Open Enrollment and Online Application Process

Health Care Eligibility and Access

January 2010

Legislative Report

Minnesota Department of **Human Services**

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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 $5,690.14 for staff salaries and materials was spent to prepare this report.

EXECUTIVE SUMMARY

Despite extensive school-based and other outreach efforts, Minnesota still has a significant number of uninsured children who, though potentially eligible for Minnesota's public health care programs (MHCP), remain unenrolled and uninsured. Recognizing the importance of ensuring access to primary care for the state's children the 2009 Legislature directed the commissioners of DHS and MDE to work together to improve the application and enrollment process for Medical Assistance (MA) and MinnesotaCare and to provide recommendations for an open enrollment process that is coordinated with the public education system.

To prepare the report, DHS and MDE staff, aided by a broad-based advisory group, analyzed both past and ongoing efforts in Minnesota and other states to improve coordination between schools and health care program enrollment agencies. This analysis identified both successful strategies and those that encountered barriers. The two agencies used this analysis to develop short-term strategies that can be implemented by the August 2010 target date specified in the legislation and to lay the groundwork for a five-year vision for continued collaboration between DHS and the educational system to enroll public school students in MHCP.

The project team crafted the following definition of "open enrollment" in the context of this legislation to guide their work:

> A coordinated effort between DHS and the public school system to provide a simplified MHCP application process for children.

Many strategies that other states use to promote health care enrollment through the schools, such as media campaigns, outreach events and working with community organizations to provide application assistance, are similar to those currently active in Minnesota. Others, such as automatically enrolling children eligible for the School Lunch Program into public health care programs—a process sometimes known as Express Lane Eligibility, or ELE-- would require further legislative authority, additional financial resources, and extensive changes to automated eligibility systems to implement successfully. An earlier Minnesota pilot test of ELE, under

current statutory authority, had limited success due in large part to significant differences in data requirements between the programs.

Generally, the most successful approaches have centered on establishing partnerships between school staff and existing community organizations that help families complete the health care program application process. Such efforts have involved school nurses, early childhood screening programs, and Head Start, among others.

The Minnesota Community Application Assistance (MNCAA) program, established through legislation passed in 2007, currently offers application assistance to residents of all 87 Minnesota counties. As of September 2009, 84 MNCAAs known as "Level I" organizations provide individuals and families with comprehensive assistance throughout the application process, from completing the application form through receiving an eligibility determination from the county agency or MinnesotaCare Operations. The DHS MNCAA Resource Center provides support to MNCAA staff and issues a $25 payment for each successful enrollment. As of September 30, 2009, the MNCAA program has paid for 9,489 successful enrollments.

Because the MNCAA structure already exists and shows early signs of success, it will be a key component of renewed partnership efforts between MCHP and the public education system. DHS and MDE will work to establish a pilot program by August 2010 in which one or more school districts with high rates of uninsured children will test various approaches to reaching uninsured families and enrolling children in MHCP. The central focus will be on providing comprehensive application assistance through the school setting. Districts or individual schools may choose to become certified by DHS as a MNCAA organization and provide application assistance themselves, or to establish a partnership with an existing MNCAA in their area. Based on the success of the pilot project(s), similar partnerships may be expanded throughout the state.

As part of the ongoing effort to streamline the application process, a new online health care application and a shortened Children's Only Application are both scheduled for release in summer 2010.

Over the next several years, DHS, in coordination with MDE, plans to continue targeted activities to improve access to MHCP for all children who are eligible for and whose families want coverage through these programs. Chief among these will be building on the successes of the pilot project and, especially, continuing to encourage partnerships between the public education system and the MNCAA program. Other key areas of focus include promoting the soon-to-be released online and Children's Only applications; exploring new web-based and other

technologies to share health care information with families; and working to better identify and overcome barriers to effective data-sharing between school-based and health care programs.

Ideally, these efforts will ensure that all educational settings are able to provide families with information on health care options and sufficient assistance with the application process to result in successful enrollment.

INTRODUCTION

While Minnesota has an enviably low rate of uninsured residents, there are still children who may be eligible for, but not enrolled in, Minnesota Health Care Programs (MHCP). The school system offers an avenue for reaching uninsured families and helping them to enroll successfully in the MHCP. The Legislature has enacted previous requirements designed to capitalize on this partnership. For example, public and private elementary schools in which at least twenty-five percent of the students receive free or reduced price lunches must make available applications and application assistance for Minnesota Health Care Programs. [1]

The 2009 legislature directed the commissioners of DHS and the Minnesota Department of Education (MDE) to expand their cooperative efforts to enroll eligible uninsured children in MHCP, specifically:

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

(a) The commissioner and local agencies working in partnership must develop a streamlined and efficient application and enrollment process for medical assistance and MinnesotaCare enrollees that meets the criteria specified in this subdivision.
(b) The commissioners of human services and education shall provide recommendations to the legislature by January 15, 2010, on the creation of an open enrollment process for medical assistance and MinnesotaCare that is coordinated with the public education system. The recommendations must:
(1) be developed in consultation with medical assistance and MinnesotaCare enrollees and representatives from organizations that advocate on behalf of children and families, low-income persons and minority populations, counties, school administrators and nurses, health plans, and health care providers;
(2) be based on enrollment and renewal procedures best practices;
(3) simplify the enrollment and renewal processes wherever possible; and
(4) establish a process:
(i) to disseminate information on medical assistance and MinnesotaCare to all children in the public education system, including prekindergarten programs; and
(ii) for the commissioner of human services to enroll children and other household members who are eligible.

The legislation further directed that:

[1] See Minn. Stat. § 256L.05 subd. 1.

The commissioner of human services in coordination with the commissioner of education shall implement an open enrollment process by August 1, 2010, to be effective beginning with the 2010-2011 school year.
(c) The commissioner and local agencies shall develop an online application process for medical assistance and MinnesotaCare.
(d) The commissioner shall develop an application that is easily understandable and does not exceed four pages in length.
(e) The commissioner of human services shall present to the legislature, by January 15, 2010, an implementation plan for the open enrollment period and online application process.

Laws of MN 2009, Chapter79, Article 5, Section 60

To prepare the report, DHS and MDE staff analyzed both past and ongoing efforts to improve coordination between schools and health care program enrollment agencies, identifying both successful strategies and those that encountered barriers. This analysis was used to develop short-term strategies that can be implemented by the August 2010 target date specified in the legislation and to lay the groundwork for a five-year vision for continued collaboration between DHS and the educational system to enroll public school students in MHCP.

BACKGROUND

Minnesota offers two primary health care programs for children: Medical Assistance (MA) and MinnesotaCare.

Medical Assistance

Medical Assistance is the largest of Minnesota's publicly funded health care programs for children under age 21. Jointly financed by the state and federal government, MA provided coverage for over 323,500 children in calendar year 2009.

Children in families with incomes under a specified limit are eligible for MA if they meet other program requirements.[2] Children whose family income exceeds the applicable limit may "spenddown" to achieve eligibility by incurring medical expenses equal to the difference between the family's net countable income and the income limit.

MA can provide retroactive coverage for up to three months before the date of application. Individuals eligible for MA can also have other health insurance (such as employer-sponsored coverage) and MA may pay the cost of the other health insurance if it is determined to be cost effective.

MA covers a wide range of services including physician visits, hospitalizations, mental health services, and prescription drugs.

MinnesotaCare

MinnesotaCare offers health care coverage to individuals and families who do not have access to affordable health insurance. MinnesotaCare covered approximately 39,500 children in calendar year 2009. Like MA, MinnesotaCare for families and children is jointly financed by the state and federal government.

To be eligible for MinnesotaCare, children must live in Minnesota, be U.S. citizens or have an eligible immigration status, and in most cases not have current health insurance coverage available or have had access to other health insurance in the last four months. There are some exceptions to the insurance requirements for children in low-income families. Family income

[2] Other program requirements for children include but are not limited to providing or applying for a Social Security number; being a resident of Minnesota; and being a U.S. citizen or a documented immigrant with a status that qualifies for either federally or state-funded MA.

must be within specified limits depending on household size. All MinnesotaCare enrollees must also pay monthly premiums based on household income and number of individuals covered.

MinnesotaCare has separate benefit sets for children/pregnant women and adults. The benefit set for children and pregnant women is identical to the MA benefit set.

MCHP enrollment and schools

Although actual eligibility determination and enrollment is limited to county and DHS staff, numerous other entities assist applicants by providing application forms, helping clients complete the forms and obtain needed verification, and submitting the completed application to the appropriate state or county agency. Families can apply for MHCP by completing a Minnesota Health Care Programs Application, or a Combined Application Form, and submitting it to their local county agency or to DHS MinnesotaCare Operations.

Many community and government agencies offer varying degrees of application assistance. For example, the Minnesota Community Application Agent (MNCAA) program, described in detail later in this report, provides incentives for organizations that directly identify and assist potential MHCP enrollees in completing and submitting their applications.

The school setting provides an opportunity to reach some families whose children may be eligible but not actually enrolled and to help them successfully enroll. Many children enrolled in the public school system, including pre-kindergarten programs, are eligible for MA, MinnesotaCare, or both. Public and private elementary schools in which at least twenty-five percent of the students receive free or reduced price lunches must make available applications and application assistance for Minnesota Health Care Programs. [3]

The importance of identifying and reaching out to uninsured children and their families is magnified by today's economic climate. The current recession and resulting increase in unemployment means that more families are losing their employer-based health coverage and may be unable to afford coverage, (including COBRA extensions), without assistance. Some of these families may be unfamiliar with the options offered through MHCP. Further, they may be uncertain how to begin the application process, or may be reluctant to apply because of a perceived stigma attached to publicly funded health care. Since most of the families likely include children enrolled in pre-K through high school programs, enhanced school-based outreach may be an effective way to reach them.

[3] See Minn. Stat. § 256L.05 subd. 1.

The recommendations in this report focus on additional outreach and targeted assistance efforts designed to enroll children and families in MHCP, including pre-kindergarten and Head Start programs, under existing MHCP eligibility policies and procedures. Any successful strategy requires building solid connections between DHS, community organizations that assist MHCP applicants, individual school districts, and school staff such as nurses who deal directly with children's health issues. One key component of the overall vision is expanding existing outreach efforts, such as the Minnesota Community Application Agent (MNCAA) program, which has already made significant progress in building those solid connections.

Because this legislation does not provide DHS with the authority to change eligibility policies or to align eligibility policies across MHCP, these issues are not addressed in the report. A separate legislative report due on September 15, 2010, will include recommendations on aligning MA and MinnesotaCare eligibility policies and processes which, if enacted, may further facilitate future coordination with schools and MHCP enrollment.

METHODOLOGY

To prepare this report and design an implementation strategy, the DHS Health Care Eligibility and Access (HCEA) Division worked with MDE to establish a project team. The team's first task was to craft the following definition of "open enrollment" in the context of this legislation:

> A coordinated effort between DHS and the public school system to provide a simplified Minnesota Health Care Programs application process for children.

With this definition in mind, the team completed the following activities:

- **Established a legislative implementation advisory group** to provide input on the project through the August 2010 target implementation date. The group will continue to monitor progress and assist in further developing and implementing the five-year vision discussed later in this report.

  The group currently includes representatives from the following state and county agencies and community organizations:

  DHS
  - MinnesotaCare Operations
  - Cash and Food Support

  MDE
  - Food and Nutrition Services
  - Early Learning
  - Government Relations

  County Agencies
  - Anoka
  - Hennepin
  - Pope

- Ramsey

Community organizations representing enrollees and applicants

- Portico Healthnet
- Legal Services Advocacy Project
- TakeAction Minnesota
- Children's Defense Fund, Minnesota

Health care providers/health plans

- Minnesota Council of Health Plans
- Allina Hospitals and Clinics
- West Side Community Health Services

Educational organizations

- St. Paul Public Schools
- Minnesota Association of School Administrators
- Minnesota School Boards Association

DHS plans to expand group membership over the next year to include broader representation from Greater Minnesota, low-income and diverse populations, and the education system.

- **Identified project parameters and limitations, including:**

  - Limits of current policy and procedure
  - The constraints of available data and data-sharing regulations

  These issues are discussed in more detail later in this report.

- **Reviewed national best practices** to effectively enroll school-aged children in Medicaid programs. These are described in the following section.

- **Reviewed previous Minnesota efforts** to coordinate MHCP enrollment with the school system, as well as other selected outreach efforts. These findings are described in the "Historical Efforts" section of this report.

- **Analyzed and recorded the progress of current efforts,** including MNCAA and the development of online and children-only MHCP applications.

- **Developed implementation strategies** for both short-term (August 2010) and long-term coordination of enrollment efforts between DHS and the educational system, described in the conclusion of this report.

NATIONAL BEST PRACTICES

As a starting point, project staff reviewed strategies used by other states to effectively enroll pre-kindergarten and school-aged children in Medicaid programs, with an emphasis on school-based outreach efforts.

Programs varied from state to state, but common strategies involved:

- media campaigns
- outreach events
- application assistors who assist individual families in completing the application process
- elimination of required verifications for children
- simplified application forms that eliminated questions that do not apply to children's eligibility
- presumptive eligibility (approving coverage based on information provided on the application form, postponing verification)
- financial incentives for application assistors and other organizations based on applications submitted
- information on health care programs provided with the School Lunch Program application
- automatic eligibility for health care coverage to students who qualified for the School Lunch Program
- county or state agency staff available at schools to accept and process health care applications

In many projects, school staff either acted as application assistors themselves or worked with other organizations to reach families and provide application assistance.

One of the challenges in evaluating these approaches has been finding specific evidence documenting their success. As we move forward with implementation of this project, we will continue researching best practices and results while refining our own method for enrolling MHCP-eligible children and their families. Many strategies may require legislative changes or additional funding. Project staff will work with the Legislative Implementation Advisory group

and other DHS staff to identify opportunities to simplify the enrollment process and facilitate cooperation between MHCP and the public school system.

HISTORICAL COORDINATION EFFORTS IN MINNESOTA

DHS has collaborated with MDE and individual school districts in past efforts to increase enrollment of eligible children in MHCP. These initiatives are described below.

School Nurse Partnership

In 2000, DHS facilitated a partnership between school nurses and outreach agencies in order to reach uninsured children. The School Nurse Organization of Minnesota had identified the issue of uninsured Minnesota children as a top priority and welcomed this initiative. DHS conducted statewide workshops for school nurses, public health nurses and Early Childhood Health and Developmental Screening staff that included:

- Overview of MHCP and application processes.
- Information on other resources that could assist with enrolling children in MHCP.
- Introductions to outreach agency staff serving the same geographical area. This allowed outreach workers and school staff to develop referral processes to identify uninsured children and assist with the MHCP enrollment process.

While a majority of school districts employ licensed nurses or contract with public health nurses for nursing services, licensed school nurses or public health nurses are not present in all school districts throughout the state.

Early Express Lane Eligibility (ELE) Efforts

DHS conducted a pilot ELE project with 13 school districts in May and June 2002. Then, as now, there was no statutory authority to automatically enroll children who participated in the School Lunch Program into MHCP. Therefore, this project was aimed at contacting families of these children and streamlining the enrollment process.

The first step was to have school districts provide DHS with a data file of children eligible for the School Lunch Program. The data file was then matched against health care eligibility records to identify those who were currently enrolled in a Minnesota health care program. Approximately 71% were determined to be currently enrolled.

Families of the 29% of children who were not currently enrolled in MHCP were sent an application. A total of 13,671 applications were mailed during the project period with a return rate of .04%. The project identified 279 children who were enrolled into a Minnesota health care program as a direct result of the pilot.

Building Bridges: Improving Health Care Coverage for Young Children and their Families through Early Childhood Screening

The Building Bridges project was a collaboration among MDE, DHS, the Minnesota Department of Health (MDH) and the Children's Defense Fund as a result of a 2002-2003 technical assistance grant from the Council of Chief State School Officers. The purpose was to improve the lives of children in low-income families by providing assistance with enrollment in MHCP through the school system. The goal of the project was to increase health insurance coverage rates for an identified, targeted group of children participating in the Minnesota Early Childhood Health and Developmental Screening Program (Screening). The project examined whether partnerships between the Screening program and community-based outreach programs made it easier for families to apply for a MHCP.

Approximately 300 children participated in the study. Application assistance was provided by bi-lingual outreach staff from a community-based program at the location of the Screening or immediately following the Screening. The on-site outreach staff in the first study group provided direct assistance to families seeking coverage by screening for potential eligibility for MHCP and providing assistance with an application. Upon receiving family consent, school nurses conducting the Screening in the second study group faxed a family's health care coverage request to health care outreach staff at the Children's Defense Fund, who provided follow-up assistance with the application process.

The small study identified the following lessons learned:

- It is important to reach families where they are already seeking services and interacting with familiar and trusted programs.

- Multi-level partnerships are critical for success.

- Different strategies for outreach to families may be necessary dependent upon family needs and community resources.

Outcomes

Some past efforts to partner with school districts have been met with limited success. Others have not generated sufficient data to adequately gauge a project's success. However, these past experiences have helped identify issues to mitigate during future partnership efforts.

Primarily, DHS identified a need for comprehensive and accurate tracking mechanisms to adequately measure the outcomes of outreach initiatives. During the School Nurse Partnership, no processes were established for DHS to track the number of applications received or the number of children enrolled into a Minnesota health care program as a result of this partnership.

This issue was addressed with the ELE project. DHS assigned referral codes to applications sent to families whose children were identified as potentially eligible for MHCP based on data received from the School Lunch Program. Eligibility workers were instructed to enter this referral code in the Minnesota Medical Information System (MMIS) as completed applications were received. This procedure was designed to allow DHS to track the number of children who were enrolled as a result of this initiative. However, as the project progressed, it became clear that there were multiple issues with trying to match school data with MHCP data:

- Differences in the data gathered by school districts compared to that required by MHCP, along with the time and labor required for schools to gather and process the data, meant that DHS did not receive finalized data from the school districts until April of that school year. As a result, many of the applications DHS sent to potentially eligible families were returned for an incorrect address due to the target population's high mobility.

- Data received from the school districts did not include key data elements, primarily a student's or guardian's Social Security number, that would allow DHS to easily identify children who were currently enrolled in a Minnesota health care program. As a result, DHS mailed several applications to households already enrolled—sometimes multiple applications to households with more than one potentially eligible child.

The ELE project did not continue at the end of the pilot period as complex federal and state laws and regulations restricted not only what data could be shared but also when, why, how and with whom it could be shared.

CURRENT ACTIVITIES

Early Childhood Health and Developmental Screening

Prior to enrolling in kindergarten in public school, children are required to complete an Early Childhood Health and Developmental Screening (or comparable screening) provided by Minnesota school districts. Three- to four-year-old children are the target age for screening so that early intervention or other services can be provided at least one year prior to kindergarten entry to improve children's education outcomes. The screening involves a review of health, developmental and other concerns that impede young children's growth, learning, development and subsequent readiness for school. Statutory required components include physical development, speech and language, cognitive skills, hearing, vision and access to health care coverage. Health or educational professionals providing the screening offer information to families seeking health care coverage for their children.

Each year, approximately 60,000 children receive the health and developmental screening through the school district program. Over 20,000 referrals for further educational evaluation or health assessment of potential problems are made annually. In FY 2009, 1,355 children who had no access to health care coverage were referred (2.3% of children screened) to MHCP following the Early Childhood Health and Developmental Screening.

Head Start

The Head Start program provides comprehensive child development services to economically disadvantaged pre-kindergarten children and their families, with a special focus on helping children develop the early reading and math skills they need to be successful in school. In FY 1995, the Early Head Start program was established to serve children from birth to three years of age in recognition of the mounting evidence that the earliest years are critical to children's growth and development.

Head Start programs in Minnesota promote school readiness by enhancing the social and cognitive development of pre-kindergarten children through the provision of educational, health, nutritional, social and other services to enrolled children and families.

One component of the Head Start medical and dental education program is to assist parents in understanding how to enroll and participate in a system of ongoing family health care. Head Start programs in Minnesota fulfill this obligation in a variety of ways including:

- Conducting health education campaigns and health fairs targeted specifically to those who may be eligible for MHCP
- Contacting pregnant women and new parents in Early Head Start about the availability of these programs
- Providing posters, brochures and easily understood multilingual materials about MHCP to Head Start and Early Head Start families
- Informing families about enrollment sites, their hours and locations
- Assisting in assembling the necessary documents for applying for MHCP
- Initiating the MHCP application process and helping with re-determinations or reapplication if needed
- Participating in the MNCAA program to allow families to submit MHCP applications at the Head Start site
- Working with others in the community to address barriers to enrollment encountered by families.

Annual School Notification of the Availability of Minnesota Health Care Programs

Minnesota statute currently requires school districts to provide information annually to all students on the availability of health care coverage through Minnesota's health care programs. Currently, MDE supplies a flier describing MHCP to school districts, which then mail the flier to every student in the district at the beginning of the school year.

Prior to the 2009-2010 school year this statute also required that school districts designate an enrollment specialist to provide application assistance and follow up services to families that indicated interest in Minnesota Health Care Programs. School districts found this requirement to be an unfunded mandate and a heavy burden to the schools, thus this requirement was repealed during the 2009 legislative session.

Third Party Payment

School districts are required under IDEA and Minnesota Statues Section 1125A.21 to seek third party payment from insurers and similar third parties including MHCP for the costs of health and related services provided to a child under an individualized education program

(IEP) that would otherwise be covered by the child's health coverage. School districts are obligated to provide these services to students with disabilities according to their IEP even if third party payment is not received. This financial obligation provides a direct incentive for school districts to refer potentially eligible families to apply for MHCP coverage. MDE provides a flier on MHCP to all school district third party billing coordinators for IEP managers, and special education coordinators to share the information with students and their families during the IEP review process.

McKinney-Vento Homeless Education Act

The federal McKinney-Vento Homeless Education Act requires school districts to provide referrals to homeless children and youth for medical and dental services. Since many homeless families are eligible for MA, MDE strongly encourages school districts to refer these families to their local county human services agency. This information and additional technical assistance for school districts is included on the MDE Website.

Minnesota Community Application Agent (MNCAA) Program

In 2007, state legislation was passed that required DHS to establish an incentive program for organizations that directly identify and assist potential MHCP enrollees in filling out and submitting an application. The legislation directs DHS to pay organizations designated as "Level I" an application assistance bonus of $25 for each applicant successfully enrolled in MHCP.

As of September 30, 2009, 11,369 applications have been received through the Minnesota Community Application Agent (MNCAA) Program. Those 11,369 applications included 16,952 applicants. The MNCAA program has paid for 9,489 successful enrollments in MHCP. MNCAA offers three levels of participation for interested community organizations.

- **Level I** organizations contract with and are certified by DHS to serve as MHCP application sites for people who need help in completing the Minnesota Health Care Programs Application (HCAPP). These organizations identify potentially eligible enrollees and assist them in completing the application and obtaining necessary verifications as well as provide follow-up support until eligibility is determined. These organizations are eligible for the $25 bonus for each successful enrollee.

  Organizations are eligible to participate at Level I if they have connections to uninsured populations and do not already receive state or federal funds for providing application

assistance. Likely sites include hospitals, clinics, community health centers and Head Start programs.

As of September 2009, there were 84 Level I organizations statewide. Level I MNCAA assistance is available to residents of all 87 Minnesota counties.

- **Level II** outreach organizations provide application materials and referrals for further assistance with the process to anyone they encounter who may be uninsured. Some of these organizations may choose to assist applicants in completing the HCAPP but generally do not assist with the entire process. As of September 2009, there were 104 Level II organizations.

- **Level III** outreach organizations promote awareness of the MHCP in the communities they serve at venues like health fairs, group presentations and other community events. These sites do not provide application assistance. There were 330 Level III organizations as of September 2009.

Level II and Level III organizations receive limited support from the DHS MNCAA resource center and are not eligible for the $25 assistance bonus.

The MNCAA resource center at DHS provides direct assistance to Level I MNCAA partners throughout the application process. Key resource center activities include:

- Reviewing completed applications and verifications from the MNCAAs for completeness and forwarding them to the appropriate agency for processing.

- Answering questions from MinnesotaCare Operations and county workers about MNCAA-assisted applications.

- Conducting training sessions for organizations seeking to become MNCAAs.

- Providing two-hour introductory sessions in counties throughout the state to cover basic MHCP information and promote participation in the MNCAA program by community organizations.

- Maintaining information for MNCAAs on the DHS web site. Topics include information about upcoming events and training, contact information for the MNCAA resource center, and links to policy manuals, forms and other tools for MNCAA partners.

- Publishing the "MNCAA Minute," a biweekly update covering resources, best practices, reminders and other valuable information for MNCAA partners. MNCAAs are encouraged to submit suggestions and tips to help their peers.

MNCAA Schools Outreach

Several MNCAA organizations throughout Minnesota have developed health care outreach efforts targeted to individual schools or entire school districts. Most outreach activities are aimed at students from early childhood through high school, with some MNCAA organizations extending the outreach activities to adult basic education students and community colleges.

Outreach methods range from displays at school open houses, health fairs and parent nights to presentations to school nurses and counselors. Some MNCAA organizations station staff on-site during school enrollment days, while others have full-time staff at school resource and enrollment centers. The latter has proved to be a particularly successful strategy because it gives MNCAA staff direct access to families. Depending on the make-up and needs of the school or district, bilingual and culturally competent staff have proven especially effective in reaching out to diverse families.

MNCAA organizations have measured success of the health care programs outreach to schools or school districts by collecting data on the number of referrals from school sources, the number of contacts made at school events, as well as numbers of MHCP eligibility screenings, applications completed, and successful enrollments in a Minnesota health care program.

MNCAA organizations have learned that it is hard to target uninsured students from middle class families because of those families' reluctance to reach out for help. Schools are valuable partners in these situations, because school staff understand the needs of the students and can assist in identifying hard-to-reach students and their families. School nurses can identify students who use school health services as their primary health care because of lack of health insurance.

Additionally, MNCAA organizations have learned that there is no "one-size-fits-all" approach that fits the needs of every school and district. MNCAA staff must be flexible and willing to use different methods and approaches to outreach initiatives and make a concerted effort to understand the school or school district culture to gain and maintain credibility to ensure success and continued cooperation.

The sheer size of some school districts makes building the partnerships necessary for a successful initiative more difficult than with smaller school districts. Securing support from school district administrators and individual school staff is very important to the success of the outreach initiatives. Once the MNCAA organization establishes a relationship with the school district based on mutual trust, collaboration should continue for as long as possible to ensure that referrals, applications, and successful enrollments continue and grow.

On-Line Application

Although DHS provides electronic access to the Health Care Programs Application (HCAPP) via the DHS public website (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3417-ENG), this application cannot be submitted online. The HCAPP allows people to apply for any or all of the Minnesota Health Care Programs on one form. In response to earlier legislation, DHS is designing an online application that will be easily accessible on the Web. This will be a "smart" application that will limit the questions an applicant needs to answer based on the previous answers. For example, men will not be asked if they are pregnant.

The online application will allow potential enrollees to submit their application for MHCP, as well as for Minnesota's cash and food support programs, electronically. The electronic application will be routed to the appropriate county or MinnesotaCare Operations via an Electronic Document Management Services (EDMS) interface. Eligibility will continue to be determined at the state or county level depending on the program(s) requested.

The online application will be available through the new "Health Link" section of the MinnesotaHelp.info site and on the DHS public web site. Both of these sites will include information about Minnesota Health Care Programs. MinnesotaHelp.info will also will include a Live Chat feature for partners, applicants and enrollees to interact directly with health care eligibility staff to have their questions immediately addressed as well as information on accessing non-public health care options.

The site will also include a list of MNCAA organizations available for application assistance arranged by county. This feature will provide school districts that choose to partner with a MNCAA agency with ready access to the list to aid them in referring potential enrollees to an organization that can assist with the application process.

The on-line application is scheduled for implementation by June 30, 2010 (see Appendix A). Future planned enhancements include:

- Electronic submission of signatures and verifications by both applicants and enrollees

- Electronic submission of eligibility renewal forms

- Secure applicant and enrollee log-in accounts

These options will further assist DHS partners in providing direct application and enrollment services to potential and current enrollees.

Children's Only Application

A children's only application will be available by August 1, 2010. The application will focus on the collection of information specific to MHCP eligibility requirements for children, resulting in a shorter application which should in turn decrease effort required to complete an application for MHCP.

CHALLENGES OF DATA COLLECTION AND DATA SHARING

Issues surrounding data collection and data sharing between MDE and DHS have presented challenges to successful implementation of both past and current initiatives. This is particularly true for those projects seeking to streamline health care enrollment of children receiving benefits from the School Lunch Program. Further, a lack of complete and reliable data has made it difficult to gauge the success of various approaches. Although these barriers do not preclude continuing efforts to promote cooperation between schools and MHCP, they limit the development of short-range options and must be considered when developing long-range plans. The primary challenges are outlined below.

Federal and State Regulations on Education Data

As a state educational agency, MDE is bound to follow both state and federal law whenever it collects, maintains, disseminates, or shares educational data. Educational data is any data maintained by an educational agency or institution that is directly related to a student. Educational data is classified as private data, and may not be shared without the consent of the student's parent, or the student if the student is of majority age[4]. Thus, with limited exceptions explicitly allowed under state and federal law, MDE generally cannot disclose private, personally identifiable student or parent data, such as the child or parent/guardian's Social Security Number[5].

None of the exceptions outlined in federal law would permit MDE to share personally identifiable student data with DHS, including for the purpose of facilitating enrollment in MHCP. Minnesota's educational data statute, which largely incorporates the federal provisions, includes an additional exception that could allow schools and MDE to disclose educational data without consent if the disclosure is pursuant to a statute specifically authorizing access to the private data[6]. This provision may allow MDE to disclose educational data in circumstances beyond those specifically permitted by federal education laws. Other federal laws, such as the public health and welfare laws that govern the School Lunch Program, may permit the sharing of data that is otherwise classified as educational data. However, these provisions set up a potential conflict between the state and federal laws that govern educational data. These conflicts should

[4] 20 U.S.C. 1232g, 34 C.F.R. § 99.31 Minn. Stat. § 13.32, subd. 3.
[5] Both state and federal law have established a limited number of exceptions that allow schools to disclose and MDE to re-disclose private educational data without parental consent in specific circumstances. These exceptions generally are found in 99 C.F.R. § 99.31(a) and in Minn. Stat. § 13.32, subd. 3.
[6] Minn. Stat. § 13.32, subd. 3(c).

be considered and addressed if MDE is directed to share data for the purpose of identifying children potentially eligible for MHCP.

In order to ensure full compliance with the laws that govern educational data, a program established to support identification of eligible participants in or enrollment in medical assistance programs ideally would:

- incorporate a consent process at the school level;
- involve sharing only of de-identified data, such as for informing DHS about how to target its identification and enrollment efforts; or
- rely on local school districts to perform responsibilities such as matching individuals or providing communications and outreach about state medical assistance to potentially eligible individuals.

DHS Data Issues and Possible Measures of Success

Existing data will not accurately measure the number of children enrolled through the efforts of proposed coordination activities.

The data that MDE collects and shares, in accordance with state and federal law, does not contain data elements such as social security numbers or address information that would create positive matches with MHCP eligibility systems in order to identify children who are currently enrolled in MHCP.

Currently, DHS eligibility systems can provide only limited data to track the success of the initiatives proposed in this report. Future changes may be possible but are outside the scope of this project. In the interim, other possible measures of success include:

- addition of health care access information on school district websites
- increased number of MNCAA agents working with local schools
- number of applications received through partnerships with schools and school districts
- number of successful enrollments
- number of eligibility denials

DHS will explore further measures as the project progresses.

IMPLEMENTATION STRATEGIES FOR AUGUST 2010

MDE and DHS plan to undertake the following activities by August 2010 to achieve greater coordination between state and local human services agencies and the public school system to enroll eligible children in MHCP.

Pilot project: Targeted outreach and enrollment activities

DHS and MDE will explore the potential for a partnership with one or more school districts with high rates of uninsured children as identified through existing Minnesota Department of Health data, as well as districts with high rates of free or reduced lunch enrollment data. The purpose of the proposed partnership is to test various approaches to reaching uninsured families and enrolling children in MHCP.

Past experience has shown that application assistance for families is the primary component of successful strategies for enrolling children without health care coverage. The MNCAA program exists to provide this assistance and will therefore be the cornerstone of this project. School districts interested in participating in the pilot can choose to either:

- Certify as a MNCAA. Individual staff could be certified at either the district or school level.

- Enter into a partnership with an existing MNCAA organization. DHS would identify MNCAA organizations with a high level of saturation in the area and an interest in participating in the pilot.

Once a MNCAA partner is recruited, local county agency staff will be consulted to determine what impact the pilot project might have on their ability to process applications.

DHS will facilitate discussions among all partners to establish project parameters, including:

- Length of pilot
- Project time line
- Role of each partner
- Specific targeted outreach activities to be conducted
- Evaluation process

The partnership will then be formalized by means of a Memorandum of Agreement among DHS, MDE, the school district, and MNCAA, if applicable. DHS will provide technical assistance, including formal MNCAA training and certification if the school/district chooses this option.

Specific outreach activities conducted as part of the pilot may include:

- Promote MHCP coverage at school events throughout the year to families without coverage who may wish to apply, as well as families who are currently enrolled in an MHCP and need help with the renewal process.

- Provide telephone assistance in completing the application when in-person assistance is not available at the school.

- Provide culturally diverse activities and materials, including written materials in languages other than English, depending on the specific needs of the school or district.

- Determine the feasibility of setting up a work station at the school where families could find application and informational materials, receive help in completing an application, and/or complete and submit an online application. Specific services would depend on available staff and funding for required equipment and supplies.

- Explore additional activities to help enroll children during Early Childhood Health and Developmental Screening programs.

DHS, MDE and partner school districts will work together to determine if a coordinated data-sharing system is possible to target families in districts in which significant numbers of children lack health care coverage. The School Lunch Program application currently asks families if they have coverage and if their private data can be shared with DHS. Working within existing state and federal data-sharing restrictions, the partnership will use this information to develop a "work-around" to assist in identifying potential enrollees.

At the conclusion of the pilot project, partnership staff will produce an evaluation addressing:

- Degree of success of the pilot activities and their potential for expansion in other parts of the state

- Challenges and barriers

- Additional training, support and other resources needed for improved success

- Language and cultural consideration outcomes

The project team will seek similar partnerships with Head Start programs. Pilot activities will be similar to those conducted with K-12 schools but geared toward families of pre-school aged children.

OTHER ACTIVITIES

Review of promotional materials

In addition to the pilot, DHS and MDE will inventory and review existing MHCP materials and formats available to pre-kindergarten and school-aged families in the public school system. Existing materials will be evaluated and if necessary new materials will be developed and other formats explored, based on their potential effectiveness for a given target audience. The results of this review will ensure that the most appropriate materials and formats for each audience are made available.

Web links

DHS and MDE will identify online host sites, such as MN Parents Know, that are likely to be used by uninsured families with pre-kindergarten and school-aged children and that are willing to promote a link to a DHS health care portal. This portal would link to MHCP eligibility information and application materials. Social networking sites will also be explored for potential dissemination of MHCP materials.

These strategies are those that can be accomplished by the August 2010 implementation date established by the legislation. The results will yield valuable lessons as we continue to develop a long-term vision.

FIVE-YEAR VISION

DHS and MDE share the goal of facilitating access to MHCP for all children who are eligible for and whose families want coverage through these programs. Educational settings from pre-K through high school provide a means of reaching virtually all of these children. Ideally, all educational settings would provide information on health care options and sufficient assistance with the application process to result in successful enrollment.

DHS, in partnership with MDE, plans the following activities over the next several years:

- Build on the successes and lessons learned as a result of the pilot open enrollment project.
- Promote the soon-to-be released DHS children's only application, online application and renewal forms.
- Continue to work with an advisory group made up of county staff, community organizations and other stakeholders to guide the development of future efforts.
- Continue to explore efficient processes for sharing data between educational systems and DHS to better identify potentially MCHP-eligible children. Past experience with the ELE pilot shows that attempting to supply DHS with a list of children enrolled in the School Lunch Program has a minimal effect on overall MHCP enrollment. A detailed examination of the available, albeit limited, data may help identify children who are eligible but not enrolled in MHCP and what heretofore unidentified barriers to successful enrollment they may face.
- Continue to explore and use new Web technologies to share health care program information with families.

CONCLUSIONS AND RECOMMENDATIONS

DHS, MDE and individual schools and school districts have worked together for many years to improve access to public health care coverage for students enrolled in the public education system. Specific projects have met with varying levels of success. Future efforts should build on key lessons taken from these endeavors.

- The educational system, at all levels, recognizes that good health care and health screening are essential components of ensuring students' ability to learn. At the same time, school staff is already stretched thin providing basic education services, as well as dealing with other social factors like nutrition, student mobility, degree of parental involvement and language and cultural barriers. Schools simply do not have resources to devote exclusively to helping families enroll their children in health care programs, public or private. However, they may be able to reach more children by partnering with other organizations such as MNCAAs.

- Minnesota is a large, geographically and increasingly ethnically diverse state comprising multiple school districts of varying sizes. Successful approaches used in one district may prove less effective in others. Past experience has shown that approaches based on developing local partnerships and efforts targeted to the needs of a given area have a higher potential of successfully enrolling children in MHCP than do those that depend on a statewide, one-size-fits-all strategy.

- Previous projects based largely on data-sharing, particularly the ELE pilot, have highlighted the barriers imposed by the complex labyrinth of state and federal laws governing what data can be shared. This issue is further complicated by the differing interpretations of existing law among state agencies. Unless and until these differences can be resolved, scarce resources are better targeted toward cooperative outreach efforts that do not rely heavily on sharing individual student data.

Recommendations

The Minnesota Legislature could consider the following actions to further enhance joint efforts between DHS and MDE to enroll eligible children in MHCP.

- **Continue to support efforts to engage community organizations.** Early results of these efforts, specifically in the MNCAA program, show promising results in

successfully enrolling eligible people in MHCP. Encouraging cooperation between individual schools and school districts and locally-based organizations such as the MNCAAs, would relieve schools of the burden of assigning staff exclusively to assisting families with health care enrollment while taking advantage of existing community resources. This involvement will be crucial to both the success of the pilot enrollment project and to continuing cooperative endeavors between MHCP and schools.

- **Establish a cross-departmental team to review existing data-sharing laws and recommend statutory changes to enable effective targeted data sharing.** Without such an effort, legislative directives to share data among agencies with the goal of simplifying enrollment of children in MCHP are likely to meet limited success.

- **Continue to fund the use of expanded technology,** especially online applications and other Web-based applications that can be easily accessed at school settings.

- **Recognize existing differences in eligibility requirements between school-based programs and MHCP.** Many, but not all, children participating in programs like Head Start and the School Lunch Program may be eligible for coverage through MHCP but are not actually enrolled. Additional resources may be needed to undertake a thorough analysis of who these children are and how to alleviate any barriers to enrollment these children and their families may face.

DHS and MDE staff look forward to continuing cooperation with the Legislature and children's advocacy groups to improve access to health care for Minnesota's children.

Online Health Care Application Development Timeline

November 25, 2009- Scope Statement completed and circulated to county partners

January 10, 2010- Statement of Work published for external bidding by vendors

February 15, 2010- Vendor comes on board

February 28, 2010- Initial requirements gathering and design documents completed

March 1, 2010- Vendor begins building of online application

April 1, 2010- Testing of online application begins for usability, accessibility and correctness.

April 15, 2010- County user testing begins

May 1, 2010- All changes from testing are made and final testing begins.

May 15, 2010- Online Application is rolled out to a small group for testing with live cases

June 15, 2010- Online Application goes live statewide

Enrollment and Schools Project:
Implementation plan

Tasks:	Steps:
Promotional materials are identified and distributed	1) Inventory all available materials. 2) Review materials for potential effectiveness /use 3) Identify: Who - target audience What - best material(s) How - to distribute When - to distribute 4) Create new materials if necessary 5) Coordinate effort with MDE. 6) Establish a systematic process for distribution.
Web Links are posted	1) What materials will be linked 2) Identify target audience. 3) Finalize host sites. 4) Coordinate the posting of links with host sites. 5) Explore other technological options (social networking sites, etc.).
School District partner is established	1) Identify potential sources of uninsured data. 2) Gather and report the data. 3) Explore district's willingness / feasibility to partner through solicitation letter to administrators, principals, social workers, nurses.
MCHP Training is provided to School(s) / Districts	1) Identify target audience. 2) Determine content of training materials. 3) Explore existing curriculum to determine if new curriculum is necessary. 4) Create new curriculum if needed. 5) Facilitate training.
MNCAA Certification is provided to School / District staff	1) Gauge interest of school / district in certifying individual staff via Letter of Interest. If no interest, this task is complete, move on to next task. If interested, move forward with additional steps. 2) Determine level of certification - school versus district, etc. 3) Finalize MNCAA contract between school / district and DHS. 4) Provide MNCAA training.

MNCAA Partner is identified	(Necessary if school / district does not certify as MNCAA.) 1) Determine MNCAA saturation of area. 2) Recruit new partner if necessary. 3) Determine MNCAA's interest in partnering via Letter of Interest. 4) Provide training as needed.
Pilot Project implementation with school district, DHS and MNCAA organization is explored	In coordination with MDE, MNCAA organization and school district(s): 1) Establish timeline for the pilot. 2) Determine length of pilot. 3) Define each partner's role in relationship. 4) Identify target activities for MNCAA involvement. 5) Formalize partnership between DHS, MNCAA, MDE and School / District. (If necessary via Memorandum of Agreement or similar document.) 6) Create an evaluation plan. 7) Determine if / what technical assistance may be needed. 8) Additional training / support and resources for success are identified.
Determine potential for workstation	In coordination with school/district(s): 1) Determine operational hours, availability, etc. 2) Evaluate potential cost (computer, printer, supplies). 3) Create maintenance plan. 4) Determine requirements for optimal functioning: Resources Equipment Staffing 5) Identify limits of use and security parameters needed. 6) Identify cost solutions.
Additional opportunities for collaboration are identified	1) Identify additional opportunities for collaboration in coordination with school/district(s), MDE and MNCAA partner. Examples: Enrollment during Early Childhood Screening Partnerships with Head Start Diverse materials

Targeted Outreach process is established through a data share process	1) Inventory what information is collected by the schools / district. 2) Document the specific data that is unable to be shared due to federal / state restrictions. 3) Explore a "work-around" for the pilot of data is unattainable or is not viable. 4) Identify potential means to contact targeted students / families. 5) Implement a data sharing agreement if viable data may be used.
Evaluation Plan	1) Review planned activities and resources 2) Identify Measures of Success 3) Establish methods for data collection 4) Gather and analyze results 5) Produce final report of first year activities to include measures of success, barriers, etc. and provide recommendations for future activities and project growth