



Minnesota Department of  
**Human Services**

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## **Health Care**

### **Our Mission**

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

### **Our Values**

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

*We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.*

## **Report to the Legislature**

# **Automation and Coordination for State Health Care Programs**

Laws of Minnesota 2008  
Chapter 358, article 3, section 12

**January 2009**



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# Cost to Prepare the Report

Minnesota Statutes, Chapter 3.197 requires the disclosure of the cost to prepare this report. Approximately \$13, 806.39 for staff salaries and materials was spent to prepare this report.

## Executive Summary

The 2008 Legislature directed the commissioner of the Department of Human Services (DHS) to report to the legislature on ways to improve coordination between state health care programs and social service programs, including, but not limited to, WIC and food stamps. The report must address options for the development of automated systems and statutory changes necessary to improve such coordination.

To prepare the report, DHS:

**Reviewed recent national literature on the topic of strategies to enroll eligible children in federal and state health care programs.** Three national reports focusing on strategies to increase children's enrollment in state health plans, whether through Medicaid, the State Children's Health Insurance Program (SCHIP) or independent state initiatives, were reviewed and evaluated for possible applicability to Minnesota's programs. Each report had a slightly different focus, but all discussed the importance of simplified enrollment procedures and eligibility rules.

**Identified several social services programs for which increased coordination with health care programs could result in higher health care enrollment rates for low-income and uninsured individuals and families, particularly children.** The existing level of coordination between Food Support and health care and between WIC and health care was reviewed in detail in accordance with statutory direction. Food Support and health care were found to be well-coordinated administratively through the use of common application forms, access points and automated systems, although some improvement could be achieved through several small administrative steps. Automated

coordination between WIC and health care is limited, but other outreach and coordination efforts are underway to ensure enrollment of eligible people in both programs.

Other programs showing promise of improved coordination include the School Lunch Program, where efforts are currently underway to improve automated data sharing between the Departments of Education and Human Services; the Child Care Assistance Programs; and programs such as Energy Assistance that are administered by community action agencies.

**Reviewed existing options for the development of automated systems and outreach strategies designed to improve coordination between programs and increase enrollment in the health care programs.** Several systems currently used by DHS or social services programs in Minnesota were found to have potential applicability to improved coordination between health care and other social services programs. Among them are the DHS Shared Master Index (SMI); Minnesota Community Action Partnership's Visions database; and the Children's Defense Fund Minnesota's Bridge to Benefits.

The SMI provides a common database for client demographic data and a comprehensive view of client program participation across programs administered by DHS. This allows county workers to identify clients who may be eligible for programs in which they may not be enrolled. The SMI design holds out the promise of more reliable data sharing and matching that could be expanded over time to matches and information exchanges with agencies and programs other than those administered by DHS.

The Visions database system supports and provides coordination for the Community Action Programs, and also helps clients complete the Combined Application Form to apply for Food Support and other public assistance programs including health care.

Bridge to Benefits, a multi-state initiative by the Children's Defense Fund, includes an online screening tool that helps determine potential eligibility for many programs, including health care as well as many social services programs like Food Support, School Meal Program, and Energy Assistance.

In addition to or in conjunction with automation, community outreach is a key component to improve program coordination. One recently enacted outreach initiative is the Minnesota Community Application Agent (MNCAA) program, which provides organizations an application assistance bonus for each applicant successfully enrolled in MA, GAMC, or MinnesotaCare.

**Reviewed legislative options.** While there are potential legislative changes that would simplify eligibility and thus make it much easier to enroll people in multiple programs with minimal administrative effort, many of these would require federal as well as state action and might not be immediately feasible. However, a review of existing data privacy legislation with an eye to removing barriers to effective data sharing, such as lack of a common means to identify individuals and differing legal interpretations among agencies, could enhance further development of automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program.

# Background

The 2008 Legislature directed the commissioner of the Department of Human Services (DHS) to report to the legislature as follows:

## **Automation and Coordination for State Health Care Programs.**

(a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By January 15, 2009, the commissioner of human services shall report to the legislature on ways to improve coordination between state health care programs and social service programs, including, but not limited to, WIC and food stamps. This report must include a review of options for the development of automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. The report shall identify to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation between state health care programs and social service programs.

*Laws of MN 2008, Ch. 358 (SF3780), Article 3, Section 12*

To prepare the report, DHS reviewed recent national literature on the topic of strategies to enroll eligible children in federal and state health care programs. DHS then identified several social services programs for which increased coordination with health care programs could result in higher health care enrollment rates for low-income and uninsured individuals and families, particularly children. For each program, DHS staff gathered information on eligibility requirements, application procedures and existing automation and compared these elements with those of the health care programs.

This report identifies existing coordination strategies and recommends enhancements to the most promising among them, as well as discussing legislative and technological opportunities and challenges that could affect the success of these efforts.

# Introduction

Low-income families and individuals may be eligible for an array of financial assistance and social services programs, including but not limited to direct cash assistance, targeted financial assistance such as help paying for child care and energy costs, nutritional assistance and health care. Often these programs have similar — but not identical — eligibility requirements, especially income limits. Differences, including application procedures, location, verification requirements and technological support, often outweigh the similarities, making coordination among programs difficult.

A number of initiatives have been developed over the years at both the national and state levels to address these problems and simplify enrollment. Many of these initiatives have focused on data-driven approaches: using data obtained by one program, shared electronically to the extent possible, to determine eligibility for other programs. Several variations on this theme are discussed in the section of this report that summarizes recent national literature.

Common problems associated with data-driven approaches include:

**Differences in data collection.** Data collected by one agency may be insufficient for eligibility or even identification purposes for another agency for various reasons:

- One agency may use Social Security numbers as primary identifiers while another may not collect them at all.
- Some programs might require the use of full legal names along with some type of identity verification, while others may accept nicknames, alternate spellings or other variations.
- Two programs may each request “family income” but define the concept differently.
- Technical differences may make transmitting the data in usable form difficult or impossible even when identical or nearly identical data is collected.

### **Differences in eligibility requirements.**

- Besides defining “family/household” and “countable income” differently, income eligibility standards vary. Eligibility for one program may be a very good indicator of potential eligibility for another program with roughly the same (or lower) limit, but it is not a guarantee.
- Meeting income standards alone may not result in actual program eligibility. The health care programs, for example, have strict regulations governing not only acceptable citizenship and immigration status but also acceptable means of verifying said status. Other programs have no status restrictions.

**Data sharing and privacy issues.** A complex web of federal and state laws and regulations restricts not only what data can be shared but also when, why, how and with whom it can be shared. These restrictions can make concepts like data-driven enrollment difficult to put into play, heightening the need for interagency staff cooperation and client assistance.

The program descriptions in this report analyze where these difficulties are most likely to occur with respect to identifying and enrolling eligible people in health care programs, as well as where the greatest opportunities for better coordination lie.

# Report Methodology

Staff reviewed national literature on enrollment strategies in search of ideas from researchers or from other states that could readily be adapted to Minnesota's programs. Three reports in particular seemed most relevant:

## **Report One**

### **"Seven Steps to Covering Children Continuously"**

National Academy for State Health Policy, October 2006

## **Report Two**

### **"Opening Doorways to Health Care for Children"**

The Children's Partnership, 2004

## **Report Three**

### **"Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals"**

Urban Institute/Robert Wood Johnson Foundation, August 2007

The executive summary for each of these reports is included in Appendix A.

Staff also gathered information on the following programs:

- Food Support (formerly Food Stamps)
- Women, Infants and Children (WIC) nutrition program
- Free and Reduced-Price School Lunch Program
- Child Care Assistance Program (CCAP)
- Energy Assistance
- Head Start
- Food Distribution Programs
- Unemployment Insurance
- Low-Income Tax Credits

The primary means of gathering information was through telephone surveys. Program representatives were asked to describe the following aspects of their program:

- Clientele
- Program administration
- General eligibility requirements
- Application procedures
- Level of automation
- Coordination between this program and other programs

Information from the surveys was supplemented by program descriptions available on the various agencies' public web sites.

A copy of the survey questions is included in Appendix B.

Staff then reviewed coordination activities currently taking place within DHS or between DHS and other agencies. These included both systems-based initiatives and facilitated enrollment projects. The goal was to determine which social services programs offered the greatest opportunities for enhanced coordination with health care based on the available tools.

Finally, staff analyzed the above data, which resulted in the following findings presented in this report:

- Highlights from the three national reports with commentary on whether and how they reflect current conditions in Minnesota
- A summary of how the requirements, processes and automated systems of each of the surveyed programs compares to the health care programs, and what opportunities or barriers to increased coordination exist
- A description of active automated systems development and outreach initiatives applicable to coordination between social services and health care programs
- A discussion of legislative and automated systems options and barriers
- Conclusions and summary

# National Report Highlights

Each of the three reports focuses on strategies to increase children's enrollment in state health plans, whether through Medicaid, the State Children's Health Insurance Program (SCHIP) or independent state initiatives. While there are some similarities among them, each has its own points of emphasis. The following discussion both highlights and critiques the major points of each study.

## Report One

### **"Seven Steps to Covering Children Continuously"**

National Academy for State Health Policy (NASHP), October 2006

This report, the result of a symposium on child health coverage held in March 2006, identified seven steps states could take to reduce the number of uninsured children and ensure they remain continuously enrolled in coverage. The first three steps involve concrete activities, while the last four deal with culture change, engaging leaders and partners, and marketing efforts. Several of the concrete steps mirror efforts previously discussed or underway in Minnesota.

#### **Simplified enrollment and renewal**

This step includes a number of oft-discussed concepts, including:

- Short applications
- Continuous eligibility
- Passive renewals

There is little disagreement that simpler procedures, at least those coupled with an eye toward maintaining program integrity, are highly desirable in getting eligible people enrolled and maintaining coverage. However, these solutions are sometimes designed without taking into consideration the complexity of the eligibility rules themselves.

**Short applications.** Calls for shorter application forms are a prime example. Fewer pages to complete or fewer questions to answer may appear less intimidating to applicants, but unless the application form gathers all of the information needed to apply all of the eligibility rules,

completing the form is no guarantee of successful enrollment. Workers are required to contact the applicant to obtain any missing information, which can delay the eligibility determination without reducing the effort required from the applicant. Combining shorter applications with granting presumptive eligibility — approving coverage based on statements on the application and postponing verifications — merely delays the need for follow-up and does not help meet the goal of maintaining continuous eligibility.

**Continuous eligibility and passive renewals.** The concepts of continuous eligibility and passive renewals (the process in which enrollees must provide information only if their circumstances have changed, and are otherwise assumed still eligible) have current parallels in Minnesota.

The MinnesotaCare program renews eligibility annually and until recently did not act on income increases during the 12-month enrollment period.

The MA program allows a form of passive renewal for enrollees who have only stable unearned income or whose only income is from a source that is not considered for health care eligibility. These enrollees are required to submit written renewal forms annually, rather than every six months like enrollees with earnings or other variable income sources. At the time of the scheduled six-month review, the county financial worker reviews the case record and checks existing sources to verify that income remains within program limits and eligibility continues.

Many of these enrollees receive income from the Social Security Administration, which can be easily verified through an existing interface with the MAXIS system. The lack of available real-time data for income sources such as wages is a barrier to employing this review method for other populations at this time but is worthy of consideration as a future initiative.

### **Community-based outreach**

This second of the seven steps recommended in the report has been in widespread use in Minnesota for several years through outstationing, providing grants to community agencies to provide outreach and education to potential enrollees, and currently, the Minnesota Community Application Agent (MNCAA)

project described later in this report, which provides monetary incentives to agents who successfully facilitate individual enrollment.

These approaches can be especially useful in increasing enrollment among populations that may have limited English skills or cultural barriers that make it more difficult to complete the application process unassisted.

### **Program coordination through technology**

The third step outlined in the report urges continued improvement in data sharing between agencies and programs, along with other uses of technology with applicability in Minnesota:

**Universal application forms.** Minnesota's universal application (the Combined Application Form, or CAF) is currently limited to the cash, Food Support and health care programs supervised or administered by DHS. Expanding this concept to include other programs such as WIC and child care might be more feasible in the future with more centralized administration and systems coordination.

Past experience indicates the need for careful planning to identify and group programs and populations for which a common application would be likely to encourage people to apply rather than overwhelming them by requesting too much information or information not relevant to their situations. For example, in the past, when DHS did not offer any health care-only application forms but required everyone to apply on the CAF, elderly people often wondered why they were asked questions about pregnancy and employment history, while young families were stymied by requests for detailed information about life insurance and burial funds.

Designing separate applications for programs serving primarily children and their families and programs serving primarily the elderly and people with disabilities can ameliorate this problem, recognizing that some households comprise members from both groups.

**Online application forms.** Minnesota has been working toward the goal of making an online health care application available for several years. Although there have been a number of obstacles, these efforts continue through a joint effort between DHS and Hennepin County. In the meantime,

the current paper application forms can be easily completed online and downloaded to be mailed in or dropped off.

**Online screening tools covering multiple programs.** Initiatives such as the Bridge to Benefits project described later in this report are prime examples of efforts to provide online screening tools that enhance access to multiple programs. Such tools would enable people to enter basic data and receive information and referrals to a variety of programs simultaneously, rather than visiting multiple web sites.

## **Report Two**

### **“Opening Doorways to Health Care for Children”**

The Children’s Partnership, 2004

The second report, prepared by The Children’s Partnership in cooperation with the Kaiser Foundation on Medicaid and the Uninsured, analyzed national research and state-based activities to develop a 10-step plan to open doorways to Medicaid and SCHIP for children who appear to be eligible for one or both programs but are not enrolled. Like the NASHP report, several of the steps recommend familiar approaches:

- Multiple “doorways,” or access points where families can apply
- Common applications
- Continuous enrollment
- Greater use of technology to share and verify information on key eligibility factors such as income

Unlike the NASHP report, this one addresses legislative and funding issues that need to be addressed before a “doorways” system could be completely implemented. Major legislative themes include:

#### **Immigration status**

The report recommends restoring federal funding for legal immigrant children who lost eligibility in 1996. Minnesota, like many states, continues to cover these children with state funds, but the need to identify and track the funding source for each legally present child adds administrative complexity.

A second related recommendation would allow a verified Social Security number to take the place of documentation of citizenship and immigration status. This idea runs counter to the federal citizenship documentation requirements enacted in 2005, but would greatly simplify administration if adopted.

While these two recommendations would increase funding available to the state and simplify enrollment, neither addresses the issue of undocumented and non-immigrant children. As long as there is no health care eligibility for this group, other than emergency care, it will not be possible to automatically enroll all children on the basis of limited information provided to other programs like WIC and the school lunch program.

### **Confidentiality and data exchange**

The report's authors state that, in order to maintain and promote trust between families and doorway programs that exchange information with Medicaid and SCHIP, it will be essential to not only maintain existing confidentiality and data privacy laws but also to change some of the existing federal and state laws in this area. However, the report does not address situations where existing data privacy laws may actually be barriers to data sharing. Some tradeoffs may be necessary to achieve the goal of increasing enrollment without unnecessarily jeopardizing confidentiality.

A list of specific recommendations for federal law changes contained in the "Doorways" report are included in Appendix C.

## Report Three

# “Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals”

Urban Institute/Robert Wood Johnson Foundation, August 2007

The final report, authored by Stan Dorn of the Urban Institute, has a slightly different focus. Its recommendations are geared toward helping states improve the rate of “take-up,” or enrollment, in new programs and coverage expansions. Programs and expansions that fail to meet their stated enrollment goals risk being deemed ineffective before they have had a chance to, as Dorn puts it, prove themselves. Further, “more fundamentally, unless eligible people enroll, a health coverage expansion cannot reach its most basic objective of improving access to essential health care.”<sup>1</sup>

The MinnesotaCare program has been operating successfully for well over a decade, so Minnesota does not face the same public perception and political challenges as states in the midst of launching new children’s programs. Nonetheless, the report touches on a number of areas with relevance to efforts to coordinate health care enrollment with other programs.

### Enrollment models

Dorn identifies three automatic enrollment models, which he labels as “default,” “data driven” and “facilitated.”

In a **default** system, people are enrolled in a program unless they proactively “opt out” of coverage. Dorn offers several examples, among them Medicare Parts B and D and Massachusetts’ Commonwealth Care program. What is notable about these examples is that those eligible for automatic enrollment in these programs were first declared to be fully eligible in all respects — not merely income-eligible.

- In the two Medicare examples, the enrollees had already passed the basic Medicare eligibility tests, i.e. they were already enrolled in at least Medicare Part A. No other eligibility requirements were imposed. In the case of Part D, all dual eligibles (people enrolled in both

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<sup>1</sup> Stan Dorn, “Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals,” Robert Wood Johnson Foundation, August 2007, Executive Summary.

Medicare and Medicaid) were deemed eligible for the full low-income subsidy regardless of their individual states' Medicaid requirements.

- Similarly, the Massachusetts Commonwealth Care program automatically enrolled all individuals previously served by the state's Uncompensated Care Pool who had income at or below 100 percent of FPG.<sup>2</sup>

In Minnesota, no other programs have eligibility rules that are identical in all respects to MinnesotaCare or MA, making automatic enrollment impossible without substantial state and federal legislative changes. However, automatic eligibility determination — particularly for MFIP and Food Support applicants who can apply for health care on the same application — is an option. Applicants could be advised that their eligibility for health care programs will be determined unless they specifically decline (opt out), instead of being asked to specifically request health care on the CAF. Since data from DHS automated systems, MAXIS and MMIS, show that approximately 96 percent of MFIP participants and 92 percent of Food Support participants are enrolled in health care programs, this approach would not result in large enrollment increases but might catch some eligible people who would otherwise be missed.

A **data driven** approach, as noted in the other reports, uses data available to other government agencies to determine eligibility for health care coverage, such as obtaining income data from Food Support and the school lunch program for use in determining health care eligibility.

**Facilitated enrollment** involves going beyond providing information, referral, and application forms to actually completing forms on the applicants' behalf, helping them obtain documentation, and staying involved throughout the application process. This is the approach currently used by the MNCAA program.

### **Program integrity**

Dorn advances the argument that concerns for program integrity can sometimes allow states to impose what he calls "covert" program controls — reducing

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<sup>2</sup> Ibid., Examples of Enrollment Models in Action.

caseloads and costs through tightened procedures and less outreach — instead of more transparent means like lowering income limits or reducing benefits, which require legislation and therefore open public debate. While this concept is intriguing, it should be noted that procedural requirements can be and often are imposed legislatively as well.

Program integrity is often emphasized in leaner times, and this has been the case in Minnesota over the past several years as tighter income reporting and insurance verification requirements have been statutorily mandated for MinnesotaCare. Points of note:

- Such requirements can result in more accurate eligibility determinations, but also present obstacles to simplified enrollment procedures and maintaining continuous enrollment.
- It may be difficult in the current economic climate to advance proposals that would increase enrollment, and hence costs, particularly if the proposals were seen to increase the likelihood of enrolling people who were not actually eligible.
- Continuing efforts to improve systems coordination to allow more passive verification may alleviate some of the tension between simplified enrollment and program integrity in the future.

### **Redefining eligibility to fit available data**

Dorn suggests that one eligibility change that could facilitate greater use of data held by other agencies in place of direct verification from the client is to define eligibility, or more specifically verification requirements for each eligibility factor, to better fit the readily available data. For example, if wage data from the previous calendar quarter were easily available, the health care program could use that data to determine eligibility instead of requiring households to submit more recent proof of income.

A key issue with this approach is that the data may no longer accurately reflect the current household situation. Some households whose current income exceeds the limit would be found eligible, while households who had experienced a job loss or wage decrease could be denied based on their previous higher income. The first outcome would likely be unacceptable to those most concerned with program integrity and limiting program costs, while the second would raise concerns among children's health advocates.

One possible solution would be to inform the household that their eligibility would be determined based on the income shown unless they report a difference by a given date. Given the relative frequency of income changes in the target populations, it is far from certain that this approach would simplify enrollment significantly, but it may merit further study.

# Program Summaries and Comparisons

The following sections of the report compare and contrast eligibility, administrative and technical aspects of selected social services programs with those of the health care programs. Where applicable, existing coordination and data-sharing activities are noted.

## Minnesota Health Care Programs

The primary Minnesota Health Care Programs discussed in this report are Medical Assistance and MinnesotaCare. Because of its lower income limits and its relatively small target population of adults without children, the General Assistance Medical Care (GAMC) program offers fewer opportunities for coordination and outreach, but is mentioned in some sections. The umbrella term "Minnesota Health Care Programs" (MHCP) is also used.

Medical Assistance (MA) is Minnesota's name for the federal Medicaid program. It is administered by county agencies and provides health care coverage to children under the age of 21, parents or other relative caretakers of dependent children, pregnant women, people who are age 65 or older and people who have a certified disability or blindness.

MinnesotaCare (MCRE) is a subsidized premium-based program that provides health care coverage for families with children and adults without children. MCRE is administered both by DHS and, as of December 2008, by 56 county agencies that have elected to be MCRE enrollment sites. All 87 county agencies administer Transitional MinnesotaCare, for which some adults without children are eligible while making the transition from GAMC to MCRE eligibility.

Generally, the MHCP have more eligibility requirements than many social services programs, as well as having multiple income standards for different groups. Some of these requirements make it difficult to ascertain whether a person might be fully eligible for MHCP even when enrollment in another program indicates likely income eligibility.

Eligibility requirements for MA and MCRE include things such as:

- Income limits (see Appendix D for DHS-3461, MHCP Income and Asset Guidelines)
- Verification of U. S. citizenship
- Immigration status requirements
- Insurance requirements, also called insurance barriers. These barriers affect only MinnesotaCare. Having current or recent past coverage or access to subsidized coverage through a current employer can result in ineligibility. While MA does not have these barriers, it does require information about other coverage. MA will pay premiums for other coverage found to be cost-effective.
- Cooperation in obtaining medical support from non-custodial parents
- Premium payments for all MinnesotaCare enrollees
- Assets. MA and MCRE limit the amount of real and personal property an adult can own and still qualify for coverage. There are no such limits for pregnant women and children under age 21.

Eligibility determinations for MA are largely, although not completely, automated on the MAXIS system. Payments to providers are made through the Medicaid Management Information System (MMIS), which also houses eligibility for MinnesotaCare.

## Food Support

The Food Support program is Minnesota's name for the federal Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp program. Food Support provides electronic benefits to be used to purchase food. The amount of benefits depends on household size and income.

### Eligibility guidelines

The Food Support program serves many of the same client groups as the MHCP, including:

- Families and children eligible for the Minnesota Family Investment Program (MFIP) and the Diversionary Work Program (DWP).<sup>3</sup> Food and cash benefits are issued using a single set of eligibility criteria as permitted under the Food Stamp Act and federal waivers.
- Working poor families with children and adults without children with gross incomes up to approximately 130% of the federal poverty guidelines (FPG)
- People who receive Supplemental Security Income (SSI) based on age, blindness or disability
- People who are blind, have disabilities or are age 65 or older with net incomes up to 100% of FPG

Medical Assistance (MA) allows some deductions from gross income before comparing income to the limit. The limit for children ages 2 through 18 is 150% FPG.<sup>4</sup> Even though the income evaluation rules for Food Support and MA are not identical, it is reasonable to conclude that children who qualify for Food Support by virtue of being part of an MFIP or DWP family or a family with gross income under 130% FPG would also be eligible for MA without a spenddown.<sup>5</sup>

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<sup>3</sup> MFIP and DWP are programs authorized under the federal Temporary Assistance to Needy Families (TANF) block grant to provide cash assistance and employment support to families with dependent children.

<sup>4</sup> Children ages 0-1 have automatic MA eligibility if they were born to women enrolled in MA or MinnesotaCare. The income limit for other children ages 0-2 is 280% of FPG.

<sup>5</sup> People with incomes over the specified MA limits may become eligible by "spending down," or incurring medical expenses equal to or more than the amount of their excess income. Since there is no upper income limit for qualifying with a spenddown, eligibility for Food Support is not a reliable indicator of MA eligibility for this group.

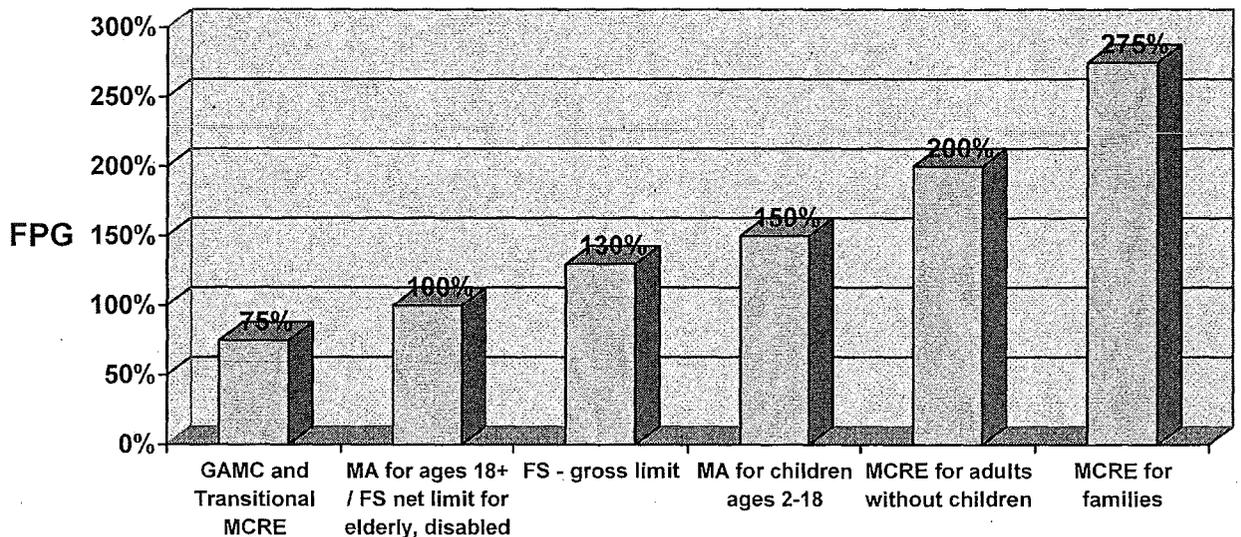
Further, both programs are subject to federal regulations governing the eligibility of non-citizens and provide state benefits to some lawfully present non-citizens.

The income limit for MA eligibility without a spenddown for people age 19 and older is lower — 100% of FPG for parents, children ages 19 and 20, and people who are blind, have disabilities, or are age 65 or older. Because Food Support allows more deductions from gross income, people could meet both the gross income limit (if applicable) and the net income limit for Food Support but still be ineligible for MA without a spenddown. Some of those people could qualify for premium-based MinnesotaCare, but only if they had no other health coverage such as Medicare or employer-based insurance.

The income limit for GAMC and Transitional MinnesotaCare (T-MCRE) for adults without children is lower than the corresponding Food Support limits (75% FPG) while the income limit for premium-based MinnesotaCare is higher (200% FPG). Food Support participants in this group would meet the income limits for one of these programs, but could be ineligible for other reasons (such as assets for GAMC/T-MCRE or other coverage for premium-based MinnesotaCare).

The chart below compares income limits for some Food Support and MHCP populations.

**Food Support and MHCP Income Limits**



## **Automation and coordination**

Food Support, MA and GAMC already share the same automated system (MAXIS) and point of administration (local county agencies) and allow people to apply for Food Support and health care (and cash assistance) on the same application. Although people are not required to request both programs, county workers are trained to follow up during the required personal interview for Food Support to ensure that all clients who want eligibility determined for health care have the opportunity.

Food Support and MinnesotaCare are not as closely integrated since not all counties process MinnesotaCare eligibility for all client groups. However, it is possible to apply for MinnesotaCare and Food Support concurrently. Those counties who do not provide MinnesotaCare services for all clients are instructed to transfer health care requests for people found ineligible for MA or GAMC to MinnesotaCare Operations at DHS along with all relevant information collected as part of the Food Support application process. MinnesotaCare eligibility is maintained on the Medicaid Management Information System (MMIS).

Data pulled from the MAXIS and MMIS systems show that in August 2008, 91.6 percent of Food Support participants were enrolled in MHCP, primarily MA or GAMC.

## **Women, Infants and Children (WIC)**

WIC is a program of the USDA Food and Nutrition Service that provides nutrition education and counseling, food vouchers, and referrals to other health and social services for pregnant women, infants and young children. In Minnesota, WIC is overseen by the Minnesota Department of Health (MDH) and administered by county public health agencies.

WIC serves a subset of the MA population, including:

- Pregnant women
- Breastfeeding women who have had a baby in the past year
- Women who have been pregnant or had a baby in the past six months
- Children from birth to age 5

### **Eligibility guidelines**

Pregnant women, infants and children enrolled in the MHCPs, MFIP, Food Support or Supplemental Security Income (SSI) are automatically eligible for WIC, as are those certified eligible for programs with comparable income guidelines such as free and reduced-price school lunches, Energy Assistance or Head Start.

WIC applies a gross income limit of 185% of FPG to families who are not certified eligible for one of the programs listed above. Since the MinnesotaCare program has a higher income limit (275% of FPG for families and children), some people who would otherwise be ineligible for WIC because of income can become eligible by being approved for MinnesotaCare.

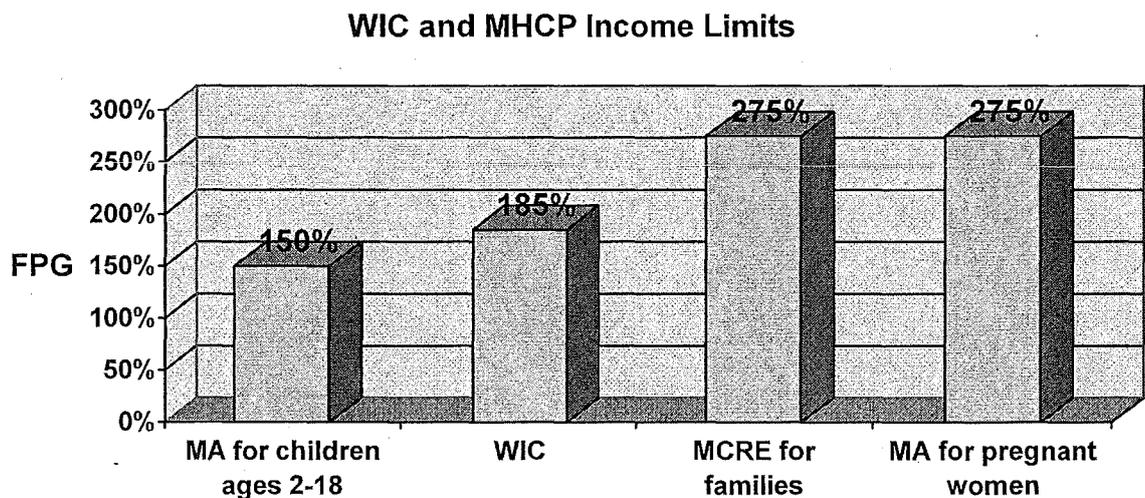
Until November 2008, WIC approved eligibility for people whose applications for MHCPs were pending. Beginning November 1, 2008:

- WIC applicants with incomes between the WIC limit of 185% of FPG and the MinnesotaCare limit of 275% of FPG may be enrolled in WIC presumptively if they report they have applied for MHCP.
- Applicants must then provide verification of the pending MHCP application in order for WIC eligibility to continue.
- WIC follows up after three months to verify the status of the application.

This new policy has already resulted in increased requests for application assistance from agencies certified as MNCAA organizations and is expected to increase the numbers of eligibles enrolled in both WIC and MHCPs. However, WIC eligibility does not guarantee eligibility for MHCP because:

- MA and MinnesotaCare have very specific rules governing citizenship verification and immigration status that do not apply to WIC. Although undocumented and non-immigrant pregnant women can qualify for MA through federal SCHIP provisions or through Minnesota's state-funded program, women who are no longer pregnant or in the 60-day postpartum period cannot, nor can undocumented and non-immigrant children.
- Although the MinnesotaCare income limit is higher than the WIC limit, and both programs use gross income, MinnesotaCare applies insurance barriers to pregnant women and parents, as well as to children in families with incomes over 150% of FPG.<sup>6</sup> Thus some WIC-eligible working families could be ineligible for MA because of income and for MinnesotaCare because of the availability of employer-subsidized insurance. Others may find the MinnesotaCare premiums unaffordable.

The chart below shows income limits for WIC and some MHCP populations.



<sup>6</sup> Although pregnant women are subject to the MinnesotaCare insurance barriers, they could qualify for MA instead because the income limit is the same (275% of FPG).

## **Automation and coordination**

It is reasonable to conclude that WIC-eligible children who:

- Are U. S. citizens or lawfully residing immigrants, and
- Have family incomes no more than 150% of FPG, or
- Do not have access to other health coverage

should also be eligible for MHCP. However, there are barriers to effective coordination that don't exist with Food Support, including:

- Separate supervising agencies (DHS and Health).
- Separate application forms and different locations to obtain and file applications.
- Different application procedures. WIC eligibility requires an in-person visit while MHCP requires more information and verifications. Some clients may find the WIC process relatively easy but be intimidated by the MHCP rules and choose not to follow through with both.
- Different automated systems and levels of automated support. MA and MinnesotaCare are supported by DHS' MAXIS and MMIS systems, while WIC contracts with an outside source for limited automated support.

Because of these differences, direct coordination and outreach assistance in actually completing the application process may prove more effective than referral processes and data sharing.

## **Free and Reduced-Price School Lunch Program**

The free and reduced-price school lunch program (sometimes referred to as the National School Lunch Program, or NSLP) serves low-income children through Grade 12 attending public or non-profit private schools. Authorized and funded by the federal Department of Agriculture's Food and Nutrition Service (FNS), Minnesota's program is supervised by the Department of Education (MDE) and administered by local school districts.

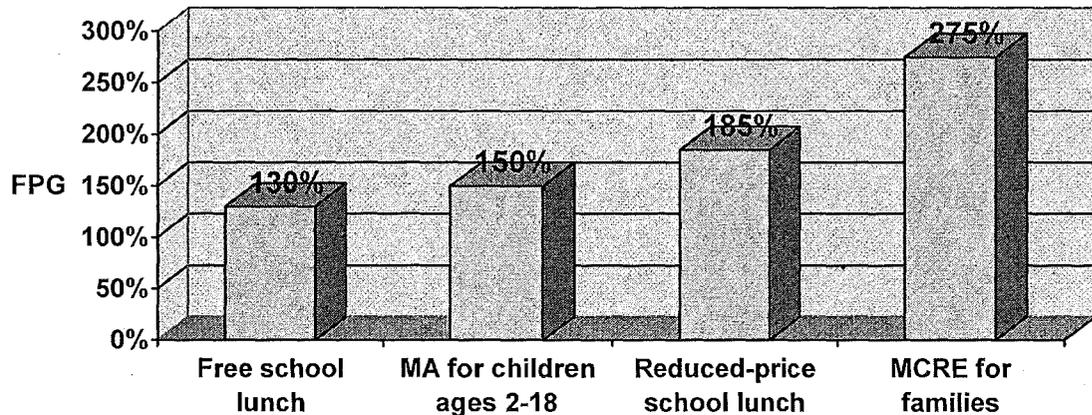
### **Eligibility guidelines**

Children in households participating in Food Support, Food Distribution Program on Indian Reservations (FDPIR) and MFIP are automatically eligible for the school lunch program. Children who do not receive Food Support, FDPIR or MFIP are eligible for free lunches if household income is at or below 130% of FPG, and for reduced-price lunches if household income is no more than 185% of FPG.

Although the school lunch program uses gross income for everyone in the household regardless of relationship, while MA uses net income and counts only the income of the child and parents, it is likely that all of the children eligible for free lunches and some of those eligible for reduced-price lunches would be under the 150% of FPG income limit for MA eligibility without a spenddown. The rest of the reduced-price group would be under the 275% of FPG MinnesotaCare limit.

The chart below shows income limits for the school lunch program and some MHCP populations.

### School Lunch Program and MHCP Income Limits



This does not mean that all of these children would be eligible for MHCP. The same reasons discussed earlier with regard to WIC would affect these children as well: immigration status and insurance barriers. However, it is probably reasonable to assume that the majority would qualify for one of the MHCPs.

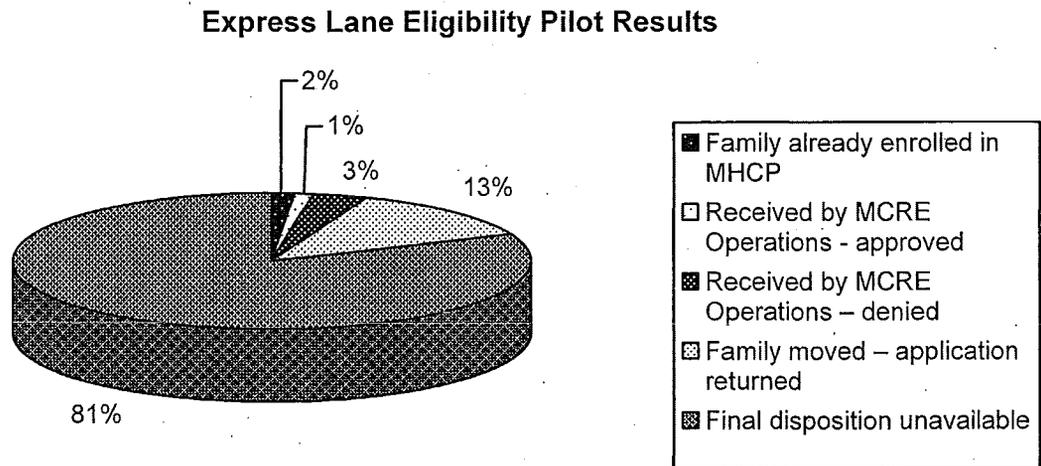
#### "Express Lane" eligibility pilot

DHS tested this assumption several years ago with a pilot "Express Lane" project involving 13 school districts using common software to process school lunch applications.

- School personnel, after indicating whether the family had requested that their data not be shared with MHCP by checking the "opt-out" box, transmitted data files on children certified for free or reduced-price school lunch to MDE (then called the Department of Children, Families and Learning).
- MDE then transmitted identifying information on families who had not "opted out" to DHS.
- DHS performed a data match to remove families who were already enrolled in or had applications pending for MHCP — just over 70 percent of the total. The remaining families received an application form with basic demographic information filled in along with instructions on how and where to complete the application process.

Because of technical difficulties, DHS did not receive a usable data file from MDE until April of the school year, resulting in 13,761 applications being mailed to families at the end of the school year (in May). Although complete data is not available because some county agencies failed to track these applications, it is known that:

- Approximately 1,750 applications were returned to DHS because the family had moved.
- Approximately 200 applications were mailed in error to families who were already enrolled in MHCP.
- MinnesotaCare Operations at DHS received 599 applications (about 4 percent of the total mailed), of which 78 percent were denied:



In summary, the pilot appeared to result in MHCP enrollment for only a small portion of the approximately 30 percent of children receiving free or reduced-price school lunches who were not already enrolled in MHCP.

**Automation and coordination**

The school meal program enrollment process for MFIP and Food Support children is largely automatic. DHS sends a file to the MDE listing MFIP and FS enrollees under the age of 21. MDE matches that data with school records to produce a list of children eligible for automatic certification for school meal benefits. Certification letters with the names of students eligible for the “Free or Reduced-Price School Meal Program” are sent to the school districts and to all

parents/guardians so they have a choice to apply or not apply for the program. The families may apply at the school if they do not receive a letter or if their income changes during the school year.

Families who are not eligible for automatic certification may apply through the school.

2008 legislation mandated DHS and MDE to establish a data-sharing agreement for the purpose of identifying children who may be eligible for MHCP. Staff from both departments are approaching this task in conjunction with updating the interface currently used for MFIP and Food Support. The current interface will be expanded to include data elements that MDE needs to identify children who may be eligible for MHCP. It will also be improved to provide MDE with information more frequently.

In the future, MDE may also be able to receive near real-time updates from DHS using the DHS Shared Master Index (SMI). The SMI offers a fresh approach to data matching across DHS and county systems. It could also be used to match client data across departments. The SMI effort is described in more detail in the section of this report that describes automated system options.

School districts have also renewed efforts to notify families of the availability of MHCP coverage and to facilitate applications. For the 2008 school year, MDE provided a simple flyer, "Does Your Child Have Health Insurance?" for schools to provide to parents. School districts are also required to designate enrollment specialists to provide application assistance and follow-up services. School districts are eligible to participate in the MNCAA program and to receive the \$25 application assistance bonus for each successfully completed application.

## Child Care Assistance Program

Minnesota's Child Care Assistance Program (CCAP) is administered by the Minnesota Department of Human Services (DHS) in partnership with county and tribal agencies and other community partners. Child care assistance is available to:

- Families participating in the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP).
- Certain families that had an MFIP or DWP case close within the last 12 months.
- Low-income families that may be eligible for the Basic Sliding Fee program.

Clients apply for CCAP at the local county human services agency, and may use either of the following forms:

- Minnesota Child Care Assistance Program Application (DHS-3550). This form does not inquire about or refer to health care program eligibility. However, there may be potential for increased coordination. For example, a question inquiring about whether the family receives health care benefits could be added under the existing "Family Services" section, which gathers information about other programs in which the family is participating for reporting purposes. This could give the CCAP worker the opportunity to follow up with health care program information or referrals as indicated.
- Combined Application - Child Care Addendum (DHS-5223D). This form was designed to simplify the child care assistance application process for families who are also applying for cash or food assistance programs or health care. Families who choose to use the form have already been given the opportunity to apply for health care during the required interview for cash or food assistance.

During state fiscal year 2007, on average, 29,500 Minnesota families received child care assistance services each month.<sup>7</sup> The number of children receiving

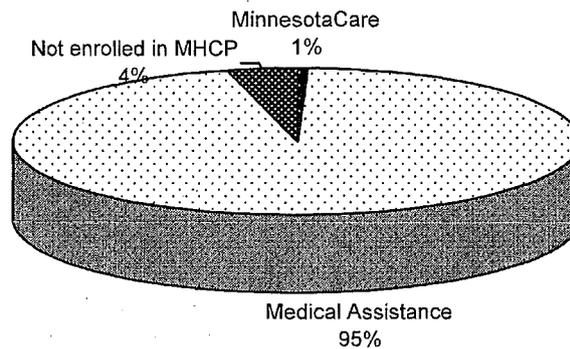
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<sup>7</sup> Minnesota Department of Human Services information sheet, "Child care assistance: Facts and figures" (DHS-4745), May 2008.

child care assistance who are also enrolled in Medical Assistance (MA) or MinnesotaCare was not readily available. However, some related data indicate:

- For State Fiscal Year 2007, a monthly average of 14,600 children (approximately 50%) who received child care assistance were from families participating in MFIP or DWP.<sup>8</sup>
- As seen in the chart below, in August 2008, there were 104,768 total MFIP/DWP participants, of which:
  - 597 (.6%) were enrolled in MinnesotaCare.
  - 4,000 (3.8%) were not enrolled in a health care program.
  - 100,171 (95.6%) were enrolled in Medical Assistance.<sup>9</sup>

**MFIP/DWP Participants Enrolled in MHCP**



### **Eligibility guidelines**

The CCAP income guidelines are generally higher than those for Minnesota Health Care Programs. Income eligibility is determined using the state median income. A CCAP applicant's income may be compared to 47% or 67% of the state median income, depending on the applicant's circumstances. The upper income limit for all CCAP applicants and participants is 67% of the state median income.

<sup>8</sup> Ibid.

<sup>9</sup> Minnesota Department of Human Services Data Warehouse.

This exceeds the income guidelines for MA without a spenddown for most applicants. However, it is lower than the MinnesotaCare income standard of 275% FPG for families and children, as shown in the table below.

### CCAP and MHCP Annual Income Limits

Household size	MA for adults 100% FPG	MA for children ages 2-18 150% FPG	CCAP 47% of state median income	CCAP 67% of state median income	MCRE for families 275% FPG
2	\$14,004	\$21,000	\$26,040	\$37,120	\$38,508
4	\$21,204	\$31,800	\$38,294	\$54,589	\$58,308
8	\$35,604	\$53,400	\$52,846	\$75,332	\$97,908

As seen above, as the household size increases, the CCAP income limits begin to overlap the Medical Assistance (MA) income limits for children. However, except for children in large households, there is little certainty of MA income eligibility for CCAP participants.

CCAP households are more likely to be income-eligible for MinnesotaCare for families and children. However, since child care assistance costs are paid for qualifying families while they work, look for work, or attend school, some of these families may have insurance or access to insurance through their employers, creating insurance barriers to MinnesotaCare eligibility.

### Automation and coordination

The Child Care Assistance Program is currently implementing a new version of the Minnesota Electronic Child Care Information System (MEC<sup>2</sup>). This will be a statewide, Internet-based computer system that provides automated assistance in determining eligibility, establishing child care authorization, and issuing child care assistance payments.

The new MEC<sup>2</sup> is integrated with MAXIS, which is the system used to determine eligibility for MA, GAMC, and cash and food assistance programs. Both systems draw the same unique client identifier from the Person Master Index (PMI)

database. This integration will make client data entered in either system readily available to the eligibility worker, and to the DHS Data Warehouse.<sup>10</sup>

Once the new MEC<sup>2</sup> is fully implemented statewide, there will be greater potential for tracking and coordination between CCAP and MHCP. Using the data warehouse, further study of CCAP participants who are not enrolled in MHCP may help identify the potential for targeted outreach and other efforts.

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<sup>10</sup> The DHS Data Warehouse supports data analysis and decision making throughout the Department. The Warehouse copies source system data and optimizes it for reporting.

## Energy Assistance Program

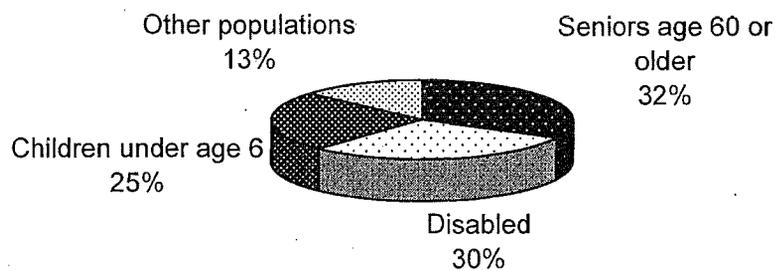
Low-income households may be eligible for the Energy Assistance Program (EAP), which is administered by the Minnesota Department of Commerce, in partnership with Community Action and other agencies. EAP is designed to assist with energy bills, primarily in the form of a grant to the energy provider on behalf of the household.

Priority is given to households with:

- Adults age 60 or older
- People with disabilities
- Children under age six

In Federal Fiscal Year 2007, this resulted in the following percentage served statewide for these priority populations:

### EAP Demographic Data



As shown in the chart above, there is a high percentage of EAP households with demographics (seniors, people with disabilities, and children) that are similar to the MA population.<sup>11</sup> However, there are some dissimilarities when it comes to income and other eligibility criteria.

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<sup>11</sup> Minnesota Department of Commerce EAP Rate of Incidence Reports.

## Eligibility guidelines

The EAP income guidelines are generally higher than those for Minnesota Health Care Programs. Households (renters or homeowners) who are at or below 50 percent of the state median income are eligible for the program. This exceeds the income guidelines for MA without a spenddown for most applicants; however, it is lower than the MinnesotaCare income standard of 275% FPG for parents and children.

**EAP and MHCP Annual Income Limits**

Household Size	MA for adults 100% FPG	MA for children ages 2-18 150% FPG	EAP 50% of state median income	MCRE for families 275% FPG
2	\$14,004	\$21,000	\$27,702	\$38,508
4	\$21,204	\$31,800	\$40,738	\$58,308
8	\$35,604	\$53,400	\$56,219	\$97,908

As seen in the table above, as the household size increases, the EAP income limits become slightly closer to the Medical Assistance (MA) income limits for children. However, like the Child Care Assistance Program, there is little certainty of an income eligibility overlap between EAP and MA. MinnesotaCare for families and children is the more likely health care program option for EAP households from an income eligibility standpoint.

Income aside, other eligibility factors that are considered for MA and MinnesotaCare, such as citizenship, immigration status, and insurance, are not considered for EAP. These factors would present barriers to MHCP eligibility for some EAP participants.

## Automation and coordination

EAP applications are entered directly onto the Department of Commerce' Electronic Household Energy Automated Technology (eHEAT) system by the local energy assistance provider. There is some coordination between the eHEAT system and the Minnesota Community Action Partnership's Visions database (described later in this report) that makes EAP information for Community Action clients available to Community Action agency staff.

Many of the Minnesota Community Action agencies (see Minnesota Community Action Partnership below) are also energy assistance providers. This provides an opportunity for Community Action agency staff to identify potential eligibility for other programs for which the EAP applicant may be eligible. Increased coordination between Community Action agencies and Minnesota Health Care Programs may be the best opportunity for targeted outreach for potential MHCP enrollees who apply for the Energy Assistance Program.

## Head Start

Head Start is a federal program administered by the Office of Head Start (OHS), Administration for Children and Families (ACF), Department of Health and Human Services (HHS). The purpose of Head Start is to promote the school readiness of low-income children by enhancing their cognitive, social and emotional development in a supportive learning environment and through comprehensive services.

Head Start primarily serves three and four-year-olds from low-income families. The 1994 reauthorization of the Head Start Act established Early Head Start to also serve pregnant women and families with children up to three years of age.

Data about the number of Head Start participants in Minnesota who are also MHCP enrollees was not available. However, nationally, there were 908,412 Head Start enrollees in federal fiscal year 2007.

- 93 percent had health insurance.
- 85 percent of those with health insurance were enrolled in the Medicaid/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or a state-sponsored child health insurance program.<sup>12</sup>

### Eligibility guidelines

Head Start agencies must demonstrate an effort to first serve families with incomes that are at or below 100% of the federal poverty guidelines (FPG). Thereafter, up to 35% of their enrollment may be families with incomes from 101-130% FPG. In addition:

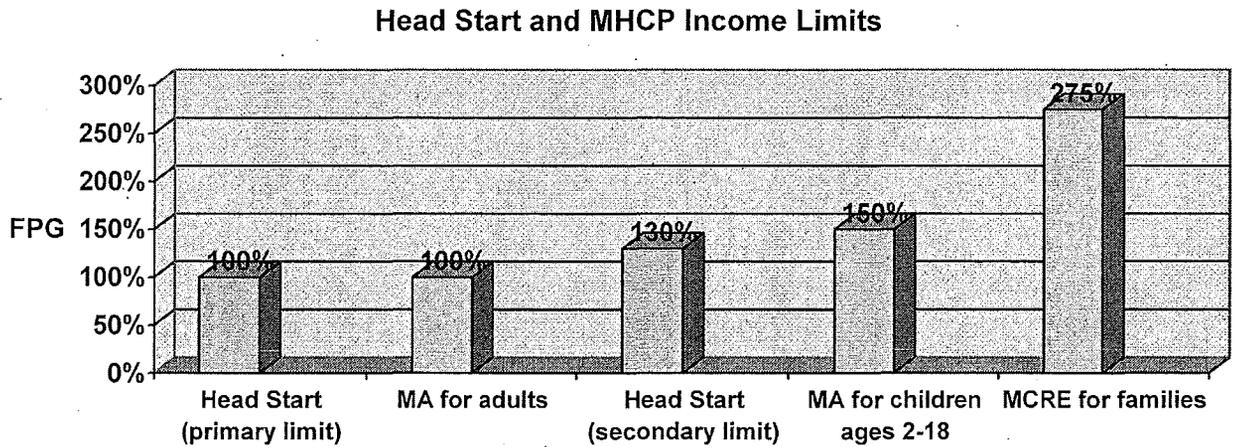
- At least 10% of the population served must be children with a diagnosed disability.
- Children who are homeless, in foster care, or recipients of public assistance (such as MFIP) are categorically eligible.
- No more than 10% of the population may have incomes greater than the above income guidelines.

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<sup>12</sup> <http://www.acf.hhs.gov/programs/ohs/about/fy2008.html>.

Head Start applicants must provide proof of age and income. Those who are recipients of public assistance must provide proof of their current status.

As shown in the chart below, the income guidelines for Head Start, Medical Assistance (MA), and MinnesotaCare overlap to a great extent. However, other eligibility factors that are considered for MA and MinnesotaCare, such as citizenship, immigration status, or insurance barriers are not considered for Head Start.



### Automation and coordination

Head Start is one of the programs offered by Minnesota Community Action Agencies, which utilize the Visions database, which is described later in this report.

## Other Programs

Several of the programs reviewed are not good candidates for targeted coordination with MHCP at this time for reasons such as limited automation or insufficient commonality in eligibility requirements and populations served. They include:

### Food Distribution Programs

The FNS administers three food distribution programs for targeted groups. These programs provide an alternative to Food Support for people who, for whatever reason, find the larger program difficult to use or whose needs are better met through receiving food products directly. The three programs are:

- Food Distribution Program on Indian Reservations (FDPIR), which provides nutritious food packages monthly to households residing on Indian reservations or households living in approved areas near reservations with at least one person who is a member of a federally recognized tribe
- Mothers and Children (MAC) Program, which provides one of seven nutritious food packages to pregnant and postpartum women, infants and children not served by WIC. The program is a precursor to WIC and serves roughly the same population.<sup>13</sup>
- Nutrition Assistance Program for Seniors (NAPS), which provides one of seven nutritious food packages to seniors age 60 or older who live in the community and prepare their own meals

These three programs are not particularly good candidates for concentrated efforts to expand coordination with MHCP for several reasons:

- Decentralized administration. FDPIR is administered by individual tribes; MAC and NAPS are available through food shelves.
- Limited automation possibilities

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<sup>13</sup> Besides the WIC groups, MAC serves children between ages 5 and 6 and non-breast feeding women with children between ages six months and one year.

- Relatively small numbers. MAC and NAPS combined serve about 14,000 people each month, of which only 8.7 % are women and children. The remainder are seniors, who may not qualify for any of the MHCPs because of income or enrollment in Medicare.
- Existing coordination with other programs.
  - Children who receive FDPIR are automatically eligible for the school lunch program and would therefore be part of that program's coordination efforts.
  - MAC coordinates with WIC.
  - NAPS enrollees are often referred by the Senior LinkAge Line®, and the program coordinates closely with Food Support.
  - Uncertain future. Because MAC and NAPS serve the same target populations as Food Support and WIC, proposals to eliminate the programs arise frequently.

In short, strengthened coordination with the other nutrition programs — Food Support, WIC and the school lunch program — is a more promising route to reaching the target populations.

## **Unemployment Insurance**

The Minnesota Department of Economic Development (DEED) administers the Unemployment Insurance (UI) program. UI provides a temporary partial wage replacement to help those unemployed through no fault of their own to become reemployed.

UI is not a strong candidate for targeted coordination efforts primarily because it is not a means-based program. Benefits are based on the weekly salary and reason for separation from the applicant's previous employment.

DHS already receives data matches from DEED as part of the Income Eligibility and Verification System (IEVS) and through the New Hire employment registry. Attempting to get further data on all new UI claims would be of limited value since it would result in receiving information on many people who would not qualify for MHCP. Good coordination with the other programs for which these families might qualify (Food Support, MFIP, school lunch and WIC) combined with ensuring that basic information on the MHCP is readily available to UI beneficiaries is likely to be a more fruitful approach.

## **Low-Income Tax Credits**

The federal Earned Income Tax Credit (EITC) and the Minnesota Working Family Tax Credit (WFC) are after-tax credits for low-income employed people. 2008 qualifying income levels are within the MinnesotaCare limits; some of the lower-income filers would be within the MA limits as well. However, pursuing information on people who qualify for these credits would not necessarily identify people potentially eligible for MHCP because income information from tax records is not current and does not provide information on the availability of other coverage that might affect eligibility for MinnesotaCare.

# Automated System Options

As noted earlier in this report, the use of technology to aid in health care program enrollment may take many forms, and include automated systems that:

- Identify potential enrollees from other sources.
- Facilitate program coordination and outreach.
- Estimate potential eligibility (screening tool).

Some of the types of systems currently used by DHS or social services programs in Minnesota and their potential applicability to improved coordination between health care and other social services programs are discussed below. They include DHS' **Shared Master Index (SMI)**; Minnesota Community Action Partnership's **Visions** database; and the Children's Defense Fund Minnesota's **Bridge to Benefits**.

## Shared Master Index (SMI)

The DHS Shared Master Index (SMI) was designed to assist counties, tribes and DHS staff in coordinating client services across state and county systems. Many clients participate in multiple county, state and tribal programs which are tracked on different automated systems. This makes it difficult for staff working with these clients to develop a complete picture of what services they receive. SMI provides a common database for client demographic data and a comprehensive view of client program participation.

SMI comprises a master index of client data from DHS major systems:

- MAXIS, which supports eligibility processes for cash, Food Support, MA and GAMC, as well as supporting the child care assistance programs.
- MMIS, which supports other health care programs and functions including MinnesotaCare, the HIV/AIDS programs, and the Consolidated Chemical Dependency Treatment Fund.
- PRISM, the child support enforcement system.
- SSIS, which supports social services programs.

DHS has also established partnerships with several counties to assist them in integrating their county databases with DHS systems. For example, Hennepin County is implementing the Enterprise Communication Framework (ECF) system which provides an electronic case file, using the SMI as its database, enabling county workers to more easily view client participation data. DHS will also be working with Ramsey County to integrate its Common Access Front End (CAFÉ) system. Similar efforts have been implemented or are underway in Dakota, Carver, and St. Louis Counties.

The SMI design significantly enhances the accuracy of client identification by assigning a single identifier for each client. It also provides a uniform means of appropriately accessing data from DHS systems, and between DHS and county systems. These design features hold out the promise of more reliable data sharing and matching that could be expanded over time to matches and information exchanges with agencies and programs other than those administered by DHS.

Efforts currently underway between DHS and county agencies could lead to wider use of the SMI to coordinate and share data between DHS and other outside programs. WIC in particular would be a promising avenue of exploration because it is often administered through county public health agencies, who may be a part of their counties' ongoing systems coordination with SMI.

## **Visions**

Visions is a new database system designed to help Minnesota Community Action Programs and their staff provide better services to their communities and their clients.

### **Minnesota Community Action Partnership (MinnCAP)**

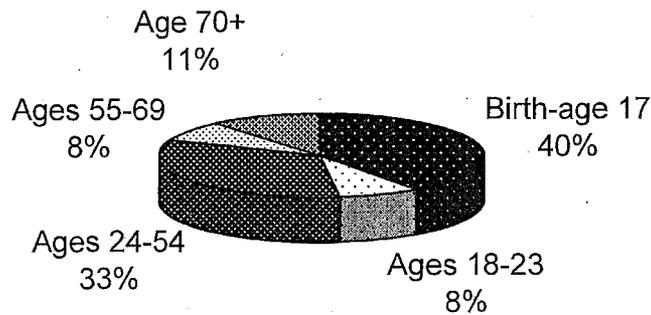
The Minnesota Community Action Partnership (MinnCAP) is a network of Community Action agencies that serve all 87 counties in the state of Minnesota. These agencies provide an array of services to raise the health, education and economic standards of Minnesota's economically disadvantaged citizens, and include 28 Community Action Agencies and 11 Tribal Governments.

Community Action agencies offer many programs and services for people in need, such as education, emergency services, employment services, health services, housing services, income management, nutrition, and self-sufficiency. See the MN Community Action Programs Grid (Appendix E) for further information.

### **MinnCAP and MHCP**

There is a great deal of potential overlap between those served by Community Action Programs and Minnesota Health Care Programs. In addition to likely income eligibility for MHCP, MinnCAP participants are demographically similar to the MA and MinnesotaCare populations. Many participants (40%) are children under age 18. There is also a good percentage of seniors (19%) age 55 or older served by Community Action programs. See the chart below for further details.<sup>14</sup>

**MinnCAP Participants By Age**



### **Visions Database**

Each Community Action agency cooperates to operate the statewide Visions database. It is designed to help Community Action agencies deliver more comprehensive/integrated services to clients, and support the day-to-day operations of Community Action Programs.

Visions will:

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<sup>14</sup> 2006 Minnesota Community Action Report.

- Allow clients to answer basic questions only once for all programs.
- Simplify eligibility determinations.
- Improve tracking of clients through all programs.
- Be a single interface to the existing multiple systems.

In addition to supporting and providing coordination for the Community Action Programs, Visions also helps clients complete the Combined Application Form, or CAF (DHS-5223), to apply for Food Support and other public assistance programs (Minnesota Family Investment Program, Medical Assistance, etc.). Visions will pre-fill the fields on the CAF with any pertinent client information already in the database. Agency staff can then print the application for the client to complete and submit to the appropriate county agency.

Possible future enhancements for this feature of Visions include:

- Adding the same functionality for the Minnesota Health Care Programs Application, or HCAPP (DHS-3417).
- Working with counties to establish functionality so that forms generated by Visions can be used to facilitate and expedite the application process.

## **Bridge to Benefits**

Bridge to Benefits (formerly known as "Covering All Families") is a multi-state initiative by Children's Defense Fund Minnesota to increase awareness and participation in public programs that benefit low-income Minnesota families and individuals. To participate in all the programs for which they may be eligible, people may have to:

- Complete multiple applications
- Visit a variety of eligibility offices
- Try to understand an array of differing eligibility standards and requirements.

The Bridge to Benefits project tries to help people overcome these obstacles and simplify the application process to get them enrolled. A core component of the

project is an online screening tool that helps determine potential eligibility for these programs. These include the MHCP as well as many of the social services programs described in this report (Food Support, School Meal Program, CCAP, EAP, and tax credits).<sup>15</sup>

By answering a few simple questions on the Bridge to Benefits web site, people can:

- Learn if they qualify for these programs.
- Print application forms.
- Get county-specific information about how and where to apply.
- Establish a connection with organizations that provide one-on-one application assistance.

A family's contact information may be forwarded, via the Bridge to Benefits web site, to an organization that agrees to follow up with them. These organizations provide the assistance (such as completing a program application) that is needed to ensure that a family completes the enrollment process. This could include a Community Action Agency that provides assistance in applying for Energy Assistance, a food shelf that helps families apply for Food Support, or a health care organization that helps families apply for Medical Assistance.

Various outreach organizations described in this report are among those that utilize Bridge to Benefits. For example, Minnesota Community Action agencies (described earlier) may direct their clients to this online tool to screen for other potential benefits when they come in for free tax assistance, to apply for Head Start, etc. MNCAA organizations (described later in this report) are another group that are likely to use Bridge to Benefits to assist their clients in assessing potential eligibility for public programs.

Other potential screening organizations (some of which may also be Community Action agencies or MNCAA organizations) may be schools, job placement centers, social service agencies, housing organizations, family resource centers, family service collaboratives, WIC sites, Head Start programs, etc.

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<sup>15</sup> [http://www.bridgetobenefits.org/Learn\\_About\\_Programs.html](http://www.bridgetobenefits.org/Learn_About_Programs.html).

## Other Ways to Improve Coordination

In addition to or in conjunction with automation, community outreach is a key component to improve program coordination. Indeed, as noted in various sections throughout this report, the two are very good partners in some circumstances, and inextricably linked in others.

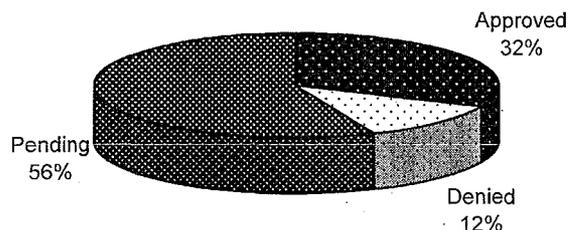
### Minnesota Community Application Agent (MNCAA) Program

In 2007, state legislation was passed that required the Department of Human Services to establish an incentive program for organizations that directly identify and assist potential Minnesota Health Care Program (MHCP) enrollees in filling out and submitting an application. The legislation directs DHS to pay the organization an application assistance bonus of \$25 for each applicant successfully enrolled in MA, GAMC, or MinnesotaCare.

As of November 2008, 2477 households (which included 3740 individuals) had applied through the Minnesota Community Application Agent (MNCAA) program. Of those 2477 applications, 1081 (44%) have had an eligibility determination completed. As illustrated in the chart below:

- 1091 individuals have been approved (from 783 households).
- Approximately 406 individuals have been denied (from 298 households).<sup>16</sup>

#### MNCAA Eligibility Determination Results



<sup>16</sup> Minnesota Department of Human Services MNCAA Resource Center.

## **MNCAA Resource Center**

The MNCAA Resource Center is located at DHS and provides direct assistance to MNCAAs during the application process. MHCP applicants work directly with MNCAAs to complete the application form and gather verifications. MNCAAs then submit completed applications to the MNCAA Resource Center, where staff review them for completeness and forward them to the appropriate agency for processing. Resource Center staff also answer questions and provide assistance to MinnesotaCare and county workers regarding MNCAA-assisted applications.

## **MNCAA organizations**

Outreach organizations that participate in the program are those that do not already receive state or federal funding for application assistance, and that have connections to an uninsured population. Hospitals, clinics, Head Start programs and community health centers are all likely program sites.

Some organizations currently participating in the program include the Center for Africans New to America (Minneapolis), Lake Superior Community Health Center (Duluth), Olmsted Community Action Program (Rochester), St. Cloud Area Legal Services (St. Cloud), Tri-County Community Action (Little Falls), and Vietnamese Social Services (St. Paul). A list of MNCAA agents is available on the DHS website (Minnesota Community Application Agent Participants, DHS-5475). The list continues to grow; the December 2008 list is included in Appendix F.

Community organizations may choose to participate in the program at one of three levels. Only Level I organizations are eligible to receive the \$25 application assistance bonus.

**Level I** outreach organizations, referred to as Minnesota Community Application Agent (MNCAA) organizations, contract with and are certified by DHS to serve as application sites for those needing assistance with the Minnesota Health Care Programs Application (HCAPP). There are currently 50 Level I organizations.

Level I sites are contracted to:

- Identify potential health care enrollees and assist them in completing the HCAPP.
- Assist applicants with obtaining documentation needed to determine health care eligibility.
- Offer use of fax and copy services.
- Follow up as needed until an eligibility determination is reached.

**Level II** outreach organizations provide materials and referrals for application assistance to any suspected or identified uninsured person they encounter. Some organizations may choose to assist with a portion of the HCAPP but usually do not assist with the entire application process. There are currently 16 Level II organizations.

**Level III** outreach organizations help raise awareness in the community but do not assist with applications. They provide information about MHCP through events in the community, health fairs and group presentations. There are currently 3 Level III organizations.

### **Current program coordination**

The MNCAA program provides an excellent opportunity to build on an existing DHS outreach effort to coordinate with other programs. For example, as noted in the earlier discussion of the WIC program, WIC applicants must now provide proof of applying for a health care program to maintain automatic eligibility for WIC. This new policy has already resulted in increased requests for application assistance from MNCAA organizations, and is expected to increase the numbers of eligibles enrolled in both WIC and MHCPs.

MNCAA organizations may administer, or be co-located with other organizations that administer, other social services programs that serve potential MHCP enrollees. 22 MNCAA organizations responded to a recent survey on administration of several of the programs included in this report. The survey questions:

- 1) Does your organization currently administer the Energy Assistance Program, Head Start, or WIC?
- 2) If your organization does not currently administer these programs, is it co-located with another agency that does?

<b>Social Services Program</b>	<b>Number that administer program</b>	<b>Number that do not administer program</b>	
<b>Energy Assistance</b>	<b>2</b>	<b>20</b>	
		<i>Co-located with an agency that administers the program?</i>	
		<i>Yes</i>	<i>No</i>
		<b>3</b>	<b>17</b>
<b>Head Start</b>	<b>2</b>	<b>20</b>	
		<i>Co-located with an agency that administers the program?</i>	
		<i>Yes</i>	<i>No</i>
		<b>4</b>	<b>16</b>
<b>Women, Infants and Children (WIC)</b>	<b>2</b>	<b>20</b>	
		<i>Co-located with an agency that administers the program?</i>	
		<i>Yes</i>	<i>No</i>
		<b>6</b>	<b>14</b>

As the survey results indicate, at this early stage of the MNCAA program, the overlap is small; however, the potential for future co-location and coordination is great. See below for information about current coordination efforts between the MNCAA and Sage Screening programs.

## **Sage Screening Program and MHCP**

The Sage Screening Program provides breast and cervical cancer screening and diagnostic services through a statewide network of private and community clinics. The program is administered by the Minnesota Department of Health (MDH). It was established in 1991 with funds from the Centers for Disease Control and Prevention (CDC). While the CDC remains the primary funding source, additional program funds are provided by the State of Minnesota, and by the Komen Foundation (through the Twin Cities Race for the Cure).

### **Eligibility guidelines**

Women are eligible for the program if they:

- Are age 40 or older (with some exceptions for younger women at increased risk)
- Are uninsured or underinsured
- Have income at or below 250% of the federal poverty guidelines.

Eligibility for the Sage Screening Program is based on self-reported information from the applicant; unlike MA and MinnesotaCare, no verification is required. Also, other eligibility factors that are considered for MA and MinnesotaCare, such as citizenship and immigration status, are not considered for the Sage Screening Program.

### **Sage and MHCP coordination and outreach**

The Sage Screening Program and DHS already coordinate Medical Assistance (MA) eligibility for women who are not otherwise eligible for MA (or MinnesotaCare) but are eligible for Sage. Women who participate in Sage are potentially eligible for MA under the MA-BC (MA for Breast/Cervical Cancer) basis of eligibility. Initial eligibility for MA-BC may be determined by an authorized health care provider, or by the county human services agency.

MDH has expressed an interest in also working with DHS to increase outreach and data sharing efforts to enhance recruitment for the Sage Screening Program. The Sage Screening Program uses direct mailings, television spots, and a variety of other recruitment methods to reach its target population. MDH has identified

the MHCP population as a potential source for direct mail and other recruitment efforts.

Further coordination, outreach, and data sharing between MHCP and Sage are in progress on several fronts. Although the primary objective of these efforts is to increase Sage Screening Program participation, the ancillary benefits will include enhanced interagency communication and data sharing, which opens the door to additional coordination between MDH and DHS programs.

### **Training and data sharing**

One coordination effort that is already well underway is training Minnesota Community Application Agents (MNCAs) to recruit Sage clients through an incentive program. DHS and MDH staff have begun meeting to set up this process, and plan to conduct training and implement the incentive program in early 2009.

A data-sharing agreement is needed to meet data privacy requirements. There is an existing data-sharing interagency agreement between DHS and MDH that already facilitates data sharing between a number of DHS and MDH programs, and is a potential starting point for this coordination effort as well.

MDH has also identified a need for Sage training for county human services agencies to increase program awareness. One such training occurred recently at the December 2008 MAXIS mentor meeting.<sup>17</sup> MDH staff gave a very well-received presentation on Sage and distributed outreach materials for county agency use. The presentation also clarified Sage program requirements and the role of the county worker in relation to the MA-BC basis of eligibility. Further training plans for county staff are under discussion.

### **Direct mail**

MDH and DHS are also exploring data sharing to identify targeted groups for Sage recruitment mailings and other efforts. This would include sending direct mail pieces about the Sage Screening Program primarily to age-eligible women who are denied MA, GAMC, or MinnesotaCare coverage, or whose MHCP

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<sup>17</sup> The MAXIS mentor meeting is a standing meeting of key county agency staff who gather information about DHS (and related) programs to disseminate to fellow agency staff.

coverage has ended. The DHS Data Warehouse would be used to identify these potential Sage participants.

Several meetings have already taken place to iron out the primary issues and options. There are a number of possible approaches, including:

1. DHS sends data to MDH; MDH completes the mailing process (both agencies have access to the data).
2. DHS sends data, and MDH sends direct mail pieces, to central mail site (neither accesses the data).
3. DHS uses data to mail MDH direct mail pieces from DHS (only DHS accesses the data).

Approach #3 may be the best for an initial effort; future options may develop as data sharing and other project considerations are explored further.

# Legislative Issues and Options

One of the key directives of this report was to identify statutory changes to state health care and social services programs that would improve coordination and automation between the programs. This section describes several categories of changes that would facilitate greater coordination.

## Automatic eligibility

The only way to ensure that all people participating in a given cash, food assistance or other social services program are also enrolled in health care is to provide automatic eligibility for Medicaid (or another health care program like MinnesotaCare) based solely on receipt of benefits from the other program. “Automatic eligibility” in this context means just that: Because you receive, for example, Food Support, you are entitled to and will be enrolled in MA. The Food Support determination would substitute for the MA determination in all respects — not just income — and the family would provide all needed information as part of the joint Food Support/MA application. This is the approach used historically to provide Medicaid coverage to family cash assistance recipients.

Before the federal Temporary Assistance to Needy Families (TANF) program was enacted in 1996, individuals receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program were automatically eligible for and enrolled in Medicaid.<sup>18</sup> Federal legislation in 1996 delinked Medicaid and TANF, tying certain Medicaid requirements to those of the former AFDC program in an effort to ensure that states that established more restrictive TANF programs did not end Medicaid for people who formerly received it through eligibility for AFDC.

Minnesota already offered MA to non-AFDC recipients and sought to retain the previous system: automatic eligibility for Minnesota Family Investment Program (MFIP) participants, as well as continuing eligibility for MA-only recipients under the pre-TANF standards. The federal agency denied Minnesota’s request on the grounds that the income limits were not identical because MFIP limits for working families could in some cases be higher than the MA limits for certain groups. Minnesota began requiring separate eligibility determinations for MFIP and MA in

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<sup>18</sup> Individuals could refuse Medicaid, but in Minnesota the practice was to enroll them unless they proactively asked to be disenrolled. No “opt-out” statement was requested or required.

response to the federal directive. Families can still apply for both programs simultaneously on a single application and submit a single set of documents to verify common program elements like citizenship, Social Security numbers and income. DHS data from August 2008 shows that approximately 96 percent of MFIP participants are also enrolled in MHCP.

**Legislative changes.** Allowing automatic eligibility for MFIP, Food Support, or both, would require adding these groups to the eligibility categories listed in Minnesota Statutes §256B.055 effective upon federal approval. Since there is currently no federal statute explicitly authorizing such a category, federal approval would be required.

### **Costs and risks**

- This change would not be cost-neutral. Even though the vast majority of MFIP and Food Support participants are already enrolled in health care programs, granting automatic eligibility would pull in the relatively few who aren't, including some adults who might not meet the existing MA income limits.
- The federal agency would probably be reluctant to approve such a request on a state-by-state basis and at a minimum would want to ensure that identical income standards were applied to non-MFIP and Food Support MA applicants as well.
- Pursuing automatic enrollment for participants in non-DHS programs, such as WIC and school lunch, would be even less likely to obtain federal approval because there are too many differences in program requirements. Immigration status in particular is an obstacle because those programs serve undocumented and non-immigrant children, which is barred under both Medicaid (other than in emergency situations) and state-funded medical coverage. Citizenship and immigration status requirements cannot be waived for Medicaid.

## Aligning income requirements

A somewhat more modest approach than pursuing automatic eligibility involves aligning MA income requirements more closely with those of other programs. Having identical income standards, preferably based on gross income, increases the likelihood that someone found eligible for a program like school lunch or WIC would in fact be income eligible for MA, even if the program rules still differed in the area of exactly what income counts.

**Legislative changes.** Both WIC and the school lunch program apply an upper gross income limit of 185% of FPG. The appropriate subdivisions of Minnesota Statutes §256B.056 could be modified to raise the MA standard — either for children only or for children and parents — and base the determination on gross income subject to federal approval. Federal approval could be requested via state plan amendments and the use of income disregards authorized under the Social Security Act.

### Costs and risks

- Even if the income standard was raised only for children, costs would increase. Such a proposal would be difficult to pass in times of large budget deficits.
- It is unknown whether federal approval would be granted, also in part because of cost.

## Aligning non-financial requirements

Aligning MA income limits and computation method (gross instead of net) with the WIC and school lunch programs would simplify the income determination, but it would not eliminate the need for a separate eligibility determination and additional information from the families. That would require effectively eliminating eligibility requirements other than income, such as citizenship and immigration status and cooperation with third party liability.

**Legislative changes.** The primary change required would be to add undocumented and non-immigrant children to the group of legal immigrants for whom Minnesota currently provides state-funded MA as

stipulated in Minnesota Statutes §256B.06. Federal funding is not possible at this time absent a change in federal law.

### **Costs and risks**

- Such a proposal would increase costs and could be controversial, because families would still need to disclose the child's status (which they don't have to do for WIC or school lunch) to ensure that the state did not seek federal reimbursement for ineligible children, and to comply with federal requirements for verifying citizenship. This might discourage some families from enrolling their otherwise eligible children.
- Bypassing pursuit of third party liability, including medical support from non-custodial parents, would also be unlikely to obtain federal approval. An alternative would be to request this information after enrolling eligible children.
- The federal waiver authorizing federal funding for the MinnesotaCare program requires that families be given the opportunity to make an informed choice between MA and MinnesotaCare. Families interested in MinnesotaCare would still have to supply insurance information before enrolling.

### **Data privacy and data sharing**

Even when agencies are directed by statute to enter into data-sharing agreements for specific purposes, the existing patchwork of data privacy laws can slow or even prevent progress on accomplishing these mandates. For example, as noted earlier in this report, the Departments of Education and Human Services continue to encounter difficulties in sharing data accurately because of differences in the type of data they can collect from families. A comprehensive review of data privacy laws together with efforts to arrive at a common interpretation of these laws across departments may be necessary to allow substantial progress in data sharing.

Federal and state laws governing data privacy and data sharing include:

- Health Insurance Portability and Access Act (HIPAA)

- Social Security Act information safeguarding regulations
- Minnesota Statutes Chapter 13

These laws exist primarily to protect the subjects of data from unauthorized and improper disclosure of data rather than to facilitate open data sharing among agencies.

- HIPAA imposes strict penalties for failure to safeguard private health data.
- The Social Security Act restricts Medicaid agencies from sharing data for purposes other than meeting state plan requirements.
- Minnesota statutes regulate the use and disclosure of specific types of data, including but not limited to educational data, tax debtor data matches, and public health data.
- In recent years, protection of individuals' Social Security numbers has taken on increased importance because of the risk of identity theft.

It is somewhat of a paradox that these complex regulations, designed to protect the rights of individuals, can impede giving these same individuals better access to public programs through data sharing. The Shared Master Index (SMI) project has identified data sharing as a major challenge to service integration:

“Perceived legal and culture barriers to share data across program areas continue to emerge and must be resolved. Balancing holistic case management goals with program-specific data restrictions and client privacy is difficult.”<sup>19</sup>

**Legislative changes.** In light of these issues, it would be premature to identify specific statutory changes mandating data sharing or specific automation projects. A global, cross-agency review of Minnesota Statutes Chapter 13 with an eye to balancing data sharing with client privacy might be a more effective approach than these targeted mandates in the long run.

In conjunction with this global review, issues surrounding establishing some type of common identifier that could be used across departments should be examined. The lack of a common identifier has proved to be a significant barrier to effective data sharing in some instances, such as the

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<sup>19</sup> Minnesota Department of Human Services Shared Master Index information sheet (DHS-4995), April 2008.

ongoing efforts described earlier between the school lunch program and the MHCP.

### **Costs and risks**

- Systems modifications are usually needed to allow agencies to share data effectively. Costs vary depending on the degree of modification required.
- Even if state statute were amended to ease restrictions, compliance with the federal laws would still be required.

# Conclusions

Minnesota already has several initiatives in progress that, over time, will improve coordination between health care and other social services programs. Given budget constraints and the lack of a single automated system, it makes sense to build on these existing efforts rather than mandating new ones through legislation. Automatically enrolling children or adults in a health care program based on receipt of some other benefit may not be feasible at this time.

Below is a summary of ongoing activities and possible additional administrative initiatives that could enhance coordination through automation and outreach.

## Coordination between Food Support and MHCP

Food Support and MA are already well coordinated, with high rates of MA participation by people getting Food Support. Because the programs already have common administration and systems support, data is freely shared and often handled by the same worker. No additional legislation is needed.

Minnesota has had policies in place for at least 15 years directing workers to align renewal dates between the programs whenever possible to avoid requiring enrollees to submit duplicate information and documentation separately for each program. An initiative currently underway seeks to further link the two programs through the use of six-month renewals for Food Support, mirroring MA and using a common renewal form for both programs.

Several small steps could be considered to strengthen coordination and possibly lower the percentage of Food Support participants who are not enrolled in MHCP:

- Conduct a case-specific analysis of the individuals, particularly children, who are not enrolled in health care to determine the reasons and if there are barriers that could be eased, including further alignment of renewal procedures.
- Remind workers to ask Food Support and cash applicants who do not proactively request health care on the application whether they do wish to apply for coverage.

- Modify the application to advise cash and Food Support applicants that their eligibility for MHCP will be determined at the same time unless they check a box stating they do not want to be considered for health care coverage.

## **Coordination between WIC and MHCP**

Data-sharing options between WIC and MHCP are currently fairly limited because WIC has no centralized data collection. Also, receipt of WIC benefits provides relatively little information about a child's potential eligibility for MHCP given the difference in income limits and non-financial eligibility factors. However, the WIC processes described earlier in this report, together with continued development of the MNCAA initiative, offer opportunities for facilitated enrollment.

- Coordination between WIC and MHCP should be strengthened as much as possible by building on the current effort WIC has undertaken to monitor the progress of WIC enrollees' applications for health care as described in the earlier discussion of the WIC program.
- WIC staff should be encouraged to refer applicants to MNCAA organizations for help in completing the MCHP application process.
- DHS staff could offer basic MHCP training to WIC staff to assist them in making these referrals.

## **Data sharing, data privacy and automated system development**

The lack of a common means of identifying clients across systems, combined with complex data privacy laws and differing interpretations of those laws, pose significant challenges to accurate and efficient data sharing. Some type of central data clearinghouse would provide a framework for addressing these issues.

The SMI project is one possible future avenue. While the SMI currently serves as a clearinghouse only for programs administered by DHS, the success of the recent partnerships between DHS and counties described earlier could in time lead to better coordination not only for DHS-administered programs but also between MCHP and non-DHS programs administered by county agencies.

Finally, the time may be ripe to revisit longstanding data privacy requirements in light of today's technology. The best approach would bring together data privacy and systems experts from all state agencies. This group would be charged with recommending appropriate changes to Minnesota Statutes Chapter 13 and others.

## Summary

Effective coordination and data sharing between the MHCP and other social services programs hinges on several factors, including:

- Common eligibility factors
- Common client identifiers
- Common understanding of legal requirements surrounding data sharing and data privacy
- Vigorous outreach, referral and application assistance programs
- Development and use of technology to assist clients in finding and applying for services that meet their needs

Some of these factors, like establishing common eligibility factors, may be difficult to achieve. However, considerable progress has been made over the years in other areas like outreach and application assistance. In addition, inter-departmental efforts such as those between DHS and MDE for the school lunch program and DHS and the Sage Screening Program continue to identify and address technical issues surrounding effective data exchange. All of these efforts serve the goal of streamlining health care enrollment.

**Report One – Executive Summary**

"Seven Steps Toward State Success in Covering Children Continuously "

National Academy for State Health Policy (NASHP), October 2006

In March 2006, the National Academy for State Health Policy (NASHP) convened a small invitational symposium on child health coverage. The symposium, *Continuously Covering all Kids: State Action and Ideas for the Future*, was supported by the David and Lucile Packard Foundation and the Robert Wood Johnson Foundation.

A select group of state and national public and private sector experts were invited to review progress and generate ideas for further achievements in covering all children and youth continuously. The ideas and perspectives in the conversation included those of state health agencies, foundations, managed care organizations, research groups, and the federal government.

NASHP designed the symposium to have two distinct sets of discussions. During the first half day, participants reviewed and discussed recent progress and remaining barriers for states in reducing numbers of uninsured children and youth. During the second half day, participants generated and discussed ideas about restructuring child health coverage to move closer to a goal of covering all children and youth continuously. NASHP will issue a paper discussing these latter ideas in the future.

Over the past decade, with the implementation of the State Children's Health Insurance Program (SCHIP), expansions in Medicaid, and state and local innovations in outreach, enrollment, and renewal, states have achieved many successes in increasing health coverage for children. The push to enroll children in SCHIP has led to increased enrollment levels in Medicaid as well. Nationally, the rate of uninsurance among children has declined from 15.0 percent in 1997 to 11.2 per-cent in 2005, even as rates of employer sponsored insurance have declined.

Despite this progress, much work still needs to be done to increase the number and proportion of children and adolescents who have health insurance coverage – public or private – on a continuous basis. Disparities in child coverage still exist among socio-economic levels, with children from families with lower incomes experiencing lower rates of insurance. Coverage disparities also exist across racial and ethnic groups. In 2004, 21.1 percent of non-White Hispanic children, 13 percent of Black children, 9 percent of Asian children, and 7.6 percent of non-Hispanic White children were uninsured. A greater percentage of older children also tend to be uninsured compared to younger children, and immigrant children have higher levels of uninsurance than native and naturalized citizen children. Over the past few years, employer-sponsored insurance for children has decreased at a higher rate than for adults. Overall, more than 60% of those children who are uninsured are eligible for public programs such as Medicaid or the State Children's Health Insurance Program (SCHIP), but are not enrolled. Reasons for not

being enrolled can include lack of awareness, difficulty completing the necessary paperwork, or “churning,” which occurs when children are repeatedly dropped and re-enrolled due to short eligibility periods, lengthy re-enrollment processes, and complex paperwork.

This brief summarizes key suggestions which emerged during the symposium discussion about lessons learned over the past decade of state efforts to increase rates of child health coverage. These ideas do not necessarily reflect the opinions of all symposium participants, but rather themes in the discussion. Meeting highlights are supplemented with additional information from the current literature, and examples from states.

## **Report Two – Executive Summary**

### **"Opening Doorways to Health Care for Children"**

#### **The Children's Partnership**

Steadily rising health care costs and an emphasis on voluntary, employer-based health coverage are just two reasons the uninsured continue to pose a significant public policy challenge. Yet, a number of factors make it possible to move the agenda forward by providing health coverage to nearly every American child.

- 1) States and local communities have learned over the last decade how to maximize coverage through Medicaid and SCHIP.
- 2) An overwhelming majority (90%) of the public believes that providing insurance to children is the right thing to do.
- 3) There is bi-partisan support both in Washington, D.C. and the states.
- 4) The price tag is affordable.

According to the most recent data, 8.4 million children under age 18 in America remain uninsured, yet more than 70% of these are eligible for public health coverage. By focusing on these “eligible but uninsured” children, we can cover up to 95% of America’s children. This report sets out a 10-step plan for opening doorways to Medicaid and the State Children’s Health Insurance Program (SCHIP) coverage for all of these eligible children. The enrollment doorway approach will

- Increase and make routine families’ access to enrollment opportunities;
- Streamline the administration of public health insurance programs;
- Broaden eligibility minimally to help the system make administrative sense; and
- Assure program integrity so only eligible children obtain insurance.

#### **Health Insurance Matters to Kids**

Children who have no health insurance are less likely to receive appropriate health care when they need it. This situation increases the likelihood of avoidable hospitalizations and unnecessary emergency room visits, both of which are expensive. Meanwhile, children whose health coverage is conditioned upon jumping bureaucratic hurdles are regularly dropped from coverage—most of them only to re-enroll soon thereafter at great public expense and inconvenience. These inefficiencies just do not make sense.

The United States needs a public health insurance enrollment structure that is designed to keep children covered, not one that aims to keep them out. With such a structure, everyone benefits: the children who are healthier and better able to learn; the children who surround these healthier, more productive members of society; the families who are relieved of the stress of not knowing how to get their children the help they need; and society at large—which currently pays heavily, though indirectly, for all the inefficiencies in the system.

## **Learning from Our Mistakes**

Since the introduction of SCHIP nearly ten years ago, extensive effort has been made to reach and enroll eligible but uninsured children in all available health insurance programs. And, yet, nearly 6 million of these children remain uninsured. Looking at this experience, there are some obvious conclusions that should be factored into any solutions that are developed.

First, it is clear that outreach and enrollment assistance are not enough to reach and enroll these children. Second, major administrative and technological inefficiencies burden the public health insurance system and keep it from moving into the modern era. Third, failure to retain children in the system means that they lack continuity of care while also saddling the program with the cost of re-enrolling them later. Fourth, because children's health coverage depends so heavily on states' economies, funding for the system is less stable than it needs to be.

## **Ten Steps to Create an Effective Enrollment Doorway System**

This report lays out a plan for creating a series of enrollment doorways that make enrollment and renewal both routine and timely—as close to automatic as possible. The following steps require a combination of both state and federal action, as discussed at greater length in the report.

- 1. Enroll children into Medicaid and SCHIP through multiple doorways to ensure maximum efficiency and greatest reach.* A system of enrollment doorways will give low-income families the opportunity to enroll their children in public coverage at convenient public access points that are a routine part of their lives (including schools, hospitals, and certain means-tested public program application spots).
- 2. Institute a one-stop process for establishing eligibility that also provides immediate coverage to children.* When a family enters these designated public access points (the doorways), the family already provides information that can initiate an application for Medicaid or SCHIP. Under the enrollment doorway system, the family will be able to give limited additional information and receive immediate temporary coverage if uninsured.
- 3. Establish a mechanism for income evaluation that eliminates unnecessary documentation, creates system efficiencies, and maintains program integrity.* Under an enrollment doorway system, the eligibility evaluation will proceed ex parte, without requiring any action from a large portion of families, through greater coordination of the information already held by government agencies.
- 4. Re-establish coverage for low-income, legal immigrant children who have been cut out of the system.* Since Congress imposed limits on coverage for legal immigrant children in 1996, nearly half of states have opted to insure legal immigrant children with state funds. They have done so for public health reasons, fairness, and because it is very difficult to make eligibility sensible and simple with special rules for certain children. It makes good policy and administrative sense to again authorize eligibility for health insurance for all legal immigrant children.

5. *Redefine Medicaid/SCHIP immigration rules to allow the social security number to establish qualifying status for children.* In order to obtain a social security number, families already present proof of legal immigration status and/or citizenship to the Social Security Administration (SSA), which verifies that information through the same channels currently used by Medicaid and SCHIP. The streamlined enrollment doorway system would take advantage of the effort already made by the SSA, allowing the presentation of the social security number to establish that a child is of eligible immigration or citizenship status. The new federal policy enacted as part of the Deficit Reduction Act of 2005 imposes new documentation requirements of United States citizenship. Although the guidelines have yet to be issued, this new requirement could make enrollment more complicated and runs counter to efforts to streamline bureaucratic enrollment hurdles.

6. *Establish a renewal system that encourages uninterrupted participation of eligible children in Medicaid/SCHIP.* At each periodic encounter with a doorway, a family should have the opportunity to renew coverage, just as it has the opportunity to enroll—with the difference being that renewal will be accomplished by updating any change of circumstances, building upon the information already held in agency databases.

7. *Maintain confidentiality and promote trust.* Efforts to build upon existing relationships that families have with the doorways must enhance, not jeopardize, the trust that is part of that relationship. In addition to maintaining existing confidentiality rules, the use of enrollment doorways will likely require corresponding changes in confidentiality rules at the federal and state levels.

8. *Invest in technology to enhance the interface between doorway programs and Medicaid/SCHIP administrative processes.* The efficiency and success of the enrollment doorway process will depend on achieving the following capabilities in the technology available to agencies:

- Allow privacy-protected data entry and retrieval across agencies;
- Link enrollment doorways directly with Medicaid/SCHIP;
- Automate database review of current health program enrollment; and
- Allow ex parte inquiry by the health agency into available databases.

9. *Maintain employer coverage as a piece of the solution.* Efforts to improve, rather than radically overhaul, the current health insurance system cannot afford to lose employers as crucial providers of affordable dependent coverage. For the public and private insurance systems to work together through the enrollment doorway system, a mechanism must be established that allows Medicaid or SCHIP dollars to be used for the purchase of quality employer-based dependent coverage when an uninsured child passes through the doorway.

10. *Provide sufficient federal funding and incentives to states.* Because states are pushed to the limit by their health care expenditures, the successful implementation of a doorway system will require enhanced funding for planning and technology development as well as reliable funding

for new enrollees. Ideally, to assist states all children enrolled in Medicaid and SCHIP would receive an enhanced federal match, rather than just those in SCHIP.

### **It Is Possible**

Such a simple, family-friendly approach is not a pipe dream but rather an achievable goal that must be built now as part of the unfolding technological revolution in government and the healthcare industry. An effective doorway system will require substantial investment in technology up front, but that investment will support a truly streamlined, interoperable, functional structure and will have financial pay-offs in the form of efficiency and reduced bureaucracy. The enrollment doorway system maintains the integrity of Medicaid and SCHIP while investing in the technology and procedural streamlining that can strengthen the system as a whole.

Though it runs counter to some of the new proposals and policies at the federal level—most particularly, some of the changes enacted in the Deficit Reduction Act of 2005—the enrollment doorway approach in this report grows out of what experience shows will make the greatest difference in insuring children. As such, it builds new efficiency and reaches children who need coverage rather than erecting procedural hurdles that create a need for duplicative bureaucracy.

While some of the streamlining that underlies the doorways system can occur now, the agenda will require some legislative changes as well as dedicated funding—for additional coverage, enrollment assistance, and technology—in order to move forward as a complete system. If 80% of “eligible but uninsured” children were to enroll and remain covered through these doorways, the cost of their coverage would be about \$8.8 billion annually—only \$3.6 billion more than we already spend on medical care for these uninsured children. At least \$1 billion will be required to support this major technology overhaul, as well. Whatever the cost incurred, it will remain a miniscule part of the Medicaid budget, which runs at \$316 billion per year, only 16.5% of which funds children. This investment in an effective enrollment doorway system is worth every penny, because it will improve the health of our health insurance system at the same time that it improves the health of our children.

### **Report Three – Executive Summary**

"Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals"  
Urban Institute/Robert Wood Johnson Foundation, August 2007

“If you build it, they will come,” cannot be the motto of state health reformers. Simply offering health coverage subsidies, even coupled with vigorous outreach and simple application forms, is no guarantee that uninsured residents eligible for subsidies will receive insurance. Without careful attention to enrollment mechanisms, take-up can be slow, endangering a new program’s reputation and even survival before it has a chance to prove itself. More fundamentally, unless eligible people enroll, a health coverage expansion cannot reach its most basic objective of improving access to essential health care.

With a range of public and private benefits, automatic enrollment has achieved great success in quickly reaching a large proportion of the target population. For example:

- Less than six months following its first effective date, Medicare Part D provided low-income subsidies for prescription drug coverage to 74 percent of eligible beneficiaries because subsidies went automatically, without any filing of applications, to all Medicare beneficiaries who received Medicaid or Supplemental Security Income (SSI) the prior year.
- At firms where new workers establish 401(k) accounts by completing application forms, 33 percent enroll. At companies where new employees are placed in 401(k) accounts unless they reject participation by completing “opt out” forms, 90 percent enroll.
- Medicare Part B covers more than 95 percent of eligible seniors by automatically enrolling them and deducting premium payments from their Social Security checks unless, within a certain time after turning 65, the seniors complete forms opting out of coverage.
- By its eighth month of implementation, the new Commonwealth Care program in Massachusetts reached 32 percent of eligible individuals who were limited to traditional enrollment strategies. For an eligibility category where individuals were enrolled based on income information known to the state’s previous uncompensated care program, the total number of enrollees exceeded the state’s estimated size of the entire eligible population – effectively reaching 100 percent take-up.

Similar strategies can help other state-based coverage expansions succeed. Automatic approaches can address three critical functions: identifying the uninsured; determining their eligibility; and enrolling them in coverage. For example:

- States can tap into sources of data about income and coverage that identify uninsured residents who may qualify for subsidies, enrolling them in coverage unless they “opt out.”

- Uninsured schoolchildren can be identified on child health forms that parents complete when their children start school in the fall. For such uninsured children, states can access income data to identify those who appear likely to qualify for Medicaid or the State Children's Health Insurance Program (SCHIP) and provide them with presumptive eligibility, followed by assistance completing forms and transitioning to ongoing coverage. Uninsured children with incomes too high for subsidies can be offered unsubsidized coverage. For example, their parents can be mailed insurance cards that are activated by calling a toll-free number.
- Among both children and adults, the uninsured can be identified when they seek health care, when state income tax forms are filed (particularly in states that offer an Earned Income Tax Credit), when W-4 forms are completed to establish or change wage withholding on the job, when the newly unemployed apply for unemployment compensation, when children age off their parents' insurance policies or Medicaid/SCHIP coverage, and at other key life junctures. When any of these mechanisms identifies an uninsured person, the state can use available data to ascertain potential eligibility for subsidies and facilitate enrollment. As with the approach to children described above, uninsured adults who are ineligible for subsidies can be offered unsubsidized coverage and mailed telephone-activated insurance cards.
- Residents could apply for coverage by providing little more than basic identifying information and allowing the state to access existing data and determine eligibility for coverage.
- When other means-tested programs have already found that an individual has income low enough to qualify for health coverage subsidies, the state could automatically deem that individual income-eligible for such subsidies.
- The state could define eligibility in terms that fit with available data. For example, household income could be determined based on recent quarters of wage earnings data combined with prior-year income tax data about other forms of income, with opportunities for households to come forward and show lower income levels qualifying for larger subsidies. A similar approach is now used to means-test premium subsidies for Medicare Part B.

These are relatively novel strategies in the context of state coverage expansions, and working through the details involves complex challenges. For example, it will be essential to incorporate strong safeguards of privacy and data security into any data-driven enrollment system. States pursuing such systems will also need to be assiduous and creative in maximizing federal matching funds to support development and operation of the necessary information technology.

Rigorous testing of information exchange systems before implementation may need to be coupled with strong early warning systems, phased-in implementation, and clearly designated "rapid response" capacity after implementation to address the possibility of error, particularly during a new program's early days. Despite these and other challenges, pursuing automatic enrollment strategies is worth serious consideration as a key and often-overlooked building block for major health care reforms now being debated in state capitols across the country.

**State Health Care and Social Service Program Coordination  
Social Services Program Summary**

Program Name:

Description:

Address:

Contact (s):

Who administers the program?

Who is eligible for this program?

What services does the program provide?

What are the eligibility rules for the program?

What information do you ask for from applicants?

What is the application process?

Is it manual or automated?

If automated what software or system do you use?

Contact name, phone, and e-mail for this system:

List the other social service or health care programs with which you coordinate and explain.

What other social service or health care programs do you want to coordinate with and what would be the benefit of doing so?

Please provide us with any other information you feel is relevant.

Coordination Options:

Questions/Clarifications/Follow Up:



**Report Two – Specific recommendations for federal law changes**

"Opening Doorways to Health Care for Children"

The Children's Partnership

**Moving Forward**

To implement the ten steps laid out in this report, federal authorities must enact key changes to federal law, set out requirements for states, and establish incentives that then push states to implement their part of the policy effectively. States would be given federal financial support to make these changes, such that in the end, program benefits, maintenance of effort provisions, cost sharing, and the primary make-up of Medicaid and the State Children's Health Insurance Program (SCHIP) would be unchanged.

**Federal Legislative Changes**

States already have the authority to implement a number of the streamlined enrollment procedures that would support an enrollment doorway process. These include the ability to use a shortened application, allow self-certification of income and deductions, and implement presumptive eligibility. In addition, states can already improve technology interfaces, implement some ex parte procedures, and build solid systems for verifying eligibility information.

Unfortunately, no state has taken all these steps to their fullest potential. Under this proposal, states would be required to make all of these changes. Specific federal-level actions would include revising Title XIX and Title XXI of the Social Security Act to:

- Require states to implement an enrollment system through schools, hospitals, and other public programs, utilizing a shortened one-page doorway application, presumptive eligibility, and self-declaration of income;
- Establish new enrollment incentives, including reliable funding for children enrolling through the doorways, as well as enhanced federal support through technology and assistance grants to states, schools, and other public program entities;
- Extend eligibility to legal immigrant children and approving utilization of the social security number in place of immigration documentation; and
- Allow states to utilize the income determination of another public program for Medicaid and SCHIP, regardless of differences in methodology.





Minnesota Department of Human Services

# Minnesota Health Care Programs Income and Asset Guidelines

Effective 7/1/08 through 6/30/09

MAXIS Standard					****				K		G***		E		E		C*		E**	
	MinnesotaCare \$48 Annual Premium		MinnesotaCare Adults without Children		MinnesotaCare Children to Age 21 and Families with Children		MinnesotaCare Covered Services No \$10,000 Inpatient Cap for Parents		MA Infants under Age 2		MA Children – Age 2 through 18		MA Children – Age 19 and 20		MA Adults with Children		MA Pregnant Woman		MA Elderly, Blind, Disabled (No spenddown)	
	150% FPG		200% FPG		275% FPG		175% FPG		280% FPG		150% FPG		100% FPG		100% FPG		275% FPG		100% FPG	
Family Size	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually
1	1,300	15,600	1,734	20,808	2,384	28,608	1,517	18,204	2,427	29,124	1,300	15,600	867	10,404	867	10,404	NA	NA	867	10,404
2	1,750	21,000	2,334	28,008	3,209	38,508	2,042	24,504	3,267	39,204	1,750	21,000	1,167	14,004	1,167	14,004	3,209	38,508	1,167	14,004
3	2,200	26,400	Not Eligible		4,034	48,408	2,567	30,804	4,107	49,284	2,200	26,400	1,467	17,604	1,467	17,604	4,034	48,408	1,467	17,604
4	2,650	31,800	Not Eligible		4,859	58,308	3,092	37,104	4,947	59,364	2,650	31,800	1,767	21,204	1,767	21,204	4,859	58,308	1,767	21,204
5	3,100	37,200	Not Eligible		5,684	68,208	3,617	43,404	5,787	69,444	3,100	37,200	2,067	24,804	2,067	24,804	5,684	68,208	2,067	24,804
6	3,550	42,600	Not Eligible		6,509	78,108	4,142	49,704	6,627	79,524	3,550	42,600	2,367	28,404	2,367	28,404	6,509	78,108	2,367	28,404
7	4,000	48,000	Not Eligible		7,334	88,008	4,667	56,004	7,467	89,604	4,000	48,000	2,667	32,004	2,667	32,004	7,334	88,008	2,667	32,004
8	4,450	53,400	Not Eligible		8,159	97,908	5,192	62,304	8,307	99,684	4,450	53,400	2,967	35,604	2,967	35,604	8,159	97,908	2,967	35,604
9	4,900	58,800	Not Eligible		8,984	107,808	5,717	68,604	9,147	109,764	4,900	58,800	3,267	39,204	3,267	39,204	8,984	107,808	3,267	39,204
10	5,350	64,200	Not Eligible		9,809	117,708	6,242	74,904	9,987	119,844	5,350	64,200	3,567	42,804	3,567	42,804	9,809	117,708	3,567	42,804
Add'l	450	5,400	Not Eligible		825	9,900	525	6,300	840	10,080	450	5,400	300	3,600	300	3,600	825	9,900	300	3,600
Asset Test	No asset test for children.		No asset test for pregnant women and children. \$10,000 for household of one. \$20,000 for household of more than one.				None		None		None		<ul style="list-style-type: none"> <li>Adults with children: \$10,000 for hh of 1</li> <li>\$20,000 for hh of more than 1</li> </ul>		None		<ul style="list-style-type: none"> <li>\$3,000 for a single person</li> <li>\$6,000 for hh of 2, plus \$200 for each dependent</li> </ul>			

FPG = Federal Poverty Guidelines

\* Pregnant Woman – Minimum household size of 2.

\*\* Persons with income over 100% FPG must spend down to 75% FPG.

\*\*\* Children 2–18 with income over 150% FPG must spend down to 100% FPG.

\*\*\*\* Parents with income over \$50,000 are ineligible for MinnesotaCare.

**Note: Income and asset guidelines change. Use this chart for general reference only. Refer to the Minnesota Health Care Programs Manual for the most current information.**

Next →

**Minnesota Health Care Programs Income and Asset Guidelines** Effective 7/1/08 through 6/30/09

MAXIS Standard	F		U*****		Q*****		W*****		S*****		H		H		V				
	Transition Year MA		MA Qualifying Individuals (QI)		MA Qualified Medicare Beneficiaries (QMB)		MA Qualified Working Disabled Individuals (QWD)		MA Service Limited Medicare Beneficiaries (SLMB)		MA Elderly, Blind, Disabled (with a Spenddown)		GAMC		GAMC Hospital Only Above 75% FPG		Family Planning Program		MA for Employed Person with Disabilities (MA-EPD)
Family Size	185% FPG		135% FPG		100% FPG		200% FPG		120% FPG		75% FPG		75% FPG		to 175% FPG		200% FPG		To qualify for MA-EPD, an individual must: <ul style="list-style-type: none"> <li>• Be certified disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT).</li> <li>• Be 16 to 65 years of age.</li> <li>• Be employed and have required taxes withheld or paid from earned income.</li> <li>• Have monthly earnings of more than \$65.</li> <li>• Meet the MA-EPD asset limit of \$20,000 per enrollee.</li> <li>• Pay a premium and</li> <li>• Pay an unearned income obligation, if required.</li> </ul>
	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	Monthly	Annually	
<b>1</b>	1,604	19,248	1,190	14,280	887	10,644	1,754	21,048	1,060	12,720	650	7,800	650	7,800	1,517	18,204	1,734	20,808	
<b>2</b>	2,159	25,908	1,595	19,140	1,187	14,244	2,354	28,248	1,420	17,040	875	10,500	875	10,500	2,042	24,504	2,334	28,008	
<b>3</b>	2,714	32,568	2,000	24,000	1,487	17,844	2,954	35,448	1,780	21,360	1,100	13,200	1,100	13,200	2,567	30,804	2,934	35,208	
<b>4</b>	3,269	39,228	2,405	28,860	1,787	21,444	3,554	42,648	2,140	25,680	1,325	15,900	1,325	15,900	3,092	37,104	3,534	42,408	
<b>5</b>	3,824	45,888	2,810	33,720	2,087	25,044	4,154	49,848	2,500	30,000	1,550	18,600	1,550	18,600	3,617	43,404	4,134	49,608	
<b>6</b>	4,379	52,548	3,215	38,580	2,387	28,644	4,754	57,048	2,860	34,320	1,775	21,300	1,775	21,300	4,142	49,704	4,734	56,808	
<b>7</b>	4,934	59,208	3,620	43,440	2,687	32,244	5,354	64,248	3,220	38,640	2,000	24,000	2,000	24,000	4,667	56,004	5,334	64,008	
<b>8</b>	5,489	65,868	4,025	48,300	2,987	35,844	5,954	71,448	3,580	42,960	2,225	26,700	2,225	26,700	5,192	62,304	5,934	71,208	
<b>9</b>	6,044	72,528	4,430	53,160	3,287	39,444	6,554	78,648	3,940	47,280	2,450	29,400	2,450	29,400	5,717	68,604	6,534	78,408	
<b>10</b>	6,599	79,188	4,835	58,020	3,587	43,044	7,154	85,848	4,300	51,600	2,675	32,100	2,675	32,100	6,242	74,904	7,134	85,608	
<b>Add'l</b>	555	6,660	405	4,860	300	3,600	600	7,200	360	4,320	225	2,700	225	2,700	525	6,300	600	7,200	
<b>Asset Test</b>	None		• \$10,000 for a single person • \$18,000 for hh of 2		• \$10,000 for a single person • \$18,000 for hh of 2		• \$4,000 for a single person • \$6,000 for hh of 2		• \$10,000 for a single person • \$18,000 for hh of 2		• \$3,000 for a single person • \$6,000 for hh of 2, plus \$200 for each dependent		• \$1,000 per household		• \$10,000 for hh of 1 • \$20,000 for hh of more than 1		None		• \$20,000 per enrollee

\*\*\*\*\* \$20 disregard is included in totals

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.







## Minnesota Health Care Programs

# Minnesota Community Application Agent Participants

The following organizations are available to help people complete the Minnesota Health Care Programs application. These organizations are referred to as Minnesota Community Application Agents (MNCAs).

Anoka County	Big Stone County	Chippewa County
<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>	<p><b>Prairie Five Head Start</b> PO Box 166 Madison, MN 56256 (320) 598-3118</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>	<p><b>Prairie Five Head Start</b> PO Box 166 Madison, MN 56256 (320) 598-3118</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>
	Carlton County	
	<p><b>Lake Superior Community Health Center</b> 4325 Grand Ave Duluth, MN 55807 (218) 722-1497 www.lschc.org</p>	Chisago County
		<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p>
Becker County	Carver County	<p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>
<p><b>Birthright of Fargo Moorhead</b> 512 Center Ave, Suite D Moorhead, MN 56560 (701) 237-0359</p> <p><b>Lakes and Prairies Community Action</b> 715 11th St N, Suite 402 Moorhead, MN 56560 (218) 299-7000 www.lakesandprairies.net</p>	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>South Lake Pediatrics</b> 17705 Hutchins Drive #250 Minnetonka, MN 55345 (952) 401-8282</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>	
Benton County		Clay County
<p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>		<p><b>Birthright of Fargo Moorhead</b> 512 Center Ave, Suite D Moorhead, MN 56560 (701) 237-0359</p> <p><b>Lakes and Prairies Community Action</b> 715 11th St N, Suite 402 Moorhead, MN 56560 (218) 299-7000 www.lakesandprairies.net</p>

Clearwater County	Goodhue County	
<p><b>Inter-County Community Council Head Start</b> PO Box 189 Oklee, MN 56742 (218) 796-5144</p>	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Northfield Community Action Center</b> 1651 Jefferson Parkway HS 200 Northfield, MN 55057 (507) 664-3550</p> <p><b>Regina Medical Center</b> 1175 Nininger Road Hastings, MN 55033 (651) 480-4132</p>	<p><b>Hennepin Care North</b> 6601 Shingle Creek Parkway Suite 400 Brooklyn Center, MN 55430 (612) 873-8818</p> <p><b>Hennepin Care South</b> HUB Shopping Center 44 West 66th Street Richfield, MN 55423 (612) 873-8220</p>
Crow Wing County		<p><b>Indian Health Board</b> 1315 E 24th St Minneapolis, MN 55404 (612) 721-9800 www.ihb-mpls.org</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>Sabathani Community Center</b> 310 E 38th Street Minneapolis, MN 55409 (612) 238-2390</p> <p><b>South Lake Pediatrics</b> 17705 Hutchins Drive #250 Minnetonka, MN 55345 (952) 401-8282</p> <p><b>Southside Dental Clinic</b> 4243 4th Ave S Minneapolis, MN 55409 (612) 822-9030 www.southsidechs.org</p> <p><b>Southside Medical &amp; Eye Clinic</b> 4730 Chicago Ave S Minneapolis, MN 55407 (612) 822-3186 www.southsidechs.org</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>
<p><b>Tri-County Community Action</b> 501 LeMieur Street Little Falls, MN 56345 (320) 632-3691 www.tccaction.com</p>	Hennepin County	
Dakota County	<p><b>Aspire Insurance Agency</b> 14173 Flagstone Trail Apple Valley, MN 55125 (952) 891-5864 www.aspireinsurance.biz</p> <p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Northfield Community Action Center</b> 1651 Jefferson Parkway HS 200 Northfield, MN 55057 (507) 664-3550</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>Regina Medical Center</b> 1175 Nininger Road Hastings, MN 55033 (651) 480-4132</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>	
<p><b>Aspire Insurance Agency</b> 14173 Flagstone Trail Apple Valley, MN 55125 (952) 891-5864 www.aspireinsurance.biz</p> <p><b>Center for Africans New to America (CANA)</b> 3333 4th St N Minneapolis, MN 55412 (612) 276-1535</p> <p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>City South Cluster Ministries</b> 3751 17th Ave S Minneapolis, MN 55407 (612) 728-9221</p> <p><b>Green Central Medical Clinic</b> 324 East 35th Street Minneapolis, MN 55408 (612) 827-7181 www.southsidechs.org</p> <p><b>HCMC Family Medical Center</b> 5 West Lake Street Minneapolis, MN 55408 (612) 545-9000</p> <p><b>Hennepin Care East</b> 2700 East Lake Street Minneapolis, MN 55406 (612) 873-8120</p>		

<b>Isanti County</b>	<b>Meeker County</b>	<b>Ramsey County</b>
<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530  <b>City South Cluster Ministries</b> 3751 17th Ave S Minneapolis, MN 55407 (612) 728-9221  <b>Indian Health Board</b> 1315 E 24th St Minneapolis, MN 55404 (612) 721-9888  <b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org  <b>Safezone – Face to Face</b> 1165 Arcade Street St. Paul, MN 55106 (651) 772-5555  <b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org
<b>Kandiyohi County</b>	<b>Mille Lacs County</b>	
<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	
<b>Lac Qui Parle County</b>	<b>Morrison County</b>	
<b>Prairie Five Head Start</b> PO Box 166 Madison, MN 56256 (320) 598-3118  <b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org  <b>Tri-County Community Action</b> 501 LeMieur Street Little Falls, MN 56345 (320) 632-3691 www.tcccaction.com	
<b>Lake County</b>	<b>Norman County</b>	
<b>Lake Superior Community Health Center</b> 4325 Grand Ave Duluth, MN 55807 (218) 722-1497 www.lschc.org	<b>Lakes and Prairies Community Action</b> 715 11th St N, Suite 402 Moorhead, MN 56560 (218) 299-7000 www.lakesandprairies.net	
<b>Lincoln County</b>	<b>Pennington County</b>	
<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>Inter-County Community Council Head Start</b> PO Box 189 Oklee, MN 56742 (218) 796-5144	
<b>Lyon County</b>	<b>Polk County</b>	<b>Red Lake County</b>
<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org	<b>Inter-County Community Council Head Start</b> PO Box 189 Oklee, MN 56742 (218) 796-5144	<b>Inter-County Community Council Head Start</b> PO Box 189 Oklee, MN 56742 (218) 796-5144
		<b>Renville County</b>
		<b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org

Rice County	Scott County	Swift County
<p><b>HealthFinders Collaborative, Inc.</b> PO Box 731 Northfield, MN 55057 (507) 696-3013</p> <p><b>Northfield Community Action Center</b> 1651 Jefferson Parkway, HS 200 Northfield, MN 55057 (507) 664-3550 www.northfieldcac.org</p> <p><b>Regina Medical Center</b> 1175 Nininger Road Hastings, MN 55033 (651) 480-4132</p>	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>South Lake Pediatrics</b> 17705 Hutchins Drive #250 Minnetonka, MN 55345 (952) 401-8282</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>	<p><b>Prairie Five Head Start</b> PO Box 166 Madison, MN 56256 (320) 598-3118</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>
		Todd County
		<p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p> <p><b>Tri-County Community Action</b> 501 LeMieur Street Little Falls, MN 56345 (320) 632-3691 www.tcccaction.com</p>
St. Louis County	Sherburne County	Washington County
<p><b>Aspire Insurance Agency</b> 14173 Flagstone Trail Apple Valley, MN 55125 (952) 891-5864 www.aspireinsurance.biz</p> <p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Lake Superior Community Health Center</b> 4325 Grand Ave Duluth, MN 55807 (218) 722-1497 www.lschc.org</p>	<p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>Portico Healthnet</b> 2610 University Ave W, Suite 550 St. Paul, MN 55114 (651) 603-5100 (866) 430-5111 www.porticohealthnet.org</p> <p><b>Regina Medical Center</b> 1175 Nininger Road Hastings, MN 55033 (651) 480-4132</p> <p><b>St. Croix Medical Clinic</b> 5640 Memorial Ave N, Suite B Stillwater, MN 55082 (651) 430-1880 www.southsidechs.org</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>
	Stearns County	
	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p> <p><b>Vietnamese Social Services</b> 1159 University Ave, Suite 100 St. Paul, MN 55104 (651) 644-1317 www.vssmn.org</p>	

Wilkin County	Wright County	Yellow Medicine County
<p><b>Birthright of Fargo Moorhead</b> 512 Center Ave, Suite D Moorhead, MN 56560 (701) 237-0359</p> <p><b>Lakes and Prairies Community Action</b> 715 11th St N, Suite 402 Moorhead, MN 56560 (218) 299-7000 www.lakesandprairies.net</p>	<p><b>Children's Dental Services</b> 636 Broadway Street NE Minneapolis, MN 55413 (612) 746-1530</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p> <p><b>South Lake Pediatrics</b> 17705 Hutchins Drive #250 Minnetonka, MN 55345 (952) 401-8282</p>	<p><b>Prairie Five Head Start</b> PO Box 166 Madison, MN 56256 (320) 598-3118</p> <p><b>St. Cloud Area Legal Services</b> PO Box 866 St. Cloud, MN 56302 (320) 253-0121 www.midmnlegal.org</p>

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