Lacs band of Ojibwe Health and Human Services. And I've been working there for about 8 years. And interestingly enough, currently in our Health and Human Services departments, we are trying to engage some spiritual advisors into our programming and recognizing that our community members when they come in for their health and wellbeing. Whether that be primary care clinic appointments or substance use disorder treatment or whatever they're in family

services because they're dealing with child welfare issues. Whatever it is. And having, engaging directly with a spiritual advisor helps. Improve the quality of the care that they're giving.

- Yes, family and cultural traditions play a role in my health. We emphasize cooking fresh, balanced meals and gathering for regular family dinners, which support both nutrition and emotional wellbeing. Our culture encourages practices like yoga and meditation for mental health. I don't currently work with traditional healers, but I'd be interested in exploring options like acupuncture or herbal medicine. I value access to mindfulness practices and community support groups. I'd like more access to holistic health resources and cultural ceremonies that promote overall wellbeing.

Question 3: Do you have any experiences with Medicaid / MN Care? If so, what have those experiences been like? Are there ways that Medicaid / MN Care plays a role in helping or hindering the health and opportunities available to you and your community to thrive? What policies or structural changes should be prioritized to improve the health and opportunity of American Indians in Minnesota healthcare programs (Medicaid/MA and MinnesotaCare)? If you or someone you love needed to enroll in Medicaid / MN Care, would you know what steps to take?

May 14, 2024 – dIZI #1

- Barriers with relatives who identify as Native American on state health insurance with access and funding for residential rehab centers or dual licensed facilities for low-income families. Discussion on feeling judged. Delayed responses and lack of communication on update. Creating a vast and more updated system that is more user friendly. Healthcare too expensive for families to afford who have incomes full time. Shortage of workers to assist the population.

- Medicaid helps the community when it comes to low-income, homeless, and we appreciate Medicaid for the help that it has provided to the community.
- Medicaid has been helpful in the community and people with issues of low-income or that don't have money. A friend of mine had a heart condition and he was able to have his condition managed due to having Medicaid.
- I had never had the need to use Medicaid in my previous job, once I got laid off, I had to get Medicaid. Medicaid is an important program to have around for low-income group. Private insurance is very expensive and health insurance is a basic need. Medicaid is a lifesaver to help in the low-income groups.

- For the MN care question, is my Parents overcoming cultural practices like trying to self-medicate
- For the Medicaid, I like their coordinated care,
  but they have complex eligibility requirements.

- Medicaid was very helpful during pregnancy; provided coverage and necessary care

- Medicaid has played an important role for students. Expanding Medicaid would be very beneficial to the student community, including indigenous people.

- Yes, I do

- The application process went well, no problems with it. sometimes there were issues with accessing care. a complex health issue was not covered by Medicaid, so it felt useless.
- Medicaid helped with covering costs for family health things, in addition to a primary insurance

- Experience with Medical Assistance was helpful and a nice experience.

- When covid hit, me and my daughter who was just born was on Medicaid for the entire time. I have experience. I also have experience with MN Care with all three of my babies. The state supported me through all three pregnancies. I'm not eligible anymore, it's very funky, my son is private insurance, my daughter qualifies. My niece is on Itasca care. I'm uninsured, which is a surprise to me, so I'm hoping to get on ta program. When the public emergency stopped, I was thrown off and now I'm trying to figure out what comes next.
- my MN care experience is the complex eligibility requirements.
- I thought I would qualify, but I think my income was just above it, so it really threw me off and confused me.
- Yeah, I have the experience of Medicaid. And then, it's been a nice experience and then, you know, I qualified for Medicaid and then I've really enjoyed it.
- I did a TPT PSA for renewing Medicaid, the intersection with me on redetermination of Medicaid, it's been tremendous. I was a tribal liaison with a private health insurer.
- I'll say that I love most of your experiences and it's kind of it's helpful to learn from your experience
- I often MC powwows.

- I have a person who helps me with my Medicare. Her name is N—— and she lives in South Carolina but is able to help me here. But there's kind of a wait time that can be hard, and you have to deal with the wait if you want the service.

- Medicaid was really helpful to me.
- I do work for the medical clinic, and we have patient navigators. Patient navigators will often help patients to apply for Minnesota care. I wish that could be extended to help with Medicaid enrollment. That's kind of an experience. It's a wish of mine, but who knows where that's gonna go in the future. We see a lot of advertisements on TV that changes are coming and do you want to apply for plan c or d and here's a number to call. But I think it needs to be a lot more focused than that, where you can have a navigator to go over the different Minnesota care plans and then go over the cost of care and help you eventually make a decision. It can be so complicated, and it takes so much time, the amount of time you spend on the phone… the decision I made ultimately was just based on wanting it to end and be over. I did get good care eventually through SSI, but it needs to be more focused.

May 28, 2024 – Duluth, MN

- Example of family whose dad had kidney transplant
- If you don't feel safe where you go to have your healthcare, you won't go to have your healthcare

June 5, 2024 – Minneapolis, MN

- I had MA when younger, we went to certain clinics – didn't know.

- Difficult, intimidating, all the application hoops. If you don't know, learning about navigation.
- Have not successfully applied since a kid
- Online application questions, gathering the information
- WI Native community in MN, there are resources
- NACC – smaller community, built here.
- Helps, never had issues with MN Care, coverage is good, copays cheap.
- More funding for these spaces. Gym, wellness, etc.

- No copays were great!
- I didn't like that they kept changing their high-cost drugs that I needed monthly.
- Diabetic supplies and insulin change constantly.
- Kept my kids on. Good for them.
- Medicare. Sixty-five years old and everything went chaotic.
- Support MNSure navigator at NACE [possibly MAIC, the Minneapolis American Indian Center or NACC the Native American Community Clinic in Minneapolis] and other tribal and urban clinics. It's helpful

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- Access to health insurance

- Experiencing challenges in accessing healthcare and mental health

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- Never had, always Hennepin Health, United Healthcare only covers meds, SSI, disability, challenging process to get into Medicaid. NACC will help you too, IHB. Breakdown a lot of red tape, not getting help – help insurance, co-pay (no money), don't get meds.
- Massachusetts state la – on Medicaid – pay nothing for Medicaid. If they can't pay (co-pay), sign waiver, support to lower cost
- State law, no cost to any coverage under Medicaid – discriminate people in this county and outside
- Single payer – collect
- Set up private places for detox with areas to use drugs away from students, kids, families (safe center to use drugs)

- Yes. Renewal process causes gaps that could/should be avoided. Navigation was a LOT. Problems with understanding coverage, dental especially. Reliance – need to acknowledge it as a support system that is not available to all. Incentive to not be able to grow because you risk losing your insurance. Holes that need to be covered.
- Customer care – giving confidence to seek help, care, compassion in the process. Provider knowledge expanding. What does it look like to grow and be willing to learn and be people centered?

June 11, 2024 – Bemidji, MN

- At Red Lake they get put on Prime West, but living on reservation they don't need that, there's an exemption so they can be straight MA. Lapse in coverage can be challenging.

- I had to apply when I was pregnant. It was hard to navigate and explain.
- There were so many benefits, but it was so hard to navigate
- Somme of the elders in our community do not have access to rides. It is very complicated to set up rides. Lots of stipulations to getting a ride.
- Better communication in outlining what it takes to get service.
- If a service like "dentures" is not available on the reservation, we have to pay for it
- Dentistry is very difficult. They would rather pull your tooth than work on it.
- Dental is really hard to access, they would rather take private insurance.
- It's too difficult to receive service.
- What if we had someone to help us with the processes. Especially our elders, they didn't have the internet and forms are confusing.
- You sit on the phone on hold for too long.
- What type of training is DHS staff taking to work with the Native community?

- Want to hear the outcomes of these conversations

- Ensuring the community knows what's being done
- Wanting community awareness around the outcomes of the report; come back to share out with the community

June 13, 2024 – dIZI #2

- I used to be a MNsure Navigator so I'm very familiar.
- Medicaid should open more priorities to telehealth.
- The process was always very complicated (with MA and MCRE). I used to work for DHS and what I heard from AI clients was that they didn't understand how MA interacted with Indian Health Services. People were confused about where they could use MA and didn't understand they had access to insurance even though they were enrolled.
- I have had mixed experience with MA. Benefit from coverage but struggle with administrative delays. Needs more efficient process and better communication. Prioritizing easier access and culturally sensitive care would improve outcomes for American Indians. More straightforward instructions (to enroll) are needed.
- I agree with what she said- benefits are good but delays and confusion are a problem. (Another person also agreed)
- MA needs to provide affordable insurances.
- People don't know difference between straight MA. I believe American Indians can request straight MA.
- Health plans aren't always honest about benefits that are available (like transportation for MA enrollees). We saw that across many plans. Plans are not well-educated in MA benefits. Provide conflicting info to what the state says.
- No obstacles
- No obstacles
- I have experienced language barriers and lack of culturally competent care. Highlighting the need for training and better language services and training for health care providers.
- My only bad experience is bad prices for health care.

- I don't have it, but I usually go to the Native Clinics. I use insurance with the state at NACC.

- Biggest obstacle is cost**.** Health care is expensive. Has experience with Medicaid.
- Want more ways to know how to go about enrollment
- I have used Medicaid and found it helpful for covering essential health services. However, the application process can be confusing and slow. Simplifying enrollment and increasing awareness would improve access and opportunities for American Indians. If needed, I would know the steps to enroll but support would be beneficial.

- Positive in terms of coverage, but difficult due to bureaucracy

- Streamline process and enhance cultural competency
- My experience with MN has been positive and I think they are doing perfectly well
- Services I have been provided were great and also helped me to aim towards a healthy lifestyle and I will say it has been of great help to me, my family, and people in the community
- I am satisfied with Medicaid Services

- Administrative issues, sometimes I don't get attended to in time, just sitting down there and not getting anything for a long time because of administrative issues. Probably the world is going extremely virtual and digital, so I think some sort of [something] system could really go a long way.
- I think my experience has been really good so far.
- I have had a sweet experience so far. I can't complain.

- So, maybe I'll share my personal experience with, Minnesota Medicaid. I'm just to kind of, get the ball rolling. So, for the first 21-22 years of my life, my primary source of health care was the IHS [Indian Health Service] health system…as well as Minnesota medical assistance. It was not until I had delivered my first child that I had ever subscribed to my own health plan or not been the dependent of somebody on Medicaid. So that was kind of a rude awakening for me and my paycheck, I remember. But one of the most meaningful experiences that I have with Medicaid, and even the IHS health system, is that with my first pregnancy, I was deemed a high risk, and my child was diagnosed with a birth defect that required a higher level of care than some place like CAS like I guess…could provide to me or my child, and through the IHS contract program as well as Medicaid, I received a referral, to the U of M in the cities, for all of my maternal fetal care as well as the month long NICU stay that my son had when he was delivered. And if not for Medicaid, and the referral system that was in place, his care would have ultimately ended up costing me close to a half a million dollars. Luckily, he's gonna be turning 9 next month and he is, perfectly healthy and I'm just incredibly grateful for, the support and the systems that were in place when I needed that higher level of care and the people who were involved in facilitating that process.
- Yeah. Medicaid has been absolutely, invaluable to my life and the quality of life that my children have had as well.
- And that is, the[y] dislike the annual renewal and filling out the application. And it's such a struggle to get all of our patients to get them, get them done and get it up to date.
- So, I don't know if there's an answer to that, but it's tough, man.
- Yeah, I've had experiences with Medicaid, sometimes it wasn't so good especially when it came to verifying my insurance
- Medicaid is a favorable insurance for families with average income and their reluctance to be of help sometimes is concerning
- My experience with Medicaid is kinda conflicting to me. I'm a huge fan of the benefits but some of the processes and criteria involved causes a lotta unnecessary delay sometimes

- The paperwork, the endless paperwork. Kind of, segue into that then obstacles, maybe that any, any of you want to share about, your ability to access healthcare, whether it's in your community.
- Yeah, maybe even experiences getting health insurance, whether it's MA or, you know, it's transitioning to or from MA to like an employer sponsored health plan.
- I remember feeling overwhelmed, when I was going through the process, and I was told I had a 30-day deadline to enroll in my employer's health coverage or else.
- And for somebody who, you know, as young as I am, I've had some pretty complex health care. I've had a number of surgeries over my lifetime. Going any period of time. Not knowing if I was gonna be able to pay those bills. Not knowing if I was going to be able to access the specialists that I need particularly in in rural Minnesota. I sometimes joke that I feel like the is kind of the butthole of Minnesota because you have to go 2 hours in any and in any direction whether it's, Fargo more head, Duluth, the cities, even going further sometimes for a lot of people in order to access the specialists or to access larger networks for healthcare. And there's a lot of patients. Who experience particular barriers even with transportation like if we don't have neurologist or psychiatrists here in the Bemidji area, for example, and, we're being, asked to refer patients to Fargo to Duluth to the Twin Cities, people experiencing significant transportation barriers.
- To tell a med, whether or not they have, you know, a computer or a phone capable of doing those types of appointments.
- Medicaid is a favorable insurance for families with average income and their reluctance to be of help sometimes is concerning
- My family is considered lower middle class. Both my husband and I work full time as parents and even though I am not – no longer – eligible for Medicaid based on my income as an adult, I am still particularly grateful for the coverage that I still receive for my children. I love that Medicaid has expanded benefits for my children. I love that Medicaid has expanded benefits for children under the age of 18. And that even for some of these families who are a bit higher income than others in the community that we're still receiving that help and that cost-effective reimbursement. That's an extra $300 back in my pocket every month that I otherwise would not have because I'm still within that. The income guideline for my dependents, so for larger families especially, if you have that primary insurance it takes a little bit of the brunt away from the impact that paying for that health insurance, especially in some of our markets, can otherwise have.
- Central Minnesota, Hinckley, Onamia, McGregor, in Hinckley, we have dead spots for telecommunications, so we have real problems with telehealth appointments. I'm sure there are places that have dead spots, but it really makes it harder.
- In the northern areas, the wifi/broadband is not well developed, you have people living on farmsteads for generations, don't have the access or familiarity to the technology.
- Cell phones are super popular on the reservation Mille Lacs, but it doesn't do any good if you can't connect to cell service.

Question 4: Are there any obstacles you face when seeking healthcare? If so, are there specific resources or forms of support that would help you to overcome those obstacles?

Have you or a family member used audio-only (telephone only) telehealth services to access care? If so, what was your experience? What would you like to see Medicaid / MN care prioritize? Are there any supportive resources you wish more people knew about and were able to access? How can MN Medicaid add value to and support what Tribal nations and American Indian communities are already doing to help members realize their full health and potential?

May 14, 2024 – dIZI #1

- Discussion on delayed responses when seeking or reaching out about healthcare. New updated systems and making it user friendly to all education levels.

- Biggest obstacles I'm faced [with] is discrimination and the way doctors explain or miscommunicate and talk to me as a patient**.**
- When it comes to the lack of information in the healthcare system it can be confusing and overwhelming.
- Limited access to appropriate healthcare facilities especially in remote areas don't provide appropriate care.
- Understanding who qualify for Medicaid and understanding who are eligible for Medicare. The process can be cumbersome and time consuming to complete the application form when English isn't your first language.

- Availability of resources would go a long way
- Emergency resources for quick response
- Awareness and accessibility would help.

- Primary obstacle is finances.
- Shyness in approaching healthcare personnel.

- Not having the treatment, I need to be covered by my insurance.
- Where to find a doctor to go to, and making a commitment, navigating the h[ealth]c[care] system
- Using tele-health that was very helpful, able to attend with other family members
- Physical distance from healthcare; commuting to doctor, transportation
- No internet access issues can also be a barrier
- Expensive for healthcare, no subsidy available

- Dental care: no way to find any appointments in the Twin Cities to get dental care
- Working at a free clinic in the Phillips Neighborhood, difficult to find places to refer patients to who are seeking dental care

- Experience with Medicaid is cultural competencies issue and there is limited providers' network.
- Trying to figure out what is actually covered by insurance and what is not covered by insurance
- Obstacle I face is shyness to approach the health care personnel
- Fear of the unknown and not wanting to find out you have a health problem; lot of Native American families have historical health disparities in the family history (i.e. high blood pressure, diabetes)
- Lot of people like UCare because you get a free gym membership; if more MCOs had health care benefits like free gym memberships, that would help a lot of families get exercise and access health care.

- Cost of healthcare alone is a lot, and I don't have a car so time and cost of transportation. Having somebody who is culturally competent or looks like me is rare to find.
- Cost of healthcare is relatively high - reduction in the cost of healthcare would go a long way

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- Issues with accessing medication, the medication wasn't covered, and they had to pay out of pocket. Was helped to find a way to reduce cost, but it was not convenient or useful.
- Choosing a plan was difficult because it was unclear what the differences were, and being assigned one meant the pediatrician their kid went to fell out of network and was turned away. The process for correcting that took too much time, so had to pay out of pocket.
- Telehealth is convenient, saves time for routine appointments such as for medication prescriptions.

- People shared that their "health is their wealth" and another person shared that they make food that is good for their immune system. Another person shared that their family has a twice-monthly yoga session that they value.
- A major obstacle one person shared was that telehealth did not provide an emotional connection and by that, they meant the provider was not able to understand how they felt.
- This person feels like telehealth could be useful for consultation but not urgent. Telehealth may not be able to validate your feelings, or you may not be able to understand your concerns and it can be difficult to diagnose someone.
- Another person and other people echoed that the delayed response in healthcare is a major obstacle. Another person further said that a long waitlist if it is very difficult to make an appointment with a healthcare provider, a long wait time might inhibit the person from going back to the service they need. The delayed response in healthcare

was emphasized by another person as well. Somewhat related to this a person wrote that inefficient workers were another obstacle in accessing health care.

- Shyness is an obstacle. Not everyone has the courage to advocate for themselves. To some extent, finances are an obstacle. There needs to be more awareness programs, more flyers, more information.

- They often don't talk about my stress, the things affecting me every day. But my doctors often just tell me I'm fat. I'm a caregiver for my husband, it's hard to find the support.

- I think this is really an important question also. I had mentioned some of those disparities when I spoke the last time, but to have some other kinds of considerations, esp. for elders who might say that my eyesight isn't that good, I can't read what's on this form here, or I don't know how to use the technology here, or even the font is hard to read or too small – these can seem like small things, but they are important to elders who can't see very well. There are a lot of people I know who are elders who talk about these issues with technology and not being able to access telehealth for example, for those reasons. Or they might have seen on tv about this phone that reads out whatever the person you are talking to said, I don't know what the service is called but it's supposed to be for people who are hearing impaired or sight-impaired – I wish that they could have access to those resources. It would be great to make these resources available with some training for how to use them. Often, I think there can be some shame about saying that they can't hear you, so they will nod along even though in reality they can't hear, which leads the provider to think that they can hear them. I think there can also be some anger when they feel like they are having issues that aren't being heard or taken seriously. I have a friend who is an attorney and a doctor also – which is a strange mix – but he worked at one of the reservations up there, and he started losing his eyesight, and called me up one day and said what's going on down at the clinic there, they sent me a report on my metabolics and I can't read it, so I said I will go down there and read it to you.
- I think for me, I can kind of speak for my dad who is going to be 88 this summer. He's kind of hard hearing and so I'm seeing for the first time the lack of patience people have with explaining what's going on and what he needs to do, and so as his caretaker, I have to really make sure that I understand really well so I can explain it to him later. I saw one provider do something that worked really well, she took the time to ask him after each step what he heard to make sure he really understood, and that was really effective. So, I'd like to see more people do that.
- I'd like to bring up something that relates to this and the question before – the experience of being an adoptee. Forms to this day don't leave a place to indicate that you are adopted and that can be really frustrating. And the blatant racism.
- I've used telehealth services before, it's a very good service but I prefer the physical visits. I think it is more effective than the telehealth services.

- I agree. I prefer in-person too.

May 28, 2024 – Duluth, MN

- Medical needs respectful to care?
- No, was cut off from medical needs for the entire family. Currently I— and baby don't have healthcare. We don't know how to go about it.
- Someone is using my social security and causing the issue.
- Caretaker for father
- Health care was accurate?
- They sent letter for more information in healthcare
- I haven't gotten letters, not one for dental
- I just need to go about the social security, and I don't have a social worker. I put an application for bus passes. I don't have a vehicle. Kids are in Duluth school districts.
- How do you feel your healthcare is here?
- It's okay. Fon du Lac can't help here. No one takes MA here. Daughter needs dental surgery, needs braces and it needs monitoring.
- In order to get healthcare, I need to go to the cities.
- Dental provider also told me that I need to go to the cities.
- No one accepts MA here
- Fon Du Lac only helps with enrolled members, blood quantum rule
- Transportation is a big problem
- Housing → all a domino effect
- Social security and resource access and collections took taxes which was going to be used for a vehicle
- My son needs glasses, but medical insurance is a problem

- Private insurance network limits
- Medical providers judging people not taking patients' concerns seriously. Assuming people are seeking pain meds – need true representation at all levels in healthcare.
- Discrimination/racism in healthcare
- Example of patient at Essentia speaking in Ojibwe and nurse saying, "Didn't the boarding schools take care of that?"

June 5, 2024 – Minneapolis, MN

- I live in Grand Portage – very rural. Feels like not high-caliber health care providers. Family friend needs help but no hospice in entire county. Wonder what will happen when husband is dying?
- Dental is a concern. People will drive to another town to see a dentist.

- Accessibility
- Knowing you are worth having health insurance

- Access to therapy, past the stigma
- Intimidating. I deserve good health. Common thing that younger generation has internalized.
- Mental health – understanding mental health
- Becoming more aware of the generational trauma, what families have been through.
- Systems that impact their people.
- Acknowledgment of the obstacles, history
- There is a distrust with women. Looking for female practitioners.

- Constant reminders for things you need to follow up
- Prefer reminders from healthcare provider and maybe not your insurance provider
- Infographics – MNSure and Medicaid could do better here
- Access traditional medicines and foods
- Land – place and space to grow foods and medicines, foraging
- Water, access to clean water

- Finding quality mental health care
- Wants to go where he wants to go and worried about the bill and no insurance. Son is already on bills. People cannot afford to twice and has no food
- Disconnection to food and to people and to health
- How about a program that is including food and healthy food? "Garden is women's sweat" Having hands in soils.
- Restrictions and make too much to qualify for MNSure

- Phone, do not have a phone, cover a phone, have no phone, landline or cell phone, can't have both, lose cell phone then no more phones
- Telehealth is good, Zoom to increase work
- Waitlist, need a 24/7 phone call for service
- Access to internet to get help. Waitlist on telehealth too long, setting up appointment is big barrier, need on call.
- More internet providers, not just Xfinity only at Red Lake building, need more internet service providers.
- Contact is limited too, technology didn't help
- Communities that are walkable – close to the area, rural areas (accessibility)

- Participants consider themselves very fortunate and adds that as an anecdote.
- Renewal process is a huge obstacle. Language and conversations that are not explained/reasonable. Engagement that provokes arguments based in frustration.
- Transport – physically, emotionally (tensions and emotions that are caused by trying to use your healthcare).

June 11, 2024 – Bemidji, MN

- Financial barriers, transportation, limit hours, I've used phone only appointments and it was okay. I used them but didn't have my chart on file, so they didn't know my personal background.
- Drive long distances to go to IHS but now I go to Sandford.
- Mental health coverage/access for invisible diagnosis, midwife coverage, having a local mental health provider that I could see that takes my insurance because I have to do all telehealth for mental health appointments.

- There should be better protection for elder. Sometimes guardians are needed.
- We had a mentorship program for our youth, but the program ended.
- It's hard to find someone to do a Rule 25. It takes so long people end up going back out for lack of support.
- There is no support entailed to help people get the treatment they need
- There should be a 24-hour treatment center here in Bemidji
- We need to have these sessions more often
- DHS is perpetuating the disparities we see
- DHS needs to change the policies that are in place
- If we could get our leaders who run the reservation to have an open meeting to discuss these things.
- If we could have a bigger meeting maybe that might make a difference
- Many people will neglect their health because of the barriers that prevent them
- I just feel like when you go to IHS to get help, they are not giving us quality care
- We need transparency to what is happening in Medicaid.

- Rural transportation; access to transportation
- Having to drive 70 miles to deliver your baby
- Seasonal family traditional activities

June 13, 2024 – dIZI #2

- MA should open more options for telehealth.

- No, I have access.

- System was quite easy to navigate.
- My experience has been good. Pretty easy, in person.
- No obstacles when seeking care. Having people we can approach, someone that can just put us through to where we need to go.

- My experience with audio-only telehealth services has been positive for routine check-ins, but I believe in-person visits are essential for more comprehensive care and examinations.
- My experience with MN has been positive and I think they are doing perfectly well. My sister really loves their service
- Transportation is a challenge when seeking healthcare. Access to affordable transportation services or telehealth options would help overcome this obstacle. I haven't used audio-only telehealth services, but I see its potential for remote areas. Prioritizing telehealth accessibility and culturally competent care through Medicaid would greatly benefit our community.

- Language barriers- having an interpreter available
- Multilingual resources
- Audio-only telehealth services
- Prioritize language accessibility and telehealth options for all
- Cost/affordability
- Racial discrimination and low accessibility
- Time is a challenge- busy schedules
- Availability of resources and finance to get the resources

- I usually on a scale of 1 to 10 [unintelligible] so I usually just say it's good, having my family members call me is good.
- Long wait times, fear and anxiety about diagnosis.
- I would say personally I haven't really experienced any, in my case the diagnosis process was amazing. But there's this administrative delay, and not for me but for some of my family members there's [something] controlled by us, which I haven't experienced personally, but I think of the administrative delay.
- I will also say that I felt very taken care of as a pregnant woman, keeping my baby on it. I wasn't in a very solid financial position, in a state of transition, and I just give thanks for being on it as a pregnant person, because I walked out of the hospital without a huge bill, which is a big deal in the U.S. You can document that in the notes, I'm grateful for that.

- One of the obstacles I encountered you couldn't get equitable access to services. I feel there's a way to be introduced or enlightened on what resources where we need to search. The healthcare as a whole should be upgraded to in terms of availability. Outreach is so important.
- What is the best way for you to be reached?
- Flyers should consist of the best resources.
- Where you can access resources where you can find the best hospitals, you know. That goes a long way.
- What about social media?

- I've always thought it was frustrating that when you go on social media, if you want to know something about like health like for example, I wanted to fill out a survey for my area school district. The school district wanted us to participate in the survey and I'm like where is this survey I can't find it anywhere, but you know if I logged on to my Facebook page and wanted to know gossip or like some dramatic thing that's happening, I would know it in 2 seconds. So, I've always found that frustrating that if data really is super available and you can really make a presence with things on social media but It seems like people are so much more interested in in sharing drama and negative things than they are about sharing things that are beneficial to our health. So, I always found that frustrating.
- The application process is slow and increased awareness would be important
- My role is in quality and compliance and making sure programs are credentialed. I make sure the programs from the providers are credentialed, one thing that is frustrating, we need to register differently because we're a tribal entity, so we have to reach out and ask questions. The help desk doesn't understand tribal healthcare and don't understand how to help us navigate those forums. It's an opportunity to really improve the folks working the help desk had more understanding on how tribal healthcare works and how the tribes connect with State of Minnesota healthcare system.
- I have experience with Medicaid/MN Care, which has provided essential healthcare but can be difficult to navigate. These programs help but sometimes delay access to treatment.
- To improve health for American Indians in Minnesota, we need simpler processes, more funding for culturally competent care, and better access to traditional healing practices.
- If I or a loved one needed to enroll, I would visit the Minnesota Department of Human Services website and seek help from community health workers

Question 5: Do you have any questions for DHS? Is there anything you'd like to know more about? Anything DHS should know?

May 14, 2024 – dIZI #1

- Discussion on dropping barriers when accessing healthcare needs.

- Is employment equal to all the races?
- Will a qualified doctor from a minority community receive the equal opportunities?
- Does Medicaid target any specific group?
- How do you get people to know about Medicaid? What strategies do you use to reach out to people?

- I just want to tell DHS to carry out more awareness programs and more studies like this

May 28, 2024 – Duluth, MN

- DHS should make mental health care more accessible
- Medicaid should cover fresh fruits and veggies
- More transportation coverage
    - Help to fix cars, replace transmissions
- Low interest loans to support needs
    - Fix car
    - Pay rent
- There is no access

June 5, 2024 – Minneapolis, MN

- Why are things so expensive?
    - Drugs, childbirth
- Waterbirths?

- What should I be doing as a kid?
- How do we more easily get health information that is relevant and answerable?

- 9/10 birthing people on MA
    - Where is the data coming from?
    - Is it through work?

- Income changes jeopardize care – how can we curb this? Cushion period?
- Can we create a service of coverage that is aimed at relief? Percentage based.

June 11, 2024 – Bemidji, MN

- Why aren't midwives covered? Home births specifically.

June 13, 2024 – dIZI #2

- DHS should know that there is still a lot of mistrust in DHS – especially in American Indian communities. For hundreds of years that information has been used against us. So, if you are having a hard time getting the info you want from AI communities that's why. Repairing that trust is a MUCH larger project than these small reports like this. Sharing is difficult for us for that reason. If you are hearing silence when you want data that's why.

- I'd like to know more about how DHS plans to improve healthcare accessibility for marginalized communities. Are there specific initiatives in place to address cultural competency in care? What steps are being taken to streamline the Medicaid enrollment process?

- Learn more about social determinants of health within Medicaid programs. How is DHS collaborating with community organizations to provide support beyond medical care? How does DHS plan to enhance healthcare access in rural areas, especially for American Indian communities?

- Part of me feels like there if there was a better process for even automatic enrollments or some sort of streamlined ability to identify people in the community who maybe lack access to healthcare or, you know, have maybe reduced access or, you know, the financial eligibility [it would be a huge improvement].
- In a lot of different I think other areas of our life you know health care being the one that we really need.
- There's a simpler application process and there's so many people who go without health care coverage just because navigating the system, advocating for themselves.
- Those can be real challenges. Whether we have communication, language barriers, you know, our, cultures are not intersecting, I think, sometimes.
- I feel like maybe if there was more of like that, like. Door to door type knocking type effect that sometimes we would get more enrollment numbers because open enrollment I think can be really overwhelming for a lot of people too.

Question 6: Is there anything that we didn't ask that we should have? What isn't here that you would like to see? Are there any questions you have? Please share your question(s), and any answers that your group discusses.

May 14, 2024 – dIZI #1

- No questions asked

- Wellbeing is very important and not just one thing. It means different things for everyone (it's not just health, but also other components.

- Creating more insights and more of this program, it's really educative
- Keep being stronger and getting better

- Participants discussed health and wellbeing in urban communities, emphasizing the importance of addressing the needs of vulnerable populations. Speaker 3 emphasized the need to lift up all members of a community together. Speaker 1 discussed the impact of cultural practices on health and wellbeing, and Speaker 5 shared their personal struggles with feeling disconnected and alone in their urban environment. Later, participants shared their personal experiences with healthcare systems, highlighting challenges faced by marginalized communities, including denial of disability benefits, lack of access to transportation and healthcare services, discrimination, and poor treatment from healthcare providers. Someone emphasized the importance of collective action and advocacy to address these issues and create a more inclusive and supportive society.
- Health and wellbeing in a community setting:
- Participants discuss personal interpretations of "health and wellbeing" in a group chat.
- Speaker 1 shares about their family dynamics
- Speakers discuss health and wellbeing in relation to community resources and access to green spaces.
- Struggles with mental health and access to healthcare:
- Speaker 5: Feeling disconnected from culture and community despite living in urban areas.
- Used Indian Health Services outside of the city when living with the tribe but had to learn about Medicaid on their own and didn't have someone to turn to for help.
- Speaker 5 shares personal struggles with discouragement and frustration due to a lack of fulfillment in their life.
- Speakers share experiences with the healthcare system, and desire for empathetic listening.
- Disability struggles, advocacy, and marginalization:
- Speaker 5 shares personal struggles with disability benefits, custody battle, and medical issues.
- Speaker 5 feels frustrated and defeated by the system, fearing for their life and well-being.
- Speakers share personal experiences and perspectives on marginalization and activism.
- Transportation and healthcare accessibility challenges:
- Speaker 1 shares their experience with Medicaid and transportation challenges, highlighting the need for improved access to care.
- The transportation system currently offered by insurance is not effective as it either picks the patient up hours in advance, right at the time of the appointment or time after causing patients a huge inconvenience or to miss their appointment due to tardiness.
- Speakers discuss the difficulties of navigating the healthcare system, including transportation and insurance issues such as copay and meeting the requirements to Medicaid and MN Care.
- Speaker 5 shares personal experiences of discrimination and lack of accessibility in various settings.
- Healthcare access and trust among marginalized communities is a theme that came up a lot and noting that there is still a lack of trust.
- Speaker 5 shares frustration with lack of empathy towards people with disabilities.

- Speaker 6 discusses invisible disabilities, misgendering, and difficulty accessing healthcare.
- Speaker 3 shares personal experiences with lack of trust in healthcare systems due to upbringing on reservation with limited access to care.
- Speaker 3 still struggles with navigating healthcare systems despite being educated on healthcare and passionate about it.
- Distrust in communities, particularly in healthcare systems, was a major concern. Speaker 3 emphasized the importance of hiring people from marginalized communities to understand their needs. Speaker 2 stressed the need for more respectful and comprehensive care that considers the impact of external factors on a person's health. Speaker 4 proposed cultural training for medical professionals to address biases and misdiagnosis.
- Healthcare access and cultural sensitivity for marginalized communities.
- Speaker 1 discusses high levels of distrust in a community due to past actions.
- Participants discuss healthcare access and advocacy for marginalized communities.
- Speaker 3 describes a traumatic experience of being separated from their family and culture during a medical procedure, feeling unwelcome and unheard.
- Speaker 3 expresses gratitude for culture navigators in healthcare systems in Minnesota, who understand and respect their traditional medicines and practices.
- Improving healthcare for American Indian, including cultural competency and access to care.
- Speaker 2 desires more transportation services and culturally responsive healthcare providers.
- Speaker 2 suggests a directory for culturally competent care providers.
- Speaker 4 expresses frustration with misdiagnosis and biases towards indigenous people, suggesting cultural training for healthcare professionals.
- Action items
- Develop a directory or ratings system indicating healthcare providers' experience and cultural competency working with indigenous communities.
- Consider requiring cultural competency training for Medicaid providers to address biases and misdiagnoses.

- I will advise the organizers that more of this program should be carried out. Like more outreach.
- Lot of MCOs attend Native American events as vendors, it would be great to see DHS at these events tabling.
- Hennepin County has a community-events calendar they can share
- MA-PD program, Native Americans don't have a premium they need to pay but after the pandemic, a lot of people are getting put on spend-downs. Native American people should not have to pay spend downs.

- Some of the sub-questions could have been their own questions, especially the specific ones about community resources and needs

- We had a very organic conversation that considered all of the questions at once, we did not do them one at a time
- D— said resources and being in community makes health and wellness more possible.
- R— said connection to both our relatives and cultural practices to connect to them no matter where we are at, through ceremony or general companionship, is essential. It is so hard to feel so alone/disconnected in the city.
- E— said comparatively, he's ok but it is hard to know if *this* level of health is fulfilling.
- R— said a lot of folks are living paycheck to paycheck, and we can't afford to be doing anything fulfilling because we are just surviving. Feels so discouraged. So much need.
- M— came in and reminded folks that this is a vulnerable space. Shared she's experiencing health issues to help us get the ball rolling.
- R— shared that she's working on disability and is having trouble because she "looks" able bodied and the systems in place are not actually helping her. She works hard for her clients but doesn't have the spoons to take care of her health. She's battling Medicaid, going to the ER four times, trying to be a role model, would be easier if I just quit… "I feel like I am shortening my life by years… fighting something (the gov't) and for what?"
- M— was reminding us we can make a change in this room. Marnita's Table is a nonprofit, yes, and we're committed to doing this because we are tired of being pushed to the margins.
- D— is currently on Medicaid, in the past has had to choose between paying co-pays and buying groceries. More work needs to be done of course. Transportation systems are not working! Insurance transportation systems are not in working order.
- R— wanted to add about the Metro Mobility system. Partner works in civil rights/disability lawyer. Dumbfounded by the work her partner needs to do so much labor to get to appointments on time and they mess up his wheelchair.
- Lack of accessibility is lack of care. We want to believe the systems are trying their best, but realistically they're ruining our mobility aids/doing a terrible job.
- R— notices people treat her wheelchair-bound partner like shit. She says people need to treat
- We all deal w the feelings of being paid too little, exploited, and they seem to forget how to treat people with dignity and respect
- T— talked about not having health insurance years ago, and having to go back to their IHS on their reservations
- First gen people with health insurance outside of IHS. The deep distrust of health systems, carried over from IHS trauma.
- E— remembers when covid vaccines were rolling out on the reservations, and how the gov't confronted all the distrust. We expect the worst. People should not blindly trust institutions that don't align with a duty of care.
- This group began very quietly so the participants were being switched into our group mid-discussion.

- D— said the dental care system does not accept Medicaid and wishes there was uber for medical services that was reliable. Having more culturally responsive care workers is a need.
- T— wishes there was a list of recommendations for practitioners that have experience working with native people. Has noted racism, where in the ER native people are often asked to tell us "What are you on" – often assumed.
- R— suggests if healthcare workers are CE requirements for cultural competency.

May 28, 2024 – Duluth, MN

- Why is there not more community involvement?
- Why is there not Indigenous people at all levels of DHS and healthcare?
- Why do they want to use us in photos but not actually help?
- More scholarships for Native people to become doctors

June 5, 2024 – Minneapolis, MN

- More specific questions about mental health. What do you need that will help you? Impacting employment.
- Social security/disability benefits.
- Culturally relevant, communication about practitioners, different kinds of therapy.

- Finding more stable federal funding to support more community health programs that address social and cultural and economic barriers to healthy eating, exercise

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- Networking and connecting and staying connected.
- Need more information and discussions.
- Strengthen our relationship
- Where are the decision makers in the space? We need them here.
- Being shared openly, umbrella
- Feedback to community
- Come back and engagement
- Reimbursement of community story
- Had to put a lot of trust in the Table and vulnerability and may cause body responses
- An individual has a lot of courage to share their story
- Involvement of community story

- What is missing? What is your dream for care? No room for imagining the ideal.

- How do you imagine care for yourself, your community?
- More opportunities for a mutual imagining within community practices and initiatives.

June 11, 2024 – Bemidji, MN

- DHS accountability measures for equity

June 13, 2024 – dIZI #2

- DHS could be more transparent with what they are hoping to do with this information.
- You covered everything.
- No questions.
- I feel that DHS should do more to get more public opinions on more subject matters.
- Transparency is key.
- Need more awareness.

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversation & Dinner
Duluth, MN | 28 May 2024

Circle Share-in Notes

Prompt: *I want you to see me as…*

- Kind
- Charismatic
- A powerful individual
- Healthy
- Creative
- A strong, powerful person
- Your son
- A good mom
- Strong
- Hopeful
- Kind
- Empathetic
- Thoughtful
- Here
- Loved
- A good mother
- An accomplice
- As humble
- Getting old
- An ally
- Caring
- An advocate
- Big bro
- Needed
- A strong, Indigenous woman
- A loving mother
- Respectful
- Grateful
- Creative
- A sided

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversation & Dinner
Minneapolis, MN | 5 June 2024

Circle Share-in Notes

Prompt: *I want you to see me as…*

- Charming
- Young, hot and sexy
- A helper, a beautiful red lake helper
- Strong
- Healthy
- Authentic
- Advocate
- Advocate
- Anishinaabe and fellow human being
- A peaceful person
- As helping
- Strong
- Resourceful, resilient
- Your superhero mom
- A soccer player
- Skinny
- Empowered
- Ancestral love manifested
- Just sacred
- A good relative
- Creative
- Helper
- In my humanity
- Living traditions
- A partner
- A contributor
- generous
- my grandma
- a human being
- a good listener
- an independent person
- creative
- committed
- Ojibwe teacher
- Your confidant
- A humanitarian
- A visionary changemaker for my people
- A learner
- An inspirer
- Someone with a big heart
- Queen mama
- Enough

DHS Engage! Pathways to Racial Equity in Medicaid
Community Conversation & Dinner
Bemidji, MN | 11 June 2024

Circle Share-in Notes

Prompt: *I want you to see me as…*

- See me as a part of the community
- Charismatic
- Electric
- Bold
- Honorable
- Brad
- A good relative
- Enthusiastic
- A friend
- Resourceful
- A human being
- Beautiful
- A helper
- A good person
- A character
- A grandma

PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

MEMORANDUM

To: Dr. Nathan Chomilo, Medical Director of Medicaid and MinnesotaCare, Minnesota Department of Human Services

From: Morgan Jones Axtell, Staff Attorney; Julie Ralston Aoki, HEAL Director, Public Health Law Center

Re: The Federal Government's Long-Standing Duty to Provide Health Care for Native Americans

Date: October 30, 2024

Introduction and Summary

On behalf of the Public Health Law Center (PHLC), we appreciate the opportunity to provide you with a summary of ways that public resources, such as Medicaid, should be used to address health inequities caused by structural racism. PHLC does not lobby, nor does it provide legal representation or advice. However, based on our experience with legal technical assistance pertaining to health policy and Tribal public health, we are pleased to provide you with this memorandum to support your own evaluation of these policies. This information is for educational purposes only; we do not request that a policymaker take any specific action, nor should our comments or information be considered a replacement for legal advice. Further, Medicaid is a complex program that presents a new area for us, and we acknowledge that we have much to learn. That said, we hope this information will be helpful.

The federal government's long-standing duty to provide health care for Native Americans are rooted in treaties and recognized and implemented through other federal laws.

The federal Indian trust responsibility is a legally enforceable fiduciary obligation on the part of the United States to protect Tribal treaty rights, lands, assets, and resources, which includes upholding the treaty responsibilities to provide health care to Native Americans.[1]

Beginning in the early 1800s, as a precursor to the Indian Health Service (IHS), treaties between Tribes and the United States provided for medical supplies and physicians' services as partial consideration for Tribal land cessions to the U.S. Many treaties included express and specific commitments to provide health, education, and social welfare supports. For example:

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- Treaty with the Makah Tribe, 1855[2]
  - "[E]mploy a physician to reside at the said central agency, or at such other school should one be established, who shall furnish medicine and advice to the sick, and shall vaccinate them . . ."
- Treaty with the Kiowa and Comanche, 1867[3]
  - "a residence for the physician, to cost not more than three thousand dollars"
  - "The United States hereby agrees to furnish annually to the Indians the physician . . . as herein contemplated, and that such appropriations shall be made from time to time, on the estimates of the Secretary of the Interior, as will be sufficient to employ such persons."
- Treaty with the Klamath and Modoc Tribes and Yahooskin Band of Snake Indians, 1864[4]
  - "The United States further engage to furnish and pay for the services and subsistence . . . for the term of twenty years of one physician. . .[.]"
- Treaty with the Ottawa and Chippewa Nations, 1836[5]
  - "Three hundred dollars per annum for vaccine matter, medicines, and the services of physicians, to be continued while the Indians remain on their reservations."

Treaties with Tribes co-located in Minnesota have similarly required the federal government to provide support for medical care. For example, through the Treaty with the Chippewa of the Mississippi, 1867,[6] the federal government promised: "Twelve hundred dollars each year for ten years for the support of a physician, and three hundred each year for ten years for necessary medicines." The Treaty with the Chippewa, Mississippi, Pillager and Lake Winnibigoshish Bands, 1864[7] and the Treaty with the Chippewa – Red Lake and Pembina Bands, 1864[8] also include provisions for a physician among other commitments in exchange for tracts of land. When adjusted for inflation and to reflect modern monetary values, these amounts would of course be significantly higher.

Congress has reinforced these treaty and trust obligations to provide health care to Native Americans through the Snyder Act of 1921, which was Congress's earliest legislative authorization of federal funds to support Indian health.[9] Subsequently in 1975, the Indian Self-Determination and Education Assistance Act (ISDEAA) authorized Tribes to choose to take over management or provision of services that IHS would otherwise have provided (and including the funding that IHS would otherwise have used if it were providing the services.)[10] This is commonly referred to as "638-ing" the services because the ISDEAA is Public Law 93-638. In the Indian Health Care Improvement Act (IHCIA) of 1976,[11] Congress again acknowledged the federal government's ongoing responsibility and duty to provide health care for Native Americans, stating:

> "Congress declares that it is the policy of this Nation, in fulfillment of its *special trust responsibilities and legal obligations* to Indians— (1) to ensure the *highest*

> *possible health status* for Indians and urban Indians *and to provide all resources necessary to effect that policy* [.]" (Emphasis added).[12]

In the 2021 case of *Rosebud Sioux Tribe v. United States*,[13] the Eighth Circuit Court of Appeals (which includes Minnesota) affirmed that the federal government has a trust obligation to provide "competent physician-led healthcare" to the Rosebud Sioux Tribe arising from the 1868 Treaty of Fort Laramie.[14] The Court pointed to the plain language of the treaty, the long history of the government's conduct in providing some kind of health care while discouraging Tribal members from using traditional medicines, and the reinforcing of that duty by the Snyder Act and the IHCIA. The court concluded that these actions and history demonstrated that the government had undertaken a commitment to fund and provide competent medical care to the Tribe and could be held accountable for its failure to do so.[15]

What Medicaid provisions reflect the federal government's trust obligations to provide health care coverage to eligible Native Americans?

As part of implementing this trust responsibility, the U.S. provides health care to American Indian and Alaskan Native (AI/AN) people through IHS, which uses a three-tier system, referred to as I/T/U (Indian Health Service, Tribally operated facilities/programs, and Urban Indian health clinics). Like anyone else, Native Americans are also eligible for Medicaid coverage if their income is below the qualifying maximum amount. Access to Medicaid allows for increased access to providers outside of the IHS system, which is needed due to the chronic underfunding of IHS (see below).[16] Through the Social Security Act, Congress authorized CMS to reimburse IHS for health care services provided to Medicaid-enrolled Native Americans at IHS facilities.[17]

For Medicaid services provided through an IHS facility, the IHCIA provides IHS with a 100% Federal Medicaid Assistance Percentage (FMAP) reimbursement.[18] This means that all medical services that Medicaid offers, and which are provided at an IHS facility should be fully reimbursed by the federal government.

In addition to the 100% FMAP, Medicaid has other specific rules that apply to AI/AN enrollees such as:

- excluding certain types of Indian trust income and property in how modified adjusted gross income (MAGI) is calculated for Native Americans, which is important because MAGI determines eligibility for Medicaid;[19]
- prohibiting states from imposing cost sharing for AI/AN enrollees — which means that states cannot require AI/AN patients to pay copayments, deductibles, coinsurance or similar charges for standard covered services;[20]
- allowing AI/AN patients to enroll or modify their enrollment in standard health plans once a month if they choose.[21]

To qualify for these types of Medicaid provisions, a person must meet the definition of an "Indian," which is defined as a person who 1) is a member of a federally-recognized Indian [T]ribe; 2) resides in an urban center and meets at least one of four demographic criteria; 3) is considered to be an Indian for any purpose by the Secretary of the Interior; or 4) is considered to be an Indian for purposes of eligibility for Indian health care services by the U.S. Department of Health and Human Services.[22]

The federal government has been deficient fulfilling its trust responsibilities to provide health care for Native Americans.

Native health outcomes lag behind other groups on almost every measure.[23] One key reason why Native Americans experience disproportionately higher rates of preventable and treatable chronic Illnesses such as heart disease, cancer, diabetes, stroke, and kidney disease is the longstanding Congressional pattern of inequitable funding for IHS —the agency responsible for providing and funding comprehensive health care for Native Americans. The Government Accountability Office has reported that other government funded health care systems, such as Medicaid, Medicare, federal prisons, and the Veterans Health Administration, receive double and even triple the amount of federal funding per patient compared to IHS.[24] Funding for IHS is also discretionary, which means Congress can deprioritize allocating the funds needed to ensure full health care coverage for all eligible Native Americans. This discretion is a major reason for the chronic underfunding that persists, leaving many Native Americans without the medical care that they were promised and that they deserve.

One positive, albeit limited, factor is that IHS is a payor of last resort.[25] If a Native American also has third-party coverage, such as Medicaid or private insurance, those resources must be used first. This preserves some of IHS's limited funding for patients who have no alternative health care coverage and would otherwise have little to no access to health services.

Financial support is only one piece of the puzzle, however. Many Native Americans also live in rural areas which also tend to be underserved with health care services.[26] A shortage of medical personnel within rural areas and at IHS facilities creates another barrier to accessing health care services.[27] This additional barrier contributes to longer wait times and many Native American patients being forced to travel significant distances to reach medical facilities or necessary specialists.[28] This inadequate access to comprehensive health care services creates further health inequities and contributes to negative health outcomes for Native Americans.

A Centers for Medicare & Medicaid Services (CMS) brochure acknowledges both that health care is a treaty right owed to Native Americans, and that the federal government fails to adequately fund it and thus fails to fulfill this obligation: *"Even though health care is a treaty right, you should still get insurance. IHS has to work within yearly*

budgets approved by Congress and does not receive enough funds to meet all the health needs of American Indian and Alaska Natives."[29]

What are the areas for improvement to uphold the federal trust responsibility?

The federal government has a legal obligation to provide competent, comprehensive health care services to Native American citizens. Unfortunately, it continues to fall short in several ways.

One of the many shortfalls of the current health care system serving AI/AN communities is the lack of culturally appropriate care options. Traditional healing should be a core component of the health care system for AI/AN people. It offers more holistic health care that connects the patient to their cultural healing ways which have been practiced for millennia. Ensuring coverage for these services would also assist in reversing the stigmatization that was deliberately created by the federal government and the states, who prohibited and punished Native Americans who tried to maintain these traditions for much of U.S. history. This horrific policy was not formally addressed until 1978 and continues to affect Native people's lives today.[30] The IHCIA contains sections reflecting acceptance of traditional healing services and promoting them.[31] However, Medicaid does not cover traditional healing services as part of AI/AN health care coverage and so fails to provide culturally competent services to AI/AN enrollees. As explained above, the *Rosebud Sioux Tribe v. United States* case held that the United States government has a duty to provide competent physician-led health care to the Tribe.[32] "Physician-led health care" is Western medicine's concept of the highest level of health care and should be calibrated to Native communities. In other words, instead of trying to make Native health care fit within the Western model, the federal government must work with Tribes to understand more about the health care they need and want. Effective health care that can lead to the elimination of health disparities experienced by Native Americans must include culturally competent interventions that are tailored to individual needs.[33]

Recognizing the importance of culturally appropriate care, four states (Arizona, California, Oregon, and New Mexico) have petitioned CMS for flexibility to provide culturally appropriate care, through their Medicaid programs using a process known as a "Section 1115(a) demonstration waiver."[34] These waivers seek permission to expand Medicaid reimbursement to include traditional healing services at I/T/Us.[35] After some initial partial approvals and several years of waiting, CMS fully approved the four states' waivers to provide coverage for traditional healing services on October 16, 2024.[36] Each approval letter and supporting documentation is hundreds of pages long. Because these approvals were issued shortly before the printing deadline for the *Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota* report, we have not had time to thoroughly review each set of documents. We noted, however, that all four waiver approvals allow for coverage of traditional health care practices received by eligible beneficiaries through facilities operated by IHS and Tribes, and three out of four (CA, NM, and OR) approved coverage for services received

through urban Indian organizations as well. For Arizona, it appears that urban Indian organization (UIO) services are covered only if the UIO is providing the services through a contract with an IHS or Tribal facility. Additionally, expenditures for UIO provided services are only eligible for the federal match at the applicable state service match level; in contrast, expenditures for services received through IHS and Tribal facilities are eligible for a100% Federal Medical Assistance Percentage. Below is a high level, preliminary summary of key information about each state's waiver request and approval:

- In 2016, **Arizona** submitted an 1115(a) Medicaid waiver to CMS requesting approval to reimburse traditional healing services provided through IHS or Tribal facilities.[37] In 2022, CMS approved most of Arizona's waiver request but did not approve the traditional healing services portion. CMS noted in a October 14, 2022 letter that it "recognizes the state's goals of addressing disparities in the American Indian and Alaska Native community and will continue to work with the state" on the request for coverage of traditional healing services.[38] Arizona's waiver application defined "traditional healing" as a "system of culturally appropriate healing methods developed and practiced by generations of Tribal healers who apply methods for physical, mental and emotional healing. The array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity."[39] In October 2024, CMS approved the traditional healing services portions of Arizona's waiver, for services received through an IHS or Tribal facility (including services received from urban Indian organizations contracted with an IHS or Tribal facility). As discussed in more detail in Memo 3, the approval letter explains that each qualifying facility is tasked with setting up a process to determine which providers and what services can qualify for reimbursement (CMS took this approach in all four of the waiver approvals covered in its October 16, 2024, letter.) In terms of qualifying facilities, the letter explains: "To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities [IHS or Tribal facility] (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid. This approval is effective through September 30, 2027.

- In 2021, **California** submitted an 1115(a) waiver to cover substance-use disorder services provided by traditional healers affiliated with Indian Health Care Providers. The coverage would be provided through the state's county-based substance use disorder managed-care delivery system.[40] CMS approved California's 1115(a) demonstration waiver request to amend the California Advancing and Innovating Medi-Cal to cover traditional health care services that are received through IHS, a Tribal facility, or an urban Indian organization facility.[41] This approval is effective through December 31, 2026.

- Since 2019, **New Mexico**'s 1115(a) demonstration waiver has provided an annual $2,000 member-managed budget for specialized therapies, including Native American healers, to enrollees who need nursing-facility level of care and who receive home and community-based services (HCBS).[42] Tribal members who need nursing-facility level of care are mandatorily enrolled in a health plan.[43] Tribal members who are ineligible for HCBS and who are enrolled in a health plan may have access to the $2,000 annual sum for traditional healing as a "value-added service," subject to the health plan. In 2020, New Mexico submitted a request to renew its 1115(a) waiver that seeks approval for an additional $500 annual self-directed budget for traditional healing services for Tribal members enrolled in managed care who do not need nursing-facility level of care.[44] CMS approved New Mexico's 1115(a) waiver amending New Mexico Turquoise Care to allow for coverage of traditional health care practices received through facilities operated by IHS, Tribes, or urban Indian organizations.[45] This approval is effective through December 31, 2029.
    - New Mexico's 2022 expanded proposal includes "prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel . . ."[46]
    - The proposal notes that "[s]ome Tribes, Nations, and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious, historical ties, and privacy."[47] This highlights the importance of protecting Tribal Nations' privacy and sacred practices as sovereign nations.

- In 2022, **Oregon** submitted an 1115(a) waiver renewal requesting reimbursement for "Tribal-based practices[.]"[48] It also requested the ability to cover health-related social need services for Tribal members who are not enrolled in a coordinated care organization.[49] On September 28, 2022, CMS approved other requests but did not approve the reimbursement for Tribal-based practices (among other things).[50] On October 16, 2024, CMS approved Oregon's waiver, allowing the state to amend the Oregon Health Plan and provide coverage for traditional health care practices delivered by or through facilities operated by IHS, Tribes, and urban Indian organizations.[51] This approval is effective through September 30th, 2027.
    - The waiver renewal request includes this language: "A medical assistance program shall consider Tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaskan Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those Tribal-based practices."[52]
    - The Oregon Health Authority includes several examples of Tribal-based practices, including sweat lodges, talking circles, and horse programs.[53]

> The Oregon Health Authority includes several examples of Tribal-based practices, including sweat lodges, talking circles, and horse programs.[54]

In addition to the above waiver requests, Tribal health centers in **Utah** have suggested that Utah should take a similar approach and seek an 1115(a) waiver to allow traditional healing services to be billed under the state's Medicaid program.[55]

States should collaborate with Tribal Nations about how to provide reimbursement for traditional healing services through Medicaid or other mechanisms. As noted above, the October 2024 approval letters explain that each qualifying facility is tasked with setting up a process to determine which providers qualify as traditional healers and what services can qualify for reimbursement as traditional healing services or practices. This is a promising development and indicates support for deferring to Tribes and Tribal organizations to make these determinations, consistent with respect for Tribal sovereignty. Nonetheless, as Tribes and health care facilities work to implement these processes and criteria, there will be important considerations to navigate, such as:

- Traditional healing practices vary widely across Tribal Nations.
- Are Tribal traditional healers in the community willing to assign or negotiate a monetary value for their healing services? If not, what are other appropriate, acceptable options?
- Would traditional healers be willing to participate in the claim process?
- How does an individual become a traditional healer and what, if anything, is the licensing or certification process for traditional healing practitioners? Is a licensing or certification process even appropriate in this context?
- How will Tribal data sovereignty be upheld? Traditional healing practices are often considered private, sacred practices, and may not lend themselves to processes designed to track patient use or outcomes.

A 2023 report by the National Council of Urban Indian Health provides information about traditional healing and policy. It also provides information from interviews with urban Indian organizations about traditional healing interventions.[56]

Full funding for the Indian Health Services should not be discretionary. Instead, IHS funding should be mandatory, as it is for Medicaid or Social Security. While the 2023 advance appropriation for IHS funding which ensured funding through the 2024 fiscal year was a positive step, it was still temporary.[57] Congress could choose to not advance appropriations for IHS next fiscal year. By contrast, Medicaid is not tied to a funding source that requires yearly appropriation by Congress – if someone is eligible, then they can expect that their services will be covered. The funding uncertainty, coupled with chronic underfunding for IHS, ensures there routinely are not sufficient funds to cover the medical needs of all (or even most) enrolled Native Americans, forcing IHS to engage in health care rationing. Without adequate and consistent funding, the federal government fails to fulfill its trust responsibility to provide health care to Native Americans.[58]

The federal trust responsibility should be unwavering and not subject to the political whims of changing administrations, but this is often not the case. For example, in 2018, HHS denied Tribes' requests to be exempt from state Medicaid work requirements, arguing that an exception for Tribes would represent an illegal race-based preference.[59] Relatedly, some states are challenging a Medicare regulation aimed at promoting health equity and addressing racism in the health care field because the regulation incentivizes providers to create and implement an anti-racism plan.[60] Racial equity is important and necessary for a just and healthy society; however, the federal government's trust responsibility is not based on racial equity goals. Its foundation is the relationship between sovereigns and the treaty obligations the federal government owes to Tribes and Tribal citizens. Further, Tribes are governmental and political entities, not racial groups.[61] This foundational principle was most recently recognized by the U.S. Supreme Court in *Haaland v. Brackeen*, in which the Court reaffirmed that Native Americans are a political class and not a racial group.[62]

Conclusion

The federal government has a legal obligation to provide health care services to Native Americans. This legal duty is based on its trust responsibility, which stems from the treaty promises made by the United States in exchange for massive cessions of Tribal lands. These obligations have also been codified in statute. The federal government attempts to fulfill its legal duty to safeguard the health of Tribal citizens through IHS, urban Indian clinics, and funding Tribally-run health care programs. However, the federal government has not committed to fully and adequately funding IHS. Instead, IHS must rely on Congress to approve discretionary funding appropriations annually. So far Congress's appropriations have fallen far short of actual need, leaving many Native Americans without access to adequate care.

Ultimately, one solution to ensuring comprehensive health care coverage for Native Americans is for the federal government to fully meet its legal duty by guaranteeing sufficient, mandatory IHS funding every year. Approving Medicaid coverage for traditional healing practices also aids in reducing the health inequities experienced by Native Americans. Some good progress was made on this issue in 2024, but reimbursement for traditional healing practices should be part of the comprehensive health care that the federal government has a duty to provide to all Native Americans, and not be dependent on a state being granted a 1115(a) waiver request.

Endnotes

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PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

MEMORANDUM

To: Dr. Nathan Chomilo, Medical Director of Medicaid and MinnesotaCare, Minnesota Department of Human Services

From: Morgan Jones Axtell, Staff Attorney, Public Health Law Center

Re: The Tribal General Welfare Exclusion Act: Intended vs. Actual Impact for Tribal Members Who Receive Tribal Benefits

Date: October 30, 2024

Introduction and Summary

On behalf of the Public Health Law Center (PHLC), we appreciate the opportunity to provide you with a summary of ways that public resources, such as Medicaid, should be used to address health inequities caused by structural racism. PHLC does not lobby, nor does it provide legal representation or advice. However, based on our experience with legal technical assistance pertaining to health policy and Tribal public health, we are pleased to provide you with this memorandum to support your own evaluation of these policies. This information is for educational purposes only; we do not request that a policymaker take any specific action, nor should our comments or information be considered a replacement for legal advice. Further, Medicaid is a complex program that presents a new area for us, as well as the federal tax code; we acknowledge that we have much to learn. That said, we hope this information will be helpful.

The general welfare exclusion doctrine is founded on the idea that income-based government benefits to people who are very low-income should not count as taxable income because that could jeopardize their ability to receive those benefits. The doctrine works to exclude governmental programs benefits, like Social Security, from the recipient's taxable income. Because a person's eligibility for Medicaid and many other public benefits depends on their level of taxable income, this ensures that people with few resources do not lose eligibility for assistance programs by having other assistance programs inflate their income calculation. This doctrine was first codified into law in the 1930s through the Social Security Act of 1935,[1] and it was later expanded to also exclude unemployment benefits, replacement housing payments, disaster relief, and other governmental assistance programs.[2]

The Tribal General Welfare Exclusion Act of 2014[3] applies the welfare exclusion doctrine specifically to Tribal assistance programs, which are tailored for the unique circumstances of Tribal Nations and their citizens. It is a federal law that affects the federal income tax liability for many Tribal citizens. It provides that payments received by Tribal citizens from benefit programs provided by a Tribal government for the general welfare of its citizens should not count as part of the Tribal member's gross income for tax purposes, so long as

the benefits provided meet certain guidelines.[4] This provides two important protections: it protects these Tribally-provided payments, programs, or services from being subject to federal income tax;[5] and it can protect Tribal members with low-income from being disqualified from receiving crucial federal services or benefits — such as Medicaid – that are income-based.

A person's eligibility for many federal programs is based on their "modified adjusted gross income," or MAGI.[6] If their MAGI goes over a certain amount, they will be cut off from income-based benefits and services.

> A person's federal income tax liability is based on their "adjusted gross income," or AGI. A person's AGI is calculated based on their gross income, which is then adjusted by adding certain types of income (for example, per capita payments based on Tribal gaming revenues and subtracting certain deductibles or tax-exempt income (such as distributions from trust/reservation property and student financial assistance)). Some of those deductions are then added back to calculate the "modified adjusted gross income," or MAGI, which is used for determining the persons eligibility for certain income-based benefits. This means that often a person's MAGI may end up being larger than their AGI. The Indian Welfare Exclusion Act of 2014 prevents some Tribal benefits from being added back into the MAGI, which helps maintain the income-based eligibility of some Native Americans for federal programs such as Medicaid.

The Act changed the federal income tax code so that Tribal citizens whose income is near the maximum income cap and who start to receive Tribal benefits are not suddenly cut off from benefits. This protection has become especially important because emergency COVID-19 Medicaid protections, such as removing reapplication requirements and ensuring continuity of uninterrupted coverage, expired March 31, 2023, with states having 12 months to return to enrollment and eligibility operations.[7]
Unfortunately, while the Act is meant to maintain income-based eligibility for Native Americans with low income, eligibility income caps are set too low and have not accounted for rising costs of living. This makes it very difficult to remain under the income eligibility cap, leaving many families ineligible and lacking necessary resources.

What kind of Tribal benefits do not count towards MAGI under the Tribal General Welfare Exclusion Act?
For a Tribal benefit to qualify for the general welfare exclusion, the benefit must meet all of the following criteria:

1) The program must be administered pursuant to guidelines specifying how people qualify for the benefit and be made to any Tribal member who meets the guidelines;
2) Be for the promotion of general welfare (meaning based on need);
3) Not be "lavish or extravagant" under the facts and circumstances; and
4) Not be compensation for services.[8]

The first element means that a Tribe must be making the payment pursuant to a Tribal governmental program, which is likely to have detailed eligibility guidelines. These programs cannot favor Tribal government officials.[9] The Act further provides that an "Indian [T]ribal government program may be established by [T]ribal custom or government practice[,]"[10] which will of course differ from Tribe to Tribe.

For a benefit to be considered "for the promotion of the general welfare," it must be based on individual or family need.[11] Due to the unique government to government relationship between Tribal governments and the federal government, the IRS will "presume that individual need is met for each [T]ribal member or qualified nonmember receiving the benefit" if the program meets the general criteria laid out above, or is in included in the illustrative list of 23 specific benefits provided by a Tribe for which individual need is presumed, and which thus qualify for exclusion under the law.[12] The main categories include:

- Housing programs, such as utility payment, home repair, and home rehabilitation (among other examples).
- Educational programs, including higher education scholarships and job retraining programs for adults (among other examples).
- Programs for Elders or people with disabilities, such as home health care and local transportation assistance (among other examples).
- Cultural and religious programs, including funerial and burial expenses as well as expenses to attend or participate in a Tribe's cultural, social or religious activities (among other examples).
- Emergency assistance, such as assistance during the COVID-19 pandemic.

This list provides some examples of "safe harbors" or benefits that are presumed to qualify; it is not meant to be exhaustive of *all* Tribal benefits that will qualify for exclusion. Tribal benefits that are not included in the illustrative list of 23 enumerated safe harbors should also be exempt so long as the benefit meets the elements discussed above.[13]

Whether the IRS considers a benefit to be "lavish or extravagant" depends on the specific facts of the situation.[14] For example, assistance to help victims of a natural disaster meet necessary needs such as medical, housing, transportation, or funeral expenses would qualify for the exclusion of gross income under the Act. However, "assistance for nonessential, luxurious, or decorative items" does not qualify.[15]

Lastly, not representing compensation for services means the benefits are not payment for doing a job. Tribal benefits applicable to the Act should be available to all citizens who qualify. The Act also explains that "any items of cultural significance, reimbursement of costs, or cash honoraria for participation in cultural or ceremonial activities for the transmission of [T]ribal culture are not treated as compensation for services."[16]

What about per capita payments made to Tribal members?

Payments that are distributed based on the number of people in a group or community (or per person) and no other criteria are commonly referred to as "per capita" payments. As a general rule, per capita distributions are distinct from general welfare payments and do count towards taxable income. Some Tribes who operate gaming facilities distribute some of their gaming revenues to members through a per capita system. These per capita payments are subject to the Indian Gaming Regulatory Act which requires them to count towards taxable income.[17] Tribes also use gaming revenues to fund Tribal programs and services such as housing, education, healthcare, and infrastructure improvements. Payments resulting from these types of programs, or "payments which have been set aside by the [T]ribe for special purposes or programs, such as payments made for social welfare, medical assistance, education, housing or other similar, specifically identified needs" are not per capita payments.[18]

There also are exceptions to the broad rule that per capita payments do not qualify for exclusion. For example, payments that Tribal members receive through funds held in trust by the Secretary of the Interior and certain settlement agreements between Tribal Nations and the federal government are not taxable income.[19] Many Tribes have entered into settlement agreements, including the Bois Forte Band of Chippewa and Leech Lake Band of Ojibwe.[20] Thus, per capita payments that Tribal members receive resulting from these settlement agreements would not be counted as taxable income for purposes of determining eligibility for governmental services.

On September 13, 2024, the IRS issued a Notice of Proposed Rulemaking about a proposed rule to better support Tribal general welfare benefits for Tribal communities by, among other things, providing that gross income should not include the value of any general welfare benefit paid to or on behalf of a Tribal citizen. At the time of writing, **comments are due by December 16, 2024**.[21]

What is the actual impact of the Tribal General Welfare Exclusion Act for Tribal members who receive Tribal benefits and are eligible for Medicaid?

The Act can provide some protection for Tribal members with low income from losing important federal, income-based benefits like Medicaid by excluding Tribal benefits from their MAGI. This can be life-changing for those who may be right at the maximum income limit. However, this positive impact is limited because the income cap for Medicaid and other benefits is based on the Official Poverty Measure, which sets the poverty line to an amount far below the actual cost of basic survival needs in the United States.[22] This means that many people are falling through the cracks—especially people whose incomes are too high to qualify for Medicaid but too low to afford commercial health care insurance.

The impact of the IRS' policies and practices on Tribal Nation and their members must also be considered. To prove that a payment qualifies for exclusion under the law, Tribal

Nation payors and payment recipients "must maintain accurate books or records" which must be available for inspection by authorized IRS agents.[23] In 2019, ProPublica investigative journalists reported on a study looking at the rates of IRS audits for people based on the county where they live. The study found that the counties with the highest rates of IRS audits were in the Deep South and have predominantly African American and rural populations. Similarly, the study found counties with Native American reservations also experienced disproportionately high audit rates, with the lowest rates being found in counties where the population is predominantly middle income and white people.[24]

Tribal laws and policies relating to general welfare assistance

Some Tribal Nations co-located in Minnesota have enacted laws and policies relating to general welfare assistance, reiterating that these Tribal benefits should be excluded from an eligible Tribal citizen's gross income when calculating their qualification for state and/or federal assistance.

- For example, Mille Lacs Band of Ojibwe has an Eligible Band Member General Welfare Assistance Program designed to "provide general welfare assistance to Eligible Band Members for services, activities, and needs, including medical expenses such as in-home services, delivered meals, and health and wellness activity expenses; emergency assistance; dependent care assistance; housing, repair, rehabilitation and utility expenses; energy assistance; health and wellness activity expenses; social services expenses; cultural, spiritual and education services; and other related expenses . . ."
- Tribal Nations have adopted resolutions establishing Tribal COVID-19 relief programs, which were designated to be exempt from taxation. [25]
- Relatedly, Lower Sioux Indian Community put out a notice in 2020 saying that the Community "operates its General Welfare Program and Tribal Elders Benefit Program in accordance with the [Tribal General Welfare Exclusion Act of 2014] and has provided its Qualified Members" funding, such as COVID-19 relief assistance, Tribal Elder Benefit Program, and General Assistance Program/Tribal Benefits Program, must be "excluded from a Qualified Member's gross income in calculating his/her qualification for state and federal assistance."[26]

Numerous other Tribes outside of Minnesota have also enacted laws or policies related to the General Welfare Exclusion Act, such as Ho-Chunk Nation,[27] Oneida Nation,[28] and Little Traverse Bay Band.[29]

Conclusion

The Act's intended impact is to exclude important Tribal benefits for the general welfare from a Tribal citizen's MAGI, making it easier for some Tribal citizens to become or remain eligible for income-based federal benefit programs, such as Medicaid benefits. However, income caps are set too low and have not accounted for inflation and the rising

cost of living. Therefore, the Act's actual impact falls short, leaving many Native families without the adequate healthcare that the federal government has a trust responsibility to provide.

Endnotes

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PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

MEMORANDUM

To: Dr. Nathan Chomilo, Medical Director of Medicaid and MinnesotaCare, Minnesota Department of Human Services

From: Morgan Jones Axtell, Staff Attorney; Julie Ralston Aoki, HEAL Director, Public Health Law Center

Re: Shifting the Landscape of Evidence to Cover Traditional Healing Under Medicaid by Indigenizing Healthcare

Date: October 30, 2024

Introduction and Summary

On behalf of the Public Health Law Center (PHLC), we appreciate the opportunity to provide you with a summary of ways that public resources, such as Medicaid, should be used to address health inequities caused by structural racism. PHLC does not lobby, nor does it provide legal representation or advice. However, based on our experience with legal technical assistance pertaining to health policy and Tribal public health, we are pleased to provide you with this memorandum to support your own evaluation of these policies. This information is for educational purposes only; we do not request that a policymaker take any specific action, nor should our comments or information be considered a replacement for legal advice. Further, Medicaid is a complex program that presents a new area for us, and we acknowledge that we have much to learn. That said, we hope this information will be helpful.

Medicaid regulations require that any activities designed to improve the quality of health care services meet certain criteria, including being "grounded in evidence-based medicine" or "widely accepted best clinical practice."[1] These criteria are rooted in a constrained view of what constitutes acceptable, credible evidence. In medical treatment, there is a "hierarchy of evidence" that focuses on Western scientific studies of various kinds.[2] This hierarchy has been criticized for giving too much weight to some types of academic knowledge while devaluing evidence based on people's actual lived experiences.[3] Related to this critique, there is growing understanding that conventional Western "widely-accepted" health care practices are not adequate to meet all the health care needs for American Indian and Alaska Native peoples, assuming such services are even sufficiently available (which they frequently are not).[4] Additionally, Western health care and medical research practices have often caused terrible harms to Native Americans.[5] Increasingly, Native American health groups are calling for formal recognition of the demonstrated effectiveness of traditional healing practices and methods, many of which have been in use since time immemorial, have served to inform advances in Western medicine, and which have been specifically designed by and for Native peoples.

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Many Indigenous health and medical innovations have predated and contributed to Western medicine.[6] Numerous medicines that are considered "western" have Indigenous equivalents that were part of traditional practices long before North America was colonized, such as salicin in willow bark which is closely related to aspirin.[7] However, Indigenous healing practices go beyond knowledge of medicinal plants; they also utilize other non-Westernized, non-clinical methods to address health and wellness in a holistic way and to heal cultural trauma. Thus, exclusive reliance on Western-based medical approaches is neither appropriate nor effective for Indigenous populations. Traditional healing practices use a strength-based approach to reduce long standing health disparities in Tribal communities.[8] Evidence suggests that culturally specific health practices lessen the negative health effects of stressors that are experienced at high rates within Indigenous communities.[9] As the Minnesota Department of Health has acknowledged, "Research consistently points to the value of traditional healing practices designed and delivered by American Indians, for American Indians. Traditional healing for American Indians has outcomes equivalent to conventional interventions in other populations."[10]

Despite the well-established effectiveness of traditional medicines and healing practices for Native Americans, many Native traditional healing practices were prohibited or even criminalized by the U.S. government. In fact, it was not until 1978, when the American Indian Religious Freedom Restoration Act was adopted, that federal law was changed to prohibit government restrictions of American Indian spiritual and cultural practices, including traditional healing practices.[11] Even so, the law did not include penalties for violations until 1994.[12] This racist, traumatic history has a long shadow and continues to impact the health and wellbeing of Tribal communities and Native Americans. Tribal communities have made huge strides in growing and reviving their spiritual and cultural healing practices over the past three decades. However, the lack of structural support and funding for traditional healing services prevents consistent, widespread access to culturally appropriate healing for Tribal members and Indigenous peoples.

The federal and state governments can actively help to address these historical injustices by equitably distributing funding and infrastructure support for traditional healing practices that have been identified by Tribes and American Indian health leaders in their regions as effective and appropriate. Some states are attempting to use Medicaid demonstration waivers to do this. These efforts represent great potential for change; whether they will be able to achieve this potential remains to be seen.

What is considered acceptable evidence for Medicaid demonstration waivers?

Medicaid is an income-based public health insurance program that is jointly funded by the federal government and each respective state. The federal government sets guidelines for how Medicaid programs must operate, but each state administers its own Medicaid program.[13] Under these broad federal rules, state Medicaid programs must provide financial coverage for "mandatory" services, such as hospital and physician care. Although not required, states can go farther by covering additional "optional" services,

like dental or vision care. Section 1115(a) of the Social Security Act permits states to apply for demonstration waivers to give states additional flexibility to extend coverage for more health care approaches and to improve their programs to better serve diverse Medicaid populations.[14] Under that law, the Secretary of Health and Human Services has the authority to determine if a pilot demonstration project will likely help achieve the objectives of Medicaid and approve the corresponding waiver.[15]

The Centers for Medicare and Medicaid Services (CMS)—an agency under the Department of Health and Human Services—reviews each proposal on a case-by-case basis to determine whether the proposed waiver is appropriate and consistent with federal policies. [16] To be approved by CMS, Section 1115(a) waivers must demonstrate and evaluate state-specific policy approaches.[17] As noted above, federal regulations also require approaches to improve health care quality "be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations."[18] Further, the activity to improve health care quality must be primarily designed to reduce health disparities among specified populations. For example, by "identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practice and evidence-based medicine."[19] Additionally, demonstrations must also be "budget neutral," meaning that Federal Medicaid spending cannot be higher than the federal spending without the waiver in place.[20]

Four states (Arizona, California, New Mexico, and Oregon) have attempted to remedy the lack of culturally appropriate care options for Native American communities by submitting Section 1115(a) demonstration waivers to expand Medicaid coverage for culturally appropriate care, such as traditional Native American healing services. After an extended delay, on October 16, 2024, CMS approved the four states' waivers to provide coverage for traditional healing practices.[21]

Each approval letter and supporting documentation is hundreds of pages long. Because these approvals were issued shortly before the printing deadline for the *Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota* report, we have not had time to thoroughly review each set of documents. Thus, this memorandum provides high level takeaways from these approval letters. Additionally, we note that deeper understanding of how these new demonstration waivers will be implemented and applied will require time and evaluation, once these waivers have been operationalized.

How should traditional Native American healing practices be "demonstrated" to qualify for Medicaid reimbursement?

To the extent that a waiver may require Tribal Nations to apply a Western lens of "evidence-based medicine" to their sacred traditional healing practices, this is problematic in several ways. This approach lacks respect for the sovereignty of Tribal Nations and ignores the well-established, proven effectiveness of many traditional medicines and practices. Additionally, this approach is invasive and may not protect sacred and sometimes private Tribal practices or ceremonies. Tribal communities are the primary authorities for determining what should qualify as a widely accepted healing best practice, and some have done so. For example, the Indian Health Service lists several culturally relevant best practices used by many Tribal communities to address substance use disorder and prevent suicides.[22] Further, the IHS and professional medical associations, such as the American Medical Association also recognize the need for traditional healing practices. [23] These traditional practices that have been used for hundreds, if not thousands, of years should be deemed to meet Medicaid's standard for being evidence based and should qualify for coverage.

The federal and state governments should collaborate with Tribal Nations about how to provide reimbursement for traditional healing services through Medicaid or other mechanisms to maintain Tribal sovereignty. Importantly, what is considered to be a traditional healing practice will vary amongst Tribal Nations. Tribal Nations should be the ones to decide what constitutes "traditional healing" and how an individual is determined to be a traditional healer.

For example, Arizona's Section 1115(a) demonstration waiver application defined "traditional healing" as a "system of culturally appropriate healing methods developed and practiced by generations of Tribal healers who apply methods for physical, mental and emotional healing. The array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity." [24] Arizona's demonstration waiver also defines 1) covered traditional healing services, 2) qualified traditional healing providers, and 3) qualifying entities.

New Mexico's 2022 expanded waiver proposal includes several examples of traditional healing practices, such as: "prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel . . ."[25]

The recent waiver approvals show promising development. They expressly acknowledge that "[t]raditional health care practices vary widely by Tribe, facility, and geographic area."[26] They also recognize the need for and importance of providing flexibility for Tribes and Tribal-serving entities to define who qualifies to provide traditional health care practices, and what types of services or practices are eligible for coverage.

Regarding who qualifies to provide traditional health care practices, all four state waiver approval letters from CMS dated October 16, 2024 state that qualifying entities (IHS, Tribal facilities or urban Indian organizations) "are responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices …; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid … for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request." [27]

Regarding what traditional healing practices can qualify for coverage, the waiver approvals require that to be eligible for reimbursement, traditional healing practices must be provided by *employees* or *contracted providers*: "To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid."[28] (The waivers for California and Oregon also apply to those enrolled in CHIP.)[29]

Beyond this provider requirement, CMS again provides flexibility for qualifying facilities to determine what services should be covered, stating: "CMS will also permit IHS, Tribal, and urban Indian organization facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations."[30] The letters also note that clinical services eligible for reimbursement do *not* need to meet the definition of "clinical services" under other Medicaid regulations, and that "there is no requirement under this demonstration approval that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility."[31]

All four states waiver approval letters also require states to attest that they are providing "adequate access to secular alternatives" because some of the traditional healing practices may be considered religious or spiritual, or have religious components, to comply with federal law and maintain federal funding. [32] States also must attest that they have taken steps to ensure that "beneficiaries have a genuine, independent choice to use other Medicaid covered services" for conditions that are also being treated through traditional healing practices.[33] Additionally, states must attest that "traditional health care practices" are not "used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered" and avoid denying "access to services or settings on the basis that the

beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. [34]

At this early stage, it is unclear whether these attestation and/or documentation requirements might have unintended consequences, and if so, to what extent (if any). For example, it is unclear whether these requirements could require some kind of state intrusion into or scrutiny of private, sacred Indigenous healing practices, or into relationships between beneficiaries and traditional healing practitioners. Presumably, the states will work collaboratively with IHS, Tribal facilities, and urban Indian organizations to implement these requirements in a way that is as respectful and feasible for all, but this is an area where future evaluation could be important.

For states with the newly approved waivers, some key considerations relating to provider and service eligibility determinations that the qualifying facilities and the states will likely need to navigate include:

- Many traditional healers are not licensed or certified. To ensure respect for Tribal sovereignty, Tribal Nations should be the ones to decide what is required to become a traditional healer in their respective communities, and a standardized licensure or certification process should not be imposed upon them by other governmental or non-Tribal entities.
- Traditional healers may or may not be willing to participate in the claims process. Participating in this process would require the traditional healer to assign or negotiate a monetary value for their healing services, which may contradict cultural values or other traditional ways. Additionally, given historical persecution of traditional healers, and/or the culturally sensitivity of some practices, some traditional healers may not feel comfortable self-identifying themselves or all of their practices to the state government. Are there other ways of providing for reimbursement or handling the claims process that could be consistent with traditional ways and values, or mitigate provider concerns?
- Related to these concerns, protecting Tribal sovereignty over sensitive cultural data and other Tribal data is a pressing concern for many Tribes. Traditional healing practices are often considered private, sacred practices, and may not lend themselves to processes designed to track patient use or outcomes.

What are the potential risks relating to broadening what is considered allowable evidence for Medicaid reimbursement?

Despite the recent positive progress with the granting of these four state Section 1115(a) waivers to cover traditional healing practices, the waiver process itself is inherently problematic. Having to "demonstrate" sacred, traditional practices that have been used by Indigenous people for thousands of years also undermines Tribal Nations' cultural sovereignty. As sovereign nations, Tribal Nation's data sovereignty and sacred practices must be respected. New Mexico's proposal notes that "[s]ome Tribes, Nations, and Pueblos prefer to keep these healing therapies and practices safeguarded due to the

significance of their religious, historical ties, and privacy."[35] This highlights the importance of protecting Tribal Nations' privacy and sacred practices as sovereign Nations.

> "We don't need the latest evidence-based practice or the latest greatest intervention that have come out of academia. We just need to go back to our traditions; we had our own healing ways. If we can just recapture and recover them, that will solve our problems. It is a claim that points to therapeutic alternatives and based on, in many instances, reclaimed and revitalized traditional practices." – Dr. Gone, Faculty Director of the Harvard University Native American Program

The waiver process also structurally undermines Tribal sovereignty because it requires Tribal governments to rely on states to initiate and implement it. This process makes Tribes vulnerable to the whims and politics of state leaders, despite the fact that the federal government has a legal obligation to provide appropriate health care services based on treaty promises and the federal trust responsibility.

Fortunately, some states have shown their willingness to be better government partners to Tribes by adopting policies or laws that require their agencies to proactively consult with Tribal Nations. For example, Oregon's waiver renewal request demonstrated respect for Tribal sovereignty by requiring medical assistance programs to consider "Tribal-based practices for mental health and substance abuse prevention, counseling, and treatment services for members who are Native American or Alaskan Native as equivalent to evidence-based practice for purposes of meeting standards of care and shall reimburse for those Tribal-based practices."[36] The Oregon Health Authority (OHA) and the Tribes situated in Oregon have implemented a process by which Tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal representatives.[37] The list of approved Tribal based practices, such as sweat lodges, talking circles, and horse programs among others, and additional information about each, can be found at the following website: https://www.oregon.gov/OHA/HSD/AMH/Pages/ebp-practices.aspx.[38] However, Tribes should not have to depend on luck or the grace of state leaders to ensure that their sovereign rights are respected and that the federal trust responsibility to provide health care to Native Americans is upheld.

> "Real traditional Indian healing should not even be talked about too publicly, it is too sacred for that." – expressed by a young Native woman to the Task Force on Health of the American Indian Policy Review Commission in 1976.

Conclusion

Shifting the landscape for what is considered acceptable evidence to support Medicaid reimbursement for traditional Native American healing practices is a crucial step for advancing health equity for Native American peoples in the U.S. Although the recent waiver approvals are a promising step in a good direction, much depends on how these waivers will be implemented, and whether and to what extent the implementation process will properly center Tribal sovereignty. Traditional Native American healing practices that are identified by Tribes as having been practiced since time immemorial should be accepted as equivalent to "evidence-based" or "widely accepted" practices for purposes of Medicaid reimbursement. Several national Native health authorities and many professional health associations recognize and promote traditional healing practices that meet the criteria of their respective Tribal communities. Facilities tasked with determining whether a traditional healer has the proper qualifications and/or credentials should look to Tribal Nations to determine who is a qualified traditional healer, and what is an appropriate scope of practices. This kind of approach honors Tribal sovereignty and is a crucial part of upholding the federal government's trust responsibility to provide appropriate health care for Native Americans.

Additional Resources:

- The 2023 report[39] by the National Council of Urban Indian Health provides information about traditional healing and policy. It also provides information from interviews with urban Indian organizations about traditional healing interventions.
- At the Interface: Indigenous Health Practitioners and Evidence-Based Practice[40] provides information on how evidence is evaluated and how traditional Indigenous knowledge is being incorporated into health care among Native health professionals.

Endnotes

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MEMORANDUM

To: Dr. Nathan Chomilo, Medical Director of Medicaid and MinnesotaCare, Minnesota Department of Human Services

From: Morgan Jones Axtell, Staff Attorney; Julie Ralston Aoki, HEAL Director, Public Health Law Center

Re: Medicaid Should Address Health Inequities Caused by Structural Racism and Colonialism Through Culturally Appropriate Care and Adequate Coverage

Date: October 30, 2024

Introduction and Summary

On behalf of the Public Health Law Center (PHLC), we appreciate the opportunity to provide you with our ideas for some ways that public resources, such as Medicaid, could be used to address health inequities caused by structural racism, for consideration as part of the work your office is doing regarding improving Minnesota's Medical Assistance program for Native Americans. PHLC does not lobby, nor does it provide legal representation or advice. However, based on our experience with legal technical assistance pertaining to public health policy and Tribal public health issues, we are pleased to provide you with this memorandum to support your own evaluation of these policy ideas. Please note that this information is for educational purposes only; we do not request that a policymaker take any specific action, nor should our comments or information be considered a replacement for legal advice. Further, Medicaid is a complex program that presents a new area for us, and we acknowledge that we have much to learn. Additionally, the ideas discussed here are based on our research, which was constrained by time and access to sources; the community conversations that the Medicaid office has convened has undoubtedly led to more and different ideas. That said, we hope this information and ideas will be helpful.

The Dakota and Anishinaabe (Ojibwe) American Indian communities of Mni Sota Makoce (Minnesota) have contributed to the vibrant health and wellness of the state through supportive community systems and deep respect for non-human relatives, such as the water, land, and animals.[1] Native American culture and values have been sources of great strength and resilience as these communities have faced significant adversity.[2] Centuries of colonial oppression, forced displacement, structural and institutional racism, and abusive medical systems—including forced sterilization—have led to widespread trauma, limited economic opportunity, inaccessibility of healthy culturally relevant foods, and diminished access to healthcare for Native Americans.[3] Federal policies, such as the Indian Removal Act of 1830[4] and the General Allotment Act of 1887 [5] promoted colonialism through forced removal of Native people and land theft, thereby disrupting Indigenous food systems and ways of life that were health sustaining, and replacing them

with systems that were inadequate and in many cases, actively harmful.[6] As one study summarizes it, these and other federal policies "have undermined tribal sovereignty, disrupted growing and harvesting practices, altered the diets of Indigenous peoples, and contributed to widespread food insecurity at rates 3-4 times those of non-Indigenous peoples….The removal of Indigenous peoples to reservations and urban areas and the introduction of European foods and rations disconnected Indigenous peoples from their land, foods, cultural knowledge, and concomitant health."[7]

These policies also actively and intentionally disrupted Native American traditional healing practices and medicines, replacing them with Western health care and medical research practices that have often caused terrible harms to Native Americans.[8] For example, in the 1950's the U.S. Air Force intentionally administered radionuclides to Alaska Natives without informed consent, proper follow-up monitoring, or prospect of medical benefit, in an event known as the "Alaskan Idiodine-131 Experiment."[9] As recently as 30 years ago, members of the Standing Rock and Pine Ridge Indian Reservations sued the government over experimental hepatitis A vaccine testing carried out on Indigenous children brought to Sioux San Hospital for medical services, alleging that the government obtained parents' consent using misleading, incomplete, and inaccurate information.[10]

These practices and systems have culminated in disparately negative health outcomes for Indigenous communities, which continue to the present day despite the United States' government trust responsibility to provide health care to Tribal citizens. The disproportionately high prevalence of chronic diseases experienced by American Indians, such as diabetes, heart disease, stroke, kidney disease and hypertension, has led to shorter lifespans compared to other populations.[11] Native Americans also experience much higher rates of lung, liver, stomach, kidney, and colorectal cancer compared to white people in the United States because institutional racism and inadequate healthcare access result in fewer opportunities for early screening.[12]

These inequities are exacerbated by attempts to increase barriers to Medicaid coverage and roll back Medicaid benefits. Because so many American Indians in Minnesota and nationally rely on Medicaid for health care coverage,[13] and because IHS relies significantly on Medicaid reimbursements for funding, these attempts are particularly detrimental to Native communities' ability to access adequate health care and are inconsistent with the U.S. government's trust responsibility.[14]

Ultimately, the federal government establishes the broader parameters of Medicaid and plays a lead role in shaping its effectiveness in addressing systemic inequities. However, the federal parameters leave many key decisions to state discretion, which means that states have important opportunities to operationalize the greatest level of available health care coverage for Native Americans and Tribal communities co-located within their borders.

The Minnesota Department of Human Services (DHS) has a unique legislative mandate to address racial and health disparities in its operations, including, of course, how it administers Medicaid. In 2013, the Minnesota Legislature created the Cultural and Ethnic Communities Leadership Council, whose purpose is to "advise [DHS] on reducing disparities that affect racial and ethnic groups."[15] The enabling statute for the Council charges both DHS and the Council with taking action to address racial, ethnic, cultural, linguistic, and Tribal disparities, including review of DHS rules, statutes, and policies to identify where changes are needed to reduce these disparities.[16] The DHS has additional infrastructure (such as the Office for Equity, Performance and Development)[17] and tools (such as the Minnesota Equity Analysis Toolkit)[18] to support it in applying an equity lens to its work. Thus, there is a strong foundation for agency work to advance equity across its operations in general. However, there are also specific, concrete needs for improvement for Minnesota's Medicaid program that have been identified. The following section lays out specific steps that Minnesota could take to improve its Medicaid program, advance health equity and support better health for Native Americans in Minnesota.

Possible Calls to Action

1. For Tribes, By Tribes – Invest in Community Engagement and Community-led Solutions to Address Health Inequities

Investing in community engagement with Tribal community members and working collaboratively with Tribal leadership is critical to reach community-led solutions to address current health inequities. States should integrate culturally specific community engagement at every step of the process, from engagement of enrollees, equitably distributing resources and financial supports, and the prioritization of policies. It is critical to inclusively engage with Tribal Nations and Native American leaders and community members in shared decision-making that have the potential to affect Indigenous peoples.

Taking inclusive action means including Native communities in <u>every</u> step of the policy and decision-making process. Any policy or law with the potential to affect Tribal communities should be based off collaborative conversations with Tribal Nations as the decision makers.

Thus, community conversations regarding Medicaid should be adequately resourced to ensure Tribal leaders and Native Americans have a voice. For example, the Minnesota Department of Health held community conversations to gain community guidance on how to develop priorities in policies and structural changes to support Tribal Nations and the health of American Indian people.[19] Importantly, these community conversations must be funded and tailored to the population. For example, providing participants with a meal, transportation, and childcare can allow for more active participation. [20] Community conversations, collaboration, and other forms of community engagement cannot be accomplished in a single event, but instead should have sufficient funding for continued,

longitudinal authentic engagement. Collaborating with American Indian communities is critical to start to repair the mistrust in government among Tribal communities.

This collaborative consultation process with Tribal Nations should be solidified through a consultation policy that is co-created with Tribal Nations to encourage true power sharing. Creating a procedure to consult Tribal communities early on in the policy or budget making process on issues that will potentially impact them requires funding. At the federal and state level, a strong groundwork has been laid, which can be further operationalized through funded, longitudinal collaboration and consultation. CMS implemented a Tribal Consultation policy "to establish a clear, concise and mutually acceptable process through with consultation can take place between CMS and [T]ribes" on Medicaid matters affecting the Tribes.[21] CMS also requires states to consult with Tribes before submitting any waiver requests. States have also started implementing policies requiring specific consultation and engagement with Tribal governments. For example, Minnesota enacted a Government-to-Government Relationship with Tribal Governments law, requiring several things, including all state agencies to designate a Tribal liaison, and Tribal-relations "training for all state leaders and other employees whose work may impact Tribes."[22] MNsure also utilizes a Tribal Consultation Policy to ensure there is a deliberate process resulting in informed decision-making and better, more equitable outcomes.[23]

The Minnesota Department of Human Services (DHS) Office of Indian Policy provides guidance for the implementation and ongoing coordination and consultation with Tribal governments in the state about services for American Indians living both on and off the reservations.[24] This a great step in the right direction for Indigenous Minnesotans.

Continuing to prioritize and fund community engagement with American Indian people and Tribal leadership will result in community-led solutions to address the current health inequities for Native Americans. It is critical that this is a long-standing process, and not simply just a point in time.

2. Simplify the Enrollment and Renewal Process

The federal government and states should work collaboratively with Tribal Nations to make the Medicaid enrollment process easier and less confusing.

DHS has made good progress in this area already. It has created an online portal and phone app called MN Benefits designed to make the process of applying for public assistance programs easier.[25] It allows Minnesotans to apply for multiple assistance programs simultaneously, such as SNAP, cash assistance programs, and child care support. However, Medicaid is not included. This progress through MN Benefits could be furthered by allowing individuals to apply for Medicaid through MN Benefits while they apply for the other public assistance programs.

Increasing cultural safety is critical for achieving health equity.[26] Personal health and financial data are inherently intimate information and sharing it requires a certain level of vulnerability. Understandably, people may hesitate, or refuse, to provide such information to governments that discriminate against their communities or with agency representatives from cultural groups that have historically oppressed them. Navigators or ombudspersons can not only help to simplify the process for applicants and help them maintain coverage, but they can also help to repair distrust in government systems. Working with a trusted individual who is culturally and linguistically competent or from a similar background may help applicants to feel more comfortable in sharing the sensitive information required by Medicaid applications.

Providing culturally sensitive navigators or ombudspersons would allow for better outreach and make coverage easier for those who are eligible for Medicaid but have not enrolled.[27] Navigators should be based in culturally specific organizations or co-located in the communities they are serving. This would allow them to have broader reach and reduce inequities related to travel, particularly for those in rural Tribal communities.[28] Similarly, providing navigators who are fluent in an applicant's Indigenous language can help to close the language barrier for individuals who may feel more comfortable or have an easier time communicating in their Indigenous language. Minnesota could allocate funding for navigators fluent in Dakota and Ojibwe languages, as well as in rural Tribal areas and within culturally specific organizations, such as Tribal clinics.

Continuous eligibility (also known as continuous enrollment) policies also reduce administrative burdens and the number of people experiencing lapses in coverage. Continuous eligibility or automatic re-enrollment policies ensure that an individual's enrollment in Medicaid continues for at least 12 months, regardless of any change in circumstances, unless the individual:

- reaches the end of the 12-month period and is no longer eligible;
- moves to another state;
- Or passes away.

Continuous eligibility for children and pregnant or new parents is also important. Medicaid covers almost half of all births in the United States, and over two-thirds of births among AI/AN parents, who experience higher rates of pregnancy and childbirth related mortality and morbidity compared to white parents.[29] Federal law allows states to limit Medicaid eligibility based on pregnancy to only 60 days after giving birth because Medicaid eligibility requirements are lower for pregnant people.[30] In 2022, Minnesota opted in to provide 12 months postpartum coverage beginning on the last day of the pregnancy.[31]

The Social Security Act also gives states the option to provide continuous eligibility for up to 12 months to children under age 19.[32] Beginning January 1, 2024, states are required to provide 12 months of continuous eligibility for children under 19.[33] In Minnesota, children under 19 have 12 months of continuous eligibility.[34] Other states

have utilized Section 1115 Medicaid Demonstration Waivers to extend continuous enrollment for a longer period; for example, the Oregon Health Plan provides continuous enrollment for children until their sixth birthday, extending coverage for children with the goal of stabilizing coverage and care for families or caregivers.[35]

Minnesota could pursue additional Section 1115 demonstration waivers to further extend continuous enrollment.

3. Expand Access to Culturally Relevant Care for Native Americans on Medicaid

Medicaid services should allow for the reimbursement of culturally relevant services, including traditional healing practices in Native communities, as part of the federal government's trust responsibility to provide health care to American Indians. This would require action by DHHS and by the State. Such action would be consistent with stated commitments made by both entities in support of traditional healing services, and would be consistent with respect for Tribal sovereignty.

Many Tribal Nations have been reclaiming and raising up their cultural learnings and practices and actively incorporating them into their wellness and health services.[36] For example, Tribal Nations, such as Leech Lake Band of Ojibwe, provide culturally focused, community based substance recovery services that incorporate culture through educating participants on the historical trauma and medicinal use of substances, and the history of the Tribe through dance, drum, and traditional teachings, such as the seven sacred teachings (love, courage, respect, honestly, wisdom, humility, and truth).[37]

The IHS has long recognized the importance of supporting and respecting traditional healing practices.[38] The Minnesota DHS also recognizes that using a cultural appropriate approach to serving others that respects other traditions, cultural values, and views as strengths plays an important role in meeting health needs. [39] DHS defines cultural competency as "the ability and will to respond to the unique needs of a[n individual] and family that arises from the [individual's] culture."[40] "Cultural competency is also the ability to use the [individual's] culture as a resource or tool to assist with the intervention and help meet the [individual's] needs." [41]

The Minnesota Department of Health also has expressed support for traditional healing practices, noting that utilizing traditional healing practices is proven to: address whole health and the root cause of inter-generational trauma, promote self-esteem and resiliency, and help with identity formation and/or reclamation.[42] Further, connecting children, adults and Elders to traditional healing practices has been shown to promote positive community integration and presence.[43]

However, traditional healing services are not reimbursable under Medicaid except in very limited circumstances. These limitations are not consistent with Congress's express

recognition and promoting or traditional healing services in the Indian Health Care Improvement Act (IHCIA)[44] and the fact that increasing culturally appropriate care is a key part of DHHS's equity action plan.[45] Encouraging progress has been made in this area recently--in October 2024, CMS approved Section1115(a) demonstration waivers requested by four states (Arizona, California, New Mexico, and Oregon) to allow for coverage of traditional health care practices.[46] However, Native Americans should not have to rely on the discretion of state leaders to receive the necessary health care services to which they are entitled.

About 70% of Native Americans live in urban areas in the United States.[47] Thus, another way that CMS could expand access to traditional health practices is by expanding the definition of health care facilities who are eligible to receive Medicaid reimbursement for traditional healing services to include Urban Indian Organizations. The National Council or Urban Indian Health suggested this approach to CMS in comments regarding CMS' Proposed Framework for Traditional Health Care Practices in Section 1115(a) demonstrations. [48] Again, there are signs of progress on this issue—in the Section 1115(a) waiver approval letters issued recently by CMS, it stated that it had decided "that urban Indian organizations could be a qualifying provider type option for states."[49]

Cross-sector collaboration between states and Tribal Nations is critical to expand access to culturally appropriate care for Native Americans. Minnesota has made good progress in this area, but it could do more. For example, the Minnesota American Indian Mental Health Advisory Council and the state's Department of Human Services have collaborated to incorporate "traditional healing into Minnesota's behavioral health continuum of care and to identify and develop a sustainable funding stream for traditional healing."[50] This work could be expanded to include other types of healthcare services beyond behavioral health. Collaboration with Minnesota's Tribal Statewide Health Improvement Partnership (SHIP) program, with its focus on chronic disease prevention and reduction, presents another possibility for building capacity and understanding of traditional healing approaches outside of the behavioral health context.[51]

Providing more education and training in culturally competent care for providers also can help to foster more culturally sensitive care. For example, the Minnesota Department of Health released the Mental Health Cultural Community Continuing Education Grant Program in June 2024, for members of Indigenous communities or other communities of color that are licensed mental health professionals residing in the state of Minnesota that are working for a community mental health provider.[52] Providing more funding like this can act as a tool towards increasing the number of Indigenous community members and other people of color with specialized training in the medical field, increasing representation.

4. Pathways for Native Medical Workers

Investing in a representative health care workforce can increase equitable access to quality health care for all. Physicians with backgrounds similar to the community members they are serving often improve culturally relevant care and has been shown to positively impact outcomes for patients.[53] Increasing the number of Native healthcare professionals, from Community Health Workers to clinicians, to serve in Tribal communities can help close the gap in equitable medical care for Indigenous people.

Although AI/AN residents make up 2.9%[54] of the general population in the United States (similarly, they make up 2.7%[55] of the population of Minnesota), only 0.3% of all physicians identified as AI/AN nationally as of 2022.[56]

Funding is a big barrier for many Native Indian and Alaska Natives students. Scholarships and loan repayment programs give AI/AN students potential options to pay for their education. These grants can help motivate students pursue higher education, including in the medical field. AI/AN students from rural areas face increased challenges to completing higher education. Along with financial constraints, limited proximity to educational institutions and limited healthcare access are additional barriers.[57] Grants allow for greater accessibility to medical careers for Native American students. Some states, foundations, and organizations help fund AI/AN students' tuition for higher education.[58] In 2023, Minnesota established the American Indians Scholars Program, providing a tuition and fee-free pathway to Minnesota residents that are enrolled members of any federally recognized Tribe or Canadian First Nation to attend a Minnesota higher education institution, including the University of Minnesota.[59] IHS has a Health Professions scholarship that provides financial aid to members of federally recognized Tribes that are enrolled in an eligible health profession degree program in exchange for working in a full-time clinical practice upon graduation.[60]

Indigenizing medical training can also help to close the gap in equitable care. In Minnesota, programs such as the University of Minnesota's Center of American Indian and Minority Health show great promise.[61] The University of Minnesota Medical School in Duluth is now second among U.S. medical schools for the highest number of graduating Native American MDs.[62] The University of Minnesota Medical School also was the first medical school to require curriculum on Indigenous health for all medical students.[63] But more could be done, especially through partnerships with the Tribes co-located in Minnesota. For example, the Oklahoma State University (OSU) recently founded the country's first Tribally-affiliated medical school in collaboration with Cherokee Nation in Tahlequah, Oklahoma. [64] The program aims to improve student recruitment and health care for Native American patients by providing both clinical and cultural training.[65]

Some Tribal Nations have responded to a lack of care by implementing their own health care training programs. One example of this innovative thinking includes Alaska's dental health therapist program.[66] Because of a severe shortage of dentists in Alaskan Tribal

communities, the Alaskan Native Tribal Health Consortium developed a two-year training program designed to build a workforce of Native, midlevel oral health care provider who can provide basic oral health services such as preventative care, fillings, and simple extractions.[67] This program has been tremendously successful, and was bolstered by the Swinomish Tribe's decision to create its own dental health therapist licensing law. These Alaska-trained midlevel providers are now being employed by several Tribes in the lower 48 states.[68] Minnesota also has a midlevel dental therapist licensing law, but it requires a four year degree in contrast to the two-year degree provided through the Alaska program that has proven to be successful.[69]

Interdisciplinary health care teams including traditional healers and medical physicians also can help to ensure culturally appropriate, holistic health care plans for AI/AN patients.[70] These interdisciplinary care teams can help to address specific health needs for AI/AN patients by implementing culturally appropriate preventative care, such as early screening for diabetes, hypertension, and cancer. [71]

Minnesota could work to provide more coverage for culturally relevant healthcare for AI/AN patients by increasing support for pathways for Native Americans to enter medical professions through funding and increasing opportunities, particularly in rural areas.

5. Prioritize Data Sovereignty and the Disaggregation of Race, Ethnicity, and Language Data

Native Americans are often left out of the conversation and undercounted in data due to aggregated data, which can hide inequitable health impacts on subgroups, such as Native American communities. [72] It is critical to disaggregate racial and ethnic data to ensure that Native people's experiences are represented, leading to better policies based on more accurate data.[73] It is also important to note the ethnic, cultural, and linguistic differences between Tribal Nations and that Native Americans' access to health care often largely depends on where they live.[74]

Improving data collection methods and disaggregating data to accurately represent Native Americans and other smaller groups can help to address health inequities and disparate outcomes by supporting policy makers with accurate data to develop equitable policies to address health inequities caused by systemic racism.[75]

As sovereign Nations, Tribes should have control over what data is collected from their people, and who has access to that data.[76] It is important to note that Tribes may not wish to share some data. Some Tribal practices are sacred and private and Tribal Nations should not be forced to share this data for funding.

Data sharing agreements between Tribal Nations and states can be used to respect Tribal sovereignty and build a positive government-to-government relationships. For example, the Washington Department of Health created a Tribe Data Sharing Agreement as an effort to include Tribal governments in Washington's use of Tribal data and AI/AN

data.[77] This agreement aims to build state and Tribal government relationships, along with assuring tribal data sovereignty is protected. The Agreement has a specific provision recognizing Tribal ownership over data regarding the Tribe, its Tribal citizens, and any individuals residing within the Tribe's jurisdiction.

When Tribes choose to share their data, it should be used to promote equity driven decision-making and increase accountability for equitable health outcomes. American Indians are often left out of the picture in data and unrepresented in studies. This gap in data can lead to underfunding and lack of accountability for equitable coverage. Standardizing the disaggregation of race, ethnicity, Tribal affiliation and language data can promote equitable driven decision making and increase accountability for equitable health outcomes.

When reporting on data, a strengths-based approach should be used to illustrate the strength and resiliency of Indigenous people. The Urban Indian Health Institute developed a resource on Best Practices for AI/AN Data Collection that are grounded in the principles of Indigenous data sovereignty, which include: [78]

- Collect Tribal affiliation with an inclusive list of all federally and state recognized Tribes with a write in option for First Nations or other Tribal affiliations not listed.
- Protect Tribal sovereignty by not releasing Tribe-specific data without a Data Use Agreement from the Tribal Nation that specifically grants the release of that data.
- Allow for the selection of multiple races and ethnicities with the ability to disaggregate the data once collected.
- Mandate the collection of race and ethnicity in health data through enforcement procedures that provide best practices, training, and technical assistances for mandated state agencies.
- Avoid reporting data collected and research findings as 'other' or 'multi-racial' when possible.
- Report limitations on data collection and analysis so they can be considered when analyzing reported outcomes.

Minnesota should work collaboratively with Tribal Nations to form policies that respect data sovereignty and ensures that Native Americans are not being left out or undercounted due to aggregated data. Data use agreements are important tools that states can use to protect data sovereignty and ensure that the data is being shared with Tribal Nations and used to promote equity driven policymaking.

Potential Legal Arguments

Efforts to tailor public resources, such as Medicaid, to address historical inequities for Native Americans caused by structural racism stemming from federal law and policy have met with legal challenges. For example, in 2018, HHS denied Tribes' requests to be

exempt from state Medicaid work requirements, arguing that an exception for Tribes would represent an illegal race-based preference.[79] Relatedly, some states are challenging a Medicare regulation aimed at promoting health equity and addressing racism in the health care field because the regulation incentivizes providers to create and implement an anti-racism plan. Although this case is still pending, the states' arguments have been unsuccessful so far. [80] Racial equity is important and necessary for a just and healthy society; however, the federal government's trust responsibility is not based on racial equity goals. Its foundation is the relationship between sovereigns and the treaty obligations the federal government owes to Tribal Nations and Tribal citizens. Further, Tribal Nations are governmental and political entities, not racial groups.[81] This foundational principle was most recently recognized by the U.S. Supreme Court in *Haaland v. Brackeen,* in which the Court reaffirmed that Native Americans are a political class and not a racial group.[82]

Each described area above presents different legal challenges and arguments. We acknowledge that we were unable to comprehensively address these issues as each area requires its own careful analysis.

Conclusion

Public resources like Medicaid should be tailored to address the current historical inequities caused by structural racism, particularly for American Indians to whom the federal government has a trust responsibility to provide healthcare. Although many barriers to improved health care outcomes for AI/AN may be outside of the control of the State, the State has key opportunities to collaborate with Tribal leaders and Native American Medicaid enrollees to better optimize the scope and types of health care services covered through the State's Medicaid program.

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The U.S. District Court denied Plaintiff's Motion for Summary Judgement, alongside the Defendant's Cross-Motion for Summary Judgment which was denied without prejudice and permitted limited discovery related to the state's standing.

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